NATIONAL QUALITY FORUM

Web Meeting Agenda

Measure Applications Partnership (MAP)

Joint Meeting of the Medicaid Adult and Child Task Forces

Friday, April 1, 2016

1:00-3:00 pm ET

Participant Instructions:

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

Meeting Objectives:

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

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

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

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

Ann Hammersmith, General Counsel, NQF

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

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

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

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

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

Shaconna Gorham, Senior Project Manager, NQF
Foster Gesten

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

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

Severa Chavez, Project Analyst, NQF
Harold Pincus

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

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

Debjani Mukherjee, Senior Director, NQF
Harold Pincus

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

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

2:55 pm **Next Steps**

Shaconna Gorham

3:00 pm **Adjourn**

NATIONAL QUALITY FORUM

Final Roster

MAP Medicaid Child Task Force

TASK FORCE CHAIR

Foster Gesten, MD, FACP

National Association of Medical Directors
Albany, NY

Foster Gesten is the Medical Director for the Office of Quality & Patient Safety in the New York State Department of Health. Dr. Gesten provides clinical direction and leadership for a team of professionals engaged in quality oversight, performance measurement and clinical improvement within health plans and public insurance programs in New York. Major initiatives include the development of statewide public reporting systems for commercial, Medicaid, and Child Health managed care programs on quality, access, and satisfaction, medical home demonstrations, provider based quality measurement and improvement, and patient safety. His interests include population health, health service research, and quality improvement projects directed at prevention services and chronic care. Dr. Gesten is a member of the Committee on Performance Measurement (CPM) at the National Committee for Quality Assurance (NCQA), and a member of the Measure Application Partnership Coordinating Committee of the National Quality Forum (NQF). Dr. Gesten was trained in general internal medicine at Brown University.

TASK FORCE MEMBERS

Terry Adirim, MD, MPH, FAAP

Professor of Pediatrics and Emergency Medicine, Drexel University College of Medicine
Philadelphia, PA

Terry Adirim is Professor of Pediatrics and Emergency Medicine at Drexel University College of Medicine and an attending physician in Emergency Medicine at the St. Christopher's Hospital for Children in Philadelphia, Pennsylvania. Her academic work includes the study of health services and healthcare systems. She is a member of the executive committee and Chair of Policy and Advocacy for the American Academy of Pediatrics Council on Quality Improvement and Patient Safety. Previously, she worked for the U.S. Department of Health and Human Services where she worked on national initiatives and programs on quality, health information technology, health disparities, and child health.

Kathryn Beattie, MD

Executive Medical Director and Administrator, St. Luke's Children's Hospital
Boise, ID

Kathryn Beattie is the Executive Medical Director and Administrator of St. Luke's Children's Hospital in Boise, Idaho. After earning her Medical Doctorate at the University of North Carolina at Chapel Hill and completing an internship and residency in pediatrics at University of Medicine and Dentistry of New Jersey — Robert Wood Johnson Medical School, she began her career as a board-certified pediatrician with Princeton Nassau Pediatrics in Princeton, NJ. She concurrently

obtained an MBA from Columbia University, and was subsequently managing partner for her group prior to transitioning to hospital administration in 2005. She was the Senior Vice President of Medical Affairs for St. Charles Medical Center in Bend, OR from 2005 to 2007 and then SVP and Chief Medical Officer for UW Medicine - Valley Medical Center in Renton, WA from 2007 until 2015. She has served on the Washington State Hospital Association Public Policy Committee; the Board of Directors for First Choice Health Partners, the largest independent PPO network in the pacific northwest; the American Heart Association – Puget Sound Board of Directors; PacLab Network Laboratories Board of Directors; and Regional Long Term Acute Care Hospital Board of Directors. Dr. Beattie has extensive experience in healthcare administration including: healthcare quality, patient safety, accountable care, medical staff relationships, hospital operations, clinic and Hospital-outpatient department management, service line development, transitions of care and regulatory/accreditation compliance.

Andrea Benin, MD

Children's Hospital Association
Hartford, CT

Biography is forthcoming.

Susan Lacey, RN, PhD, FAAN

American Nurses Association
Kansas City, MO

Susan R. Lacey is Director of Graduate Studies at William Carey University. She is the immediate past director of American Association of Critical-Care Nurse's Clinical Scene Investigator (CSI) Academy, a national program. Under her leadership, the program significantly improved patient outcomes, such as falls, decubitus ulcers, catheter associated urinary tract infections, and early mobility while having a positive fiscal impact of over $30 million. The Robert Wood Johnson and Northwest Foundations funded the initial CSI Academy conducted in the Greater Kansas City area prior to the adoption by AACN. She was one of 20 nurse leaders selected for the Robert Wood Johnson Executive Nurse Fellowship program for the 2006-2009 cohort. Dr. Lacey serves as the American Nurses Association's representative for the NQF Medicaid special task force for pediatric indicators. Dr. Lacey also served as the lead investigator for the development and testing of the National Database of Nursing Quality Indicators (NDNQI) pediatric indicators, now used by more than 500 hospitals in the U.S. and abroad. She has authored numerous publications and book chapters on pediatric medication safety (Joint Commission), evidence-based practice (AHRQ), leadership, and nursing workforce supply and demand. In 2009, she co-authored the only nursing chapter in *Pediatric Clinics of North America*. Dr. Lacey serves on the editorial boards of three high-impact nursing journals: the *Journal of Nursing Care Quality*, *Journal of Nursing Administration,* and *Nursing Outlook; the highest nursing journal based on impact factor.* In addition, she reviews for several other key journals and has provided commentaries about nursing and healthcare issues for *Modern Healthcare*. Dr. Lacey holds a patent for healthcare decision-support software purchased by a major HIT vendor.

Reed Melton

Executive Director, Blue Cross and Blue Shield Association
Chicago, IL

Reed Melton is the Executive Director, Center for Clinical Practices, Office of Clinical Affairs at the Blue Cross and Blue Shield Association. His responsibilities include working with Blue Cross and Blue Shield Health Plans to improve healthcare quality and values by identifying innovations that can be implemented across the Blue System, including an emphasis on Medicaid, Medicare and Health Exchanges. Prior to joining the Association, Reed's experience included working at the American Hospital Association and international experience as an expatriate. He has an MBA for Kellogg School of Management, Northwestern University and a B.S. from the University of South Carolina.

Margaret A. Murray, MPA

Chief Executive Officer, Association for Community Affiliated Plans
Washington, DC

Margaret A. Murray is the founding CEO of the Association for Community Affiliated Plans (ACAP). She has led the organization since its inception in 2001, steering it through tremendous growth from its origins as an Association of 14 community health center-owned plans to 60 Safety Net Health Plans, covering more than 15 million people through Medicaid, Medicare and Marketplaces. ACAP's mission is to strengthen not-for-profit Safety Net Health Plans in their work to improve the health of lower income and vulnerable populations. Ms. Murray is a national expert on health care policy for people with low incomes and is a frequent speaker on these issues at national conferences and in the media. She has published several articles on the German health care system as a result of an Alexander von Humboldt fellowship in Berlin. Prior to leading ACAP, Ms. Murray was the Medicaid Director for the State of New Jersey and oversaw the expansion of the FamilyCare program to cover all children under 350% of poverty. She was also a senior budget analyst for the U.S. Office of Management and Budget, with responsibility for negotiating the budget neutrality agreements for Medicaid managed care waivers. She has served the Institute of Medicine's Committee on the Public Financing and Delivery of HIV Care, the Maryland Community Health Resources Commission and on the board of a Community Health Center in Southern Maryland.

Cynthia Pellegrini

Senior Vice President, March of Dimes
Washington, DC

Cynthia Pellegrini is Senior Vice President for Public Policy and Government Affairs at the March of Dimes. In this capacity, Ms. Pellegrini oversees all March of Dimes advocacy efforts at the federal level and in all 50 States, the District of Columbia and Puerto Rico. She also guides the organization's research on maternal and child health policy issues. Key March of Dimes policy priorities include access to health care for all women of childbearing age and children; research into prematurity, birth defects, and other aspects of reproductive and child health and development; prevention and health promotion issues, such as tobacco cessation and nutrition; and issues of concern to the operation of not-for-profit organizations. Ms. Pellegrini is a voting member of the CDC's Advisory Committee on Immunization Practices, which determines the

annual child and adult immunization schedules. Prior to joining March of Dimes, Ms. Pellegrini served as Associate Director for Federal Affairs at the American Academy of Pediatrics, where she covered a range of issues including genetics, bioethics, child abuse and neglect, environmental health, nutrition, obesity, and injury and violence. In this capacity, Ms. Pellegrini worked with AAP leadership to develop and execute strategies to advance AAP priorities through both Congress and the Administration. Ms. Pellegrini worked on Capitol Hill for over eleven years.

Robert Riewerts, MD, FAAP

Regional Chief of Pediatrics - Southern California Permanente Medical Group; Clinical Lead for Childhood Total Health – KP Care Management Institute
Baldwin Park, CA

Robert (Bo) Riewerts has been with Southern California Permanente Medical Group (SCPMG) since 1999, when he started work as a pediatrician at Baldwin Park Medical Center. Dr. Riewerts currently serves as the Chief of Pediatrics for Kaiser Permanente Baldwin Park. He is also the Regional Chief of Pediatrics for the Southern California Permanente Medical Group (SCPMG), a position he has held since 2006. Since 2013, he has been the Clinical Lead for Childhood Total Health with the Kaiser Permanente Care Management Institute. His leadership of Pediatrics extends through all of Kaiser Permanente, America's largest not-for-profit health plan. Founded in 1945, it is a nonprofit, group practice that currently serves 10.2 million members in seven states and the District of Columbia. After receiving his undergraduate degree at UC Davis, Dr. Riewerts completed both medical school and pediatric residency training at the Keck School of Medicine (USC). He is board certified in Pediatrics and is a Diplomate of the American Academy of Pediatrics. Dr. Riewerts maintains an active pediatric office practice and is one of six neonatologists providing care in the Neonatal Intensive Care Unit at the Kaiser Permanente Baldwin Park Medical Center.

Carol Sakala, PhD, MSPH

Director of Childbirth Connection Programs at the National Partnership for Women & Families
Washington, DC

Carol Sakala is Director of Childbirth Connection Programs at the National Partnership for Women & Families. She fosters use of performance measurement, innovative payment and delivery systems, consumer engagement, and other most promising levers for accelerating reliable provision of high-value maternity care. She is co-investigator of Childbirth Connection's national Listening to Mothers surveys and lead author of major reports, including Evidence-Based Maternity Care and Maternity Care and Liability. She brings a consumer stakeholder perspective to the National Quality Forum's MAP Coordinating Committee, the Learning and Action Network's Clinical Episodes Payment Work Group and many other advisory bodies.

Fatema Salam, MPH

Director of Strategy & Development, Patient-Centered Primary Care Collaborative
Washington, DC

Fatema Salam currently serves as Director of Strategy and Development for the Patient-Centered Primary Care Collaborative (PCPCC). Ms. Salam has 10 years of experience leading complex, national quality improvement initiatives, with significant experience managing grant funder and funded entity relationships, maximizing consultant and technical expert deliverables, and implementing measurement and reporting systems for key success metrics. Prior to joining the PCPCC, Ms. Salam was part of the Aligning Forces for Quality (AF4Q) initiative and advised

community-wide, multi-stakeholder leadership teams funded by the Robert Wood Johnson Foundation on accelerating achievement of quality of care and outcome goals at the regional level. Before joining AF4Q, she served as a Senior Program Director at the National Quality Forum. In that role, Ms. Salam led national committees on evidence-based health care performance measures, practices and tools for quality improvement and public reporting for a variety of health care topics.

SUBJECT MATTER EXPERTS (VOTING)

Richard Antonelli, MD

Medical Director of Integrated Care, Boston Children's Hospital, Harvard Medical School
Boston, MA

Richard Antonelli is Medical Director of Integrated Care at Boston Children's Hospital and is on the faculty of Harvard Medical School. He has published work defining mechanisms for integration and coordination of care across systems, beginning with Making Care Coordination a Critical Component of the Pediatric Health System, with support from The Commonwealth Fund. He is a member of the NQF Standing Committee on Care Coordination, and is serving his second term as the child health subject matter expert on the Measure Applications Partnership Steering Committee at the NQF. His work informs the design and implementation of care coordination and integration strategies across the US in both adult and pediatric systems.

Luther Clark, MD

Global Director, Office of the Chief Medical Officer, Merck
Rahway, NJ

Luther T. Clark is Global Director, Scientific Medical and Patient Perspective (SMPP) in the Office of the Chief Medical Officer (OCMO) at Merck. In this role, he supports the needs of the CMO by (1) gathering internal and external scientific and medical information to assist with decision-making at the highest levels and (2) collaborating across Merck to help increase the voice of patients, directly and indirectly into decision-making across the enterprise. He is a key member of the team that champions the OCMO's Health Care Equities Strategic Initiative (including promotion of health literacy and research diversity) and chairs the Health Literacy Investigator Initiated Studies Research Committee. Prior to appointment to his current position on December 1, 2014, he was the Global Director for Scientific Affairs (GDSA) for Cardiovascular & Atherosclerosis at Merck. In the GDSA role, Dr. Clark led the development and execution of the Cardiovascular Scientific Leadership Strategy, led the Cardiovascular & Atherosclerosis Global Scientific Affairs Teams (GSATs) and chaired the Merck Investigator Initiated Studies Program (MISP-RC) for Cardiovascular Diseases. Dr. Clark is a Fellow of the American College of Cardiology (FACC) and the American College of Physicians (FACP), a member of the Board of Directors of the Founders Affiliate of the American Heart Association, a member of the National Medical Association and a member of the Association of Black Cardiologists. In October 2014, Dr. Clark was recipient of the Harvard University Alumni Lifetime Achievement Award for Excellence in Medicine.

ORGANIZATIONAL MEMBER (NON-VOTING)

Deidre Gifford, MD, MPH

Director of State Policy and Programs at the National Association of Medicaid Directors.
Washington, DC

Deidre Gifford is the Director of State Policy and Programs at the National Association of Medicaid Directors. She has held numerous leadership positions in healthcare policy, focusing on quality improvement and the reform of the payment and delivery system. From 2012-2015, she served as Medical Director and then as Medicaid Director for the Rhode Island Executive Office of Health and Human Services, with responsibility for the Administration of the state's Medicaid Program. During her tenure she focused on changes in the payment and delivery system to improve the quality of care and enhance the value of Medicaid services, including the development of numerous initiatives in care coordination, information technology, and provider incentives. Dr. Gifford was co-founder and Project Director of Rhode Island's multi-payer Medical Home demonstration from 2005 until 2011 and was Director of Healthcare Policy and Programs for Rhode Island's Medicare Quality Improvement Organization until 2008. She is a graduate of Cornell University Medical College and holds a master's degree in Public Health (Epidemiology) from the UCLA School of Public Health.

FEDERAL GOVERNMENT MEMBERS (NON-VOTING)

David R. Hunt, M.D., FACS

Medical Officer, Health IT Adoption & Patient Safety, Office of the National Coordinator (ONC) for Health IT
Washington, DC

David Hunt joined the Office of the National Coordinator for Health Information Technology in October 2007. He currently serves as the medical director for health IT adoption and patient safety in the Office of Clinical Quality & Safety (OCQS), where he focuses on patient safety, healthcare disparities, and strengthening ONC programs that promote the effective and safe implementation of electronic health records. At ONC, Dr. Hunt merges years as a practicing surgeon and leader in surgical quality and patient safety with hands-on experience at all levels of information technology from programmer to systems analyst and software developer. Prior to joining ONC he served at the Centers for Medicare and Medicaid Services (CMS) from 2002 – 2007 where he led the Surgical Care Improvement Project (SCIP) and the Medicare Patient Safety Monitoring System (MPSMS), two of the largest surgical quality and patient safety programs in the nation. Dr. Hunt was awarded a bachelor's degree in biochemistry from the University of Rochester (NY) and a medical degree from the Howard University College of Medicine. He also completed his residency in surgery at Howard University and became a diplomate of the American Board of Surgery in 1991. Practicing in both private and academic settings, Dr. Hunt served as a Clinical Assistant Professor of Surgery at Howard University, chair of surgical peer review at various hospitals in the Washington metropolitan area, and has been a fellow of the American College of Surgeons since 1993.

Kamila Mistry, PhD, MPH

Senior Advisor, Child Health and Quality Improvement
Director, Research and Evaluation, Office of Extramural Research, Education and Priority Populations, Agency for Healthcare Research and Quality (AHRQ)
Rockville, MD

Kamila Mistry is the Senior Advisor for Child Health and Quality Improvement and the Director of Research and Evaluation, Office of Extramural Research, Education and Priority Populations at the Agency for Healthcare Research & Quality (AHRQ). In these roles, Dr. Mistry leads a number of national initiatives focused on improving quality of care for mothers and children including the Pediatric Quality Measures Program(PQMP). Prior to coming to AHRQ, she served as the Program Director for the Healthy Steps for Young Children National Evaluation at Johns Hopkins which focused examining a pediatric practice model aimed at improving quality of care and child outcomes. Formerly, she has also led a number of child health initiatives at the state and local levels. At the Texas Department of Health, Dr. Mistry led programs targeting maternal and child health, including designing and implementing the CDC Pregnancy Risk Assessment Monitoring System (PRAMS) for the state. Dr. Mistry completed her NRSA post-doctoral fellowship at the Johns Hopkins School of Medicine, Department of General Pediatrics in Family Health Services Research. She received a PhD in Child and Adolescent Health and Development and MPH in Health Policy from the Johns Hopkins Bloomberg School of Public Health. In addition to her role at AHRQ, Dr. Mistry is a Part-Time Assistant Professor at Johns Hopkins School of Medicine, Department of General Pediatrics where she mentors post-doctoral fellows and conducts research.

Gopal Singh, PhD

Health Resources and Services Administration (HRSA)
Washington, DC

Biography is forthcoming.

Measure Applications Partnership

Joint Web Meeting of the Medicaid Adult and Child Task Forces

April 1, 2016

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Meeting Objectives

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

Introductions of Task Force Members and Disclosures of Interest

Medicaid Child Task Force Membership

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

Organizational Members (*Voting*)

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

Medicaid Child Task Force Membership

Subject Matter Experts (*Voting*)

Richard Antonelli, MD
Luther Clark, MD

Organizational Member (*Non-Voting*)

National Association of Medicaid Directors	Deidre Gifford, MD, MPH

Federal Government Members (*Non-voting*)

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

Medicaid Adult Task Force Membership

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

Organizational Members

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

Medicaid Adult Task Force Membership

Subject Matter Experts

Ann Marie Sullivan, MD
Kim Elliott, PhD, CPHQ

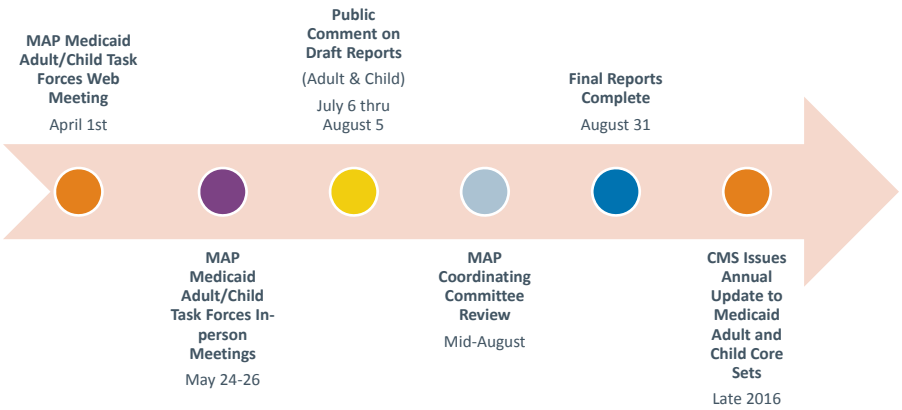
Federal Government Members

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

MAP Medicaid Child and Adult Task Forces Charge

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

2016 Timeline



Overview of the Child and Adult Core Sets

NQF Medicaid MAP Web Meeting

April 2016

Marsha Lillie-Blanton

Center for Medicaid and CHIP Services (CMCS)

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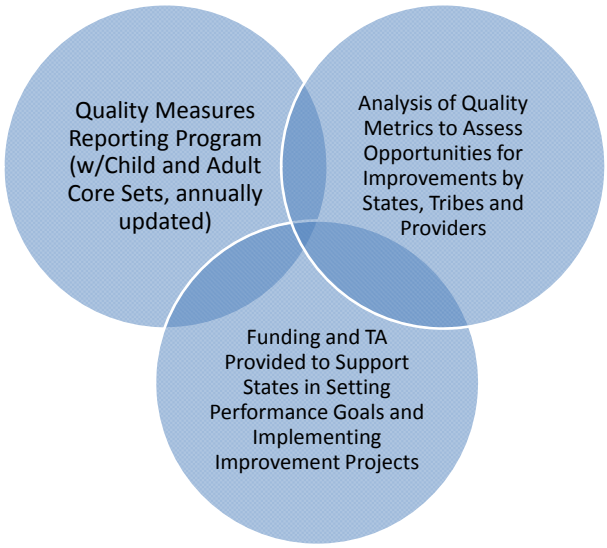
Building a Foundation for Quality Measurement and Improvement in Medicaid and CHIP



CMCS Goals for Measurement and Reporting

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

Child and Adult Core Set: In Different Stages of Maturity

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

Reporting of Core Set Measures

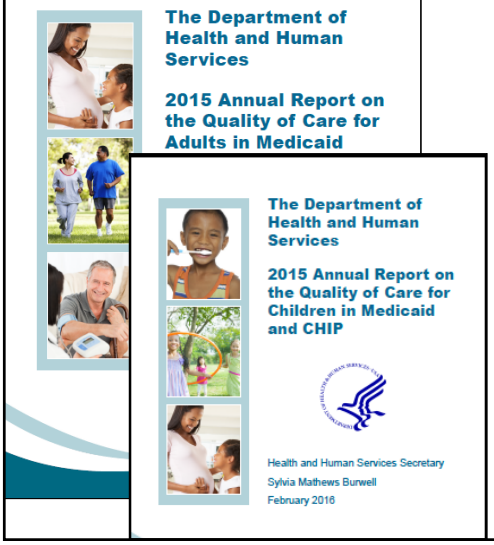
- Voluntary reporting of measures occurs at state-level
  - CMS launched two-year grant program December 2012 to support Medicaid agencies in testing the collection and reporting of the Adult Core Set
  - States currently submit Child and Adult Core set data to CMCS through MACPro
- Technical Assistance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

Strengthening the Core Sets

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

Progress Made in Measuring and Reporting on Access and Quality

2015 Annual Secretary's Reports



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

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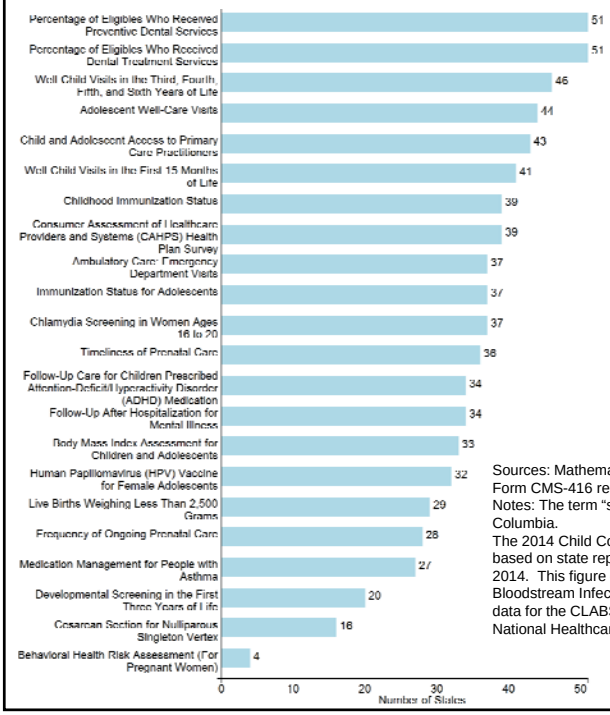

Number of States Reporting the Child Core Set Measures, FFY 2014

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

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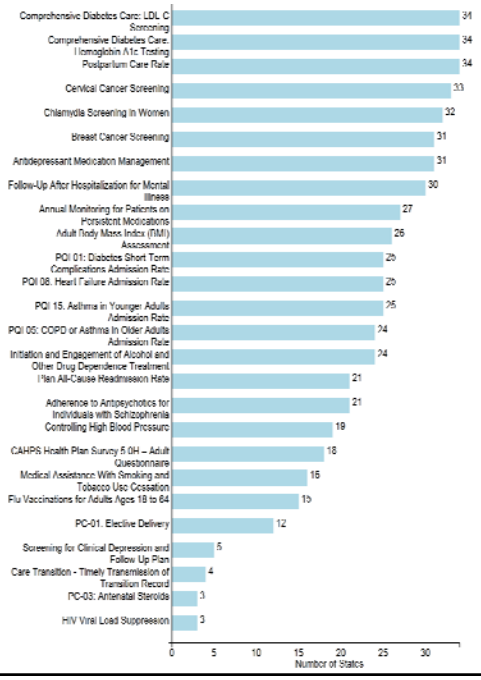

Number of States Reporting the Adult Core Set Measures, FFY 2014

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

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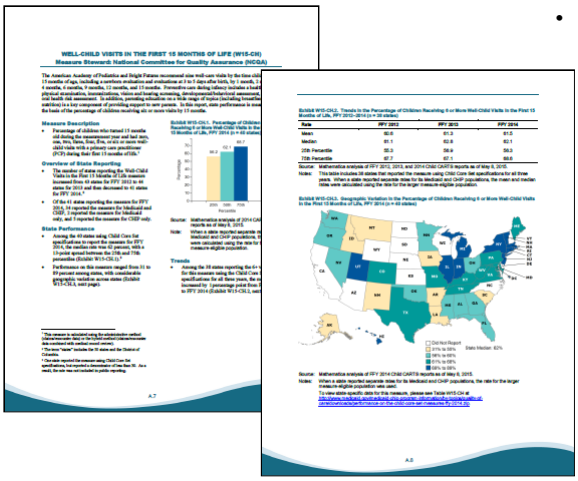
2015 Annual Secretary's Report: Domain-Specific Reports



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

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

- Includes information from EQRs of MCOs

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

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2016 NQF Child & Adult MAPs

Input Requested from MAP

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

After MAP Feedback

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

Questions?

