NATIONAL QUALITY FORUM

Agenda

MAP Medicaid Task Forces In-Person Meeting

Child Task Force: June 9-10, 2015

Adult Task Force: June 10-11, 2015

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

Remote Participation Instructions:

Streaming Audio Online

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

Teleconference

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

Meeting Objectives:

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

June 9: MAP Medicaid Child Task Force

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

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

Foster Gesten, Medicaid Child Task Force Chair

Sarah Lash, Senior Director, NQF

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

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

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

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

Sarah Lash, NQF

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

Jeff Schiff, Medical Director for Minnesota Health Care Programs

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

11:35 am **Public Comment**

11:45 pm **Lunch**

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

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

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

Foster Gesten
Shaconna Gorham

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

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

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

Foster Gesten

Shaconna Gorham

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

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

Foster Gesten
Nadine Allen

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

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

Foster Gesten

June 10: Joint Meeting of Child and Adult Task Forces

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

9:00 am **Welcome**

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

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

9:30 am **Measure Alignment**

Harold Pincus
Sarah Lash, Senior Director, NQF

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

10:00 am **Break**

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

Foster Gesten
Shaconna Gorham, Senior Project Manager, NQF

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

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

12:30 pm **Lunch**

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

Harold Pincus
Foster Gesten
Sarah Lash, Senior Director, NQF

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

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

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

Harold Pinus
Sarah Lash

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

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

Foster Gesten
Harold Pincus

June 11: MAP Medicaid Adult Task Force

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

9:00 am **Welcome Back**

Harold Pincus

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

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

Zehra Shahab, Project Manager, NQF

Shaconna Gorham

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

10:15 am **Break**

10:30 am **State Perspectives Panel**

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

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

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

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

12:15 pm **Lunch**

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

Harold Pincus

Sarah Lash

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

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

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

Harold Pincus
Zehra Shahab

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

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

Harold Pincus

Measure Applications Partnership

Medicaid Child and Adult Task Forces
In-Person Meeting

June 9-11, 2015

Welcome, Introductions, and Review of Meeting Objectives

Medicaid Child Task Force Membership

Task Force Chair: Foster Gesten, MD, FACP

Organizational Members

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

Medicaid Child Task Force Membership

Subject Matter Experts

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

Federal Government Members

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

In-Person Meeting Objectives

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

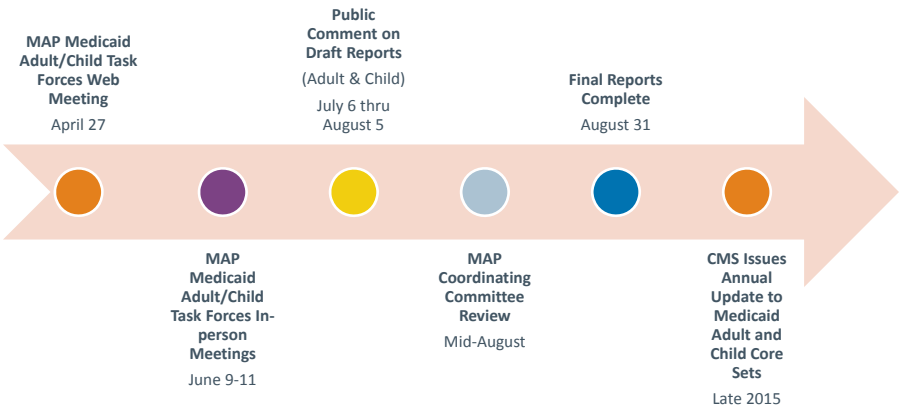
MAP Medicaid Child Task Force Charge

- For this review, the charge of the MAP Medicaid Child Task Force is to:
  - Review states' experiences reporting measures to date
  - Refine previously identified measure gap areas and recommend potential measures for addition to the set
  - Recommend measures for removal from the set that are found to be ineffective
- The task force consists of current MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise.

Themes from April's Web Meeting

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

2015 Timeline



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

CMS Goals
Child and Adult Core Sets

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

How CMS Uses Core Set Data

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

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

MAP Measure Selection Criteria

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

Potential Reasons for Removal from Core Set

If a measure has:

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

Decision Categories

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

Health Issues for Children in Medicaid/CHIP

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

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

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

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

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

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

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

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

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

Other High-Impact Health Conditions

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

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

Other High-Impact Health Conditions

Use of Antipsychotic Medication among Medicaid-Enrolled Children

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

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

CMS - Child Core Set Update for 2015 Reporting

Issued December 30, 2014

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

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

Medicaid Child Core Set Measures for FFY 2015 Use

NQF #	Measure Name	Measure Steward
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/Adolescents	NCQA
0033	Chlamydia Screening in Women	NCQA
0038	Childhood Immunization Status	NCQA
0108	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA
0139	Pediatric Central-line Associated Bloodstream Infections–Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC
0471	Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	Joint Commission
0576	Follow-up After Hospitalization for Mental Illness	NCQA
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment*	AMA-PCPI
1382	Live Births Weighing Less than 2,500 Grams	CDC
1391	Frequency of Ongoing Prenatal Care	NCQA
1392	Well-Child Visits in the First 15 Months of Life	NCQA

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

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

Medicaid Child Core Set Measures for FFY 2015 Use - Continued

NQF #	Measure Name	Measure Steward
1407	Immunization Status for Adolescents	NCQA
1448	Developmental Screening in the First Three Years of Life	OHSU
1516	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA
1517	Timeliness of Prenatal Care	NCQA
1799	Medication Management for People with Asthma	NCQA
1959	Human Papillomavirus (HPV) Vaccine for Female Adolescents	NCQA
2508	Prevention: Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk*	DQA (ADA)
n/a	Ambulatory Care - Emergency Department (ED) Visits	NCQA
n/a	Adolescent Well-Care Visit	NCQA
n/a	Behavioral Health Risk Assessment (for Pregnant Women)	AMA-PCPI
n/a	Child and Adolescents' Access to Primary Care Practitioners	NCQA
n/a	Consumer Assessment of Healthcare Providers and Systems® CAHPS 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	NCQA
n/a	Percentage of Eligibles That Received Preventive Dental Services	CMS