Child Core Set: Prior Recommendations and Updated 2016 Measure Set

Medicaid and the Child Core Set

Background

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

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

Medicaid and the Child Core Set, Continued

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

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

MAP 2015 Assessment of the Child Core Set

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

Medicaid Child Core Set Measures for FFY 2016 Use

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

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

Medicaid Child Core Set Measures for FFY 2016 Use - Continued

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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

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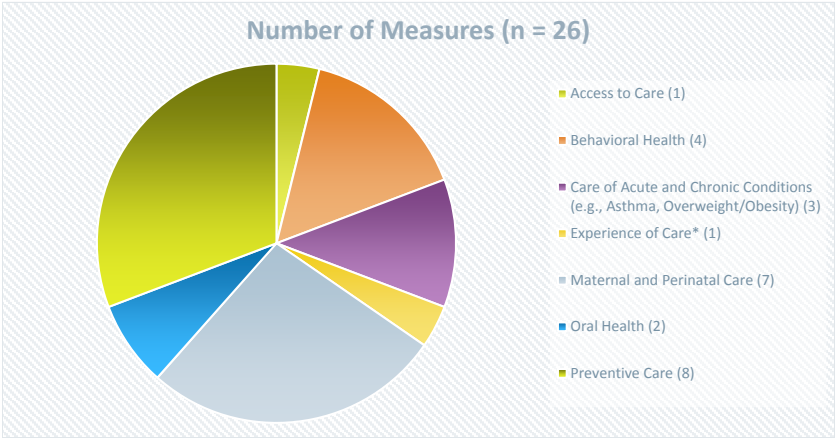
Medicaid Child Core Set Properties: Conditions



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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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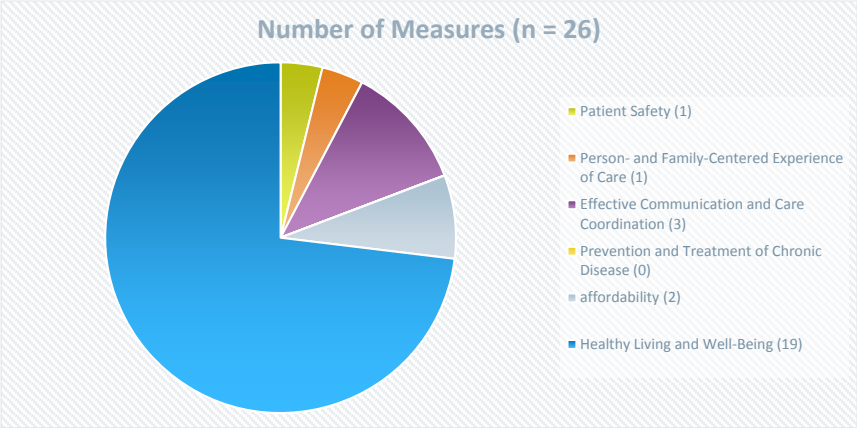
Medicaid Child Core Set Properties: NQS



Medicaid Child Core Set Properties: Measure Characteristics

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

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

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

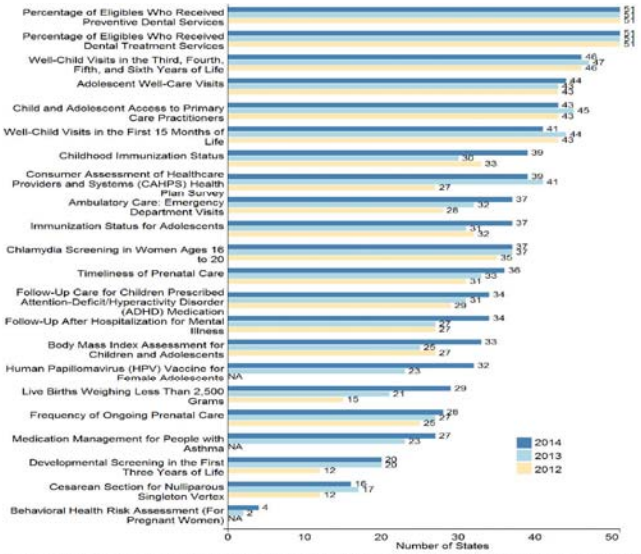
All states voluntarily reported two or more of the Child Core Set measures

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

Overview of Medicaid Child Core Set FFY 2014 Reporting

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

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



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

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

High-Priority Gaps in Child Core Set

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

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

High-Priority Gaps in Child Core Set - Continued

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

Task Force Measure-Specific Recommendations

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

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

CMS - Child Core Set Update for 2016 Reporting

Issued December 30, 2015

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

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

Strategic Issues for State-Level Medicaid Reporting

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

Child Task Force Discussion and Questions

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

Adult Core Set: Prior Recommendations and Updated 2016 Measure Set

Medicaid Adult Population Background

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

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

Additional information

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

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

Medicaid Adult Core Set

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

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

MAP 2015 Assessment of the Adult Core Set

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

Medicaid Adult Core Set Measures for FFY 2016 Use

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

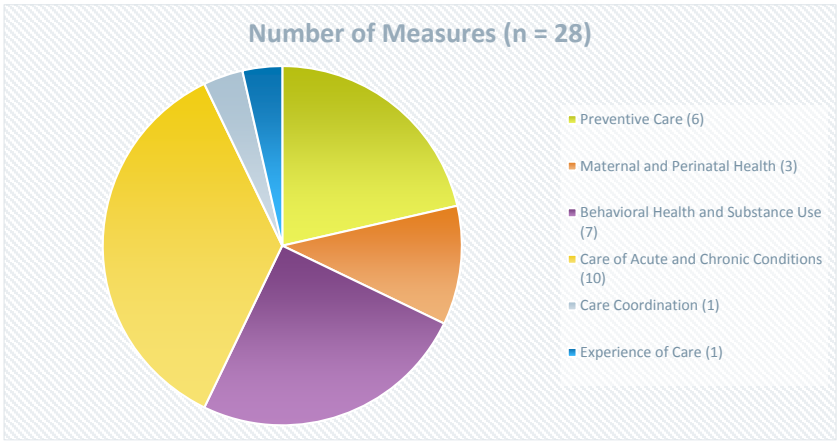
* This measure was added to the 2015 Adult Core Set.

Medicaid Adult Core Set Measures for FFY 2016 Use - Continued

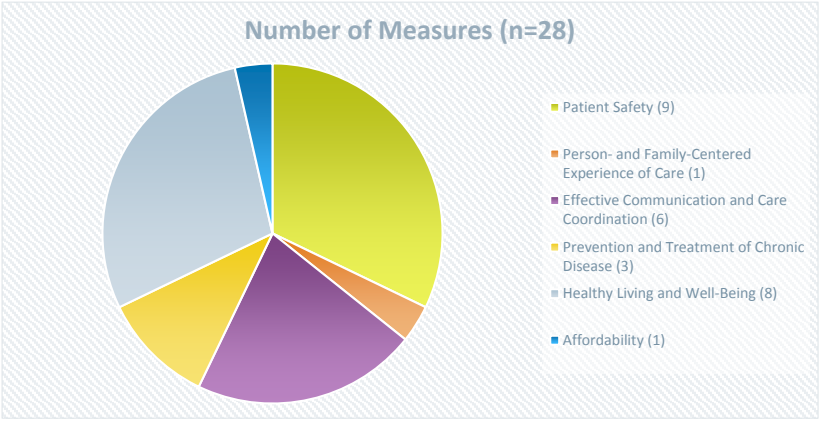
NQF #	Measure Name	Measure Steward
0418	Screening for Clinical Depression and Follow-Up Plan	CMS
0469	PC–01: Elective Delivery	Joint Commission
0476	PC–03 Antenatal Steroids	Joint Commission
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0648	Care Transition—Transition Record Transmitted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

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

Medicaid Adult Core Set Properties: Conditions



Medicaid Adult Core Set Properties: NQS



Medicaid Adult Core Set Properties: Measure Characteristics

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

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

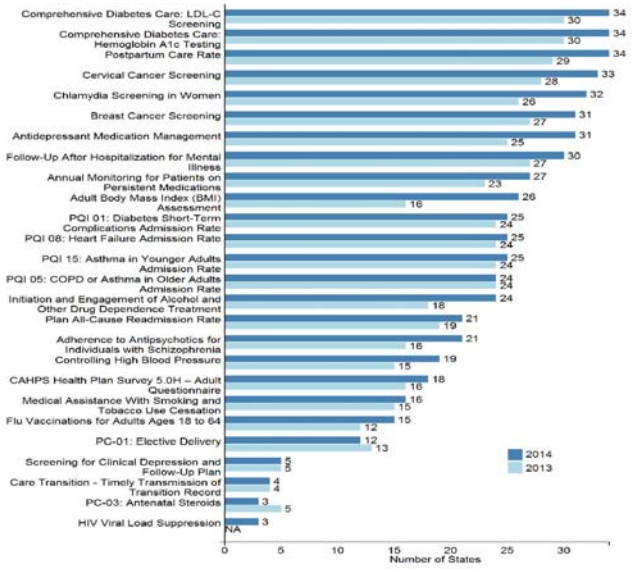
Overview of Medicaid Adult Core Set FFY 2014 Reporting

Adult Core Set participation is strong, with room for improvement

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

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

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



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

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

MAP's 2015 Recommendations to Address High Priority Gaps

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

MAP's 2015 Recommendations to Address High Priority Gaps

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

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

Task Force Measure- Specific Recommendations

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

Measures for Phased Addition: Prioritized Additions to Fill Gaps

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

CMS– Adult Core Set Update for 2016 Reporting

Issued December 11, 2015

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

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

Strategic Issues for State-Level Medicaid Reporting

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

Adult Task Force Discussion and Questions

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

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

May In-Person Meeting Objectives

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

Institute of Medicine's (IOM) Vital Signs

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

SWOT Analysis Results: Adult Core Set

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

SWOT Analysis Results: Child Core Set

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

Resonant Themes

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

Task Force Policy Issues for Consideration

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

Definition of Alignment from Coordinating Committee

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

Technical Definition of Alignment

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

  Note: Alignment is not synonymous to harmonization.

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

Task Force Homework Assignment-Policy Issues

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

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

Task Force Homework Assignment-Policy Issues

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

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

Planned Sources of Information

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

Planned Sources of Information

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

Additional Information Sources

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

Discussion

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

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

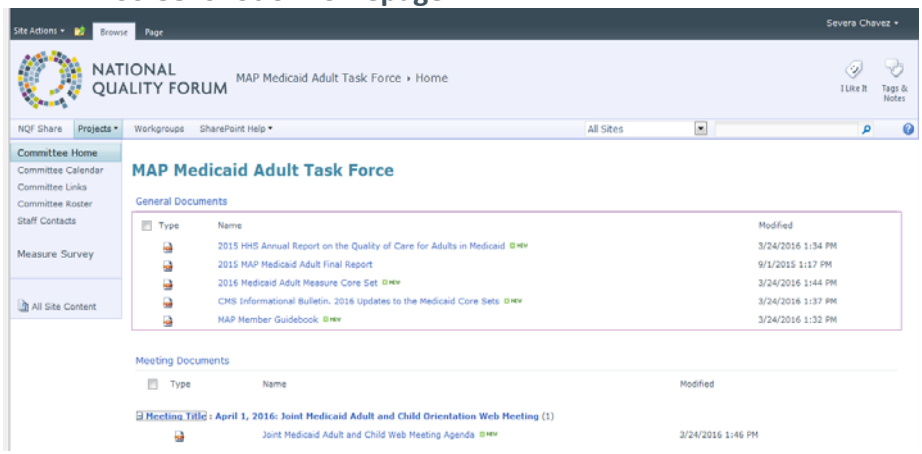
SharePoint Overview

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

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

SharePoint Overview

- **Screenshot of homepage**



SharePoint Overview

Please keep in mind:

- + and – signs :

MAP Medicaid Adult Task Force

General Documents

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

Meeting Documents

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

Opportunity for Public Comment

Next Steps

Structure of May Task Force Deliberations

May 24

Adult TF Only

- Adult Core Set Measures

May 25

Joint Attendance

- Shared Strategic Issues
- State feedback

May 26

Child TF Only

- Adult Core Set Measures

Important Dates

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

Project Contact Info

- Email
  - Adult Task Force: mapmedicaidadult@qualityforum.org
  - Child Task Force: mapmedicaidchild@qualityforum.org
- NQF Phone: 202-783-1300
- Project page: http://www.qualityforum.org/MAP_Task_Forces.aspx
- SharePoint site
  - Adult Task Force: http://share.qualityforum.org/Projects/MAP%20Medicaid%20Adult%20Task%20Force/SitePages/Home.aspx
  - Child Task Force: http://share.qualityforum.org/Projects/MAP%20Medicaid%20Child%20Task%20Force/SitePages/Home.aspx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Measure Applications Partnership
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87

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

CMCS Informational Bulletin

DATE: December 11, 2015

FROM: Vikki Wachino
Director
Center for Medicaid and CHIP Services

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

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

Background

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

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

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

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

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

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

2016 Child Core Set

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

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

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

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

2016 Adult Core Set

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

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

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

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

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

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

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

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

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

Next Steps

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

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

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

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

[9] Measure steward: NCQA, NQF #1932

2016 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name
Access to Care		
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP)
Preventive Care		
0033	NCQA	Chlamydia Screening in Women (CHL)
0038	NCQA	Childhood Immunization Status (CIS)
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15)
1407	NCQA	Immunizations for Adolescents (IMA)
1448	OHSU	Developmental Screening in the First Three Years of Life (DEV)
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV)
NA	NCQA	Adolescent Well-Care Visit (AWC)
Maternal and Perinatal Health		
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)
0471	TJC	PC-02: Cesarean Section (PC02)
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW)
1391	NCQA	Frequency of Ongoing Prenatal Care (FPC)
1517	NCQA	Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)
1360	CDC	Audiological Evaluation No Later Than 3 Months of Age (AUD)*
NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)
Behavioral Health		
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)
1365	AMA-PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)
NA	AHRQ-CMS CHIPRA NCINQ	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*
Care of Acute and Chronic Conditions		
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)
1799	NCQA	Medication Management for People with Asthma (MMA)
NA	NCQA	Ambulatory Care – Emergency Department (ED) Visits (AMB)
Oral Health		
2508	DQA (ADA)	Prevention: Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL)
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT)
Experience of Care[a]		
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)

[a] The Centers for Medicare & Medicaid Services will pilot a reporting process for the Child Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (NQF # 2548) to determine whether to include the HCAHPS measure in a future Child Core Set.

* This measure was added to the 2016 Child Core Set.

AHRQ = Agency for Healthcare Research and Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CDC = Centers for Disease Control and Prevention; CHIPRA = Children's Health Insurance Program Reauthorization Act; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCINQ = National Collaborative for Innovation in Quality Measurement; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University.

The Department of Health and Human Services

2015 Annual Report on the Quality of Care for Children in Medicaid and CHIP

Health and Human Services Secretary

Sylvia Mathews Burwell

February 2016

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CONTENTS

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FIGURES

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EXECUTIVE SUMMARY

Together, Medicaid and the Children's Health Insurance Program (CHIP) served more than 43 million children in federal fiscal year (FFY) 2014, representing more than 1 in 3 children in the United States.[1,2,3] Medicaid and CHIP play a key role in ensuring that low-income children get health care coverage, access to a comprehensive set of benefits, and other medically necessary services. This report, required by Section 1139A(c)(2) of the Social Security Act (the Act), as added by section 401(a) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), summarizes state-specific information on the quality of health care furnished to children covered by Medicaid and CHIP.

The Department of Health and Human Services (HHS) is working closely with states, health care providers, and program enrollees to ensure a high quality system of care for children in Medicaid/CHIP. As the HHS agency responsible for ensuring effective health care coverage for Medicare, Medicaid, and CHIP beneficiaries, the Centers for Medicare & Medicaid Services (CMS) plays a key role in promoting quality health care for children in Medicaid/CHIP. CMS's quality agenda is closely aligned with that of the HHS National Quality Strategy's three aims of achieving better care, a healthier population and community, and more affordable care.[4]

Over the past five years, CMS and states have continued to break new ground with reporting on CMS's core set of children's health care quality measures (referred to as the Child Core Set).[5] This report presents findings on the Child Core Set and summarizes information on managed care quality measurement and improvement efforts as reported in the external quality review (EQR) technical reports.[6] The 2014 Child Core Set includes a range of 23 children's quality measures encompassing physical, behavioral, and oral health.[7]

Data Limitations

The legislation that created the child health care quality measurement program established it as a voluntary reporting program, at the discretion of state Medicaid/CHIP agencies to participate.

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[1] In this report, "children" are defined as individuals age 21 and younger. The technical specifications for each measure specify the age of children to be included in each measure.

[2] http://medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.

[3] U.S. Census Bureau. "Health Insurance Coverage Status and Type by Selected Characteristics for Children Under 18 (All Children): 2013." Table HI08, available at http://www.census.gov/hhes/www/cpstables/032014/health/hi08.xls.

[4] More information on the HHS National Quality Strategy is available at http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2014annlrpt.pdf.

[5] The 2014 Child Core Set is described in a Bulletin, available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

[6] Previous Secretary's Reports are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

[7] For a list of the 2014 Child Core Set measures, see Supplemental Table CH-1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

While 50 states[8] voluntarily reported at least one Child Core Set measure for FFY 2014, only 19 of the measures were reported by 25 or more states, limiting the ability to use the data to make national observations about the quality of care provided to children in Medicaid and CHIP. Additionally, states may not always adhere to the measure technical specifications when reporting, and may differ in the populations included in the measures (i.e., Medicaid versus CHIP), often making it difficult to compare results from state to state. The extent to which reported data have been validated is also unknown in all states, though CMS is seeking to more consistently obtain this information from states with future reporting.

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

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

Quality Measurement Using the Child Core Set

- CMS has made substantial efforts to streamline reporting of Child Core Set data, reduce the burden on states, and improve consistency of the data. For FFY 2014, data on the Child Core Set measures were obtained through three sources: (1) the CMS CHIP Annual Reporting Template System (CARTS) web-based data submission tool, (2) Form CMS-416, and (3) the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN).
- Forty-one states voluntarily reported at least 11 of the 22 Child Core Set measures to CMS for FFY 2014, and 51 states reported at least one of the measures (see Figure 1 and Table 1).[9] The median number of measures reported by states for FFY 2014 remained consistent with reporting for FFY 2013 (16 measures for each year), increasing from a median of 14 measures reported for FFY 2012. Two states, Georgia and South Carolina, reported all 22 Child Core Set measures for FFY 2014.
- The completeness of Child Core Set data reported by states improved for FFY 2014. More states reported measures for both Medicaid and CHIP enrollees (increasing from 38 states for FFY 2012 to 41 states for FFY 2013 and 44 states for FFY 2014).

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

[9] The 2014 Child Core Set includes 23 measures. The base of 22 measures excludes the Central Line-Associated Blood Stream Infections (CLABSI) measure, which was obtained from the CDC's NHSN beginning in FFY 2012.

- The measures most frequently reported by states assess children's access to primary care, percentage with well-child visits, use of dental services, receipt of childhood immunizations, and satisfaction with care received (see Figure 2). This is the first year of public reporting of four measures: Human Papillomavirus (HPV) Vaccine for Female Adolescents, Low Birth Weight (LBW), Asthma Medication Management, and Emergency Department (ED) Visits. These measures were reported by 32, 29, 27, and 37 states, respectively.
- As in the previous years' reports, CMS conducted detailed analysis of state performance on Child Core Set measures (including percentiles, trends, and geographic variation) reported by at least 25 states. The number of measures analyzed increased from 16 measures for FFY 2013 to 19 measures for FFY 2014. This information is presented in five domain-specific reports: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, (4) behavioral health care, and (5) dental and oral health services.[10] The domain-specific reports include state-specific findings (including percentiles, means, medians, trends, and geographic variation) on the frequently reported measures, reflecting a continuum of quality measures for children and pregnant women.

State Performance on the Child Core Set

1. Primary Care Access and Preventive Care

- In FFY 2014, as in FFY 2013, states continued to report relatively high rates (i.e., at or above 85 percent) of children's access to primary care. The vast majority of children, across all states, had at least one visit to a primary care practitioner (PCP) during the reporting period, with the median rate ranging from a high of 96 percent among children ages 12 to 24 months to 89 to 91 percent for the other age groups (see Table 2).
- Despite high rates of overall primary care access, the proportion of children with a well-child visit remained below the recommended guidelines,[11] ranging from a median of 44 percent for adolescents ages 12 to 21 to a median of 67 percent for children ages 3 to 6 (see Table 2).
- The content of a well-child visit can be indicated by several Child Core Set measures (see Table 2):
    - The median childhood immunization rate for children turning age 2 and the median adolescent immunization rate among 13-year-olds were both 67 percent (35 states reporting).
    - A median of 18 percent of female adolescents had received three doses of the HPV vaccine by their 13th birthday (32 states reporting).
    - The median Chlamydia screening rate among sexually active women between the ages of 16 and 20 was 48 percent (37 states reporting).

[10] The domain-specific reports are available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip. In last year's annual report, this information was presented in an appendix to the main body of the report.

[11] The American Academy of Pediatrics and Bright Futures recommend nine well-child visits in the first 15 months of life and annual well-child visits for children ages 3 and older.

- A median of 43 percent of children ages 3 to 17 with a primary care visit during the year had their body mass index (BMI) percentile documented in the medical record (33 states reporting).

2. Perinatal Health

- The health of a child is affected by a mother's health and the care she receives during pregnancy, as well as the care of the child after birth. In FFY 2014, data on four maternity and infant care measures in the Child Core Set indicate (see Table 2):
  - The vast majority of pregnant women had a prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid/CHIP (the median rate among 34 states was 81 percent).
  - Two-thirds of women received at least 80 percent of the expected number of visits during their pregnancy (based on when they enrolled in Medicaid/CHIP and when they delivered) (the median rate among 27 states was 66 percent).
  - The median percentage of live births paid for by Medicaid or CHIP weighing less than 2,500 grams (5 pounds, 8 ounces) at birth was 9 percent (29 states reporting).
  - Among the 41 states with state-level rates for Central Line-Associated Blood Stream Infections (CLABSIs) in Neonatal Intensive Care Units (NICUs), 33 had a significant decrease in CLABSI infections in calendar year (CY) 2013 since the 2006–2008 baseline period, and 8 had no change in infections since the baseline period. No states had a significant increase in infections.[12]

3. Care of Acute and Chronic Conditions

- The care of acute and chronic conditions among children enrolled in Medicaid and CHIP can be indicated by two Child Core Set measures (see Table 2):
  - Among children ages 5 to 20 with persistent asthma, the median percentage who remained on an asthma controller medication for at least 75 percent of their treatment period was 31 percent (25 states reporting).
  - Among children ages 1 to 19, the median rate for ED visits was 46 visits per 1,000 enrollee months (37 states reporting).[13]

[12] This measure is obtained from data reported by hospitals to the CDC's NHSN. It includes all neonatal CLABSI incidents not just those for infants covered by Medicaid/CHIP. The statistic reported indicates whether the rate of infections increased, decreased, or did not change significantly relative to the baseline U.S. experience (calculated using data for 2006–2008). For further information on the methods used to assess state performance, see http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf.

[13] Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year.

4. Behavioral Health Care

- Two measures of care for children with a diagnosis of a behavioral health problem were available for analysis for FFY 2014 (see Table 2):
  - The median rate of a 30-day follow-up visit after hospitalization for mental illness among children ages 6 to 20 was 65 percent, while the median rate of a follow-up visit within 7 days of discharge was 44 percent (34 states reporting).
  - A median of 44 percent of children newly prescribed medication for attention-deficit/ hyperactivity disorder (ADHD) had a follow-up visit during the first 30 days (known as the Initiation Phase) (34 states reporting), and of the children with a visit during the Initiation Phase, a median of 57 percent had two visits during the next nine months (known as the Continuation and Maintenance [C&M] phase) (31 states reporting).

5. Dental and Oral Health Services

- Children's access to dental services in FFY 2014 was similar to patterns observed in previous years (see Table 2):
  - A median of 48 percent of children ages 1 to 20 received at least one preventive dental service (such as application of topical fluoride or dental sealants) in FFY 2014 (51 states reporting).
  - A median of 22 percent of children ages 1 to 20 received at least one dental treatment service (such as dental fillings) in FFY 2014 (51 states reporting).

Managed Care External Quality Review Findings

1. Overview: External Quality Review (EQR) Technical Reports

- Of the 41 states[14] that currently contract with managed care plans to deliver services to Medicaid and CHIP enrollees, 38 submitted EQR technical reports to CMS for the 2014–2015 reporting cycle.[15] The most frequently reported children's performance measures included in the EQR technical reports are the same as or similar to those most frequently reported in the Child Core Set (see Figure 4).

2. Performance Improvement Projects

- Through their managed care entities, states are engaged in various types of improvement projects specific to children. Behavioral health care was the most common performance improvement project (PIP) topic among states for the 2014–2015 reporting cycle (22 states and 161 PIPs).

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

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

- Among the 28 states that submitted EQR technical reports during the current and previous two reporting cycles, PIP topics demonstrated a few notable shifts (see Figure 5). The number of states conducting improvement projects focused on ADHD or other behavioral health topics, ED visits, hospital readmissions, oral health, well-child care, asthma, and primary care access all increased in the 2014–2015 reporting cycle compared to the number of states reporting these projects in previous years. In addition, while the total number of *states* conducting improvement projects related to immunizations and lead screening declined from the 2012–2013reporting cycle, there was an increase in the total number of improvement *projects* in these categories for the 2014–2015 reporting cycle.
- PIP topics, target populations, and interventions and activities were generally specific to the managed care entities in a state, but 18 states mandated improvement projects on priority health care topics. For example, Georgia and Missouri required all MCOs to implement improvement projects related to dental care for children, while the District of Columbia, Florida, Georgia, Illinois, and New Hampshire required MCOs to implement improvement projects related to prenatal and postpartum care.
- CMS conducted detailed abstractions of EQR technical reporting on PIPs in four topic areas: (1) childhood obesity, (2) oral health, (3) prenatal and postpartum care, and (4) adolescent well care. Analysis of the PIPs indicates that states are using a diverse set of interventions to improve quality of care. A summary of these findings is available in the domain-specific reports referenced earlier.

Summary and Conclusion

This report shows the continued progress made by HHS and states in building a national, cross-state quality measurement and reporting system for children's health care in Medicaid and CHIP. CMS conducted detailed analysis of state performance on Child Core Set measures reported by at least 25 states. The increase in the number of measures reported by states allowed CMS to analyze 19 measures for FFY 2014, up from 16 measures for FFY 2013. The evolving quality measurement field offers data on performance as a new tool for states to use in driving improvements in care.[16] Through managed care entities that now are the main delivery system for children and their parents, states are engaged in various types of improvement projects specific to children. States had relatively high performance on the children's primary care access measure; however, this report highlights the need for improvement in areas such as the use of preventive services by young children and adolescents, dental and oral health care, coordination of care for children with behavioral health needs, and care of acute and chronic conditions. Quality measurement and improvement initiatives underway in the states and at CMS are gaining momentum to accelerate improvements in children's health care and health outcomes in Medicaid and CHIP.

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

I. INTRODUCTION

Over the first five years of state reporting on the core set of children's health care quality measures (referred to as the Child Core Set), the Centers for Medicare & Medicaid Services (CMS) and states have made substantial progress in building the foundation for quality measurement. Working collaboratively with its many partners including states, health care providers, and program enrollees, CMS is now engaged in various efforts to use this information to drive improvements in care for children in Medicaid and the Children's Health Insurance Program (CHIP).

Together, Medicaid and CHIP served more than 43 million children in FFY 2014, representing more than 1 in 3 children in the United States.[17,18] Children's enrollment increased nearly 2 percent between FFY 2013 and FFY 2014.[19] These data should be viewed in the context of 2013 data that show that in 23 states at least 90 percent of children eligible for Medicaid and CHIP are enrolled in these programs.[20] In contrast, in 2008, only five states had rates at or above 90 percent.[21] Medicaid and CHIP participation rates have increased as a result of outreach, enrollment simplification, and retention efforts, including regulations and program changes adopted as a result of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). Reductions in the percentage of children without health insurance reflect these gains; the uninsured rate for children under age 18 decreased from 9.8 percent in 2010 to 7.3 percent in 2013.[22] Given that Medicaid and CHIP are key sources of coverage for children, it is important to continue to build a strong foundation for children's health care quality measurement and improvement.

The majority (about 70 percent) of children covered by Medicaid and CHIP obtain care from managed care arrangements, although the rate of enrollment and range of services included in these plans vary across states.[23] For example, some states provide behavioral health and dental services through their managed care plans, while others provide these services using fee-for-service arrangements. Because of the varying arrangements, a diverse set of quality measurement and improvement efforts are under way across payment and service delivery settings.

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[17] http://medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.

[18] http://kff.org/other/state-indicator/children-0-18/.

[19] http://medicaid.gov/chip/downloads/fy-2014-childrens-enrollment-report.pdf.

[20] http://www.insurekidsnow.gov/professionals/reports/index.html.

[21] http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf.

[22] U.S. Census Bureau. "Health Insurance Statistical Tables." Table HIB-3, available at http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html and Table 2. Type of Health Insurance Coverage by Age 2013, available at http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2013/Table2.pdf.

[23] CMS analysis of FY 2014 Statistical Enrollment Data System (SEDS) data.

The objective of this report, as required by CHIPRA,[24] is to summarize state-specific information on the quality of health care furnished to children under Titles XIX (Medicaid) and XXI (CHIP) of the Social Security Act (the Act). Section 1139A(c)(1)(B) of the Act specifically requests information gathered from the external quality reviews (EQRs) of managed care organizations (MCOs)[25] and benchmark plans.[26] The Secretary of the Department of Health and Human Services (HHS) is required to make this information publicly available annually. The 2014 Child Core Set includes 23 children's health care quality measures developed through a multi-stakeholder process, encompassing physical, behavioral, and oral health.[27,28] This year's report provides a snapshot of states' performance on 19 of these measures for which at least 25 states voluntarily provided information to CMS.[29,30]

[24] Section 1139A(c)(2) of the Social Security Act, as added by section 401(a) of CHIPRA.

[25] Established under the authority of Section 1932 of the Social Security Act.

[26] Established under the authority of Sections 1937 and 2103 of the Social Security Act.

[27] For a list of the 2014 Child Core Set measures, see Supplemental Table CH-1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

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

[29] The CAHPS Health Plan Survey measure is not profiled in this report. For more information about state collection of the CAHPS Health Plan survey, see Table CAHPS-CH at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2014.zip.

[30] Previous Secretary's Reports are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

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

A. Data Limitations

The legislation that created the child health care quality measurement program established it as a voluntary reporting program, at the discretion of state Medicaid/CHIP agencies to participate. While 50 states voluntarily reported at least one Child Core Set measure for FFY 2014, only 19 of the measures were reported by 25 or more states, limiting the ability to use the data to make national observations about the quality of care provided to children in Medicaid and CHIP. Additionally, states may not always adhere to the measure technical specifications when reporting, and may differ in the populations included in the measures (i.e., Medicaid versus CHIP), often making it difficult to compare results from state to state. The extent to which reported data have been validated is also unknown in all states, though CMS is seeking to more consistently obtain this information from states with future reporting.

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

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

B. Quality Measurement Using the Core Set of Children's Health Care Quality Measures

For the past five years, CMS and its partner states have continued to break new ground with reporting on CMS's Child Core Set.[31] CMS continues to work with states, through its Quality Measures Technical Assistance and Analytic Support (TA/AS) Program,[32] to achieve the following internal goals for quality measurement and improvement:

[31] For a list of the 2014 Child Core Set measures, see Supplemental Table CH-1 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

[32] The TA/AS Program is led by Mathematica Policy Research in collaboration with National Committee for Quality Assurance (NCQA) and Center for Health Care Strategies (CHCS). More information about the TA/AS Program is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

- Increase the number of states voluntarily reporting on the core measures;
- Maintain or increase the number of measures reported by each state;
- Improve the completeness of the data reported (that is, report on both Medicaid and CHIP enrollees);
- Improve the accuracy and consistency of data reported through an enhanced data quality outreach effort;
- Streamline data collection and reporting processes, to the extent possible;
- Assess states' managed care performance improvement projects (PIPs) related to the core measures; and
- Support states to drive improvements in health care quality using Child Core Set data.

Together, these activities are strengthening the federal-state partnership in quality measurement and improvement in Medicaid and CHIP.

Section 1139A(b)(5) provides that, beginning no later than January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the Initial Child Core Set.[33] Part of the process of collecting, reporting, and using the Child Core Set measures is to establish a way to periodically identify new measures for possible inclusion in future Child Core Sets. This process serves several purposes: (1) build upon the original measure set by addressing gap areas; (2) improve upon existing Child Core Set measures; and (3) better align with national quality measurement activities. The intended result is a Child Core Set that is more robust and better able to support states' and CMS's quality measurement needs.[34] CMS currently partners with the National Quality Forum Measure Applications Partnership to strengthen its Child Core Set.[35,36] In December 2013, CMS issued an Informational Bulletin detailing updates to the 2014 Child Core Set.[37]

In addition to ensuring that the measures are relevant to current health care delivery approaches, reflect updates to clinical guidelines, and incorporate feedback from states, CMS is devoting the resources necessary to continue developing the pediatric measurement field. Through a partnership with the Agency for Healthcare Research and Quality (AHRQ), CMS has spent the past four years working with the seven Centers of Excellence (COEs) that comprise the AHRQ-

[33] The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required HHS to identify and publish a core set of children's health care quality measures for voluntary use by State Medicaid and CHIP programs. In December 2009, the Secretary published an initial core set of 24 measures. More information is available at https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO11001.pdf.

[34] Background on the Initial Core Set can be found in a February 2011 State Health Official letter, available at http://www.cms.gov/smdl/downloads/SHO11001.pdf.

[35] http://www.qualityforum.org/setting_priorities/partnership/measure_applications_partnership.aspx.

[36] CMS issued a January 2013 State Health Official letter outlining updates to the Initial Child Core Set and the multi-stakeholder process used to inform the decision-making process available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf.

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

CMS Pediatric Quality Measures Program (PQMP).[38] Additionally, CMS continues to work with the Office of the National Coordinator for Health Information Technology (ONC) to develop pediatric measures in areas that address gaps in the Child Core Set and that can be collected through an electronic health record (EHR).[39,40]

As with the measures themselves, the data systems and sources used to collect information and monitor progress are also subject to periodic adjustments. In FFY 2012, CMS decided to abstract data from other sources on behalf of states for three Child Core Set measures: (1) preventive dental services, (2) dental treatment services, and (3) central line-associated blood stream infections (CLABSI) in neonatal intensive care units (NICUs).[41] CMS also has continued making progress toward a modernized and streamlined Medicaid and CHIP data infrastructure known as the Medicaid and CHIP Business Information Solutions (MACBIS) initiative. In the future, information collected as part of MACBIS will serve as the primary data source for the Center for Medicaid and CHIP Services' (CMCS's) quality reporting and performance measurement capacities.

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

- Reviewed and analyzed findings on the Child Core Set measures reported to CMS by states for FFY 2014, including analyses of 19 measures reported by at least 25 states;[42]
- Conducted outreach by email and telephone to selected states about the completeness and accuracy of their Child Core Set data;[43]
- Analyzed dental services utilization data submitted by states on Form CMS-416;
- Reviewed and analyzed neonatal CLABSI data submitted to CDC's NHSN;
- Abstracted and summarized information on the quality measures and PIPs reported in the EQR technical reports from states that contract with managed care plans to deliver services to Medicaid and CHIP enrollees (see Chapter III); and
- Prepared detailed analyses of state performance on Child Core Set measures in five domains: (1) primary care access and preventive care, (2) perinatal health, (3) care of acute and chronic conditions, (4) behavioral health care, and (5) dental and oral health services.[44]

[38] http://www.ahrq.gov/policymakers/chipra/factsheets/index.html.

[39] https://healthit.ahrq.gov/health-it-tools-and-resources/childrens-electronic-health-record-ehr-format.

[40] http://www.ahrq.gov/policymakers/chipra/demoeval/childhealth/index.html.

[41] CMS calculates the two dental measures on behalf of states using data reported on Form CMS-416. CMS obtains state-level CLABSI data from the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN).

[42] The child CAHPS Health Plan Survey measure is not profiled in this report. To view state-specific information on which states reported collecting the child CAHPS Health Plan Survey, see Table CAHPS-CH at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2014.zip.

[43] Data reported in previous years' Secretary's Reports may have changed as a result of data quality outreach efforts conducted for the 2015 Secretary's Report.

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

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

Similar to last year, all 51 states reported at least one Child Core Set measure for FFY 2014 (Figure 1 and Table 1).[45] Altogether, 41 states reported at least 11 of the 22 measures to CMS for FFY 2014 (Figure 1 and Table 1).[46,47] Two states—Georgia and South Carolina—reported on all 22 of the measures for FFY 2014, and eight states reported on 21 of the 22 measures for FFY 2014 (Figure 1 and Table 1). The two states with the largest increases in the number of measures reported from FFY 2012 to FFY 2014 were Connecticut (+13 measures) and Louisiana (+11 measures).[48] Eight states reported fewer measures for FFY 2014 than in the previous year, generally due to a lack of data availability (data not shown).

One of CMS's quality measurement-related goals is to work with states to improve the completeness of data reported. CMS continues to encourage states to report data on the Child Core Set that include both Medicaid and CHIP populations. The number of states reporting at least one measure that combines data for both Medicaid and CHIP enrollees has increased consistently over the past three years, from 38 states for FFY 2012 to 41 states for FFY 2013 and 44 states for FFY 2014. In addition, the share of measures including data for Medicaid enrollees (as opposed to just including data for CHIP enrollees) increased steadily, from 64 percent for FFY 2012 to 78 percent for FFY 2013 and 80 percent for FFY 2014.

The fifth year of voluntary reporting also saw an overall increase in the number of measures reported by each state. The median number of measures reported by each state increased over the past three years, from 14 for FFY 2012 to 16 for FFY 2013 and FFY 2014. The most frequently reported measures for FFY 2014 were the two dental measures (51 states reporting), the well-child visit and access to primary care practitioner (PCP) measures (42 to 46 states reporting), and the childhood immunization status and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures (39 states reporting) (Figure 2). These frequently reported measures are either already in use by CMS reporting programs, or are part of the Healthcare Effectiveness Data and Information Set (HEDIS®), and are often included in managed care contracts for monitoring the quality of care provided to Medicaid/CHIP enrollees receiving care through managed care entities.[49] In addition, these measures, with the exception of the CAHPS survey, are calculated primarily using Medicaid administrative data and do not require medical record review.

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

[46] The 2014 Child Core Set includes 23 measures. The base of 22 measures excludes the CLABSI measure because data were obtained from the CDC's NHSN. Additionally, three measures—Annual Pediatric Hemoglobin (HbA1c) Testing, Appropriate Testing for Children with Pharyngitis, and Annual Percentage of Asthma Patients 2 Through 20 with One or More Asthma-Related Emergency Room Visits—were retired from the Child Core Set in 2014. Updates to the 2014 Child Core Set are described in a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin, available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf.

[47] The 2014 Secretary's Report used a base of 25 measures and a threshold of 13 measures. The number of states reporting at least 13 measures increased from 33 states for FFY 2013 to 35 states for FFY 2014.

[48] For information on the change in the number of measures reported by each state, see Supplemental Table CH-2 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

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

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

- Human Papillomavirus (HPV) Vaccine for Female Adolescents (increased from 23 to 32 states reporting);
- Body Mass Index Assessment (BMI) for Children and Adolescents (increased from 25 to 33 state reporting);
- Live Births Weighing Less than 2,500 Grams (increased from 21 to 29 states reporting);
- Follow-Up After Hospitalization for Mental Illness (increased from 28 to 34 states reporting); and
- Immunization Status for Adolescents (increased from 31 to 37 states reporting).

The increase in the number of measures reported by states allowed CMS to conduct deeper analysis on 19 Child Core Set measures reported by 25 or more states for FFY 2014.[50] State performance on four measures—Ambulatory Care: Emergency Department Visits, HPV Vaccine for Female Adolescents, Live Births Weighing Less Than 2,500 Grams, and Medication Management for People with Asthma—is profiled for the first time for FFY 2014.

The least frequently reported measures in the 2014 Child Core Set—Developmental Screening in the First Three Years of Life (20 states reporting), Cesarean Section for Nulliparous Singleton Vertex (16 states reporting), and Behavioral Health Risk Assessment (For Pregnant Women) (4 states reporting)—require states to conduct medical record reviews or to link with other data sources such as birth records to collect the necessary data, which is a resource-intensive process for states. Reasons for not reporting vary by state, but data availability and data access are among the most frequently cited reasons for not reporting. Through the Quality Measures Technical Assistance and Analytic Support (TA/AS) Program,[51] CMS will continue to work with states to support their capacity for reporting.

D. Summary of Key Findings on Performance

This section summarizes CMS's analysis of performance on 19 measures for FFY 2014 reported by at least 25 states (Table 2). State-specific findings (including percentiles, means, medians, trends, and geographic variation) on these frequently reported measures are presented in the five domain-specific reports described above, reflecting a continuum of quality measures for children

[50] The child CAHPS Health Plan Survey measure is not profiled in this report. To view state-specific information on the number of states collecting the child CAHPS Health Plan Survey, see Table CAHPS-CH at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2014.zip.

[51] The TA/AS Program is led by Mathematica Policy Research in collaboration with National Committee for Quality Assurance (NCQA) and Center for Health Care Strategies (CHCS), and supports reporting of CMCS Medicaid/CHIP quality measures, including the Adult, Child, and Health Homes Core Sets, and Maternal and Infant Health Initiative measures. More information about the TA/AS Program is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

and pregnant women: (1) primary care access and preventive care; (2) perinatal health; (3) care of acute and chronic conditions; (4) behavioral health care; and (5) dental and oral health services.[52]

1. Primary Care Access and Preventive Care

Nine measures of primary care access and preventive care were available for analysis for FFY 2014:

1. Child and Adolescents' Access to Primary Care Practitioners;
2. Well-Child Visits in the First 15 Months of Life;
3. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life;
4. Adolescent Well-Care Visits;
5. Childhood Immunization Status;
6. Immunization Status for Adolescents;
7. Human Papillomavirus (HPV) Vaccine for Female Adolescents;
8. Chlamydia Screening in Women Ages 16 to 20; and
9. Body Mass Index Assessment for Children and Adolescents.

States continued to have relatively high performance rates on the children's primary care access measure, as reflected by the median rate among the 43 states reporting the measure for FFY 2014 (Table 2). The median percentage of children with a visit to a primary care practitioner (PCP) in the past year was highest for children ages 12 to 24 months (96 percent), and slightly lower for children ages 25 months to 6 years (89 percent had at least one PCP visit in the past year). Among older children, most had a PCP visit in the past two years (the median was 91 percent for children ages 7 to 11 and 90 percent for children ages 12 to 19). Among the 41 states that reported the measure for the last three years, the median rates did not change substantially across any of the four age groups.[53]

Despite high rates of overall PCP access, children received fewer well-child visits than what is recommended by the American Academy of Pediatrics and Bright Futures.[54] For example, nine well-child visits are recommended during the first 15 months of life. As shown in Table 2, about

[52] Domain-specific reports are available on state performance related to primary care access and preventive care, perinatal health, care of acute and chronic conditions, behavioral health, and dental and oral health services. The reports contain detailed analyses of 19 measures reported by at least 25 states for FFY 2014. Trends were calculated for 14 measures for which at least 20 states reported data for FFY 2012–2014. See Supplemental Table CH-3 for a comparison of performance rates for these measures, available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

[53] See Supplemental Table CH-3 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

[54] American Academy of Pediatrics. "Recommendations for Preventive Pediatric Health Care." Practice Management Online at http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.

three out of five infants received six or more visits during the first 15 months of life for FFY 2014 (the median rate among 40 states was 62 percent). More than two-thirds of children ages 3 to 6 received at least one well-child visit in the last year (the median rate among 46 states was 67 percent). Adolescents ages 12 to 21 had the lowest well-care visit rate of all age groups. The median for the adolescent well visit rate was 44 percent for FFY 2014 (44 states reporting).

The clinical quality of primary care is reflected in the Child Core Set by two measures: documentation of BMI percentiles in the medical record, and annual screening for Chlamydia (Table 2). For children ages 3 to 17 who saw a PCP, more than two out of five had their BMI percentiles documented in medical records (the median rate among 33 states reporting was 43 percent). Nearly half of sexually active women ages 16 to 20 were screened for Chlamydia (the median rate among 37 states reporting was 48 percent).

A key indicator of the continuity of primary care is whether children are up to date on their immunizations. Two out of three children who turned two-years-old received Combination 3 immunizations (the median rate among 35 states reporting was 67 percent).[55] Similarly, two-thirds of adolescents were up-to-date on recommended immunizations (Combination 1)[56] by their 13th birthday (the median rate among 35 states reporting was 67 percent). Among the 28 states reporting the Immunization Status for Adolescents measure for the last three years, the median Combination 1 rate increased by more than 10 percentage points, from 59 percent for FFY 2012 to 69 percent for FFY 2014.[57] The Combination 3 rate for the Childhood Immunization Status measure did not change substantially during the same time period among the 28 states that have reported the measure over the last three years.

The HPV vaccine is recommended for children ages 11 or 12 to help prevent the most common types of HPV and thus, protect against cancers caused by HPV infection. Among the 32 states reporting the measure for FFY 2014, a median of 18 percent of female adolescents had received three doses of the HPV vaccine by their 13th birthday. This is the first year that the HPV Vaccine for Female Adolescents measure was publicly reported.

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

[55] The Childhood Immunization Status measure includes 10 rates for the individual vaccines and 9 combination rates. The most common combination rate reported by states is "Combination 3," which includes all of the vaccines except Hepatitis A, Rotavirus, and flu.

[56] The Immunization Status for Adolescents measure includes two rates for individual vaccines (meningococcal vaccine and tetanus, diphtheria toxoids and acellular pertussis vaccine [Tdap] or tetanus, diphtheria toxoids vaccine [Td]) and one combination rate. The combination rate is a measure of children compliant for the recommended dosages of both the meningococcal vaccine (at least one dose between the child's 11th and 13th birthday) and Tdap/Td (at one dose of either vaccine between the child's 10th and 13th birthday).

[57] See Supplemental Table CH-3 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

2. Perinatal Health

Four measures of perinatal health were available for analysis for FFY 2014: (1) Timeliness of Prenatal Care; (2) Frequency of Ongoing Prenatal Care; (3) Live Births Weighing Less Than 2,500 Grams; and (4) Neonatal Central Line-Associated Blood Stream Infections (CLABSIs).

The timeliness and frequency of prenatal care can reduce pregnancy complications and improve infant health outcomes. The vast majority of pregnant women had a prenatal care visit in the first trimester or within 42 days of enrolling in Medicaid/CHIP (the median rate among 24 states reporting was 81 percent) (Table 2). In addition, more than two-thirds of women received at least 80 percent of the expected number of prenatal visits during their pregnancy (based on when they enrolled in Medicaid/CHIP and when they delivered) (the median rate among 27 states reporting was 66 percent). Among the 22 states reporting this measure for the past three years, the median rate increased by more than 8 percentage points (from 59 percent in FFY 2012 to 67 percent in FFY 2014).[58]

Two measures indicate state performance on adverse birth outcomes: low birth weight (LBW) and CLABSIs. For both measures, lower rates are better. Twenty-nine states reported the percentage of live births paid for by Medicaid or CHIP that weighed less than 2,500 grams at birth; the median rate among 29 states reporting for FFY 2014 was 9 percent (Table 2).[59] Among the 41 states with state-level rates for CLABSIs in neonatal intensive care units (NICUs), 33 had a significant decrease in CLABSIs in CY 2013 since the 2006–2008 baseline period, and 8 had no change in infections since the baseline period.[60] No states had a significant increase in infections. The Standardized Infection Ratio (SIR) in NICUs was 0.499 in CY 2013, achieving slightly below the national goal of 0.51 by the end of 2013.[61]

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

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[58] See Supplemental Table CH-3 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

[59] The U.S. rate for 2013 was 8 percent, ranging from 7 percent for non-Hispanic white and Hispanic infants to 13 percent for non-Hispanic black infants. More information on the characteristics of U.S. births is available at http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf.

[60] See Table CLABSI-CH at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2014.zip.

[61] The SIR is the summary measure used to track CLABSIs over time. It compares the number of infections reported in a given year to the number that would be predicted based on national, historical baseline data that adjust for the type of facility and patient population. The SIR indicates whether the rate of infections increased, decreased, or did not change significantly relative to the baseline (calculated using data for 2006–2008). The SIR is evaluated based on the 95 percent confidence interval, standardized to a baseline of 1. This measure is obtained from data reported by hospitals to the CDC's NHSN. It includes all neonatal CLABSI incidents not just those for infants covered by Medicaid/CHIP. For further information on the methods used to assess state performance, see the CDC 2012 National and State Healthcare-Associated Infections Standardized Infection Ratio Report, available at http://www.cdc.gov/HAI/pdfs/progress-report/hai-progress-report.pdf.

3. Care of Acute and Chronic Conditions

Two measures of care of acute and chronic conditions were available for analysis for FFY 2014: (1) Ambulatory Care: Emergency Department (ED) Visits; and (2) Medication Management for People with Asthma. This is the first year that these measures are publicly reported.

Asthma is the most common chronic condition in childhood. Among children ages 5 to 20 with persistent asthma, the median percentage who remained on an asthma controller medication for at least 75 percent of their treatment period was 31 percent (25 states reporting) (Table 2). The median rate was highest for adolescents ages 19 to 20 (33 percent remained on medication [16 states reporting]), and lowest for adolescents ages 12 to 18 (28 percent remained on medication [25 states reporting]). These findings suggest substantial room for improvement among states.

High rates of ED use may signify a lack of continuity or availability of primary care to manage acute or chronic conditions.[62] Among children ages 1 to 19, the median rate for ED visits was 46 visits per 1,000 enrollee months (37 states reporting) (Table 2).[63] The rate was lowest for adolescents ages 10 to 19 (the median rate was 38 visits per 1,000 enrollees) and highest for infants under age 1 (the median rate was 89 visits per 1,000 enrollees).

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

4. Behavioral Health Care

Two behavioral health measures were available for analysis for FFY 2014: (1) Follow-Up After Hospitalization for Mental Illness and (2) Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication.

Timely follow-up after inpatient hospitalization for mental illness is key to facilitating a child's transition to home and school and preventing readmissions. Among children ages 6 to 20 hospitalized for treatment of selected mental health disorders, the median percentage of children who had a follow-up visit within 7 days of discharge was 44 percent (34 states reporting) (Table 2). The median rate for follow-up within 30 days of discharge was 65 percent (34 states reporting).

Among children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medications, the median percentage for a follow-up visit during the first 30 days (known as the Initiation Phase) was 44 percent (34 states reporting) (Table 2). Among children with a visit during the Initiation Phase, more than half (the median rate was 57 percent) had at least two visits during the next nine months (known as the Continuation and Maintenance [C&M] Phase) (31 states reporting). Performance improved among the 26 states that reported this measure for the past

[62] Lower rates are better for this measure.

[63] Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year.

three years; between FFY 2012 and FFY 2014, the median Initiation Phase rate increased by 5 percentage points and the median C&M Phase rate increased by 8 percentage points.[64]

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

5. Dental and Oral Health Services

All children enrolled in Medicaid and CHIP have coverage for dental and oral health services. Children's access to oral health care is a primary focus of improvement efforts in Medicaid and CHIP.[65] Two oral health measures were available for analysis for FFY 2014: (1) Percentage of Eligibles Who Received Preventive Dental Services and (2) Percentage of Eligibles Who Received Dental Treatment Services.

Children's access to dental services in FFY 2014 was similar to patterns observed in previous years. Among children ages 1 to 20 enrolled in Medicaid and CHIP Medicaid Expansion programs (those eligible for Early and Periodic Screening, Diagnostic, and Treatment [EPSDT] benefits), a median of 48 percent received a preventive dental service in FFY 2014, an increase of 2 percentage points from FFY 2013 (47 states and 49 states reporting, respectively). A median of 22 percent of children received a dental treatment service in FFY 2014, compared to a median of 25 percent in FFY 2013 (Table 2).[66]

For more information on the Dental and Oral Health measures, as well as the CMS initiatives underway to improve children's access to dental and oral health services, see the Dental and Oral Health Services domain-specific report at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-SR-domain-specific-reports.zip.

[64] See Supplemental Table CH-3 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Overview-of-the-Child-Core-Set-Measures-FFY-2014.zip.

[65] More information about the Oral Health Initiative is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/dental-care.html.

[66] The two Child Core Set dental measures are obtained from data reported by states in the Form CMS-416 reports. States are to submit the CMS-416 report to CMS by April 1 of each year.

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

In FFY 2014, about 70 percent of children enrolled in Medicaid and CHIP obtained their care through managed care plans, with the rate of managed care enrollment in states using a managed care delivery system varying widely across these programs.[67] Regardless of the enrollment rate, states using a managed care delivery system must comply with certain federal requirements, including standards to assess and monitor the quality of care provided by contracted managed care plans. This chapter summarizes state activities related to monitoring and improving care for children and pregnant women in managed care.[68]

A. Overview

The Balanced Budget Act of 1997 created system-wide quality standards for states that elect to use managed care for the delivery of health care in Medicaid; these were expanded to CHIP in 2009.[69] Federal regulations implemented in 2003 require states to perform an annual external quality review (EQR) for each contracted managed care organization (MCO), prepaid inpatient health plan (PIHP), and health insuring organization (HIO).[70,71] These annual EQRs analyze and evaluate information on the quality, timeliness, and access to the health care services that an MCO or PIHP, and their contractors, furnish to Medicaid beneficiaries. Section 1139A(c) of the Social Security Act requires the HHS Secretary to include in this annual report information that states collect through EQRs.[72]

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

[67] CMS analysis of FFY 2014 Statistical Enrollment Data System (SEDS) data.

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

[69] Codified at Section 1932(c) of the Social Security Act. Extended to CHIP Managed Care by Section 2103(f)(3) of the Social Security Act.

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

[71] The EQR requirement applies to Medicaid programs and CHIP Medicaid expansion programs. For separate CHIP programs, the EQR requirement became law with the enactment of CHIPRA. Specifically, Section 403 of CHIPRA requires all states that operate a CHIP managed care program to comply with the requirements of Section 1932 of the Social Security Act.

[72] Section 1139A(c) of the Social Security Act also requires the reporting of state-specific information on the quality of health care furnished to children in benchmark plans under Sections 1937 and 2103 of the Act. There are currently no separate state reporting requirements for benchmark plans other than the EQR reporting process required for states contracting with MCOs and PIHPs. In other words, state EQR technical reports must include information related to benchmark plans that deliver care through MCOs or PIHPs; however, because this information is reported in the aggregate, which is allowable under EQR requirements, detailed data are not available for benchmark plans.

EQR-related activities: (1) validation[73] of performance measures; [74] (2) validation of performance improvement projects (PIPs);[75] and (3) a review, at least every three years, to determine the managed care plan's compliance with state standards for access to care, structure and operations, and quality measurement and improvement.[76] The state also may choose to perform additional EQR-related activities.[77]

The state must contract with a qualified EQRO to produce an annual technical report that uses information from the EQR-related activities to assess the quality, timeliness, and access to care provided by each MCO and PIHP. Per regulation, the EQR technical report is a public document, available upon request to all interested parties.[78]

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

Of the 41 states[79] that contracted with MCOs or PIHPs during the 2014–2015 reporting cycle,[80] 38 states submitted EQR technical reports to CMS.[81] These states contracted with 15 different EQROs to conduct the annual EQR, and five EQROs conducted reviews for multiple states during the 2014–2015 reporting cycle.[82] The majority of EQR technical reports focused on

[73] 42 CFR 438.320 defines validation as the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

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

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

[76] 42 CFR §438.358(b)(3).