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

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

MAP Measure-Specific Recommendations – Fall 2014, Continued

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

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

2. #2548 Child HCAHPS

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

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

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

6. #0480 PC-05 Exclusive Breast Milk Feeding

Staff Review of FFY 2014 State Reporting

Overview of Medicaid Child Core Set FFY 2014 Reporting

Child Core Set participation is strong, with room for improvement

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

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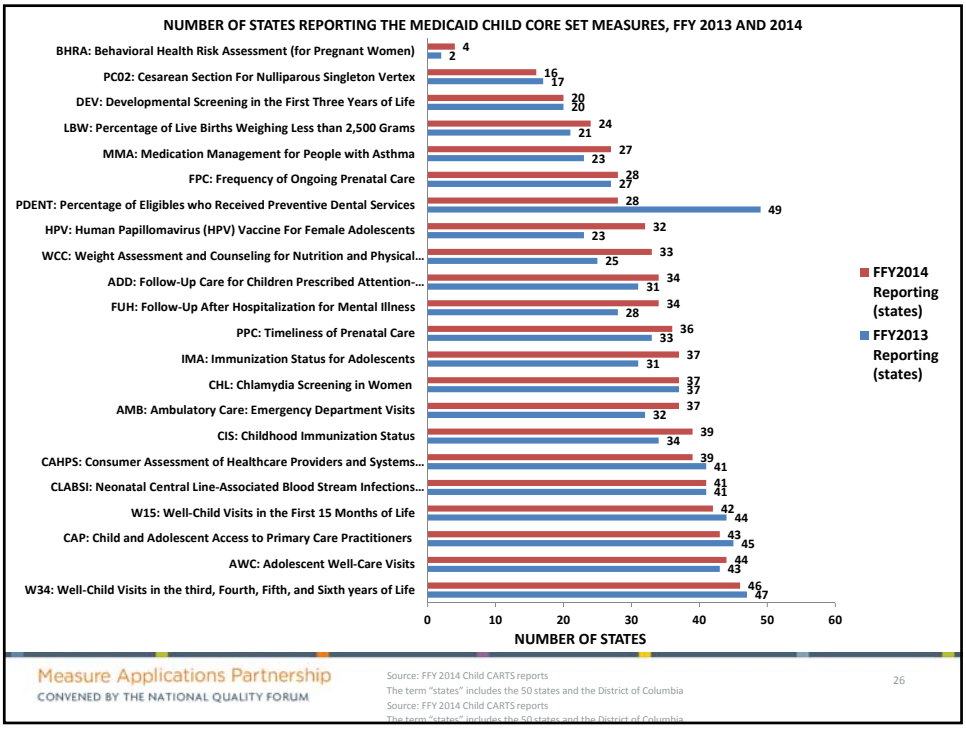
The term "states" includes the 50 states and the District of Columbia



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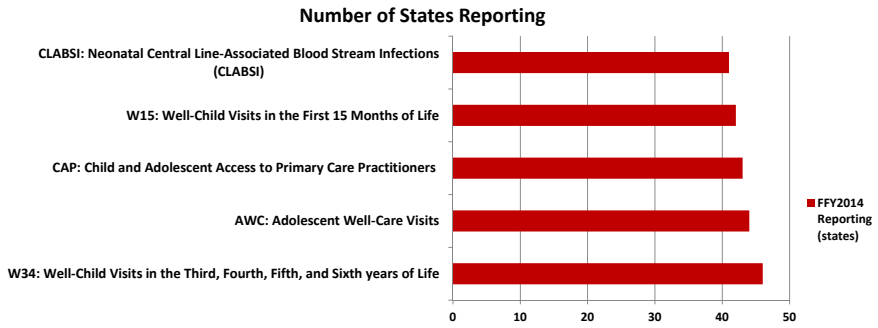
Measures with High Levels of Reporting (5)

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

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



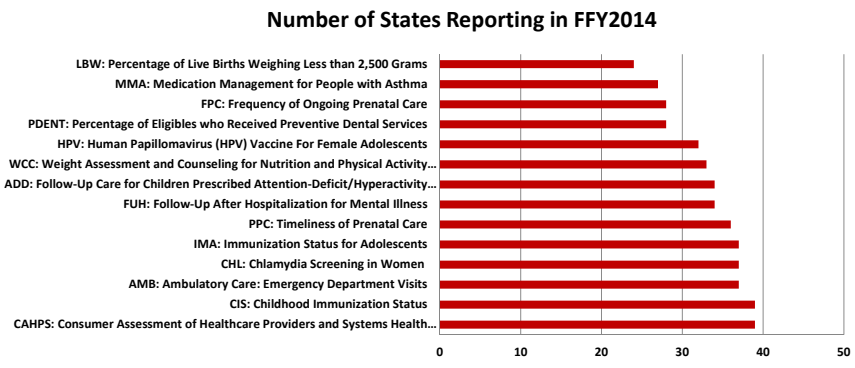
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

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

Measures Reported More Frequently in FFY 2014 (14)

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

- Most measures have increased uptake by three or more states



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

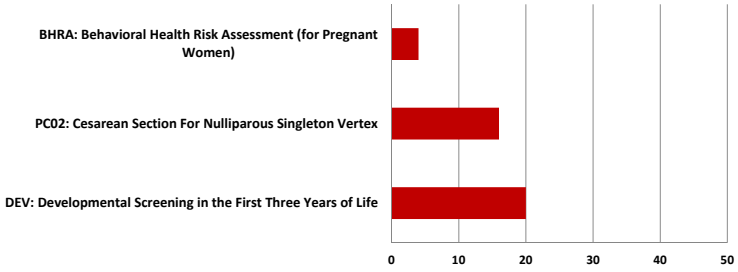
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Measures with Relatively Low Levels of Reporting (3)

Measures with 4 to 20 states reporting

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

Number of States Reporting in FFY2014



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

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

Status of PQMP Measure Development and Endorsement

MAP's 2014 Input

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

Pediatric Quality Measures Program (PQMP) Background

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

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

PQMP Background, Continued

The PQMP is comprised of…

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

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

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

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

State Perspectives Panel, Part 1

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

Measurement and reporting from a state perspective

Jeff Schiff, MD MBA
Medical director, Minnesota DHS

Key Aspects of Minnesota's Measurement Journey

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

Can we measure value?