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

[78] See 42 C.F.R. § 438.364.

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

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

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

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

physical health services, but some included information on other types of managed care services, such as dental or behavioral health.

As in previous years, the 2014–2015 EQR technical reports provide insight into the strategies and efforts that states use to improve the quality of care for managed care enrollees. This chapter profiles quality measurement and improvement efforts underway related to children and pregnant women enrolled in Medicaid and CHIP managed care entities. The EQR technical reports indicate that states and managed care entities engage in a variety of different quality measurement and improvement efforts based on factors such as the population groups enrolled, stakeholder and beneficiary feedback, and clinical areas in need of improvement.

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

C. Performance Measures, 2014–2015 Reporting Cycle

In the 2014–2015 reporting cycle, the most frequently reported performance measures for children and pregnant women focused on well-child care (28 states), primary care access (28 states), prenatal/postpartum care (26 states), childhood immunization rates (25 states), behavioral health (25 states), and adolescent well-care (25 states).[83] The reported performance measures showed considerable overlap with both the CMS Child Core Set and the HEDIS 2014 measures, though the use of these measure sets is not required by CMS.[84] Additionally:

- Of the 38 states that submitted EQR technical reports in time for this analysis, 36 identified the types of performance measures reported by MCOs and PIHPs, and 35 identified the specific performance measures validated by the EQRO.
- 32 states included the performance rates achieved by each MCO or PIHP.[85] Of these:

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

[84] See EQR Table CH-5 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Child-Findings-from-EQR-Technical-Reports-2014-2015.zip.

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

- 28 states compared MCO and PIHP performance to national HEDIS Medicaid rates.
- 25 states compared performance in the 2014–2015 reporting cycle to performance in previous years.
- 23 states compared individual MCO and PIHP performance rates to statewide managed care averages.
- 17 included comparisons to state target rates.
- 14 states reported performance rates for specific subpopulations within the state. For example, Arizona and Nevada separately reported performance results for children enrolled in Medicaid versus children enrolled in CHIP. Arizona, Florida, and New York included performance rates by geographic region, while Georgia reported results by delivery system (managed care versus fee-for-service).

D. Performance Improvement Projects, 2014–2015 Reporting Cycle

Of the 38 states that submitted EQR technical reports for the 2014–2015 reporting cycle, 36 included at least one PIP that targeted children or pregnant women and all of those states provided information on validation as required by regulation (Table 3).[86] States often deferred to the MCO or PIHP to propose and implement topics and interventions; however, 18 states mandated a specific PIP topic or required participation in a collaborative project.[87]

The topical focus and number of PIPs varied considerably among the 36 states that included at least one PIP that targeted children or pregnant women (Table 3):

- Seven states reported four or fewer PIPs targeting children or pregnant women, while Florida conducted a total of 131 PIPs, of which 31 focused on improving well-child care visit rates and another 31 focused on improving the quality of behavioral health care for children or pregnant women.[88]
- Behavioral health care was the most common PIP topic for the 2014–2015 reporting cycle (22 states and 161 PIPs). Five states accounted for the majority of these PIPs (Florida, Oregon, Pennsylvania, Washington, and Wisconsin).
- Other recurrent PIP topics included prenatal and postpartum care (16 states), well-child care (16 states), ED visits (15 states), asthma (14 states), weight/BMI assessment and counseling (13 states), and hospital readmissions (12 states).

Among the 28 states that submitted EQR technical reports during the current and previous two reporting cycles, PIP topics demonstrated a few notable shifts (Figure 5).

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

[87] States that mandated PIP topics for MCOs or PIHPs include AZ, DC, FL, GA, IL, LA, MD, MA, MN, MO, NV, NH, OH, PA, RI, VA, WA, and WV.

[88] Florida included validation scores for all PIPs within their EQR technical report; however, data was limited to validation scores alone on many of the PIPs, with no mention of outcomes or interventions.

- The number of states conducting PIPs focused on ADHD and other behavioral health topics, ED visits, hospital readmissions, and oral health increased from previous years.
- The number of states conducting PIPs in immunizations, well-child care, asthma, lead screening, and primary care access decreased from the 2012–2013 reporting cycle to the 2013–2014 reporting cycle, but the number of states with PIPs in these categories increased in the 2014–2015 reporting cycle.

These shifts in topical focus may reflect changing health care priorities within the states or may indicate that the PIPs either achieved their intended health care improvements or consistently failed to show demonstrable improvements.

E. Review of Performance Improvement Projects

The following section presents findings from detailed abstractions of EQRO reporting on PIPs in four health topic areas: (1) childhood obesity, (2) oral health, (3) prenatal and postpartum care, and (4) adolescent well care.[89] An example of a state improvement project is highlighted for each topic area. Criteria for selecting states to highlight included geographic diversity across reporting years and across PIP topics, the EQR validation rating,[90] and the amount of information related to interventions and outcomes included in the EQR technical reports.

1. Childhood Obesity

Thirteen states reported a combined total of 26 PIPs that targeted childhood obesity during this reporting cycle (Table 3). While the interventions of each PIP varied across states and MCOs, common aims included improving BMI percentile documentation, nutrition counseling, and physical activity counseling.

Since 2008, all three MCOs in Georgia have operated improvement projects focused on reducing childhood obesity. The projects aim to improve performance on the HEDIS weight assessment and counseling measure, including increasing BMI percentile documentation, nutrition counseling, and physical activity counseling for members ages 3 to 17. To achieve these goals, the MCOs focused primarily on raising provider awareness of conducting and documenting weight assessment and counseling activities. All three MCOs implemented face-to-face visits between health promotion coordinators and providers to improve provider documentation of

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

[90] Use of the term "validation" differed across EQR reports. The state examples all based the validation rating on the *EQR Protocol 3: Validating Performance Improvement Projects (PIPS): A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012*. The protocol details the following 10 activities: (1) select the study topic; (2) define the study question(s); (3) select the study indicators; (4) use a representative and generalizable study population; (5) use sound sampling techniques (if sampling was used); (6) reliably collect data; (7) analyze and interpret study results; (8) implement intervention and improvement strategies; (9) assess for real improvement; and (10) assess for sustained improvement. Each EQRO calculated the percentage score of evaluation elements met by each MCO to determine a status of met, partially met, or not met.

these services, including reviews of the provider's performance on the indicators and distribution of a billing guide, which provides correct coding for these indicators.

During this reporting cycle, all three MCOs in Georgia exceeded state target rates for each indicator: BMI percentile documentation, nutrition counseling, and physical activity counseling. In addition, two of the three MCOs demonstrated statistically significant improvement on the indicators compared to the previous measurement period. Notably, one MCO demonstrated substantial improvement from last year to this year, with an increase of 10.4 percentage points for BMI percentile documentation, 5.6 percentage points for nutrition counseling, and 9.8 percentage points for physical activity counseling. Although only one MCO met the requirements of the PIP validation process, the two other MCOs met over 90 percent of the PIP validation elements.

2. Oral Health

Eight states reported a combined total of 32 PIPs aimed at improving oral health care (Table 3). Two of the eight states, Georgia and Missouri, mandated this topic (these states also mandated PIPs on this topic for the 2011–2012, 2012–2013, and 2013–2014 reporting cycles).

Missouri required its three MCOs to implement an improvement project aimed at increasing the number of children ages 2 to 20 who had an annual dental visit. (Each of the three MCOs subcontracts with the same dental contractor to provide dental services to children enrolled in their MCO.) The state set annual performance improvement targets for the MCOs to increase the state's aggregate annual dental visit rate by 3 percentage points each year and by 10 percentage points by the end of 2016. One MCO took a leadership role in the development and implementation of the statewide PIP. The MCO conducted a variety of activities to improve performance, including establishing a PIP team to work with the dental subcontractor to ensure that all interventions and improvement strategies were implemented. The MCO also conducted targeted outreach to members, including contacting parents whose children have not seen a dental provider and referring members who sought emergency oral health care to community oral health providers. The MCO has taken several steps to expand access to oral health care, including contracting with a mobile dental provider to provide care in the community; contracting with dentists who rotate through rural areas; coordinating with schools to provide care; and working with dentists to provide after-hours and weekend appointments. The MCO increased the percentage of children with a dental visit in the past year from 35 percent in 2009 (the year the PIP was implemented) to 51 percent in 2013.

The two other participating MCOs in Missouri conducted member, community, and provider outreach activities, and they both contracted with dental vans to improve access to care. Both MCOs demonstrated improvement on the rate of annual dental visits, and one met the statewide annual goal of a 3 percentage-point improvement in 2013. The EQRO noted that although the two MCOs did not meet the requirements of the PIP validation process, the interventions and barrier analyses conducted by one of the MCOs indicated a commitment to the statewide PIP project goals. The EQRO plans to provide feedback to the other MCO in order to improve the quality of reporting.

3. Prenatal and Postpartum Care

Sixteen states reported a combined total of 62 improvement projects targeting prenatal or postpartum care during the current reporting cycle (Table 3), of which 5 mandated the topic (District of Columbia, Florida, Georgia, Illinois, and New Hampshire). Fifteen states completed PIPs on this topic during the 2013–2014 reporting cycle, and 11 states conducted PIPs in both reporting cycles. While the interventions of each PIP varied, common improvement aims focused on timeliness and frequency of prenatal and/or postpartum care, low birth weight, and postpartum depression screening.

Illinois' quality strategy identified improving birth outcomes as one of its health care priorities. The state required its three MCOs to implement a collaborative improvement project focused on prenatal and postpartum care (the state has mandated PIPs on this topic since the 2011–2012 reporting cycle). The primary aim of the PIP was to improve performance on the timeliness of prenatal and postpartum care HEDIS measures. A secondary purpose of the PIP was to improve the rate of depression screening and appropriate depression treatment for women during the prenatal and/or postpartum period. All three MCOs identified member outreach as an area for improvement. To address this, two MCOs implemented reviews of Medicaid claims/encounter data to identify pregnant women and manage their care. Another MCO conducted hospital discharge follow-up calls to assist women with scheduling a postpartum visit and arrange transportation.

The MCOs in Illinois also implemented incentive programs to increase prenatal and postpartum visits, such as gift cards, coupons for a free baby photo, and a rewards program (stroller, portable play yard, or diapers) for members who had the recommended prenatal and postpartum visits. Two MCOs implemented provider-level interventions including a provider incentive program that paid providers for notifying the MCO of pregnant members, and a provider education program involving one-on-one meetings with providers to discuss their performance on study indicators, provide them with lists of members who had not received recommended visits, guidance on billing codes, and education on the importance of screening members for depression. Overall, 60 percent of the 45 reported study indicators across all three MCOs showed improvement compared to the 2013–2014 reporting cycle, and 93 percent of the indicators showed sustained improvement compared to the baseline period.

4. Adolescent Well Care

Seven states reported a combined total of 20 projects aimed at improving rates of adolescent well-care (Table 3). Three of these states also reported PIPs on this topic during both the 2011–2012 and 2013–2014 reporting cycles. During this reporting cycle, Georgia, Maryland, and Virginia mandated that all MCOs in the state conduct PIPs to improve adolescent well-care visit rates.

Starting in 2012, Maryland required all six of its MCOs to implement a collaborative improvement project aimed at increasing the percentage of adolescents ages 12 to 21 who received a comprehensive well-care visit with a PCP or obstetrical/gynecological (OB/GYN) practitioner. The state focused on this topic after internal analyses determined that adolescents ages 12 to 20 had the lowest rates of EPSDT visits and that underutilization of adolescent well-

care visits yielded missed opportunities for prevention, early detection, and treatment. As a result, the state targeted routine adolescent utilization as an area for improved performance. The state also chose the Adolescent Well Care HEDIS performance measure as one of its value-based purchasing measures for 2013, which rewards MCOs for better performance on priority health indicators.

Maryland's MCOs implemented interventions to increase participation by members, such as home visits for members receiving Supplemental Security Income and adolescents who had not seen a provider in the past two years, member incentives, birthday card reminders, wellness letters, and automated telephone call reminders. Additional efforts sought to reach members by using Facebook; collaborating with school-based clinics; and conducting health fairs with entertainment, games, food, and gifts at pediatric offices. MCOs also implemented provider interventions including sharing lists of members who had not received well-care visits and offering provider incentives for increased visit rates. MCOs also made efforts to increase the completeness of data, including conducting medical record reviews to confirm whether well-care visits occurred.

The EQR technical report included results for the second year of this PIP. Baseline rates for the six Maryland MCOs ranged from 60 percent to 77 percent of adolescents receiving a comprehensive well-care visit, with four of the six MCOs performing above the HEDIS Medicaid 90th percentile at baseline. The two lowest-performing MCOs at baseline demonstrated improvement in adolescent well-care visit rates, with increases of 1.1 and 8.5 percentage points, respectively. The EQRO review included suggestions to the MCOs on achieving greater improvements in future years. The EQRO recommended that the MCOs complete an annual barrier analysis to direct where limited resources can be used most effectively to drive improvement. The EQRO also recommended that the MCOs improve PIP interventions, develop system-level interventions—including educational efforts, changes in policy, targeting of additional resources, or other organization-wide initiatives—and noted that face-to-face contact is usually most effective.

IV. SUMMARY AND CONCLUSION

This report shows the continued progress made by HHS and states in building a national, cross-state quality measurement and reporting system for children's health care in Medicaid and CHIP. CMS conducted detailed analysis of state performance on Child Core Set measures reported by at least 25 states. The increase in the number of measures reported by states allowed CMS to analyze 19 measures for FFY 2014, up from 16 measures for FFY 2013. Improved state reporting on four measures—Ambulatory Care: ED Visits, HPV Vaccine for Female Adolescents, Low Birth Weight, and Medication Management for People with Asthma—allowed CMS to conduct detailed analysis on new measures for this 2015 report. More states also reported measures for both Medicaid and CHIP enrollees (increasing from 38 states for FFY 2012 to 41 states for FFY 2013 and 44 states for FFY 2014).

The evolving quality measurement field offers new tools for states to use in improvement projects. CMS's detailed review of performance measures and improvement projects summarized in the EQR technical reports identified state-initiated efforts underway to assess and improve the quality of care in managed care. Through managed care entities that now are the main delivery system for children and their parents, states are engaged in various types of improvement projects specific to children. Behavioral health care was the most common improvement project topic among state managed care plans for the 2014–2015 EQR reporting cycle.

As noted in previous years, states had high performance on the children's primary care access measure (i.e., percent with a visit to a PCP); however, this report highlights the need for improvement in areas such as the use of preventive services by young children and adolescents (e.g., well-child visits for infants and for adolescents), dental and oral health care, coordination of care for children with behavioral health needs (e.g., follow-up after hospitalization for mental illness or for children newly prescribed ADHD medication), and care of acute and chronic conditions (e.g., rate of ED visits or compliance with asthma controller medications).

Despite considerable opportunities for improving the quality of care for children enrolled in Medicaid and CHIP, studies show that care for children covered by Medicaid is comparable to that for privately insured low-income children and better than care for the uninsured.[91] For example, one study found that children enrolled in Medicaid and CHIP were more likely to have a usual source of care than were uninsured children and their access was comparable to that of privately-insured children.[92] In another assessment of quality and access, children enrolled in Medicaid experienced similar quality of care as privately insured children on three out of four measures examined but did not fare as well on measures of access.[93] However, parents of children enrolled in Medicaid or CHIP were more likely than low-income parents of children

[91] See CHIPRA Mandated Evaluation of the Children's Health Insurance Program: Final Findings, available at http://www.mathematica-mpr.com/~/media/publications/pdfs/health/rpt_chipevaluation.pdf.

[92] http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/.

[93] Agency for Healthcare Research and Quality. Health care coverage analyses of the National Healthcare Quality and Disparities Reports: 2000–2008 trends. Baltimore, MD: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services; March 2014. Available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/health-coverage-analyses-of-nhqr-2000-2008-trends.pdf.

with job-based coverage to say they were very satisfied with the quality of care, the scope of benefits, and affordability.[94]

To support state efforts to further improve the completeness and consistency of reporting on performance, CMS is continuing several efforts, including: (1) the Quality Measures TA/AS Program, (2) enhancing oversight of Form CMS-416 data reported by states, and (3) aligning quality measurement and improvement efforts across Medicaid and CHIP and other CMS initiatives. Together, CMS, states, and their quality partners are working toward the goal of achieving a high quality system of coverage and care for all children enrolled in Medicaid and CHIP.

[94] http://kff.org/medicaid/issue-brief/the-impact-of-the-childrens-health-insurance-program-chip-what-does-the-research-tell-us/.

TABLES

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Table 1. Overview of State Reporting of the Core Set of Medicaid/CHIP Children's Health Care Quality Measures, FFY 2014

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Child and Adolescent Access to PCPs	Well-Child Visits in the First 15 Months of Life	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Adolescent Well-Care Visits	Childhood Immunization Status	Immunizations for Adolescents	Human Papillomavirus Vaccine for Female Adolescents	Chlamydia Screening	BMI Assessment for Children and Adolescents	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Percentage of Live Births Weighing Less than 2,500g	Cesarean Rate for Nulliparous Singleton Vertex	Behavioral Health Risk Assessment For Pregnant Women	Follow-Up After Hospitalization for Mental Illness	Follow-Up Care for Children Prescribed ADHD Medication	Developmental Screening in the First Three Years of Life	Ambulatory Care: ED Visits	Medication Management for People with Asthma	Preventive Dental Services	Dental Treatment Services	CAHPS® Health Plan Survey
U.S. Total	16 (Median)	44	43	42	46	44	39	37	32	37	33	36	28	29	16	4	34	34	20	37	27	51	51	39
Alabama	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	X
Alaska	13	X	X	X	X	X	--	--	X	X	--	--	--	X	--	--	X	X	X	X	--	X	X	--
Arizona	3	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	X	X	X
Arkansas	14	X	X	X	X	X	--	--	X	X	--	--	--	X	X	--	X	X	--	X	X	X	X	--
California	12	X	X	--	X	--	X	X	--	--	X	X	--	--	--	--	X	--	--	X	X	X	X	X
Colorado	15	X	X	X	X	X	X	X	--	X	X	X	--	X	--	--	--	X	--	X	--	X	X	X
Connecticut	19	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	X	X	X	X	X	X	X	X
Delaware	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Dist. of Col.	17	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	X	X	--	--	X	X	X	X
Florida	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	X
Georgia	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hawaii	18	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	X	X	--	X	X	X	X	X
Idaho	13	X	X	X	X	X	X	X	X	X	--	--	--	--	--	--	--	--	--	X	X	X	X	X
Illinois	20	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	--
Indiana	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	X
Iowa	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	X
Kansas	8	X	--	--	X	X	--	--	--	--	--	X	X	--	--	--	X	--	--	--	--	X	X	X
Kentucky	19	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X	X	--	X	X	X	X	X
Louisiana	18	X	X	X	X	X	X	X	--	X	X	X	X	X	X	--	X	X	--	X	--	X	X	X
Maine	12	X	X	X	X	X	--	--	--	X	--	--	--	--	--	--	X	X	X	X	--	X	X	X
Maryland	14	X	X	X	X	X	X	X	--	X	X	X	X	--	--	--	--	--	--	X	--	X	X	X
Massachusetts	20	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	--
Michigan	17	--	X	X	X	X	X	X	X	X	X	X	--	X	X	--	--	X	--	X	--	X	X	X
Minnesota	5	X	X	X	X	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	X	X	--
Mississippi	18	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X	X	--	--	X	X	X	X

Table 1 (continued)

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Child and Adolescent Access to PCPs	Well-Child Visits in the First 15 Months of Life	Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	Adolescent Well-Care Visits	Childhood Immunization Status	Immunizations for Adolescents	Human Papillomavirus Vaccine for Female Adolescents	Chlamydia Screening	BMI Assessment for Children and Adolescents	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Percentage of Live Births Weighing Less than 2,500g	Cesarean Rate for Nulliparous Singleton Vertex	Behavioral Health Risk Assessment For Pregnant Women	Follow-Up After Hospitalization for Mental Illness	Follow-Up Care for Children Prescribed ADHD Medication	Developmental Screening in the First Three Years of Life	Ambulatory Care: ED Visits	Medication Management for People with Asthma	Preventive Dental Services	Dental Treatment Services	CAHPS® Health Plan Survey
Missouri	12	X	--	X	X	X	X	X	--	X	--	X	--	--	--	--	X	--	--	X	--	X	X	X
Montana	11	--	X	X	X	X	X	X	X	--	--	--	--	--	--	--	--	--	--	X	--	X	X	X
Nebraska	2	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	X	X	--
Nevada	10	X	X	X	X	X	X	--	--	--	--	--	--	X	--	--	X	--	--	--	--	X	X	X
New Hampshire	3	X	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	X	X	X
New Jersey	17	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	X	X	--	X	X	X	X	--
New Mexico	16	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	--	X	--	X	--	X	X	X
New York	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X
North Carolina	14	X	X	--	X	X	X	X	X	X	X	--	--	X	--	--	--	--	X	X	--	X	X	X
North Dakota	8	--	X	--	X	X	--	X	--	--	--	--	--	--	--	--	X	X	--	--	--	X	X	--
Ohio	11	X	X	X	X	X	--	--	--	--	--	X	X	X	--	--	--	X	--	--	--	X	X	X
Oklahoma	20	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X	X	X	X	X	X	X	X
Oregon	17	X	X	X	X	X	X	X	--	X	X	X	--	X	--	--	X	X	X	X	--	X	X	X
Pennsylvania	18	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	X	X	--	X	X	X	X	X
Rhode Island	19	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X	X	--	X	X	X	X	X
South Carolina	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
South Dakota	2	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	X	X	--
Tennessee	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	X
Texas	20	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	X	X	X	X	X	X	X	X
Utah	15	X	X	X	X	X	X	X	X	X	X	--	--	--	--	--	X	X	--	--	X	X	X	X
Vermont	13	X	X	X	X	X	--	--	--	--	--	X	--	X	--	--	X	X	--	X	X	X	X	X
Virginia	10	X	--	X	X	X	X	--	--	--	--	X	--	X	--	--	--	--	X	--	--	X	X	X
Washington	16	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	--	--	--	X	--	X	X	--
West Virginia	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	--	X	X	X	X	X	X	X	X
Wisconsin	4	X	--	--	--	--	X	--	--	--	--	X	--	--	--	--	--	--	--	--	--	X	X	--
Wyoming	13	--	X	X	X	X	X	X	X	X	X	--	--	--	--	--	--	--	X	X	--	X	X	--

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

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

The 2014 Child Core Set includes 23 measures. This table excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC’s National Healthcare Safety Network.

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

Table 2. Performance Rates on Frequently Reported Medicaid/CHIP Children's Health Care Quality Measures, FFY 2014

Measure	Measure Description	Number of States Reporting Using Core Set Specifications	Mean	Median	25th Percentile	75th Percentile
Primary Care Access and Preventive Care						
Access to Primary Care: 12–24 Months	Percentage with a PCP Visit in the Past Year	41	95.8	96.4	94.3	97.3
Access to Primary Care: 25 Months–6 Years	Percentage with a PCP Visit in the Past Year	43	87.1	88.6	84.3	91.6
Access to Primary Care: 7–11 Years	Percentage with a PCP Visit in the Past Two Years	42	88.9	91.2	86.1	94.0
Access to Primary Care: 12–19 Years	Percentage with a PCP Visit in the Past Two Years	42	88.0	90.6	85.7	92.1
Well-Child Visits: First 15 Months	Percentage with 6 or More Visits	40	61.7	62.1	56.2	68.7
Well-Child Visits: 3–6 Years	Percentage with 1 or More Visits	46	67.1	67.4	60.6	75.9
Well Care Visits: 12–21 Years	Percentage with 1 or More Visits	44	45.5	43.5	38.0	56.2
Childhood Immunization Status: 2 Years	Percentage Up-to-Date on Immunizations (Combination 3)[a]	35	62.1	66.9	56.7	75.1
Immunization Status for Adolescents: 13 Years	Percentage Up-to-Date on Immunizations (Combination 1)[b]	35	64.9	67.1	52.6	79.7
Human Papillomavirus Vaccine for Female Adolescents	Percentage Receiving Three Vaccine Doses Before Age 13	32	17.2	17.6	12.9	22.9
Chlamydia Screening: 16–20 Years	Percentage of Sexually Active Women Screened	37	48.8	48.3	43.5	56.4
Body Mass Index Assessment: 3–17 Years	Percentage with a BMI Percentile Documented	33	41.3	42.6	12.3	63.4
Maternal and Perinatal Health						
Timeliness of Prenatal Care	Percentage with a Prenatal Visit in the First Trimester (or within 42 Days of Medicaid/CHIP Enrollment)	34	77.1	81.4	69.7	86.4
Frequency of Ongoing Prenatal Care	Percentage with More than 80 Percent of Expected Prenatal Visits	27	56.6	65.8	43.1	72.8
Live Births Weighing Less than 2,500 Grams	Percentage of Live Births Weighing Less Than 2,500 Grams	29	9.0	9.0	7.8	10.1
Care of Acute and Chronic Conditions						
Emergency Department Visits: 0–19 Years	Emergency Department Visits per 1,000 Enrollee-Months	37	55.1	45.7	40.1	52.2
Medication Management for People with Asthma: 5–11 Years	Percentage Dispensed Appropriate Medication And Remained on Medication for at Least 75 Percent of Treatment Period	26	32.6	30.3	23.4	39.0
Medication Management for People with Asthma: 12–18 Years	Percentage Dispensed Appropriate Medication And Remained on Medication for at Least 75 Percent of Treatment Period	25	29.7	28.2	23.3	37.9

Table 2 (continued)

Measure	Measure Description	Number of States Reporting Using Core Set Specifications	Mean	Median	25th Percentile	75th Percentile
Medication Management for People with Asthma: 19–20 Years	Percentage Dispensed Appropriate Medication And Remained on Medication for at Least 75 Percent of Treatment Period	16	33.7	33.2	25.2	41.2
Medication Management for People with Asthma: 5–20 Years	Percentage Dispensed Appropriate Medication And Remained on Medication for at Least 75 Percent of Treatment Period	25	32.7	31.2	24.5	38.9
Behavioral Health						
Follow-Up After Hospitalization for Mental Illness: 6–20 Years	Percentage of Discharges with a Follow-Up Visit within 7 Days	34	44.8	43.9	32.0	62.9
Follow-Up After Hospitalization for Mental Illness: 6–20 Years	Percentage of Discharges with a Follow-Up Visit within 30 Days	34	64.2	65.2	51.9	78.3
Follow-Up Care for Children Prescribed ADHD Medication: 6–12 Years	Percentage with 1 Follow-Up Visit during the Initiation Phase	34	44.2	44.1	35.3	53.3
Follow-Up Care for Children Prescribed ADHD Medication: 6–12 Years	Percentage with at least 2 Follow-Up Visits during the Continuation and Maintenance Phase	31	53.9	56.5	45.3	63.1
Dental and Oral Health Services						
Preventive Dental Services: 1–20 Years	Percentage with At Least One Preventive Dental Service	51	45.6	47.6	42.5	50.6
Dental Treatment Services: 1–20 Years	Percentage with At Least One Dental Treatment Service	51	23.5	22.3	20.2	25.2

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

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

This table includes data for states that used Child Core Set specifications to report the measures and excludes states that used other specifications and states that did not report the measures for FFY 2014. Additionally, rates were excluded if a state reported a denominator of less than 30. Means are calculated as the unweighted average of all state rates. In cases where a state reported separate rates for its Medicaid and CHIP populations, the rate for the program with the larger measure-eligible population was used. Measure-specific tables are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Performance-on-the-Child-Core-Set-Measures-FFY-2014.zip.