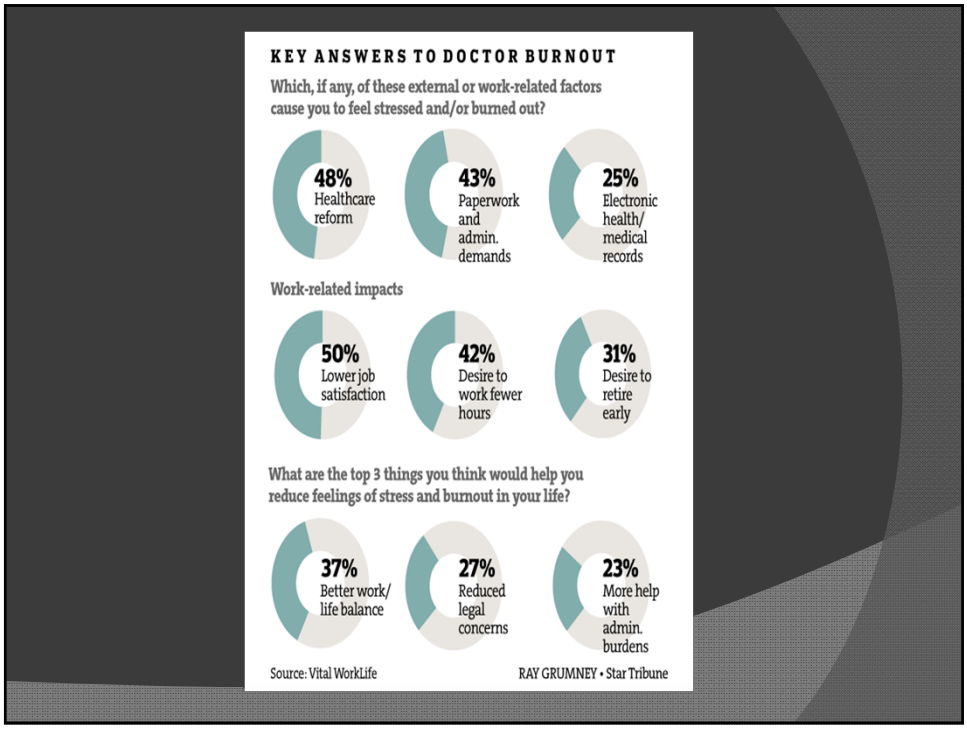
- If value = cost/quality, then what's role of quality in new payment mechanisms
- 2009 – implementation of patient centered medical home
- 2012 – Integrated health partnerships (Medicaid ACOs)

Doctor burnout is a rising problem in Minnesota medicine

Epidemic of burned-out doctors threatens care.

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

ILLUSTRATION BY ROB DOBI, SPECIAL TO THE STAR TRIBUNE



Physician burnout…

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

Medicaid levers to improve quality of care at the state level

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

MCO contracting

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

Changes to payment rates –FFS and MCO

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

Direct to provider relationships – PCMH/ACO/ Accountable communities

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

Focused policy/payment initiatives

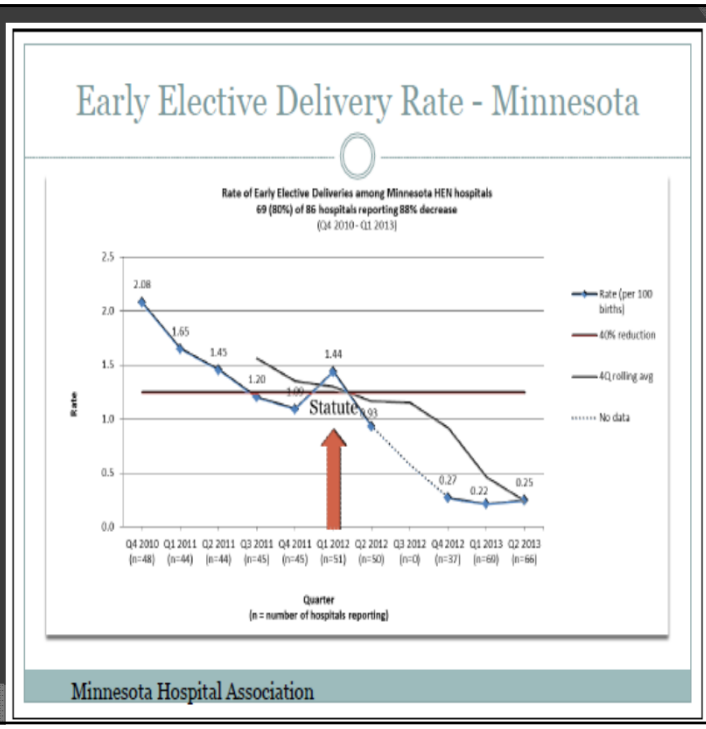
- Topic specific
- Engage provider community
  - Leadership
  - Acceptance of measure
- Process or program underlies the measure
  - Community agreement on importance
    - Measure a health outcome or a big process step to get there
    - Established evidence
    - Relevance to the population
    - Health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

Focused policy/payment initiatives (continued)

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

Evidence-based childbirth program

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



Vertical linkage of national NQF measures to patients and providers

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

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

Decisions guided by the purpose of measurement

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

In Minnesota

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

DHS Children's Medicaid Core Set Measures Annually Reported:

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

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

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

Data on post partum visit

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

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

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

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

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

Measure depth???

- Infrastructure
- Process
- Health outcome

Measure depth???

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

Which is better?