The Central Line-Associated Blood Stream Infections (CLABSI) and the CAHPS Health Plan Survey measures were excluded from this table because the measures use a summary statistic different from those in this table.

[a] Combination 3 includes four doses of diphtheria, tetanus, and acellular pertussis (DTaP); three doses of polio (IPV); one dose of measles, mumps, and rubella (MMR); two doses of H influenza type B (HiB); three doses of hepatitis B (HepB), one dose of chicken pox (VZV); and four doses of pneumococcal conjugate (PCV).

[b] Combination 1 includes one dose of meningococcal vaccine and one tetanus, diphtheria toxoids, and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) vaccine.

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

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	ADHD	Asthma	Behav. Health[c]	Childhood Immunizations	ED Visits	Hospital Readmissions	Lead Screening	Oral Health	Prenatal and Postpartum Care	Primary Care Access[d]	EPSDT	Weight/ BMI	Well-Child Care[e]	Other[f]
Total PIPs				573	10	26	161	28	43	56	10	32	62	5	28	26	68	85
Total States				36	5	14	22	11	15	12	4	8	16	3	10	13	16	15
Arizona	Varies by PIP	All	C	10	--	--	--	--	--	9*	--	--	--	--	--	--	--	1
			U	14	--	--	1*	--	--	13*	--	--	--	--	--	--	--	--
California	2013	All	C	16	1	--	1	3	--	--	--	--	7	2	--	1	--	1
			A/C	1	--	1	--	--	--	--	--	--	--	--	--	--	--	--
			U	2	--	--	--	--	1	--	--	--	--	--	--	--	--	1
Colorado	FY2013–2014	All	C	6	--	2	1	--	2	--	--	--	--	--	--	2	1	--
			U	3	--	--	3	--	--	1	--	--	--	--	--	--	--	--
Dist. of Col.	2014	All	C	8	--	4*	--	--	4*	--	--	--	4*	--	--	--	--	--
Florida	Varies by PIP	Some	C	73	--	1	12*	--	--	1	1	17	15*	--	--	--	31*	11
			A/C	17	--	2	13*	--	--	2	--	--	--	--	--	--	--	--
			U	41	--	--	6	1	2	2	--	--	--	--	--	1	--	29
Georgia	2013	All	C	21	3*	--	--	3*	3*	--	--	3*	3*	--	--	3*	3*	--
			U	6	--	--	--	--	--	--	--	--	--	--	--	--	--	6*
Hawaii	Varies by PIP	All[g]	A/C	2	--	--	2	--	--	--	--	--	--	--	--	2	--	--
Illinois	2012–2013	All[g]	C	6	--	--	3*	--	--	--	--	--	3*	--	3*	--	3*	--
			U	2	--	--	--	--	--	2*	--	--	--	--	--	--	--	--
Iowa	2013	All	C	2	--	--	1	--	--	--	1	--	2	--	1	--	--	--
			A/C	1	--	1	--	--	--	--	--	--	--	--	--	--	--	--
Kansas	Varies by PIP	All[g]	C	1	--	--	--	--	--	--	--	--	--	--	--	--	1	--
			A/C	2	--	--	2	--	--	--	--	--	--	--	--	--	--	--
Kentucky	2013	All	C	4	2	--	--	--	--	--	--	1	--	--	--	--	--	1
			A/C	6	--	1	2	--	3	--	--	--	--	--	--	--	--	--
			U	1	--	--	--	--	--	1	--	--	--	--	--	--	--	--
Louisiana	2013–2014	All[g]	C	2	--	--	--	1	--	--	--	--	1	--	--	--	--	--
			A/C	4	--	--	--	--	4*	--	--	--	--	--	--	--	--	--
Maryland	2013	All	C	6	--	--	--	--	--	--	--	--	--	--	--	--	6*	--
Massachusetts	Varies by PIP	All[g]	C	3	--	--	--	--	--	--	--	--	3	--	--	--	--	--
			U	5	--	--	5*	--	--	5*	--	--	--	--	--	--	--	--
Michigan	2013–2014	All	C	9	--	--	--	1	--	--	--	--	3	--	1	--	3	--

Table 3 (continued)

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	ADHD	Asthma	Behav. Health[c]	Childhood Immunizations	ED Visits	Hospital Readmissions	Lead Screening	Oral Health	Prenatal and Postpartum Care	Primary Care Access[d]	EPSDT	Weight/ BMI	Well-Child Care[e]	Other[f]
Minnesota	Varies by PIP	All	C	4	--	--	--	--	4	--	--	--	--	--	3	--	--	--
			A/C	3	--	--	--	--	--	--	--	--	--	--	--	--	--	--
			U	17	--	2	9*	4	1	1	--	1	--	--	--	--	--	1
Mississippi	2013	All	A/C	4	--	2	--	--	--	--	--	--	--	--	--	2	--	--
Missouri	2013	All[g]	C	4	--	--	--	--	--	--	--	3*	1	--	--	--	--	--
			A/C	1	--	--	1	--	--	--	--	--	--	--	--	--	--	--
			U	1	--	1	--	--	--	--	--	--	--	--	--	--	--	--
Nebraska	Varies by PIP	All	C	6	--	--	4	1	--	--	--	--	--	--	--	1	--	--
			A/C	4	--	--	1	--	3	--	--	--	--	--	--	--	--	--
			U	1	--	--	1	--	--	--	--	--	--	--	--	--	--	--
Nevada	2013–2014	All	C	1	--	--	--	--	--	--	--	--	--	1*	--	--	--	--
			A/C	2	--	--	--	--	2*	--	--	--	--	--	--	--	--	--
New Hampshire	2013–2014	All	C	7	--	--	--	--	--	--	--	--	2*	--	--	1	2	2*
			A/C	3	--	--	2*	--	--	--	--	--	--	--	1	--	--	--
			U	3	--	--	--	--	--	1	--	--	--	--	--	--	--	2*
New Jersey	2013	All	C	16	--	--	--	--	--	--	4	5	4	--	--	2	2	--
			U	1	--	--	--	--	--	--	--	--	--	--	--	1	--	--
New Mexico	2012–2013	All[g]	C	6	--	1	--	1	--	--	--	1	2	--	--	--	--	1
			A/C	1	--	1	--	--	--	--	--	--	--	--	--	--	--	--
North Carolina	Varies by PIP	Some	C	1	--	--	1	--	--	--	--	--	--	--	--	--	--	--
			A/C	1	--	--	--	--	--	--	--	--	--	--	--	--	--	1
			U	12	--	--	6	--	1	--	--	--	--	--	--	--	--	5
North Dakota	2013	All[g]	C	3	--	--	--	1	--	--	--	1	--	--	--	--	1	--
Ohio	2013	All[g]	C	7	--	--	--	--	--	--	--	--	--	--	7*	--	--	--
Oregon	Varies by PIP	Some	C	14	--	--	7	--	--	--	--	--	10	1	1	--	1	--
			U	12	--	--	6	--	1	4	--	--	--	1	1	--	--	2
Pennsylvania	Varies by PIP	Some	C	7	--	--	--	--	--	--	--	--	--	--	--	7*	--	--
			A/C	5	--	--	5*	--	--	--	--	--	--	--	--	--	--	--
			U	20	--	--	11*	--	8*	12*	--	--	--	--	--	--	--	--
Rhode Island	2013	All	C	2	2*	--	--	--	--	--	--	--	--	--	--	--	--	--
			A/C	4	--	--	--	--	--	--	--	--	--	--		--	--	4*
South Carolina	2013	All[g]	C	2	--	1	--	--	--	--	--	--	--	--	--	--	1	--
			U	2	--	--	--	--	--	--	--	--	--	--	--	--	--	2

Table 3 (continued)

State	Years of Data	PIPs Validated[a]	PIP Population[b]	Number of PIPs	ADHD	Asthma	Behav. Health[c]	Childhood Immunizations	ED Visits	Hospital Readmissions	Lead Screening	Oral Health	Prenatal and Postpartum Care	Primary Care Access[d]	EPSDT	Weight/ BMI	Well-Child Care[e]	Other[f]
Tennessee	2013–2014	All	C	9	2	--	--	--	--	--	--	--	1	--	5	1	--	--
			A/C	3	--	--	3	--	--	--	--	--	--	--	--	--	--	--
			U	14	--	--	--	--	--	--	--	--	--	--	--	--	--	14
Utah	2012	All	C	3	--	--	--	--	--	--	--	--	--	--	--	--	3	--
			A/C	1	--	--	1	--	--	--	--	--	--	--	--	--	--	--
			U	9	--	--	9	--	--	--	--	--	--	--	--	--	--	--
Virginia	2013	All	C	7	--	--	--	--	--	--	--	--	--	--	--	--	7*	--
			A/C	7	--	--	7*	--	--	--	--	--	--	--	--	--	--	--
Washington	2014	All	C	14	--	--	12	--	--	1	--	--	--	--	--	--	2	--
			A/C	1	--	1	--	--	--	--	--	--	--	--	--	--	--	--
			U	15	--	--	8	--	--	5*	--	--	--	--	--	1	--	2
West Virginia	2013	All[g]	C	3	--	--	--	1	--	--	--	--	--	--	--	1	1	--
			A/C	3	--	3*	--	--	3*	--	--	--	--	--	--	--	--	--
Wisconsin	FY2013–2014	Some	C	16	--	--	--	11	--	--	4	--	1	--	--	--	--	--
			A/C	7	--	--	7	--	--	--	--	--	--	--	--	--	--	--
			U	13	--	2	8	--	1	1	--	--	--	--	--	--	--	1

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

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

DE submitted readiness reviews, which did not include information about PIPs. NY submitted a summary report, which did not include information about PIPs.

This table focuses on PIPs that target children and pregnant women, and may include some PIPs that also target adults. For example, certain behavioral health PIPs, such as those that focus on the Follow-Up After Hospitalization for Mental Illness measure, may target both adults and children. PIPs that target adults are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

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

* PIP topic was mandated by the state. In some states, these PIPs operated as a single, collaborative PIP in which all MCOs participated. In other states, each MCO or PIHP separately implemented a PIP on the mandated topic.

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

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

[c] The Behavioral Health category includes measures that focus on mental health, substance use disorders, and other behavioral conditions. PIPs focused on ADHD are counted separately.

[d] The Primary Care Access category includes measures that focus on access to primary care physicians or primary care medical homes.

[e] During the 2014–2015 reporting cycle, the following states had PIPs that focused on adolescent well-care: Georgia (3 state-mandated PIPs), Maryland (1 collaborative PIP across 6 MCOs), Michigan (1 PIP), South Carolina (1 PIP), Tennessee (1 PIP), Virginia (1 collaborative PIP across 7 MCOs), and West Virginia (1 MCO).

[f] Other PIP topic areas include member satisfaction (FL, GA, SC), parent satisfaction (NH, SC), provider satisfaction (GA, FL, SC), access to primary care physicians (CA, NV), number of recipients with clinical lab data in an electronic health record (AZ), rate of school attendance (CA), patient experience (CA), medication review (FL), call center timeliness (FL), balance billing (FL), getting needed care (FL), biannual submission of child functional assessment (FL), satisfaction with health plan (FL), improving access to culturally and linguistically appropriate services (FL), reducing disparities in cultural competence among practicing physicians (FL), first call resolution (FL), telephone answer speed (FL), using an organization assessment to implement trauma-informed care (FL), improved satisfaction with cultural and language services with people living with

Table 3 (continued)

HIV/AIDS (FL), timeliness of services for long-term care services (FL), electronic health records with meaningful use (FL), number of health risk assessments (FL), number of community health workers (FL), inappropriately prescribed antibiotics in children with pharyngitis and upper respiratory tract infections (KY), medication reconciliation (MN), utilizing synagis in improving health and reducing hospitalizations in vulnerable infants and children (NM), call rollover (NC), stakeholder access to information (NC), community outreach program for members who are super-utilizers (OR), number of patient-centered primary care medical home users (OR), maternal medical home (OR), initial health screens for special enrollment populations (RI), chlamydia screening (RI), timely recredentialing of providers (TN), cultural assessment and cultural integration survey (TN), Multicultural Community Service (MCS) accountable and collaborative care (WA), and reducing volume of MCS member grievance calls (WA).

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

A/C = Adult and Child; ADHD = Attention-deficit/hyperactivity disorder; Behav. = Behavioral; BMI = body mass index; C = Child only; CHIP = Children's Health Insurance Program; ED = emergency department; EPSDT = Early and Periodic Screening, Diagnostic and Treatment; EQRO = External Quality Review Organization; FY = fiscal year; MCO = managed care organization; PIHP = prepaid inpatient health plan; U = Unspecified Age.

FIGURES

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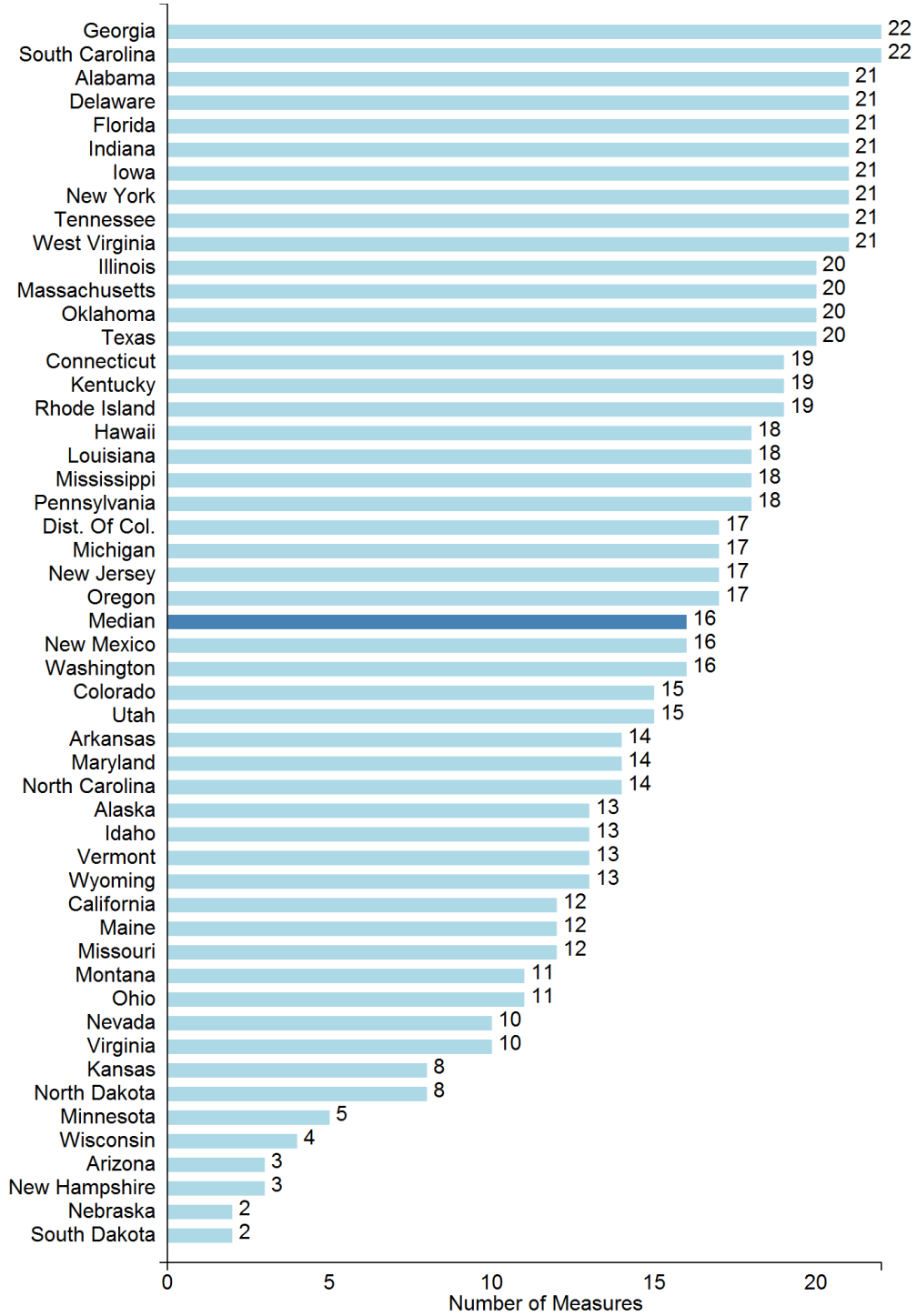
Figure 1. Number of Medicaid/CHIP Children's Health Care Quality Measures Reported by States, FFY 2014

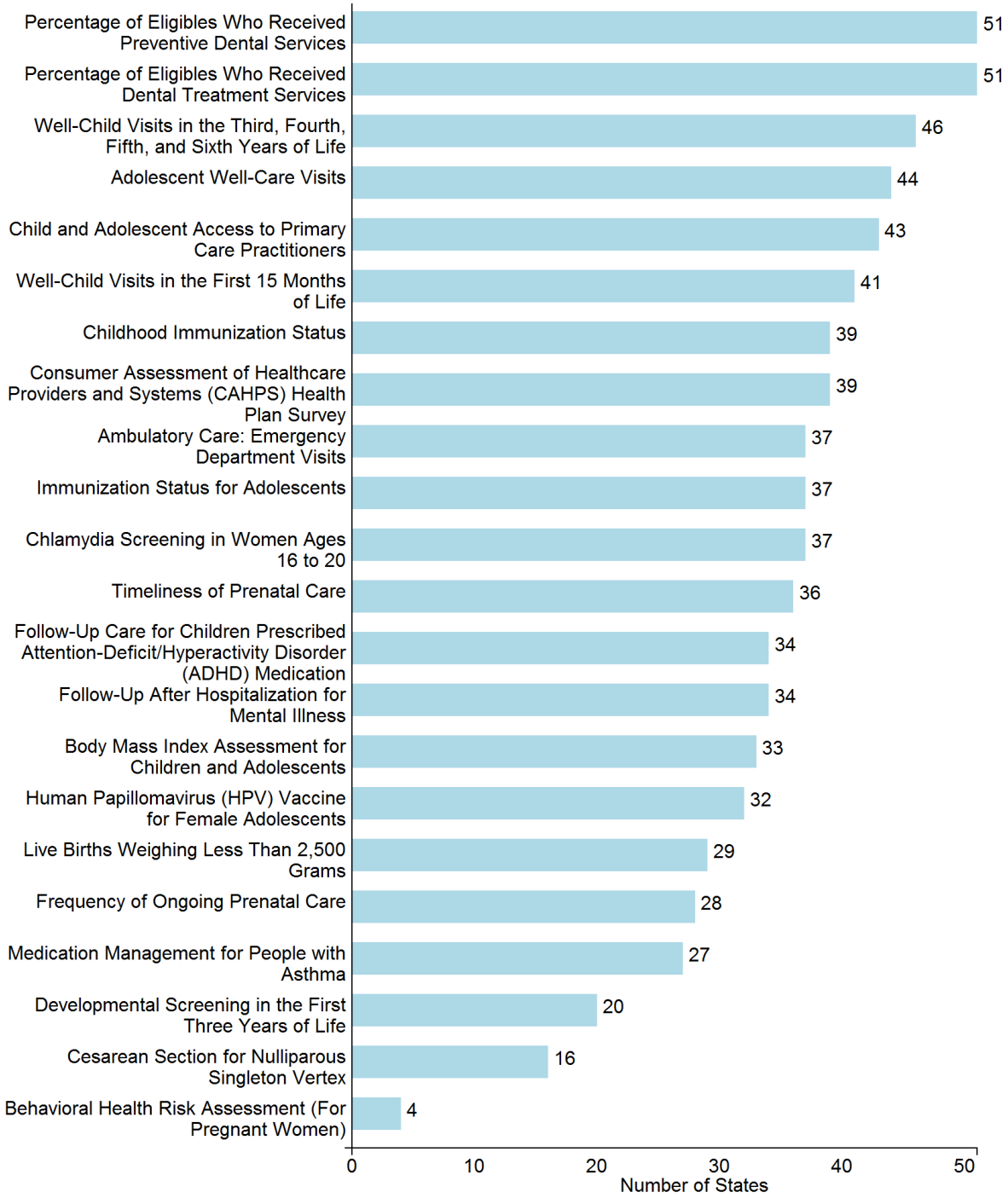


Sources: Mathematica analysis of FFY 2014 Child CARTS reports and Form CMS-416 reports.

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

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

Figure 2. Number of States Reporting the Core Set of Medicaid/CHIP Children's Health Care Quality Measures, FFY 2014

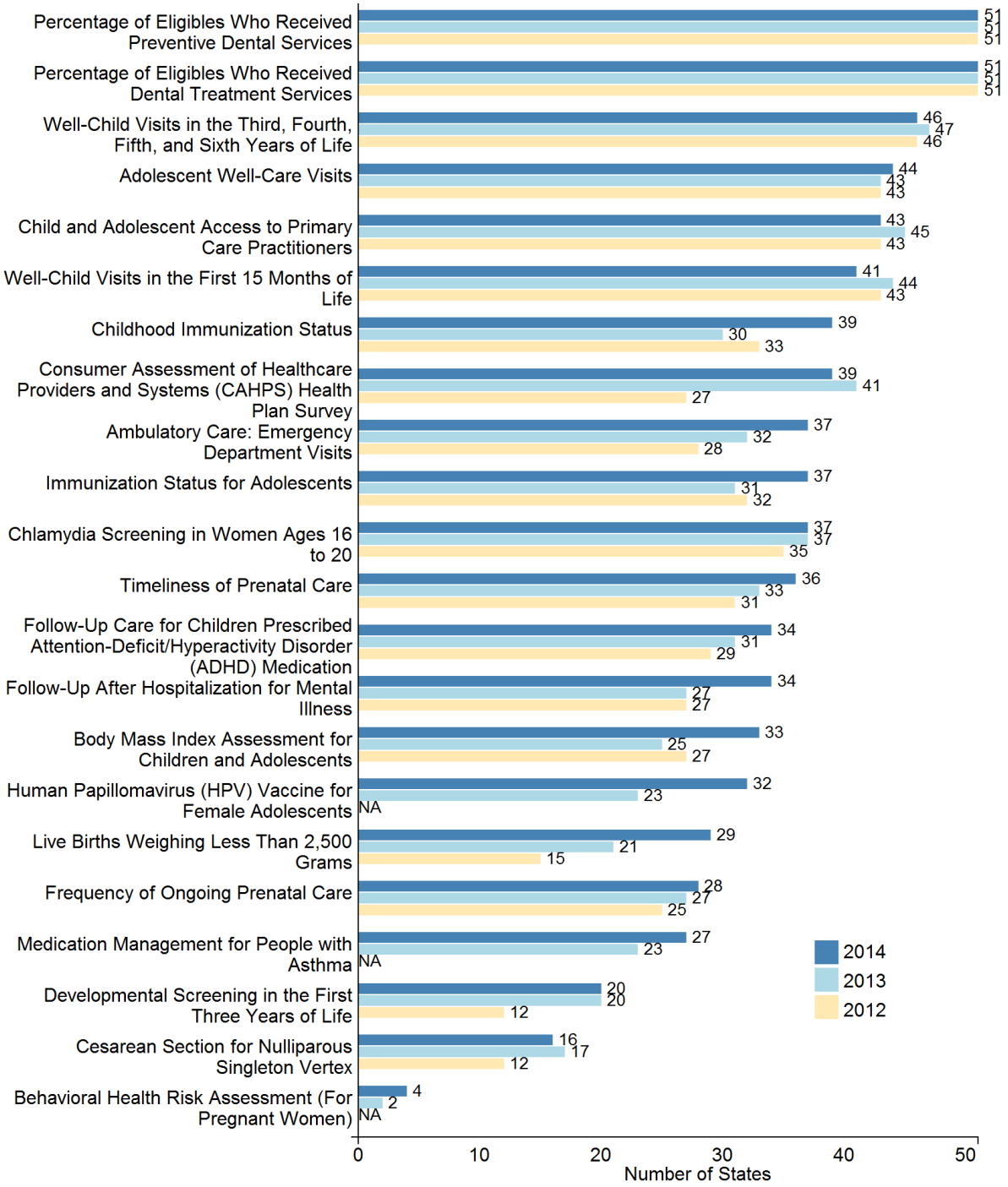


Sources: Mathematica analysis of FFY 2014 Child CARTS reports and Form CMS-416 reports.

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

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

Figure 3. Changes in the Number of States Reporting the Medicaid/CHIP Children's Health Care Quality Measures, FFY 2012–2014



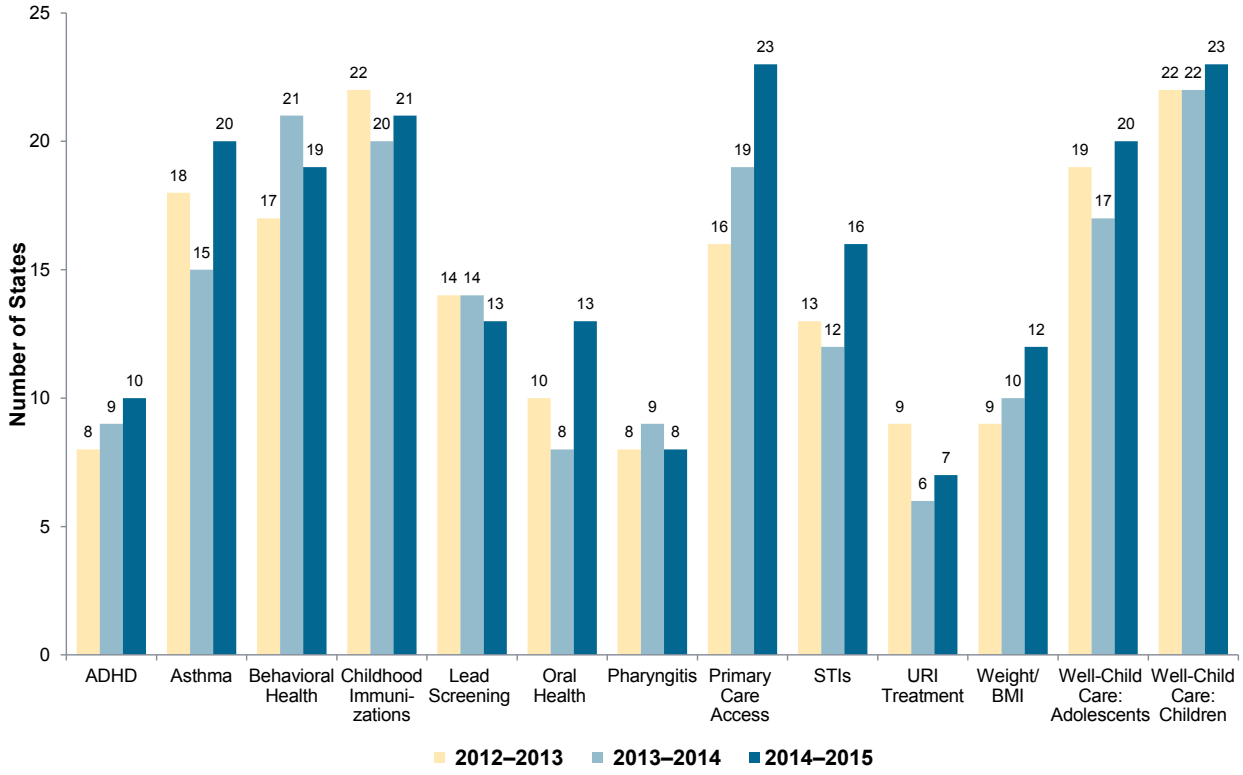
Sources: Mathematica analysis of FFY 2012–2014 Child CARTS reports and FFY 2012–2014 Form CMS-416 reports.