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

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

Opportunities

Link measures to quality improvement and policy

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

Future

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

Group Discussion: Key Themes from State Experiences

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

Opportunity for Public Comment

Lunch

State Perspectives Panel, Part 2

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

Sandra Blake, PhD, MBA
Director

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

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

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

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

June 9, 2015

BAYOUHEALTH
Your Health | Your Choice

Overview

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

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

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

2015 CHIPRA Measures Reported (2014 Measurement Year)

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

Selected 2014 Results (2013 Measurement Year)

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

Focusing on Continuous Improvement

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

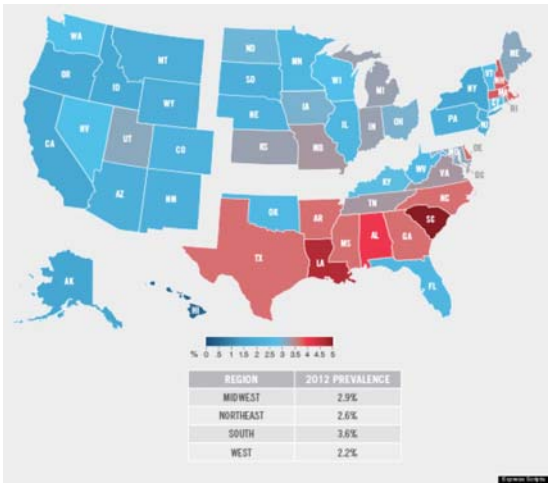
Data Collection is Moving Beyond Using Exclusively Claims Data

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

Some Initial Challenges Faced with Children's Core Set Measures

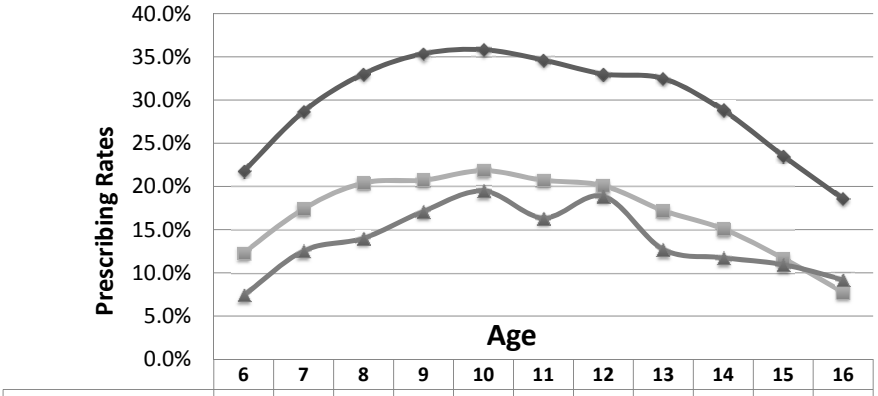
- Measures planned for reporting adjusted after assessing feasibility/data availability
  - *e.g.* Data required for Pediatric Central Line-Associated Bloodstream Infections is not readily available
- Medicaid data to Vital Records data matching process-- complex and time-consuming to create
- Chart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

The Geography of ADHD Drug Utilization



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

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



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

Strategies to Reduce Inappropriate Prescribing of Psychostimulants

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

Collecting CHIPRA Core Set Data Is Driving Quality Improvement

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

Recommendations to MAP for Strengthening Measures

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

Questions and More Information

Department of Health & Hospitals
Bureau of Health Services Financing
628 North 4th Street, Bienville Building
P.O. Box 91030
Baton Rouge, LA 70821
Website: www.dhh.la.gov

Mary Johnson, Medicaid Deputy Director for Quality
Mary.Johnson@la.gov

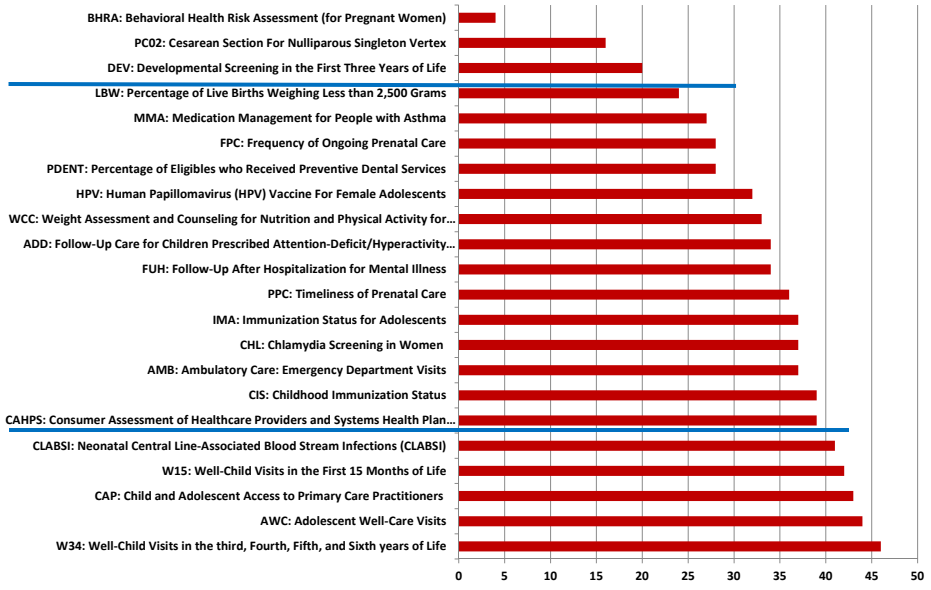
Beverly Hardy-Decuir Medicaid Quality Section Chief
Beverly.Hardy-Decuir@la.gov

Group Discussion: Key Themes from State Experiences

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

Measure by Measure Review

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



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

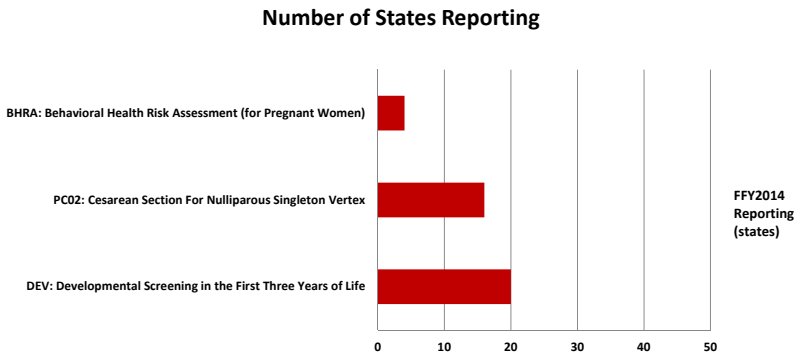
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

Measure by Measure Review

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

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

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



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

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

1448 – Developmental Screening the First Three Years of Life

NQF Endorsed – Steward: Oregon Health & Science University

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

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

1448 – Developmental Screening the First Three Years of Life

NQF Endorsed – Steward: Oregon Health & Science University

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

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

0471 – PC-02: Cesarean Section (PC02)