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

This figure excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC's National Healthcare Safety Network.

NA = measures were not collected for FFY 2012.

Figure 4. Comparison of Performance Measures Evaluating Children's Health Care Quality That Were Reported in External Quality Review (EQR) Technical Reports for the 2012–2013, 2013–2014, and 2014–2015 Reporting Cycles for 29 States, by General Topic



Sources: Performance measures for 2012–2013 and 2013–2014 were obtained from the 2014 Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. Performance measures for 2014–2015 are based on Mathematica Policy Research analysis of the 2014–2015 EQR technical reports.

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

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

This figure focuses on measures that target children and pregnant women, and may include some PIPs that also target adults. For example, certain behavioral health PIPs, such as those that focus on the Follow-Up After Hospitalization for Mental Illness measure, may target both adults and children. PIPs that target adults are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

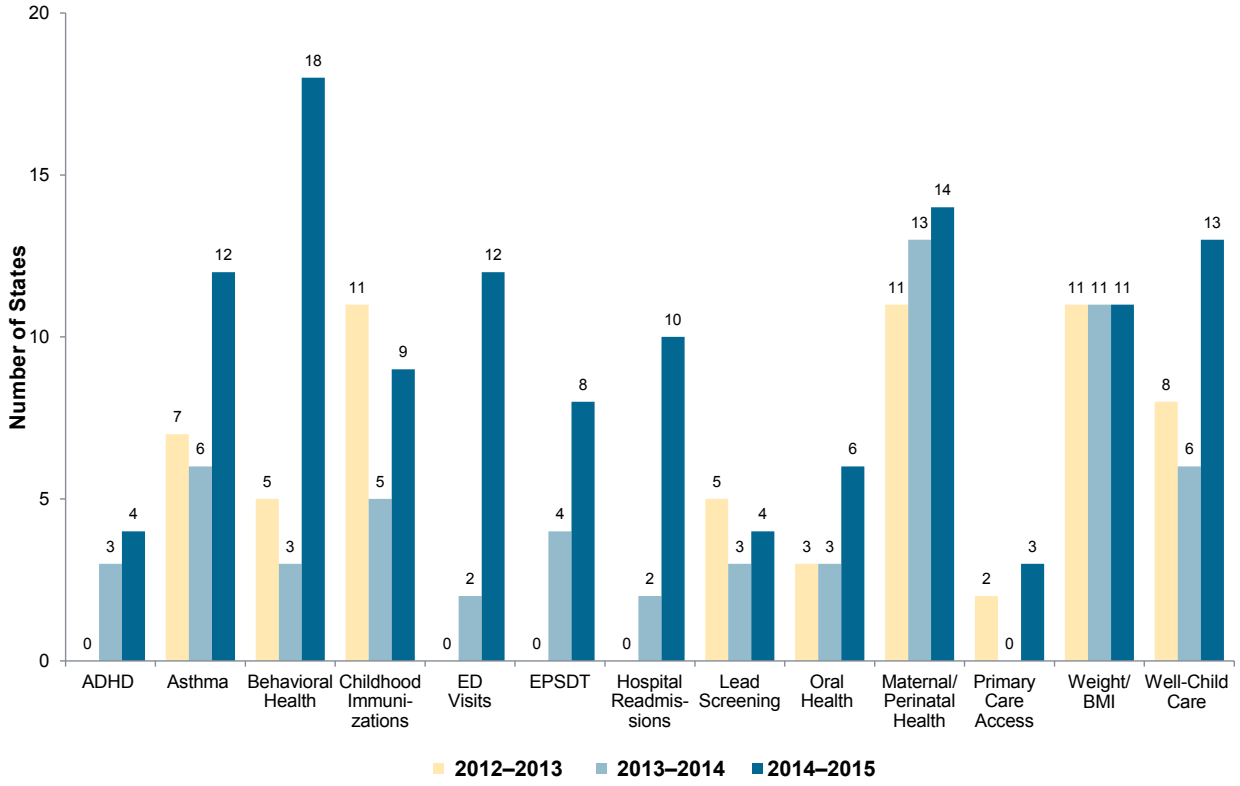
The Behavioral Health category includes measures that focus on mental health, substance use disorders, and other behavioral conditions. Measures focused on ADHD are counted separately.

The Primary Care Access category includes measures that focus on access to primary care physicians or primary care medical homes.

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

ADHD = Attention-Deficit/Hyperactivity Disorder; CHIP = Children's Health Insurance Program; Pharyngitis = Appropriate testing or treatment for children with pharyngitis; STI = Sexually Transmitted Infection; URI = Upper Respiratory Infection.

Figure 5. Comparison of Performance Improvement Projects (PIPs) Targeting Children and Pregnant Women That Were Reported in External Quality Review (EQR) Technical Reports for the 2012–2013, 2013–2014, and 2014–2015 Reporting Cycle for 28 States, Selected Topics



Sources: PIPs for 2012–2013, and 2013–2014 were obtained from the 2014 Secretary's Report on the Quality of Care for Children in Medicaid and CHIP. PIPs for 2014–2015 are from Mathematica Policy Research analysis of 2014–2015 EQR technical reports.

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

States include AZ, CA, CO, DC, FL, GA, HI, IL, IA, KS, MD, MA, MI, MN, MO, NE, NV, NJ, NM, OR, PA, RI, SC, TN, VA, WA, WV, and WI. These are the states that reported PIPs in all three comparison years.

This figure focuses on PIPs that target children and pregnant women, and may include some PIPs that also target adults. For example, certain behavioral health PIPs, such as those that focus on the Follow-Up After Hospitalization for Mental Illness measure, may target both adults and children. PIPs that target adults are available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Findings-from-EQR-Technical-Reports-2014-2015.zip.

The Behavioral Health category includes PIPs that focus on mental health, substance use disorders, and other behavioral conditions. PIPs focused on ADHD are counted separately.

The Primary Care Access category includes PIPs that focus on access to primary care physicians or primary care medical homes.

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

ADHD = Attention-Deficit/Hyperactivity Disorder; BMI = body mass index; CHIP = Children's Health Insurance Program.

GLOSSARY

ADD	Follow-Up Care for Children Prescribed ADHD Medication
ADHD	Attention-Deficit/Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
AMB	Ambulatory Care: Emergency Department Visits
AWC	Adolescent Well-Care Visits
BHRA	Behavioral Health Risk Assessment for Pregnant Women
BMI	Body Mass Index
C&M	Continuation and Maintenance
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Child and Adolescent Access to Primary Care Practitioners
CARTS	CHIP Annual Reporting Template System
CCC	Children with Chronic Conditions
CCO	Coordinated Care Organization
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHCS	Center for Health Care Strategies
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHL	Chlamydia Screening in Women
CIS	Childhood Immunization Status
CLABSI	Central Line-Associated Blood Stream Infection
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
CSEC	Cesarean Rate for Nulliparous Singleton Vertex
CY	Calendar Year
DEV	Developmental Screening in the First Three Years of Life
DTaP	Diphtheria, Tetanus, and Acellular Pertussis Vaccine
ED	Emergency Department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FFY	Federal Fiscal Year
FPC	Frequency of Ongoing Prenatal Care
FUH	Follow-Up After Hospitalization for Mental Illness
FY	Fiscal Year

HAI	Healthcare-Associated Infection
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HEDIS®	Healthcare Effectiveness Data and Information Set
HepA	Hepatitis A
HepB	Hepatitis B
HHS	U.S. Department of Health and Human Services
HiB	H Influenza Type B
HIO	Health Insuring Organization
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus Vaccine for Female Adolescents
IMA	Immunization Status for Adolescents
IPV	Inactivated Polio Vaccine
LBW	Live Births Weighing Less than 2,500 Grams
MACBIS	Medicaid and CHIP Business Information Solutions
MCO	Managed Care Organization
MCS	Multicultural Community Service
MMA	Medication Management for People with Asthma
MMR	Measles, Mumps, and Rubella
NA	Not Available
NCQA	National Committee for Quality Assurance
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
NQF	National Quality Forum
NSV	Nulliparous Singleton Vertex
OB/GYN	Obstetrical/Gynecological
OME	Otitis Media with Effusion
ONC	Office of the National Coordinator for Health Information Technology
PCP	Primary Care Practitioner
PCPI	Physician Consortium for Performance Improvement
PCV	Pneumococcal Conjugate Vaccine
PDENT	Preventive Dental Services
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PPC	Timeliness of Prenatal Care
PQMP	Pediatric Quality Measures Program
RV	Rotavirus
SIR	Standardized Infection Ratio
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TA/AS	Technical Assistance and Analytic Support

Td	Tetanus and Diphtheria Toxoids Vaccine
Tdap	Tetanus, Diphtheria Toxoids, and Acellular Pertussis Vaccine
TDENT	Dental Treatment Services
The Act	Social Security Act
URI	Upper Respiratory Infection
VZV	Varicella Zoster Virus (Chicken Pox)
W15	Well-Child Visits in the First 15 Months of Life
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children and Adolescents

MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015

FINAL REPORT

AUGUST 31, 2015

NATIONAL QUALITY FORUM

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

CONTENTS

EXECUTIVE SUMMARY

Together, Medicaid and the Children's Health Insurance Program (CHIP) cover more than 45 million children, which is more than 1 in every 3, and half of all low-income children in the United States.[1,2] Medicaid plays a key role in child and maternal health, financing healthcare services for about 40 percent of all births, on average, across the country.[3] Improving the health and healthcare of children enrolled in Medicaid and CHIP is an important opportunity and a priority for our nation.

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. The 2015 Child Core Set contains 24 measures representing the diverse health needs of the Medicaid and CHIP enrollee population, spanning many clinical topic areas. The measures are relevant to children ages 0-18 as well as pregnant women in order to encompass both prenatal and postpartum quality-of-care issues. CHIPRA also requires CMS to update the initial Core Set annually to ensure that the best available measures are being used. Changes to the Child Core Set of measures are informed by the Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to the Department of Health and Human Services (HHS) on the use of performance measures to assess and improve the quality of care. Guided by MAP's Measure Selection Criteria and feedback from several years of state implementation, MAP is providing its latest round of annual recommendations to HHS for strengthening and revising measures in the Child Core Set and identifying high-priority measure gaps.

Not finding significant implementation difficulties, MAP supported all of the Federal Fiscal Year (FFY) 2015 Child Core Set measures for continued use. In addition, MAP recommends that CMS consider up to six measures for phased addition. MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all measures supported by MAP is highly unlikely. Therefore, MAP rank ordered the measures it supports.

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

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

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

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

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 with relevant interests and expertise (Appendix B).

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

This is MAP's second set of recommendations on the Child Core Set; it follows an Expedited Review performed in 2014. It evaluates the measures in CMS's Child Core Set being used in Federal Fiscal Year (FFY) 2015 and recommends changes that would be effective for FFY 2016 reporting. The recommendations have been vetted through an opportunity for public comment (Appendix E). The annual process has allowed for a deeper understanding of the Medicaid landscape, the measures in use, and how states engage with the program. HHS uses MAP's findings, including the state perspectives, to inform the statutorily required annual update of the Child Core Set.

BACKGROUND ON MEDICAID AND THE CHILD CORE SET

Currently covering more than 45 million children, Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals.[4,5] 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.[6]

Medicaid and CHIP Benefits for Children and Pregnant Women

Together, Medicaid and CHIP cover more than 45 million children, which is more than 1 in every 3, and half of all low-income children in the United States.[7,8] Medicaid plays a key role in child and maternal health, financing healthcare services for about 40 percent of all births, on average, across the states.[9] 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).[10] The FPL is determined by family size: it is $24,250 for a family of four in 2015.[11] As of April 2015, 28 states (including the District of Columbia) covered children in families with incomes at or above 250 percent FPL.[12] Additional background on Medicaid and CHIP structure and benefits for children and pregnant women was presented to MAP and is accessible in the report from the **2014 review**.[13]

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. While most children are healthy and the focus of their care is on strong development and prevention of disease, it is important to consider with equal attention the group of children with complex health needs. Medicaid covers approximately two-thirds of all children with complex health needs, accounting for approximately 6 percent of the total number of children with Medicaid. However, this 6 percent of enrollees incur nearly 40 percent of costs.[14]

Poor birth outcomes have a disproportionately strong impact in the Medicaid population, and MAP discussed in detail the downstream negative effects of births resulting from unintended and/or closely spaced pregnancies. Risks associated with these types of pregnancies include inadequate or delayed prenatal care, premature birth, and low birthweight, among others.[15] Medicaid covers more than half of hospital stays related to short gestation, low birth weight, or inadequate fetal growth.[16]

Increased access to high-quality care before and between pregnancies, also known as preconception and interconception care, can reduce the risk of pregnancy-related complications, including maternal and infant mortality.[17] Many stakeholders, including state Medicaid agencies, are working to improve the availability and uptake of effective contraceptive methods, including long-acting reversible contraceptives (LARCs).[18] MAP's focus on this issue mirrors that of the public health field. For example, the Healthy People 2020 campaign aims to reduce unintended pregnancy in the United States by 10 percent, from 49 percent of pregnancies to 44 percent of pregnancies.[19]

Children with behavioral health issues also deserve special attention in measurement due to their

complex health needs and the impact they have on Medicaid utilization and spending. MAP explored the issue of access to appropriate behavioral health services and the rising prescription of psychotropic medications for publicly insured children.[20] Behavioral health experts are especially concerned about the recent increase in prescribing of antipsychotic drugs, in part because of their very serious side effects, including rapid weight gain and the increased risk for the development of diabetes.[21] Studies have shown that on average, 6.2 percent of noninstitutionalized children with Medicaid took psychotropic medications during a calendar year, and 21 percent of those children took an antipsychotic medication.[22] It was separately estimated that antipsychotic use increased from 8.9 percent in 2002 to 11.8 percent in 2007 and that state-specific rates of prescribing increased in 45 states over the same time period.[23]

Background and Use of the Child Core Set

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 the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009.[24] The 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. Additionally, the Adult Core Set did not yet exist when the initial Child Core Set was published.

CMS's 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. States voluntarily submit data to CMS once annually. CMS then uses the Child Core Set data to obtain a snapshot of quality across Medicaid and CHIP and to inform policy and program decisions. Data from the Core Set are also presented in several publications each year, including the **annual child health quality report** and other analyses such as **chart packs**.[25,26]

Characteristics of the Current Child Core Set

CHIPRA also required CMS to update the initial Core Set annually beginning in January 2013. For the 2015 update, CMS issued changes that were informed by MAP's 2014 review and input. Following MAP's recommendation, CMS removed the measure Percentage of Eligibles That Received Dental Treatment Services and replaced it with the NQF-endorsed measure #2508 Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk. CMS also followed MAP's recommendation to add NQF #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment to augment the emphasis on behavioral health issues. Additionally, CMS has decided to pilot test the pediatric version of the Hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS) to determine how to aggregate the data for state-level reporting before full inclusion into the Core Set. Not including Child HCAHPS, the 2015 version of the Child Core Set contains a total of 24 measures (**Appendix D**).[27]

The 2015 Child Core Set measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 1).

Viewed as an array of measure types, the set contains no structural measures, 21 process measures, 3 outcome measures, and 1 experience-of-care measure. Additionally, the Child Core Set is well aligned with other quality and reporting initiatives: nine 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.[28] Representing the diverse health needs of the Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 2).

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

National Quality Strategy Priority	Number of Measures (n = 24)
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	17
Affordability	2

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

Clinical Areas	Number of Measures (n = 24)
Access to Care	1
Behavioral Health	3
Care of Acute and Chronic Conditions (e.g., Asthma, Obesity)	3
Experience of Care	1
Maternal and Perinatal Care	6
Oral Health	2
Preventive Care	8

STATE EXPERIENCE COLLECTING AND REPORTING THE CORE SET

MAP gathered feedback on the implementation of the Child Core Set from states that participated in reporting and the **2014 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP**.[29] Representatives from Medicaid agencies in Louisiana and Minnesota shared their implementation experiences, measure-specific challenges, and quality improvement successes related to reporting the Child Core Set. Additionally, they provided feedback on strategic issues and measure gap areas to guide MAP's decisionmaking. These perspectives are a sample and not necessarily representative of all state Medicaid programs, but they informed MAP's measure-specific and strategic recommendations for the Child Core Set in support of CMS's three-part goal.

Louisiana

In the state of Louisiana, more than one million residents receive healthcare coverage through Medicaid, most of whom are children younger than 19.[30] Since June 2012 almost all children and pregnant women with Medicaid have been enrolled in a managed care benefit plan. On the whole, Louisiana's residents have below-average income, and the state consistently finds itself at or near the bottom of health rankings.[31]

During the first year of participation in the Children's Health Quality Measures reporting program, Louisiana submitted six measures in the Child Core Set to CMS. Believing that measurement processes can evolve and improve over time, state staff worked diligently to increase the number of measures reported each year. To do so, Louisiana built new capacities by partnering with public health agencies and other partners in the state. The agency also made significant strides in linking vital records and immunization registry information to their Medicaid data to enable the reporting of more measures. Louisiana was able to report an additional 10 additional measures in 2014.

Representatives from Louisiana identified several measure-specific challenges to reporting the Child Core Set. The chart review process is expensive and time-consuming; the state has worked through multiple strategies to determine the most

efficient ways of obtaining necessary medical records to support measurement. Measures based on administrative data are less burdensome. Additionally, the process of building trust in the provider network is slow but necessary; clinicians need tools and understandable data to drive improvement at the individual practice level.

Representatives from Louisiana also recommended to CMS and MAP that the Core Set include measures that address premature birth, as it influences a lifetime of health outcomes and is itself very costly. Specifically, the panelists urged more widespread access to progesterone for women at risk of a premature delivery. Representatives also suggested MAP consider measures of Attention Deficit Hyperactivity Disorder (ADHD), noting the geographic variation and potential overuse of drug treatment of ADHD they have observed in their state.

Minnesota

The state of Minnesota provides Medicaid-funded healthcare to more than 700,000 low-income Minnesotans each month. Three-fourths of the enrollees are children and families, pregnant women, and adults without children.[32] Both the state's CHIP and Medicaid programs use a managed care delivery system.

During the past three consecutive years of participation, Minnesota submitted five measures in the Child Core Set to CMS. To select and report these measures, state officials considered accountability, potential for quality improvement, population comparison, known health disparities, and development policy. Likewise, the state representative observed that making a concerted effort to improve quality on three to four measures at a time is all the state can realistically prioritize, though they could report additional measures.

Staff from Minnesota emphasized the need for vertical integration of measures and advised MAP and CMS to support measures that are meaningful to providers. The state and its delivery system partners have succeeded in reducing early elective delivery rates, in part because this quality improvement opportunity was perceived as actionable. Minnesota also identified three measure gaps in the Child Core Set: opiate exposure for neonates, behavioral health functional outcomes stemming from trauma-informed care, and care coordination/case management to address social determinants.

MAP REVIEW OF THE CHILD CORE SET

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

MAP also used the MSC to review currently available measures and identify those with the best potential to fill gaps in the current set. Using measure gap areas identified in the 2014 review as a starting place, NQF staff compiled and presented measures in the following topic areas: cost as represented by hospital readmissions, care coordination, measures in the inpatient care setting, maternal/perinatal care, and behavioral health. MAP discussed a small number of measures

that staff judged to be a good fit for the Core Set largely based on their specifications, and the MSC, and the feasibility of implementing them for statewide quality improvement. All MAP Task Force members also had the opportunity to raise other available measures for discussion and consideration.

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

NQF has not yet endorsed measures in all relevant topic areas. For example, MAP reviewed measures newly developed under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP). This grant program was established under CHIPRA to increase the portfolio of evidence-based, consensus-driven pediatric quality measures available to the field.[33] A small number of PQMP measures have completed endorsement review, and it is likely that many more will be submitted and reviewed for endorsement in the coming year. Monitoring the development of new measures will continue to be relevant for future annual reviews.

Measure-Specific Recommendations

Current Measures

Not finding any significant implementation problems with the current measure set, MAP supported all of the FFY 2015 Child Core Set for continued use. No measures were recommended for removal. In general, MAP considers removing a measure when the following factors are observed:

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

Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of states using the measures to drive quality improvement locally. MAP encourages continued focus on data fidelity and strategies to improve the completeness of data reported by states on an annual basis.

Public comment generated significant discussion regarding the current measure #1799: Medication Management for People with Asthma (MMA).

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

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 (Exhibit 3, below, and Appendix D). These measures passed the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support. MAP conditionally supported measures that are not currently NQF endorsed; MAP recommends that CMS add them to the programs once the measures are fully vetted through the NQF endorsement process and the detailed technical specifications are made publicly available. Overall, public comments indicated support for MAP's recommended additions to the measure set. A small number of commenters requested the addition of other measures; these were either reviewed and failed to gain MAP's support or did not correspond to a gap area noted by MAP.

The use of the recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including maternity care and behavioral health. MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all measures supported by MAP is highly unlikely. Therefore, MAP rank ordered the measures it supports.

EXHIBIT 3. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE CHILD CORE SET

Ranking	Measure Number and Title	MAP Recommendation
1/2 (tie)	NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care	Support
	Use of multiple concurrent antipsychotics in children and adolescents (*Not NQF-endorsed)*	Conditional Support, pending successful NQF endorsement
3	Effective Postpartum Contraception Access (*Not NQF-endorsed)*	Conditional Support, pending successful NQF endorsement
4	Use of Contraceptive Methods by Women Aged 15-20 Years (*Not NQF-endorsed)*	Conditional Support, pending successful NQF endorsement
5/6 (tie)	NQF #1360: Audiological Evaluation no later than 3 months of age (EHDI-3)	Support
	NQF #2393: Pediatric All-Condition Readmission Measure	Support

MAP conducted a lengthy discussion of possible maternal and perinatal care measures because of the central importance of reproductive health for female Medicaid enrollees and their children. These topics also generated a significant volume of public comment. Measures in this topic area are currently included in both the Child Core Set and Adult Core Set of measures. The group reviewed a large volume of available measures to determine which measures would be the most effective additions to state-level reporting, emphasizing three that relate to improving birth outcomes. MAP also recommended measures in other subject areas that are important for improving quality for children with Medicaid and CHIP. Discussion of those measures follows the maternal/perinatal measures.

NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care

MAP previously recommended this measure during the 2014 review. This year MAP's prioritization placed the measure at the top of the list, tying with the measure of multiple concurrent antipsychotic medications. Measure #0477 captures the frequency at which low birth weight babies are delivered at hospitals that are not ideally equipped to care for them. Availability of a Level 3 neonatal intensive care unit (NICU) is associated with better outcomes for low birthweight infants.[34] Poor results on this measure would indicate missed opportunities to provide guidance for women with high-risk pregnancies and the need to better coordinate care regionally across facilities. Public comments emphasized that accurate designation of NICUs underpins the ability to use this measure effectively and suggested that more widespread use of the American Academy of Pediatrics' criteria is needed.

Effective Postpartum Contraception Access (Not NQF-endorsed)

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

Use of Contraceptive Methods by Women Aged 15-20 Years (Not NQF-endorsed)

This measures the rate of contraceptive use among young women who could experience unintended pregnancy. It complements a related measure of a different age group (21-44) that MAP conditionally supported for the Adult Core Set. The measure captures use of both moderately (e.g., injectables) and highly (e.g., LARC) effective forms of contraception. After detailed discussion of potential ethical implications and strong agreement that the target rate for this measure would be well below 100 percent, MAP conditionally supported the measure and recommended that it be reviewed by NQF for endorsement.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Not NQF-endorsed)

Stakeholders have become increasingly concerned about rising rates of psychoactive medication use in the pediatric population and the risks associated with those classes of drugs. While psychotropic medications are an integral part of current evidence-based treatment for mental illness, studies have found high levels of potentially inappropriate psychotropic drug use by Medicaid enrollees places these individuals at increased risk for adverse health events and death, particularly for children.[35] A state representative presented compelling data about observed overuse of antipsychotic medication, with significant variation by race and geography. After reviewing several measures that evaluate different aspects of this problem, MAP conditionally supported the AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ) measure of

the rate at which children and adolescents are prescribed multiple antipsychotic medications. MAP intended this measure to enhance the presence of mental and behavioral health in the program. Because the measure uses administrative data, has been tested at the state level, and is included in the HEDIS program, MAP members agreed that feasibility of reporting would be relatively high.

Public comment yielded numerous requests for reconsideration of measure #2337 Antipsychotic Use in Children Under 5 Years Old. Proponents cited the fact that there are no approved uses of antipsychotic medication in this age group yet rates are rising, thus risking serious side effects including rapid weight gain and potential for diabetes. MAP had previously discussed this measure as well as seven other measures on antipsychotic use. MAP ultimately favored the measure of multiple concurrent antipsychotics, citing that it is more broadly applicable. Measure #2337 was felt to be strong, but capacity to add measures to the Core Set is limited. Additionally, participants noted that cases in which this class of medication is prescribed to a young child tend to be highly complex and lacking clear clinical guidelines. State Medicaid stakeholders have collaborated on these quality improvement opportunities and may already be tracking rates of antipsychotic use in young children independent of the Child Core Set reporting program.

NQF #1360: Audiological Evaluation No Later Than 3 Months of Age (EHDI-3)

MAP supported the addition of NQF measure #1360 to increase prompt follow-up care for infants who do not pass an initial hearing screening performed in a hospital. After learning that 2012 performance data on this measure is only 69 percent, an opportunity to improve quality became obvious. MAP agrees that this measure is an important indicator of access. In terms of alignment, the measure is also a part of the electronic health record incentive program.

NQF #2393: Pediatric All-Condition Readmission Measure

With support from the PQMP, the Center of Excellence for Pediatric Quality Measurement developed a case-mix-adjusted rate of hospital readmissions occurring within 30 days. MAP supported this measure to enhance measurement of potentially avoidable costs to Medicaid. MAP members also felt that the addition of this measure to the Child Core Set could improve discharge planning, coordination across settings, and integration with community services and supports. This measure is harmonized with #1768 Plan All-Cause Readmission Rate, which is included in the Adult Core Set. The pediatric version includes all conditions and covers patients discharged from general acute-care hospitals, including children's hospitals.

Remaining High Priority Gaps

Many important priorities for quality measurement and improvement do not yet have metrics available to address them. MAP discusses and documents these gaps in current measures to communicate its vision for the future of measurement to the developer community. Additionally, the list of measure gaps will be a starting point for future discussions and will guide annual revisions to further strengthen the Child Core Set. The Core Set includes measures related to some of the topics below, but MAP did not perceive them as comprehensive. MAP first identified other gap areas during MAP's 2014 review. An asterisk (*) denotes newly identified gap areas.

Child Core Set Measure Gaps

- Care coordination
  - Home- and community-based care
  - Social services coordination
  - Cross-sector measures that would foster joint accountability with the education and criminal justice systems*

- Screening for abuse and neglect
- Injuries and trauma
- Mental health
  - Access to outpatient and ambulatory mental health services
  - ED use for behavioral health
  - Behavioral health functional outcomes that stem from trauma-informed care*
- Overuse/medically unnecessary care
  - Appropriate use of CT scans
- Durable medical equipment (DME)
- Cost measures
  - Targeting people with chronic needs
  - Families' out-of-pocket spending
- Sickle-cell disease*
- Patient-reported outcome measures*
- Dental care access for children with disabilities – could stratify current measures*

Public commenters supported MAP's assessment of high priority measure gaps for Medicaid and CHIP enrollees. In response to the gap in measures for appropriate use of CT scans, a representative from The Joint Commission noted that their organization has become increasingly interested in this safety issue and may pursue measure development. Public commenters suggested the addition of several more measure gaps, including optimal vaccine care practices and emphasizing more measures for children with disabilities. Another comment suggested MAP could more systematically analyze measurement needs to determine if current efforts are adequate.

STRATEGIC ISSUES

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

Alignment

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

Alignment of measures has macro-level considerations. Across the health system, but especially in the context of resource-constrained state Medicaid programs, investments in quality measurement and improvement have a finite budget. Often this forces trade-offs between competing priorities. When other programs relevant to Medicaid use measures in the Adult and Child Core Sets, efficiencies are gained by reducing the number of measures that need to be collected. State panelists emphasized the importance of alignment with HEDIS, health insurance exchanges, Medicaid Health Homes, and Meaningful Use incentive programs, in particular. Another essential aspect of alignment is the use of the same measurement specifications in each of

the programs, unless there are compelling reasons why they should be different. When measures are edited by one program and not others, it reduces comparability and potentially adds burden and complexity to data collection and reporting.

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

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

Reproductive Health

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

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

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

Increasing State-Level Capacity for Quality Improvement

Peer-to-Peer Learning and Collaboration

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

Strategies to Understand and Address Disparities

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

Stratification of measures by such factors of interest is one strategy that can be used to better understand and address disparities. For example, MAP members suggested that states and CMS more deeply examine the performance of the oral health measures in the Child Core Set by stratifying results for children with special healthcare needs. High-quality, appropriate dental care for children with disabilities and/or behavioral health challenges is a well-documented area needing improvement. Different strata could be created for other measures, as appropriate. A public comment suggested that children in foster care may also warrant specific attention within measurement. Once made transparent, any disparities discovered are more easily understood and addressed with targeted action.

Appropriate Performance Benchmarks

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

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

access to effective family planning education and resources. To use another example, measurement of emergency department utilization would be expected to operate in much the same way. The expectation of the measure is not to reach zero percent; rather, it is to ensure that consumers are able to have routine health needs met in less costly and less acute environments before conditions are exacerbated to the point that urgent treatment is required.

Comments were mostly supportive of MAP's strategic recommendations. One commenter suggested that MAP further acknowledge alternate viewpoints in the reproductive health discussion to mitigate the resistance MAP and/or CMS might face with the adoption of contraceptive use measures. Comments also amplified MAP's discussion that encouraged use of measures derived from administrative and survey data, rather than chart review. Additionally, commenters appreciated MAP's emphasis on synchronizing the Child Core Set and Adult Core Set to ensure a comprehensive view of quality across an individual's lifespan.

CONCLUSION

With more than a third of the nation's children receiving healthcare through Medicaid and CHIP, it is crucial for the program to deliver high-quality healthcare. MAP's recommendations to HHS are intended to strengthen the program measure set and support CMS's goals for states' participation in the Child Core Set reporting program. MAP members found the information offered by state representatives about their implementation experiences to be highly valuable in grounding the deliberations.

To maintain stability in the measure set, MAP supports all measures in the current Child Core Set for continued use, encouraging continued focus on state-driven quality improvement projects and data accuracy and completeness. To address critical measure gap areas identified during the review, MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set. MAP also refined and expanded its list of gap areas for future action.

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

ENDNOTES

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APPENDIX A:
MAP Background

Purpose

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

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

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

MAP's objectives are to:

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

Coordination with Other Quality Efforts

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

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

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

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

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

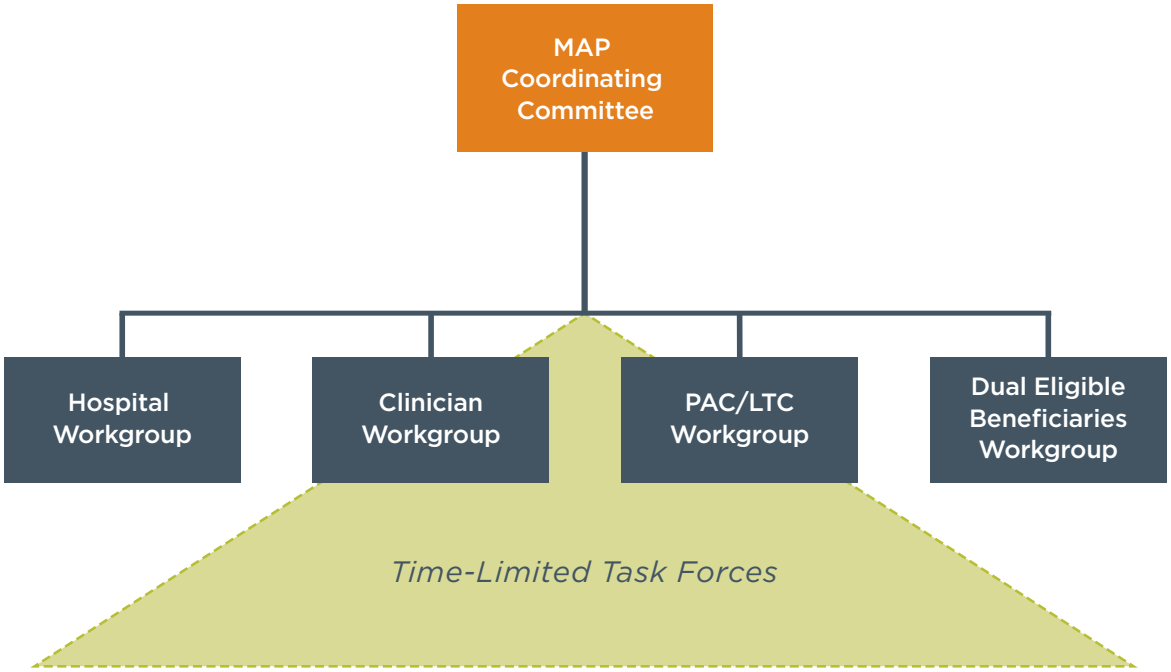
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Structure

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

EXHIBIT A1. MAP STRUCTURE



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

Timeline and Deliverables

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

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

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

ENDNOTE

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

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

Measure Applications Partnership Medicaid Child Task Force

CHAIRS (VOTING)
Foster Gesten, MD

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
American's Essential Hospitals	Denise Cunill, MD, FAAP
Blue Cross and Blue Shield Association	Carole Flamm, MD, MPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Jeff Convissar, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Luther Clark, MD
Anne Cohen, MPH
Marc Leib, MD, JD

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Agency for Healthcare Research and Quality	Denise Dougherty, PhD
Health Resources and Services Administration	Ashley Hirai, PhD
Office of the National Coordinator for Health IT	Kevin Larsen, MD, FACP

Measure Applications Partnership Coordinating Committee

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

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Lynda Flowers, JD, MSN, RN
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien
America's Health Insurance Plans	Aparna Higgins, MA
American Board of Medical Specialties	R. Barrett Noone, MD, FAcS
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Frank Opelka, MD, FACS
American HealthCare Association	David Gifford, MD, MPH
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Blue Cross and Blue Shield Association	Trent T. Haywood, MD, JD
Consumers Union	Lisa McGiffert
Federation of American Hospitals	Chip N. Kahn, III, MPH
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
The Joint Commission	Mark R. Chassin, MD, FACP, MPP, MPH
The Leapfrog Group	Melissa Danforth
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik
National Committee for Quality Assurance	Mary Barton, MD, MPP
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Network for Regional Healthcare Improvement	Elizabeth Mitchell
Pacific Business Group on Health	William E. Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Christopher M. Dezii, RN, MBA,CPHQ

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Marshall Chin, MD, MPH, FACP

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

NQF Project Staff

STAFF MEMBERS	TITLE
Sarah Lash	Senior Director
Shaconna Gorham	Senior Project Manager
Nadine Allen	Project Manager
Severa Chavez	Project Analyst

APPENDIX C:
MAP Measure Selection Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX D:
Current Child Core Set and MAP Recommendations for Addition

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 2015 version of the Child Core Set along with their current NQF endorsement number and status, including rates of state participation in 2013 reporting. Not finding any significant implementation problems, MAP recommended that all measures currently in the Child Core Set continue to be used. In FFY 2015, states will be voluntarily collecting the Child Core Set measures using the 2015 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System. Exhibit D2 lists the measures supported by MAP for potential addition to the Child Core Set.

EXHIBIT D1. CHILD CORE SET OF MEASURES FOR FFY 2015 REPORTING

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
0024 Endorsed **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)** Measure Steward: National Committee for Quality Assurance (NCQA)	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	25 states reported FY 2013 Alignment: HEDIS, Meaningful Use Stage 2 – Eligible Professionals (MU-EP), Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier, Health Insurance Exchange–Quality Rating System (HIX-QRS)
0033 Endorsed **Chlamydia Screening in Women (CHL)** Measure Steward: NCQA	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	37 states reported FY 2013 Alignment: HEDIS, Medicaid Adult Core Set, MU-EP, PQRS, Physician Value-Based Payment Modifier, HIX-QRS
0038 Endorsed **Childhood Immunization Status (CIS)** Measure Steward: NCQA	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 2013 Alignment: HEDIS, MU-EP, PQRS, HRSA program(s), Physician Value-Based Payment Modifier

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
0108 Endorsed **Follow-Up Care for Children Prescribed ADHD Medication (ADD)** Measure Steward: NCQA	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.	31 states reported FY 2013 Alignment: HEDIS, MU-EP, PQRS, Physician Value-Based Payment Modifier
0139 Endorsed **National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure** Measure Steward: Centers for Disease Control and Prevention (CDC)	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.	41 states reported FY 2013 Alignment: Hospital Acquired Condition Reduction Program, Hospital Compare, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-Term Care Hospital Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting
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).	17 states reported FY 2013 Alignment: N/A

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
0576 Endorsed **Follow-Up After Hospitalization for Mental Illness (FUH)** Measure Steward: NCQA	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.	28 states reported FY 2013 Alignment: HEDIS, Medicaid Adult Core Set, Inpatient Psychiatric Hospital Quality Reporting, HIX-QRS
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	0 states reported FY 2013 (New for 2015) Alignment: MU-EP; Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier
1382 Endorsed **Percentage of Low Birthweight Births** Measure Steward: CDC	The percentage of births with birth weight <2,500 grams	21 states reported FY 2013 Alignment: Health Resources and Services Administration/Maternal and Child Health Bureau Title V Maternal and Child Health Program
1391 Endorsed **Frequency of Ongoing Prenatal Care (FPC)** Measure Steward: NCQA	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	27 states reported FY 2013 Alignment: HEDIS

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
1392 Endorsed **Well-Child Visits in the First 15 Months of Life (W15)** Measure Steward: NCQA	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	44 states reported FY 2013 Alignment: HEDIS
1407 Endorsed **Immunizations for Adolescents (IMA)** Measure Steward: NCQA	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	31 states reported FY 2013 Alignment: HEDIS
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.	20 states reported FY 2013 Alignment: N/A
1516 Endorsed **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)** Measure Steward: NCQA	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	47 states reported FY 2013 Alignment: HEDIS, HIX-QRS
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. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	27 states reported FY 2013 Alignment: HEDIS, Medicaid Adult Core Set, HIX-QRS

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
1799 Endorsed **Medication Management for People with Asthma (MMA)** Measure Steward: NCQA	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	23 states reported FY 2013 Alignment: HEDIS
1959 Endorsed **Human Papillomavirus Vaccine for Female Adolescents (HPV)** Measure Steward: NCQA	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	23 states reported FY 2013 Alignment: HEDIS
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.	0 states reported FY 2013 (New for 2015) Alignment: N/A
Not NQF-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	2 states reported FY 2013 Alignment: N/A

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2013 and Alignment
Not NQF-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.	45 states reported FY 2013 Alignment: HEDIS
Not NQF-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 2013 Alignment: HEDIS, HIX-QRS
Not NQF-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.	41 states reported FY 2013 Alignment: HEDIS, HIX-QRS
Not NQF-endorsed **Percentage of Eligible Children Who Received Preventive Dental Services** Measure Steward: Centers for Medicare & Medicaid Services	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.	49 states reported FY 2013 Alignment: N/A
Not NQF-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.	32 states reported FY 2013 Alignment: HEDIS

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

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

Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
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.	N/A	Support addition of this measure to the program. Enhances perinatal measures and would improve regional care coordination for high-risk pregnancies.
Not NQF-endorsed **Use of Multiple Concurrent Antipsychotics in Children and Adolescents** Measure Steward: AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ)	The percentage of children 0 to 20 years of age on any antipsychotic medication for longer than 90 days during the measurement year who were on two or more concurrent antipsychotic medications for longer than 90 days.	HEDIS	Conditionally support addition of this measure to the program pending successful NQF endorsement. Addresses the challenges in tracking and measuring behavioral health issues in children.
Not NQF-endorsed **Effective Postpartum Contraception Access** Measure Steward: TBD	The percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the utilization of postpartum contraception. Part A: Highly effective postpartum contraception access. The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing. Part B: Moderately effective postpartum contraception access. The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.	N/A	Conditionally support addition of this measure to the program pending NQF endorsement. Enhances perinatal measures and would reduce the risk of pregnancy-related complications by increasing access to high-quality care before and between pregnancies.

Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
Not NQF-endorsed **Use of Contraceptive Methods by Women Aged 15-20 Years** Measure Steward: Centers for Disease Control and Prevention/ Office of Population Affairs	The percentage of women aged 15-20 years who are at risk of unintended pregnancy and who: 1) Adopt or continue use of the most effective or moderately effective FDA-approved methods of contraception. 2) Adopt or continue use of a long-acting reversible method of contraception (LARC). The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods.	N/A	Conditionally support addition of this measure to the program pending NQF endorsement. Enhances perinatal measures and would reduce unplanned pregnancies as well as the risk of pregnancy-related complications by increasing access to high-quality care before and between pregnancies.
1360 Endorsed **Audiological Evaluation no later than 3 months of age (EHDI-3)** Measure Steward: Centers for Disease Control and Prevention	This measure assesses the percentage of newborns who did not pass hearing screening and go on to have an audiological evaluation no later than 3 months of age.	N/A	Support addition of this measure to the program. Ensures that children enrolled in Medicaid receive follow-up care for an important developmental risk factor.
2393 Endorsed **Pediatric All-Condition Readmission Measure** Measure Steward: Center of Excellence for Pediatric Quality Measurement	This measure calculates case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children's hospitals.	N/A	Support addition of this measure to the program. Addresses important opportunity for quality improvement and additional cost associated with hospital readmission.

APPENDIX E:
Public Comments Received

General Comments on the Report

American Academy of Otolaryngology - Head and Neck Surgery

Caitlin Drumheller

The American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) recommends the consideration of three NQF-endorsed measures for otitis media with effusion (OME) for inclusion in the 2015 Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP. Available OME measures owned and stewarded by the AAO-HNS include: NQF #0655: Antihistamines or Decongestants – Avoidance of Inappropriate Use; NQF #0656: Systemic Antimicrobials – Avoidance of Inappropriate Use; and NQF #0657: Systemic Corticosteroids: Avoidance of Inappropriate Use. These measures satisfy the NQS priority of affordable care.

An estimated 2.2 million episodes of OME occur annual in the United States, and roughly 90 per cent of children have OME before school age, most often between the ages of 6 months and 4 years. By the age of 2, more than 60 percent of children will experience OME.

American College of Obstetricians and Gynecologists

Sean Currigan

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

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

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

ACOG is also actively seeking to include these measures in the voluntary OBGYN core measure set for commercial health plans, in a project led by America's Health Insurance Plans, the Centers for Medicare and Medicaid Services, and the National Quality Forum. ACOG has also nominated these measures for consideration within the AHIP/CMS/NQF development of the Accountable Care Organization/Patient Centered Medical Home measure set.

America's Health Insurance Plans

Carmella Bocchino

We support alignment and stratification of current measures when possible and prioritizing current measures to help reduce the number of measures in programs. Additionally, if measures are included that require medical record review, then technical specifications for the denominator/numerator

components of medical record review should be more clearly defined.

AWHONN

Kerri Wade

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

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

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Family Voices NJ

Lauren Agoratus

In general we support the pediatric measures. However, we noticed that there was only one pediatric measure regarding children with disabilities, which was dental care. As 1 in 5 childrne have special health care needs, we would expect more pediatric measures proposed related to children with disabilities.

Futures Without Violence

Lena Orourke

Futures Without Violence thanks the National Quality Forum (NQF) for the opportunity to comment on the draft report "Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015". This set of voluntary state reporting measures provide critical data on key quality indicators on the delivery of services for children and we strongly support the continued adoption of these measures by states, and the development of the additional measures to address gaps in the core data set.

Although not all children are equally affected, the empirical literature increasingly documents that traumatic exposures are an independent risk factor for poor child health and development. When children are exposed to violence and abuse, they become fearful and repeatedly mount the "fight or flight" response. Although this stress response system is adaptive in the short-term, repeatedly activating it can lead to significant and pathological changes in brain architecture and in hormonal responses. In turn, these changes compromise children's health. Abused children and children exposed to intimate partner violence have increased risk of developing asthma and of becoming obese; they also are at elevated risk for delayed language and social development including impaired memory processing and problem solving. Furthermore, the Adverse Childhood Experience study demonstrated that childhood exposure to trauma led to increased risk-taking behaviors and higher rates of multiple diseases in adulthood.

Both the IOM and USPSTF have both recognized the importance of screening for DV/IPV as a preventive service. As part of their recommended services for women, IOM recommends "screening and counseling for interpersonal and domestic violence which involves eliciting information from women and adolescents about current and past exposures to violence and abuse in a culturally informed and supportive manner to address current health concerns about safety and other current or future health problems". The USPSTF recommends that doctors and other health care providers screen women of childbearing age for IPV and refer those

who report such violence to specialty services that address IPV.

Similarly, the MAP has previously included an important measure in the Child Common Core Measures designed to provide data on the percentage of pregnant women who are screened for exposure to intimate partner violence. Futures Without Violence has strongly supported this measure and is glad that the MAP recommends no changes to this measure. Unfortunately, according to this report, only two states have reported data on this measure. We hope that in the future more states will collect and report these data.

Mason Consulting LLC

Dave Mason

On behalf of more than 8,000 pediatric nurse practitioners (PNPs) and other advanced practice nurses committed to providing optimal health care to children, the National Association of Pediatric Nurse Practitioners (NAPNAP) is pleased to offer comments on the National Quality Forum (NQF) Measure Applications Partnership (MAP) Medicaid Child Task Force report, "Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015."

PNPs are licensed advanced practice registered nurses (APRNs) who have enhanced education in pediatric nursing and health care using evidence based practice guidelines. Dedicated to improving children's health, they practice in primary care, specialty, and acute care settings, and they have been providing quality health care to children and families for more than 40 years.

In general, NAPNAP supports the report's conclusion and recommendations. We are concerned about the emphasis placed on measures evaluating birth and contraception at the expense of advancing specific pediatric measures, given the gaps the Task Force and MAP recognize. We are troubled by the potential lack of funding needed to implement these measures and fill in critical gaps. Finally, we restate our concern that providers of care be clearly identified and accountable for meeting or failing to meet these measures.

NAPNAP and its members are committed to promoting and improving the quality of health care to meet the special needs of infants, children, and adolescents, working closely with NQF and the Agency for Healthcare Research and Quality. The association is also dedicated to identifying and providing opportunities for the implementation, dissemination, and evaluation of research-based care by PNPs.

While we deeply appreciate the opportunity to review and provide comments on this draft report, NAPNAP believes the experience and perspective provided by qualified PNPs is an essential asset to ensuring that MAP is able to develop evidence-based recommendations to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Failing to include the viewpoint of PNPs would diminish the clinical and academic perspective on which MAP's recommendations are based. NAPNAP looks forward to working with you to nominate qualified PNPs to serve as members of NQF partnerships, task forces and advisory groups.

PPFA

Carolyn Cox

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

We strongly support MAP's recommendations to include additional quality measures on contraception access in the Adult Medicaid and Children's Health Insurance Program (CHIP) Core Sets. We urge MAP to adopt and support these recommendations regardless of whether NQF endorses the measures. Medicaid plays a critical role for women and their families. The vast majority of women enrolled in Medicaid are of reproductive age (18-44), and across all ages, the majority of Medicaid enrollees are female. In addition, nearly half of U.S. births are funded by the Medicaid program. Including contraceptive quality measures into the core sets

for women ages 21-44, teens ages 15-20, and postpartum women will complement the other existing reproductive health-related quality measures (e.g., Chlamydia screenings), ensure future Medicaid payment reforms reflect the majority of the Medicaid population, and improve access to the care women need.

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

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

U Mass Medical School

Louise Bannister

MassHealth, as a CHIPRA Quality Demonstration grantee, supports CMS' continued focus on child health quality and voluntary reporting on the Child Core Set. Information that MAP collected from States on their experience with using the Core Set demonstrates that States are reasonably able to focus on a handful of measures at a time. With voluntary reporting, states are able to dedicate resources to measurement and improvement efforts on the measures that are most relevant to, or most in need of improvement, the state.

MassHealth agrees with MAP's observations that the Child Core Set focuses well on several important domains of child health care quality (preventive, perinatal, and behavioral health, and care of acute and chronic conditions), but does not measure the full scope of care important to the health of children. We appreciate the MAP's recommendations to add new measures focusing on specific areas of particular import to children, namely interconception care, contraception, and a more in-depth focus on care for children with behavioral health care needs. These new measures will allow states to determine their performance on, and opportunities for improvement in, measures that support improvements in health, health care, and cost for Medicaid and CHIP enrolled children. In order to continue to control for the overall number of measures contained in the Child Core Set, and to support consistency in the measure set over time, to allow states to gain experience in collecting and reporting on the measures in the Core Set, MassHealth agrees that new measures should be added to the Child Core Set in a phased-in manner.

We appreciate the focus on aligning the Child Core Set with other measure sets, including the Adult Core Set. Such alignment efforts are important for managing the full scope of efforts required to comply with reporting on multiple measure sets, and minimizing the potential for duplication of data collection and reporting. We strongly encourage additional alignment of the Child Core Set with the HEDIS measure set, and encourage CMS and MAP to prioritize adding new measures which are part of the HEDIS measure set. Many states' Medicaid programs, including MassHealth, contract with NCQA-accredited Managed Care Organizations (MCOs). As these MCOs collect and report on HEDIS measures, aligning CMS and HEDIS measures sets creates administrative efficiencies, and allows states to dedicate less resources to data collection, and more to improving performance. To support the continued alignment of the Child Set with the HEDIS set, we recommend that the measure "Use of Multiple Concurrent Antipsychotics in Children and Adolescents" be prioritized for addition to the Core Set. Although not NQF-endorsed, this measure's inclusion in the HEDIS set is noted by the MAP as making it likely to be feasible for reporting.

Comments on MAP's Measure Specific Recommendations and Gaps

Academy of Managed Care Pharmacy

Susan Oh

Academy of Managed Care Pharmacy (AMCP) supports the inclusion of 'use of multiple concurrent antipsychotics in children and adolescents' measure.

American Academy of Allergy, Asthma and Immunology

Shazia Ali

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

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

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

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

A list of references is available upon request.

American Academy of Pediatrics

Lisa Krams

AAP comments on measures recommended for phased inclusion:

Both measures recommended for phased addition related to contraceptive access are subject to variation based on factors not controllable by practitioners, e.g. culture, religious beliefs. MAP noted "potential ethical implications" and "strong agreement that the target rate...would be well below 100%." The fact that the adjustment factors might be difficult to discern from medical records or claims data would make these measures not just difficult to compute, but also could be misinterpreted by the public. While the AAP supports contraception access

for adolescents, as currently written the AAP does not support these measures.

"Use of multiple concurrent antipsychotics in children and adolescents": AAP is concerned about overuse of antipsychotic medications for children/adolescents, and recognizes that overuse is a problem in some regions and populations. Depending on the operational definition, AAP would consider supporting the inclusion of a metric to address this.

"Audiological Evaluation No Later Than 3 Months of Age (EHDI-3)" (NQF 1360): AAP supports the addition of this measure

"Pediatric All-Condition Readmission Measure" (NQF 2393): AAP supports the addition of this measure

AAP comments on gaps:

AAP agrees with the identification of care coordination as a current gap area for quality measurement, and advocates for the endorsement and inclusion of objective care coordination measures. This is a high priority for the AAP as payment and practice models for primary care services evolve.

Objective measures related to mental health are a high priority for the AAP. Care coordination requires a high degree of interaction with behavioral health services, so patient access to and utilization of these services impacts care coordination measures.

Overuse/medically unnecessary care is currently under the purview of payers. However, carefully crafted measures for providers could potentially be helpful. Overuse of CT scans is often measured by payers, and sometimes requires prior authorization, so overuse of CT scans may not be a priority starting point. Issues such as antibiotic use for hospitalized patients may have more impact.

Use of durable medical equipment (DME) is typically measured by payers as a cost item for providers. AAP's support of additional measures related to this would depend on the operational definitions of those measures. This would not necessarily be a high priority from the AAP's perspective.

Other gap areas identified in this report lack the specificity necessary for the AAP to make concrete recommendations. However, the AAP recognizes the potential for a positive impact on child health of clinically relevant, rigorously developed measures for child abuse/neglect, screening, trauma, sickle cell disease, and other topics outlined in the gap analysis.

American College of Obstetricians and Gynecologists

Sean Currigan

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

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

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

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

In April 2015, the IOM released Vital Signs: Core

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

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

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

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

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

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

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

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

Government expenditures for family planning services are also substantial and it has been estimated that publicly funded services helped avert $12.7 billion in costs by preventing unintended pregnancies in 2010. (Sonfield and Kost, 2013).

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

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

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

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

America's Health Insurance Plans

Carmella Bocchino

We support the recommendations and gap areas highlighted within the report as well as the emphasis on addressing the needs of children with disabilities, dental care, mental health, and contraceptives. However, sub-stratification may be inadvisable as high dental quality care should be a goal for all for children. We also would support the MAP's consideration of breast feeding, early elective delivery, and cesarean section measures.

Furthermore, children in foster care or state custody present with special needs, and unique challenges with timing of care. In addition, challenges exist with care coordination in this population. As such, quality of care for child populations in foster care should be considered a gap area for future MAP consideration. A robust infrastructure for information flow across providers and health plans will also be needed for this population.

We also support the use of measures that are not limited to children, such as #0139 National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome measure.

We continue to urge the MAP to reconsider inclusion of measures that require EHR abstraction such as Contraceptive Use by Women's aged 14-20 and measures that are not part of HEDIS, such as Low Birth Weight Infant Not Delivered at the Appropriate Level of Care.

AWHONN

Kerri Wade

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

We understand the sensitivity around the perception of coercion that these measures require. Thus

is is critical that they are specified with a larger denominator at a population health level.