NQF Endorsed – Steward: The Joint Commission

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

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

0471 – PC-02: Cesarean Section (PC02)

NQF Endorsed – Steward: The Joint Commission

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

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

Steward: American Medical Association-Physician Consortium for Performance Improvement

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

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

Steward: AMA-PCPI

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

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

Discussion

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

Opportunity for Public Comment

Measure by Measure Review: Measures for Potential Addition

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

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

Gap Areas with Measures Currently Available

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

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

Decision Categories

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

Medicaid Child Core Set: Cost/Readmission Gap Area

Available Measures

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

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

Medicaid Child Core Set: Mental/Behavioral Health Gap Area

Available Measures

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

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

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

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

Medicaid Child Core Set: Care Coordination Gap Area

Available Measures

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

Medicaid Child Core Set: Inpatient Gap Area

Available Measures

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

2393 – Pediatric All-Condition Readmission Measure

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

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

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

2337 – Antipsychotic Use in Children Under 5 Years

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

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

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

Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Not Endorsed – Steward: NCINQ

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

Recommendations for Strengthening the Child Core Set

Task Force Votes to Recommend Each Measure for Inclusion

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

Recommendations for Strengthening the Child Core Set

Ranking Measures with Support for Addition

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

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

Prioritizing Remaining Gap Areas

Gaps in the Medicaid Child Core Set

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

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

Strategy for Filling High Priority Measure Gaps

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

Opportunity for Public Comment

Adjourn for the Day

Measure Applications Partnership

Medicaid Child and Adult Task Forces
In-Person Meeting

Day 2 – June 10, 2015

NATIONAL QUALITY FORUM

Introductions of the Adult Task Force Members

Medicaid Adult Task Force Membership

Task Force Chair: Harold Pincus, MD

Organizational Members

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

Medicaid Adult Task Force Membership

Subject Matter Experts

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

Federal Government Members

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

In-Person Meeting Objectives

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

MAP Medicaid Adult Task Force Charge

- For this review, the charge of the MAP Medicaid Adult Task Force is to:
  - Review states' experiences reporting measures to date
  - Refine previously identified measure gap areas and recommend potential measures for addition to the set
  - Recommend measures for removal from the set that are found to be ineffective
- The task force consists of current MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise.
- MAP convened the task force in April 2015, with a report due to CMS by August 2015.

Today's Action Items

Combined Adult and Child Task Force Discussion

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

Recap of Relevant Points from Previous Day

CMS Goals
Child and Adult Core Sets

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

How CMS Uses Core Set Data

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

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

MAP Measure Selection Criteria

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

Potential Reasons for Removal from Core Set

If a measure has:

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

Decision Categories

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

Measure Alignment

Measure Alignment

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

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

Measure Alignment: Task Force and State Panelist Discussion

Opportunities for Alignment

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

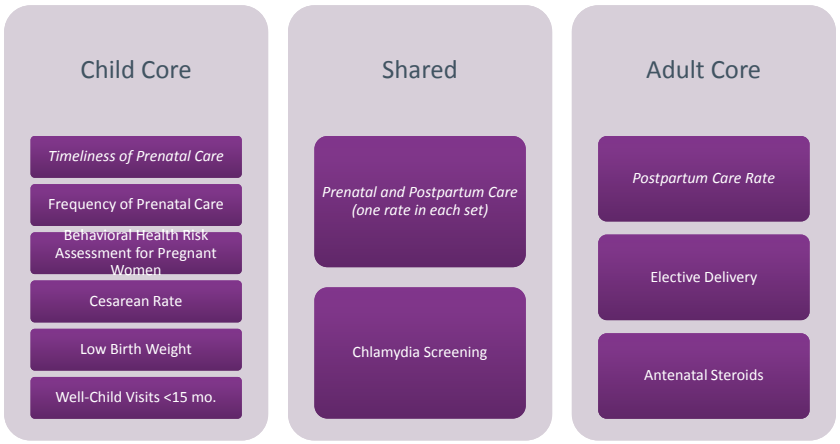
Break

Measurement of Maternity Care

Perinatal / Maternity Care Is a Measurement Priority

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

Overlapping Maternal and Child Health Measures



Potential Perinatal / Maternity Care Measures

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

Available Perinatal / Maternity Care Measures

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

Available Perinatal / Maternity Care Measures, Continued

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

Available Perinatal / Maternity Care Measures, Continued

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

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

NQF Endorsed – Steward: California Maternal Quality Care Collaborative

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

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

0480 – PC-05 Exclusive Breast Milk Feeding

(TJC is implementing significant revisions)

NQF Endorsed – Steward: The Joint Commission

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

Description:	PC-05 assesses the number of newborns exclusively fed breast milk during the newborn´s entire hospitalization. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns).
Numerator Statement	PC-05 Newborns that were fed breast milk only since birth
Denominator Statement	PC-05 Single term liveborn newborns discharged from the hospital with ICD-9-CM Principal Diagnosis Code for single liveborn newborn as defined in Appendix A, Table 11.20.1 available at: http://manual.jointcommission.org
Exclusions:	• Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization • ICD-9-CM Other Diagnosis Codes for galactosemia as defined in Appendix A, Table 11.21 • ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for parenteral infusion as defined in Appendix A, Table 11.22 • Experienced death • Length of Stay >120 days • Enrolled in clinical trials • Patients transferred to another hospital • ICD-9-CM Other Diagnosis Codes for premature newborns as defined in Appendix A, Table 11.23
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Process

Changes to breast milk feeding performance measures PC-05

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

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

Changes to PC-05a

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

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

Committee Decision on Updated PC-05

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

Use of Contraceptive Methods by Women Aged 15-20 Years

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

Description:	The percentage of women aged 15-20 years who are at risk of unintended pregnancy and who: 1) Adopt or continue use of the most effective or moderately effective FDA-approved methods of contraception. 2) Adopt or continue use of a long-acting reversible method of contraception (LARC). The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods (e.g., by calculating the median and focusing on those providers/entities that are performing well below the mean).
Numerator Statement	1: The eligible population that is using a most or moderately effective method of contraception. 2: The eligible population that is using a LARC method.
Denominator Statement	The eligible population that is at risk of unintended pregnancy.
Exclusions:	Women who are not capable of getting pregnant: women with a code for hysterectomy, bilateral oophorectomy, natural menopause (or premature menopause due to surgery, radiation or other factors); any women who were pregnant and/or received prenatal care or delivery care at any point in the 12-month reporting period.
Data Source:	Administrative Data
Type:	Intermediate Outcome (as defined by the developer)

Use of Contraceptive Methods by Women Aged 21-44 Years

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

Description:	The percentage of women aged 21-44 years who are at risk of unintended pregnancy and who: 1) Adopt or continue use of the most effective or moderately effective FDA-approved methods of contraception. 2) Adopt or continue use of a long-acting reversible method of contraception (LARC). The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods (e.g., by calculating the median and focusing on those providers/entities that are performing well below the mean).
Numerator Statement	1: The eligible population that is using a most or moderately effective method of contraception. 2: The eligible population that is using a LARC method.
Denominator Statement	The eligible population that is at risk of unintended pregnancy.
Exclusions:	Women who are not capable of getting pregnant: women with a code for hysterectomy, bilateral oophorectomy, natural menopause (or premature menopause due to surgery, radiation or other factors); any women who were pregnant and/or received prenatal care or delivery care at any point in the 12-month reporting period.
Data Source:	Administrative Data
Type:	Intermediate Outcome (as defined by the developer)

Effective Postpartum Contraception Access

Not Endorsed – Steward: Agency for Healthcare Research and Quality

Description:	The percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the utilization of postpartum contraception. Part A: Highly effective postpartum contraception access. The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing. Part B: Moderately effective postpartum contraception access. The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.
Numerator Statement	Part A: The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing. Part B: The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.
Denominator Statement	All continuously enrolled women with a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year.
Exclusions:	Exclude cases: With instrument-assisted delivery With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), or principal diagnosis (DX1=missing)
Data Source:	
Type:	Process

Committee Decision on Contraceptive Measures

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

Prioritization of Child Core Set Additions

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

Opportunity for Public Comment

Lunch

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

Enabling Outcome Measurement

What we know about this issue:

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

Enabling Outcome Measurement: Task Force and State Panelist Discussion

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

Opportunity for Public Comment

Break

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

Supporting State Participation

Factors Influencing State Participation in Reporting

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

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

Guidance for Future Medicaid Core Sets

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

Summary of the Day

Important Dates

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

Measure Applications Partnership

Medicaid Child and Adult Task Forces
In-Person Meeting

Day 3 – June 11, 2015

NATIONAL QUALITY FORUM

Meeting Objectives

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

Today's Action Items

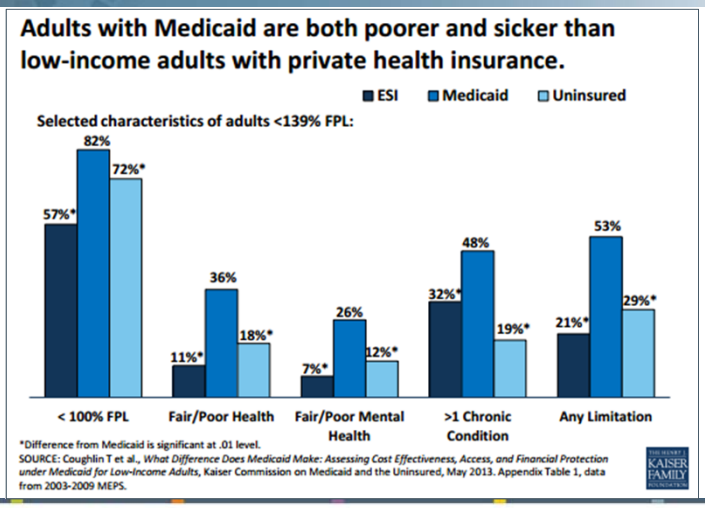
- Review highlights from the previous day
- Share staff analysis of the 2014 Adult Core Set reporting
- Consider measures with low uptake
- Select available measures to fill gap areas
- Rank selected measures for potential addition to the set
- Prioritize remaining measure gap areas