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

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

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

http://iom.nationalacademies.org/~/media/Files/Report%20Files/2015/Vital_Signs/VitalSigns_Recs.pdf

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

BlueCross BlueShield Association

Kerri Fei

Use of Contraceptive Methods by Women Aged 15-20 Years

While Plans agree that women's reproductive health is a high priority area and understanding that MAP is conditionally supporting this measure pending NQF endorsement, it may be premature to consider this measure for inclusion in the Adult Core Set. As the specifications provided are not clear as to how "risk for unintended pregnancy" is defined, it appears that Plans will not be able to rely on administrative claims for data collection/reporting as identification of the denominator will require medical record data. This requires time for implementation as well as additional cost. Additionally, even with setting an expected performance threshold below 100%, the potential for unintended consequences with this measure (e.g., potential pressure into using a certain contraceptive method) remains a concern. This measure may have limitations as an improvement measure and is not in and of itself and outcome. Given the high rates of change in eligibility status in the Medicaid population, it is unclear that the majority of women could be followed long term. Mostly likely, they can only be followed up to 60 days post-partum as that is when the majority of benefits end. We would like to see additional testing information regarding implementation and performance as well as for the measure to obtain NQF-endorsement prior to consideration for inclusion in the Child Core Set.

Effective Postpartum Contraception Access

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

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

While relevant to a small sub-population, Plans note that overuse of antipsychotics in adolescents is a growing area of concern. As the measure is included in HEDIS and based in administrative specifications, it is relatively easy to collect and report. Support inclusion of this measure in the Child Core Set pending NQF endorsement.

NQF #1360: Audiological Evaluation No Later Than 3 Months of Age

Plans agree that audiological evaluations in children are vitally important. More often than not, these evaluations occur at a well-child visit and are not

billed separately. Therefore, Plans would not be able to collect this measure via administrative data. Chart review would be required.

NQF#2393: Pediatric All-Condition Readmission Measure

Plans support the inclusion of this measure in the Child Core Set and note that monitoring pediatric readmissions provides an opportunity to improve outcomes and reduce avoidable costs. The alignment with NQF #1768 is noted an appreciated

Children's Hospital Association

Ruth Riggs

The Children's Hospital Association applauds the Medicaid MAP continued efforts reviewing the measures in the Child Core Set and provide recommendations to strengthen the measure set in support of CMS' goals for the program. We further appreciate the MAP identifying measure gap areas in the 2014 report.

Because of the importance of a gap analysis and the framework used to inform gaps, we encourage NQF, under the guidance of the MAP, to conduct a more thorough, systematic, and structured child health measure gap analysis. This analysis should include specific challenges for state's, as well as providers. The current gap analysis is a great starting point, and maps the measures into National Quality Strategy Priority and clinical areas, providing the reader with a count of measures from the core set within each.

The gap analysis should be a pathway forward, and, thereby, include a measure framework specific to children health care needs and use. The analysis should go beyond a count of measures; it would be more useful if it also assesses how well we are measuring these domains. Using a framework and gap analysis consistently in this manner is critical to understanding not just how many measures are in the core set (and to which domain they belong), but to our understanding whether we are adequately measuring priority and key domains for this population. This helps inform the pipeline, as well as efforts for more parsimony.

We support the decision to require NQF endorsement for the Use of Multiple Concurrent Antipsychotics in Children and Adolescents and the Effective Postpartum Contraception Access.

Based on the materials made available, it did not appear that the measure specifications were adequately detailed for consistent and reliable implementation. Putting the measures through the endorsement process will ensure that the specifications are in sufficient detail.

We understand the need to balance state resources and data limitations, but encourage the MAP to make recommendations that further replace low bar measures with those that will drive us toward better care, better child and family/caregiver outcomes, and smarter spending. A thorough gap analysis would better inform this charge.

We encourage NQF to include a gap analysis report as part of the new Pediatric Measure project.

Commonwealth of PA

Michele Robison

The Commonwealth of Pennsylvania highly recommends the 'use of multiple concurrent antipsychotics in children and adolescents' measure be included if NFQ endorses.

FDA

Mary Ghods

I support the inclusion of NQF-endorsed measure (#2337), Antipsychotic Use in Children Under 5 Years Old that measures the percentage of children under age 5 using antipsychotic medications during the measurement period.

Futures Without Violence

Lena Orourke

Futures Without Violence supports the measures that the MAP has documented in order to communicate its vision for the future. This vision clearly outlines the important relationship between trauma, care coordination, abuse and violence. In particular, the following measures will provide important quality data and will help improve care for women and children who are exposed to violence and abuse:

Care Coordination and Social Services Coordination; Cross sector measures that would foster joint accountability with education/criminal justice· Injuries

and trauma; and Behavioral health outcomes that stem from trauma-informed care.

The MAP also lists "Screening for Abuse and Neglect" as a goal for future work. As the MAP moves forward on this recommendation, Futures Without Violence supports measures that increase universal education on exposure to violence and the impact on health, as well as where to seek help if needed.

We encourage the MAP to move towards including valid measure for these factors as soon as possible.

FUTURES thanks NQF for the opportunity to comment on this important report and we look forward to future efforts to improve access to high quality health care and services for children and mothers who have experience violence and abuse.

GA Dept of Community Health

Janice Carson

Regarding the Child Core Set:

NQF #0477 - Will the specifications for this measure dictate that the AAP's criteria for designation of NICUs be utilized by all states as a matter of consistency? Will the measure specify how the NICUs are to be designated as Level 3 - will they be allowed to self designate? How will the measure take into consideration deliveries in areas where a level 3 NICU may not be accessible. This could skew the results.

NQF not endorsed Effective Postpartum Contraception Access - Is this measure specifically looking at immediate postpartum LARC utilization? If a significant percentage of women don't return for their post partum visit, this measure would essentially only track the number of women who had an immediate postpartum LARC insertion or women who were prescribed a contraceptive method and they filled the prescription prior to 60 days postpartum when their Medicaid coverage ended..

NQF not endorsed Use of Contraceptive Methods by Women Aged 15 - 20 - this measure may be controversial for states with strong views about contraceptive use in women under the age of 18.

NQF #1360 Audiological Evaluation no later than 3 months of Age - will need to review the specifications for this measure before final comments. The implication is that practitioners are able to pull data from the electronic health record for this measure but state Medicaid programs do not have access to the majority of their Medicaid enrolled providers' EHRs and would have to resort to medical record reviews to obtain this data.

GlaxoSmithKline

Christopher Cook

GSK commends MAP for their recent draft report continuing to support the inclusion of the NQF #1799 Medication Management for People with Asthma (MMA) in the Childhood Core Set. While we see value in the adoption of NQF #1799 to harmonize with the Childhood Medicaid Core Set we respectfully suggest MAP support adoption of NQF#1800 Asthma Medication Ratio (AMR) in addition to or as a replacement to their recommendation for NQF #1799.

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

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

quality measure harmonization efforts, we believe alignment to better measures of care remains an equal priority.

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

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

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

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

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

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

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

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

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

HEALTH MANAGEMENT ASSOCIATES

Jodi Bitterman

As the project manager of the Florida-Illinois CHIPRA Quality Demonstration Grant, I'm submitting the following comment:

The report specifically notes in regard to the Use of Contraceptive Methods by Women Aged 15-20 Years measure that the target rate would be well below 100%. It is important to establish at the outset what benchmarks are desirable. Without a valid benchmark, it is unclear how the metric is measuring quality. Measures than cannot clearly point to quality improvement opportunities are a waste of limited state resources. With all measures, we recommend determining reasonable benchmarks at the outset.

As the project manager of the Florida-Illinois CHIPRA Quality Demonstration Grant, I'm submitting the following comments:

While the report recommends a "phased addition" of 6 new measures, it does not specifically recommend a timetable by which this phased introduction should occur. A specific timetable would better allow us to determine whether adding new measures would be feasible. While incorporating a lot of new measures at once may not be feasible due to limited resources, a phased introduction can also produce its own challenges. In Florida, Child Core Set measures are reported by MCOs and aggregated for a statewide rate. This reporting structure requires that measures are added to contracts, which is not an annual process.

Full specifications would be needed to determine the feasibility of reporting the new measures. Some factors that could render a measure immediately unfeasible could include the utilization of coding sets that a state does not collect (e.g., LOINC), or the utilization of a method that the state is unable to use (EHR or medical record). A clear understanding of the measurement specifications for proposed measures would better inform states, and thus their recommendation, on whether reporting is feasible. Likewise, adequate time is needed, after introduction, to program a new measure. In the course of the CHIPRA project, states would often have to "guess" to anticipate which measures would be included and/or retired. CMS Informational Bulletins may be helpful, but are often not getting down to state-level staff. The state, or MCOs depending on who is responsible for reporting a given measure, need time to program new measures into their systems and have them reviewed by their HEDIS auditors. Thus, there is a time lag between when Child Core Set changes are announced and when they can first be reported. Sufficient time is needed between the introduction of new measures and when they can be reported.

The addition of new measures, in alignment with CMS' stated three-part goal for the Child Core Set that includes increasing the number of measures reported by each state, implies that the Core Set will continually expand and costs of reporting will accordingly escalate. However, the increasing size of the core set may not be sustainable for states. Reporting is a resource-intensive activity. Even previously reported measures are not a no-cost proposition as the specifications must be updated in each year. In Illinois, the majority of core set measures are reported to CMS and a core set of measures is in use in managed care contracts. However, new measures, despite addition to the CMS Child Core Set, will not be added without a federal mandate that these measures must be reported.

Healthfirst

Abby Maitra

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

Use of Contraceptive Methods by Women Aged 15-20 Years:

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

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

Finally, we are in strong agreement that a low target rate for this measure would need to be established, given all the factors that influence contraception usage and adherence, and that the measure be reviewed by NQF for endorsement. We expect that cultural norms around sex, pregnancy, sex education and contraception among this younger demographic to vary and rates will be effected by regional differences.

Pediatric All-Condition Readmission Measure: Healthfirst does not support this measure to be added into the FOM, as the rates of pediatric admissions are significantly less than adult admission rates. Managed care plans are devoting extensive resources, money and infrastructure to ensure that care within the adult population is well coordinated and readmissions are prevented. We believe the pediatric readmission measure should be phased-in at a later time, in order to focus resources on reducing the adult all-cause readmission rate. We also recommend that (pediatric) admissions due to sequelae of the birth event be excluded from the measure.

Kaiser Permanente

Jeff Convissar

The contraceptive measures are important ones and are being promoted nationally. The IOM has set reduction of adolescent pregnancy as a core quality measure. It is a measure Kaiser Permanente can use.

Mason Consulting LLC

Dave Mason

On behalf of more than 8,000 pediatric nurse practitioners (PNPs) and other advanced practice nurses committed to providing optimal health care to children, the National Association of Pediatric Nurse Practitioners (NAPNAP) is pleased to offer comments on the National Quality Forum (NQF) Measure Applications Partnership (MAP) Medicaid Child Task Force report, "Measure Applications

Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015."

PNPs are licensed advanced practice registered nurses (APRNs) who have enhanced education in pediatric nursing and health care using evidence based practice guidelines. Dedicated to improving children's health, they practice in primary care, specialty, and acute care settings, and they have been providing quality health care to children and families for more than 40 years.

NAPNAP acknowledges the benefits of consistency between adult and pediatric core measure. However, adoption of "NQF #2993: Pediatric All-Condition Readmission Measure" raises concerns that have also been recognized with implementation of the similar adult measure regarding the measure's lack of a methodology to exclude unpreventable readmissions or readmissions unrelated to the index admission, the lack of testing to support the absence of such exclusions and concerns about the adequacy of the measure's risk adjustment methodology, which should incorporate additional factors. We would encourage future measures that account for the preventability of readmissions.

We agree with the Task Force that many important priorities for quality measurement and improvement do not yet have adequate metrics, and we generally agree with the gaps outlined in the report. We would emphasize the lack of measures for mental health screening and care, referral to necessary developmental or supportive therapies before a child enters school. We also believe it is important to focus on pediatric-specific acute care outcome measures, not measures that largely duplicate those for adult care but consider the unique health care needs of hospitalized children. NAPNAP is also troubled by the lack of measures to address the treatment of chronic illnesses in children, care coordination and to measure patient and family engagement.

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With regard to measure-specific recommendations, NAPNAP joins MAP in supporting the continued use of all of the 2015 Child Core Set measures and the consideration of additional measures to address gaps in the current Core Set.

However, NAPNAP believes that "NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care," which tied as MAP's highest priority measure, is proposed to measure a missed opportunity to provide guidance and coordinate regional care across facilities. We believe that associating the location of a high-risk neonate delivery with the provision of guidance and coordination of care related to the delivery lacks validity as a measure of guidance and care coordination on behalf of the care providers. The measure, as proposed, can truly measure only where such deliveries occur. It does not have the depth to measure anticipatory guidance or care coordination. To make those assessments, we believe other better measures should be used.

National Partnership for Women & Families

Carol Sakala

The National Partnership for Women & Families strongly supports inclusion of Use of Contraceptive Methods by Women Aged 15-20 Years in the core child set. Developed by CDC but not yet considered for endorsement by NQF, this access measure has two parts. The first part would measure the utilization of one of the most or moderately effective FDA-approved methods of contraception by women enrolled in the state's Medicaid program. The second part would narrow the numerator definition and report the number of these women specifically using a Long Acting Reversible Contraception method.

Its adoption will permit women and women's health advocates to identify program successes and opportunities for improvement. Given the diversity of the Medicaid population across the states, it is important to recognize any target rate would bel be well below 100% nationwide.

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

The National Partnership for Women & Families strongly supports inclusion of Under 1500 Infant Not Delivered at Appropriate Level of Care in the Medicaid child core set. This measure would encourage providers to ensure that the smallest babies are born in facilities that are well-equipped to care for them, versus the less safe option of transporting the newborn after the birth. It would also educate women with high-risk pregnancies on the importance of giving birth, to the maximum extent possible, at a facility that is prepared to care for a very tiny newborn. Its adoption should also help galvanize state and regional cooperation to assure these women will be able to access such facilities. Lower income women, in particular, face significant barriers, such as the lack of transportation, to assure they can get to the appropriate facility when they go into labor. Adoption of this measure can be instrumental in motivating the creation of systems that assure their needs will be met. As this measure fosters regional coordination, it is an excellent candidate for the Medicaid child core set and, indeed, the Task Force ranked it first among recommended additions to this set.

NCQA

Paul Cotton

Thank you for the opportunity to submit comments on the draft "Measure Application Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP 2015" report. NCQA generally agrees with the report overall, which will help to advance work in improving the quality of care for this imporant population.

We especially support the recommendation for CMS to consider the measure on "Use of Multiple Concurrent Antipsychotics in Children and Adolescents" as a top priority for addition to the core set. While not yet NQF-endorsed, this measure has cleared NCQA's similarly rigorous process that includes thorough review of supporting evidence, multi-stakeholder consensus vai several NCQA advisory committees and public comment. It addresses an imporant clinical issue with significant impact on the cost, quality and experience of care. It also is part of our comprehensive and widely used HEDIS measure set and thus promotes alignment across payers.

We encourage you to also consider recommending additional mesaures that address the important issue of antipsychotic medications. These include:

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. This measure assesses whether safer and potentially more cost-effective psychosocial treatment was tried as first-line treatment before prescribing higher risk and costlier antipsychotics.

Metabolic Monitoring for Children and Adolescents on Antipsychotics. This measure assesses whether children, once on these powerful drugs, are monitored for their potentially serious metabolic complication side effects.

These are both administrative mesaures that are reported with minimal burden and that address critically important areas of care. They have been through NCQA's rigorous process for developing and vetting new measures. They also are part of our comprehensive and widely used HEDIS measure set and thus promote alignment across payers.

Finally, we support the draft report's suggestion for stratification of measure results by race, ethnicity

and other relevant factors to better understand disparities. States generally have data needed for stratification. Stratification also is a more constructive approach than risk adjusting measures for socioeconomic factors as it highlights, rather than masks, disparities in care. This allows us to track improvements in reducing disparities over time, which is a key goal we all share for the core set.

Pharmacy Quality Alliance

Woody Eisenberg

PQA is pleased to comment on the recent NQF draft report: Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015. Specifically, PQA suggests that MAP supports inclusion of NQF-endorsed measure (#2337), Antipsychotic Use in Children Under 5 Years Old that measures the percentage of children under age 5 using antipsychotic medications during the measurement period.

Children with behavioral health issues deserve special attention in measurement due to their complex health needs and the impact they have on Medicaid utilization and spending. Behavioral health experts are especially concerned about the recent increase in prescribing of antipsychotic drugs, for which there are no FDA-approved indications in children under age 5 years and because of their very serious side effects including rapid weight gain and the increased risk for the development of diabetes. Studies have shown that on average, 6.2 percent of non-institutionalized children with Medicaid took psychotropic medications during a calendar year, and 21 percent of those children took an antipsychotic medication. It was separately estimated that antipsychotic use increased from 8.9 percent in 2002 to 11.8 percent in 2007 and that state-specific rates of prescribing increased in 45 states over the same time period.

RGH Health Consulting

Bob Hussey

On behalf of Wolters Kluwer, I am writing to provide comments on the recently issued draft report entitled Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015. We appreciate the opportunity to comment.

As way of background, Wolters Kluwer (WK) is a leading global provider of information, business intelligence and point-of-care solutions for the healthcare industry. Key brands include ProVation® Medical, UpToDate®, Medi-Span®, Lexicomp®, Facts & Comparisons®, Pharmacy OneSource®, Health Language and Medicom (China). Wolters Kluwer had annual revenues in 2014 of $4.9 billion.

Our comments focus on the NQF-endorsed measure #2337, Antipsychotic Use in Children Under 5 Years Old, which captures the number of children under age 5 using antipsychotic medication. We support the use of this measure in the Core Set of Healthcare Quality Measures for Children enrolled in Medicaid and CHIP. We understand that there has been a recent increase in prescribing of antipsychotic drugs for children under age 5, despite the lack of FDA-approved indications. The use of such medications in children that young can result in serious side effects, including rapid weight gain and increased risk of diabetes. Children with behavioral issues have complex health needs that should be closely monitored using such measures as NQF #2337, and we strongly urge its inclusion in the final draft of the MAP recommendations.

Thank you for the opportunity to comment.

St. Louis College of Pharmacy

Clark Kebodeaux

I support the inclusion of NQF-endorsed measure (#2337), Antipsychotic Use in Children Under 5 Years Old that measures the percentage of children under age 5 using antipsychotic medications during the measurement period.

Comments on MAP's Strategic Recommendations

American Academy of Pediatrics

Lisa Krams

The AAP anticipates that the MIPS/APM method of reimbursement that Medicare has set in motion will address many of the issues in the alignment discussion. Although not currently directed at pediatrics, we expect that these approaches will spread to private and Medicaid payers to become germane for pediatrics.

The point that overemphasized alignment could create perseveration on specific measures is correct, but ultimately fails to address the exigency that providers respond to payers' incentives, and if a particular measure set becomes generally accepted by payers, providers will concentrate efforts in those areas. In a way, that focus is helpful, because providers typically don't have the resources to "boil the ocean", but inevitably some issues will be neglected. The AAP will continue to push the important childhood concerns to the public and to payers so that the "orphan" problems aren't ignored.

The document notes that states are burdened as new measures become a priority with CMS, but it ignores the same issues for providers. Providers also must get their vendors to make IT system changes to capture new data or modify the collection of existing data, requiring time and funding. The document should reflect the burden on providers for changes in measures, as well as the problems faced by the states.

The points made in the reproductive health discussion are well-taken, but the text ignores the marked cultural and religious variation regarding the use of contraception in some regions and among some constituencies in the US. MAP needs to include some alternate viewpoints in the discussion to mitigate some of the resistance it will likely face as these measures are developed.

The problems associated with disparities in care based on socioeconomic factors are being studied by CMS and are the subject of some Medicare Advantage metrics and incentives. The use of these factors for understanding disparities in other populations, e.g. Medicaid and commercial pediatric populations, would greatly benefit child health care. The AAP strongly supports the recommendation that rational subgrouping by socioeconomic or clinical factors should be implemented for many measures of access to and outcomes of care.

Benchmarks are helpful, and the observation that unrealistically high or low benchmarks are not useful is accurate. However, one way for an organization to deal with these issues is to benchmark internally between business units or use trends to set benchmark performance. In some instances, external benchmark data are not available, and so using internal benchmarks or trends to set goals can provide a useful alternative.

America's Health Insurance Plans

Carmella Bocchino

We agree with MAP's strategic recommendations and support the concept of synchronizing the Child Core set and Adult Core set to ensure a comprehensive view of quality across an individual's lifespan. An additional important issue for consideration is optimal vaccination care practices as many providers move away from providing vaccines due to strict audit policies associated with vaccine safety.

Children's Hospital Association

Ruth Riggs

Because of the important role the MAP plays in providing input to CMS, the Children's Hospital Association encourages the MAP to clearly delineate and state the MAP recommendation for each strategic consideration.

HEALTH MANAGEMENT ASSOCIATES

Jodi Bitterman

While we appreciate the introduction of new measures to the core set, much can be done to improve the current measure set and its utility. One significant issue with current reporting is the comparability across states. States often use different reporting methods (e.g., administrative, state-level data in Illinois and medical record review MCO-level data in Florida), report measures for

partial populations (e.g., all publicly funded persons vs. those enrolled in managed care only) or with altered specifications. These changes potentially prevent comparability across states. In its first issue brief, CMS used the Core Set to discuss "higher" and "lower" performing states. CMS should ensure comparability before making these types of comparisons.

We also appreciate CMS' efforts to balance measures that are feasible to report with measures that are aligned with state goals. We urge that this balance is continually kept in mind, both in terms of the number and types of measures that are included in the Core Set. Reporting vast amounts of data that the states are not able to use to make actionable improvements – either because of the lack of improvement evidence in that area or due to the sheer volume of opportunities – will do little to improve child health. We recommend that CMS balance measures with actionable improvement suggestions.

Mason Consulting LLC

Dave Mason

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NAPNAP generally agrees with the strategic issues raised by the Task Force and offers a few specific comments with recommendations.

With regard to alignment of reporting programs, we also note that many states are falling short in the timely, consistent reporting of existing measures. While we acknowledge the value of appropriate alignment as a way to make the most of scarce resources, we would underscore the Task Force's comment regarding the "distinctly different health and medical needs of the pediatric and adult population." We urge MAP to consider recommending that CMS and Congress provide meaningful incentives to states to improve the reporting of quality measures.

We support the report's recommendations that CMS enhance states' abilities to communicate through technical assistance in the reporting program and that performance benchmarks be designed to be reasonable but ambitious enough to produce meaningful improvement.

PNPs are also concerned that current measures fail to adequately identify the health care professional who is actually delivering care to patients and is directly accountable for compliance with a given measure. Identifying the provider of care is an essential element in the accountability for measure compliance. We urge MAP to consider including in its recommendations requirements to ensure that providers of care are identified and accountable for measure compliance.

APPENDIX F:
Additional Measures Considered

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

Measure Number	Measure Title	Measure Steward
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	National Committee for Quality Assurance
0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	Centers for Disease Control and Prevention
0344	Accidental Puncture or Laceration Rate (PDI 1)	Agency for Healthcare Research and Quality
0470	Incidence of Episiotomy	Christiana Care Health System
0478	Neonatal Blood Stream Infection Rate (NQI #3)	Agency for Healthcare Research and Quality
0480	PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice	Joint Commission
0716	Healthy Term Newborn	California Maternal Quality Care Collaborative
1335	Children Who Have Dental Decay or Cavities	The Child and Adolescent Health Measurement Initiative
1659	Influenza Immunization	Centers for Medicare & Medicaid Services
2414	Pediatric Lower Respiratory Infection Readmission Measure	Center of Excellence for Pediatric Quality Measurement
2337	Antipsychotic Use in Children Under 5 Years Old	Pharmacy Quality Alliance
2509	Sealants in 10 – 14 years	American Dental Association on behalf of the Dental Quality Alliance
n/a	Use of first-line psychosocial care for children and adolescents on antipsychotics	AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ)
n/a	Followup visit for children and adolescents on antipsychotics	NCINQ
n/a	Metabolic screening for children and adolescents newly on antipsychotics	NCINQ
n/a	Metabolic monitoring for children and adolescents on antipsychotics	NCINQ
n/a	Safe and judicious antipsychotic use in children and adolescents	NCINQ

Measure Number	Measure Title	Measure Steward
n/a	Use of antipsychotic medications in very young children	NCINQ
n/a	Reporting on supplemental CAHPS data regarding availability of treatment or counseling services for children on Medicaid for whom the family sought treatment or counseling for an emotional , developmental, or behavioral problem	AHRQ-CMS CHIPRA Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium (Q-METRIC)
n/a	Transition from pediatric-focused to adult-focused health care	AHRQ-CMS CHIPRA Center of Excellence for Pediatric Quality Measurement (CEPQM)
n/a	Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-focused Health Care	CEPQM
n/a	Pediatric Medical Complexity Algorithm Family Experiences with Coordination of Care (FECC)	AHRQ-CMS CHIPRA Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN)
n/a	Mental Health Followup Measures I: Timeliness of followup visits following hospital discharge of children with a primary mental health diagnosis	AHRQ-CMS CHIPRA Collaboration for Advancing Pediatric Quality Measures (CAPQUAM)
n/a	Accurate ADHD diagnosis	AHRQ-CMS CHIPRA Pediatric Measurement Center of Excellence (PMCoE)
n/a	Behavior Therapy as First-Line Treatment for Preschool-Aged Children	PMCOE
n/a	Pediatric global health	AHRQ-CMS CHIPRA Children's Hospital of Philadelphia (CHOP)
n/a	Perinatal I: Timely temperature for all low birthweight neonates	CAPQuaM
n/a	Perinatal II: Timely temperatures upon arrival in Level 2 or higher nurseries for LBW neonates	CAPQuaM
n/a	Perinatal III: Distribution of temperatures for LBW admitted to Level 2 or higher nurseries in first 24 hours of life	CAPQuaM
n/a	Perinatal IV: Thermal condition for LBW neonates admitted to Level 2 or higher nurseries in first 24 hours of life	CAPQuaM
n/a	Assessing the availability of the preconception component of high-risk obstetrical services by estimating the use of teratogenic medications before and during pregnancy	CAPQuaM
n/a	High-risk deliveries at facilities with 24/7 in-house physician capable of safely managing labor and delivery, and performing a cesarean section, including an emergent cesarean section	CAPQuaM

Measure Number	Measure Title	Measure Steward
n/a	High-risk deliveries at facilities with 24/7 in-house physician coverage dedicated to the obstetrical service by a qualified anesthesiologist	CAPQuaM
n/a	High-risk deliveries at facilities with 24/7 in-house blood banking/transfusion services available	CAPQuaM
n/a	High-risk deliveries at facilities with Level 3 or higher NICU services	CAPQuaM
n/a	Availability of OPD maternal fetal medicine and specialty care for women with high-risk pregnancies	CAPQuaM
n/a	Availability of multidisciplinary OPD care for women with high-risk pregnancies	CAPQuaM
n/a	Obstetric trauma (3rd or 4th degree lacerations): rate per 1,000 vaginal deliveries without instrument assistance.	Agency for Healthcare Research and Quality
n/a	Severe Maternal Morbidity	Centers for Disease Control and Prevention

ISBN 978-0-9828420-5-8

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