At Web Meeting, CMS Requested of MAP…

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

Medicaid-Eligible Adult Population Overview

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



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

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

Health conditions and risks of adult enrollees under 65

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

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

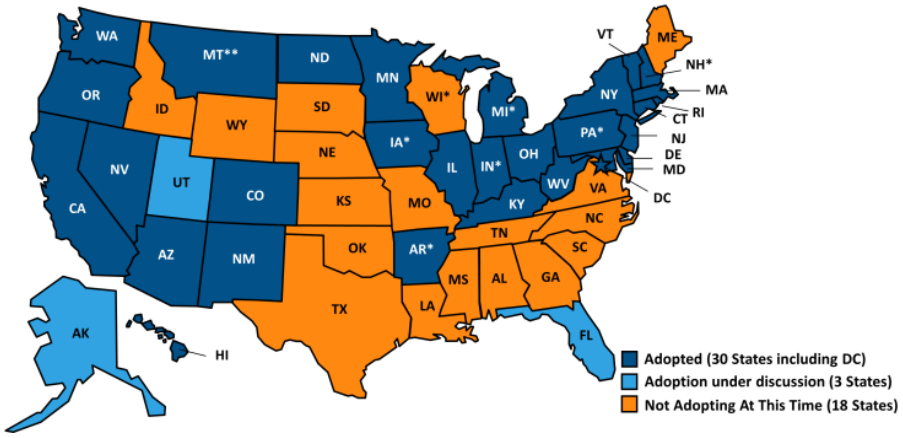
Diversity of Adult Medicaid Population

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

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

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

Current Status of State Medicaid Expansion Decisions, 2015



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

MAP Measure Specific Recommendations – Fall 2014

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

CMS - Adult Core Set Update for 2015 Reporting

Issued December 30, 2014

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

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

Medicaid Adult Core Set Measures for FFY 2015 Use

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

Medicaid Adult Core Set Measures for FFY 2015 Use - Continued

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

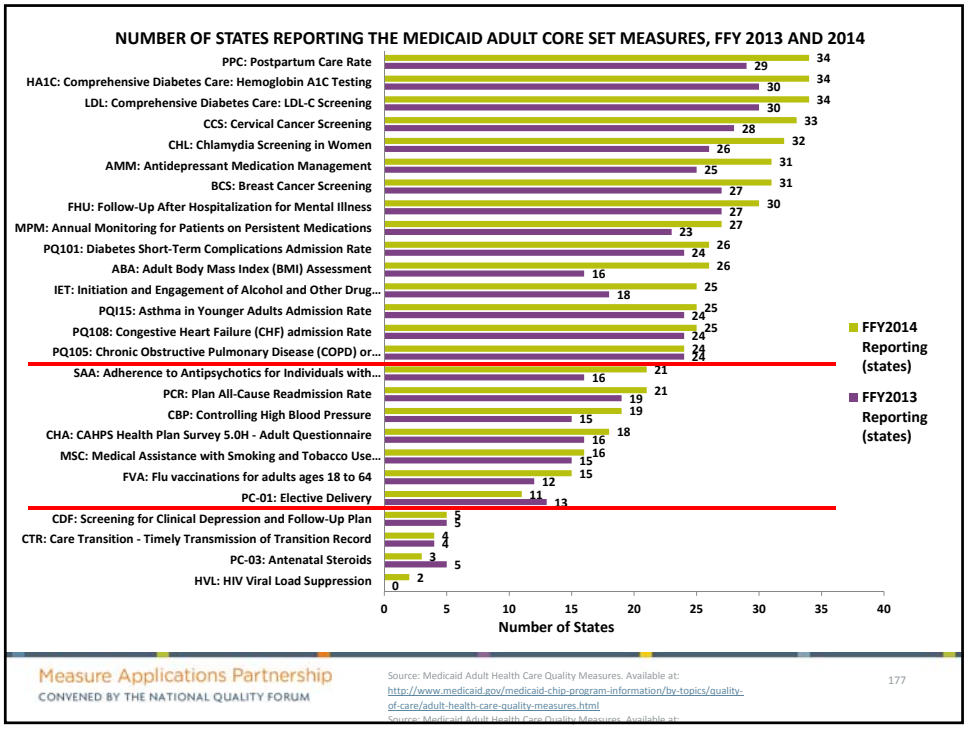
Staff Review of FFY 2014 State Reporting

Overview of Medicaid Adult Core Set FFY 2014 Reporting

Adult Core Set participation is strong, with room for improvement

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

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



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

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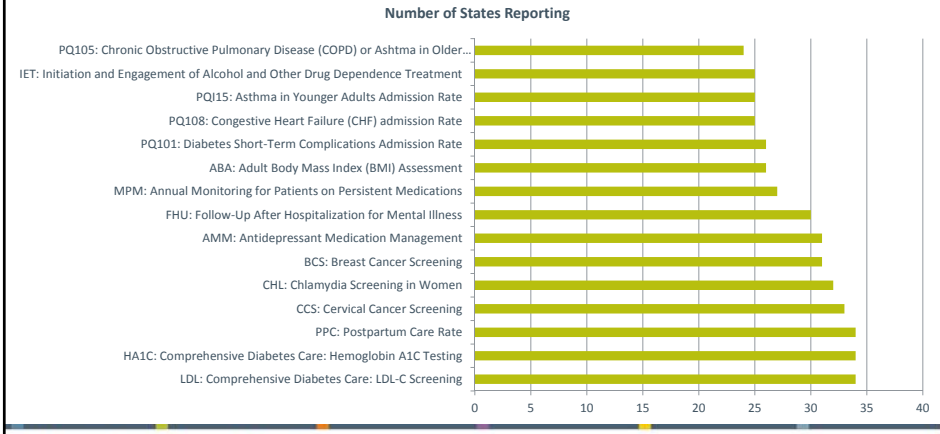
Measures with High Levels of Reporting (15)

Measures with at least 24 states reporting



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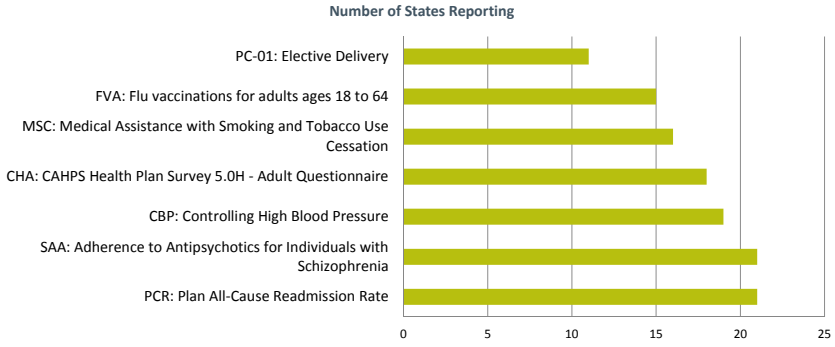
Measures with Medium Levels of Reporting (7)

Measures with 6-23 states reporting

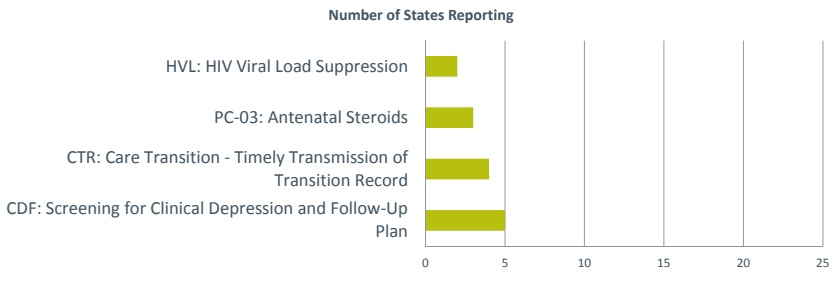
- Levels of reporting these measures are generally gaining ground or holding steady. Only PC-01 was reported by fewer states in 2014.



Measures with Low Levels of Reporting (4)

Measures with only 0-5 states reporting

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



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

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

Break

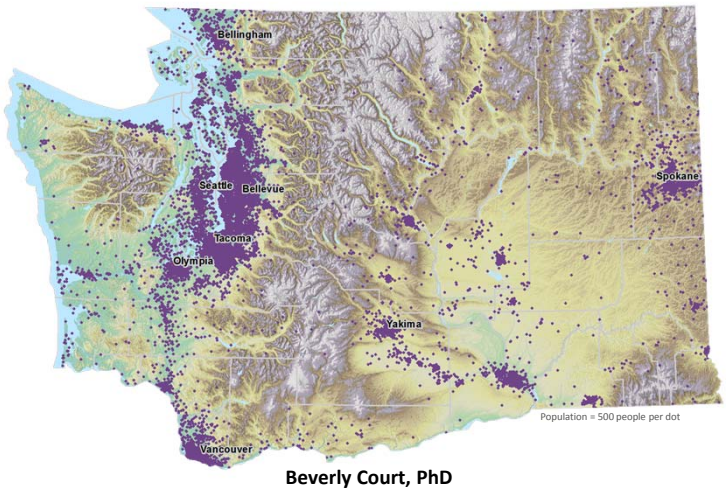
State Perspectives Panel

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

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

Medicaid Adult Core Set: Washington State Perspective

National Quality Forum | Measure Applications Partnership Presentation



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

Overview

Selecting Measures for Reporting

Data Collection Challenges

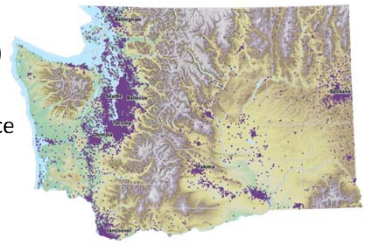
Quality Improvement

Measure Gaps

How HHS can Encourage Voluntary Reporting

Washington State Background

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



Selecting Measures for Reporting

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

Data Collection Barriers

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

Quality Improvement Activities Funded by Adult Medicaid Quality Grant

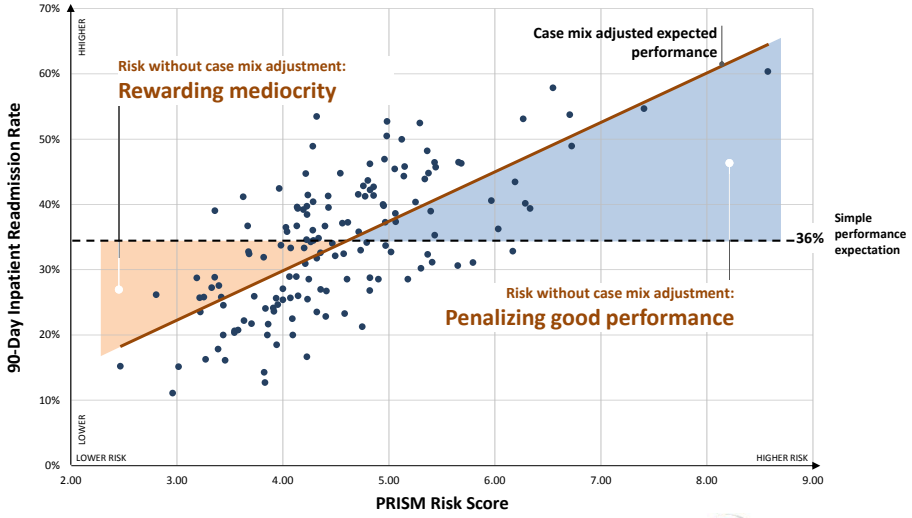
Focus on building cross system integration, especially for dual eligibles:

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

Quality Measurement and the Need for Risk Adjustment

Duals nursing facility inpatient readmission rates by average PRISM risk score

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



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

Measure Gaps

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

Voluntary Reporting

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

Recommendations

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

Questions?

Beverly Court, PhD
beverly.court@dshs.wa.gov
360.902.0726

Key Themes from State Experiences

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

Opportunity for Public Comment

Lunch

Measure by Measure Review

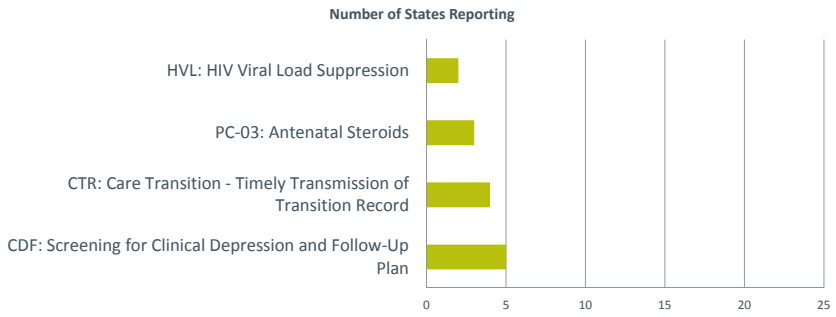
Measure by Measure Review

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

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

Measures with only 0-5 states reporting

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



2082 – HIV Viral Load Suppression

NQF Endorsed
Steward: HRSA

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

0476 – PC-03 Antenatal Steroids

NQF Endorsed
Steward: The Joint Commission

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

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

NQF Endorsed – Steward: AMA-PCPI

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

0418 – Screening for Clinical Depression and Follow-Up Plan

NQF Endorsed – Steward: Centers for Medicare & Medicaid Services

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

Discussion

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

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

MAP's 2014 Recommendations to Address High Priority Gaps

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

MAP's 2014 Recommendations to Address High Priority Gaps

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

Gap Areas with Measures Currently Available

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

Decision Categories

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

Medicaid Adult Core Set: Behavioral Health Gap Area

Available Measures

NQF #	Measure Name	Measure Steward
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	NCQA
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	NCQA
2599	Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA
2605	**Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence**	**NCQA**

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

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

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

Available Measures

NQF #	Measure Name	Measure Steward
N/A	Adults' access to preventive/ambulatory health services : percentage of members 20 years and older who had an ambulatory or preventive care visit	NCQA

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

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

Recommendations for Strengthening the Adult Core Set

Task Force Votes to Recommend Each Measure for Inclusion

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

Recommendations for Strengthening the Adult Core Set

Ranking Measures with Support for Addition

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

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

Opportunity for Public Comment

Prioritizing Remaining Gap Areas

Gaps in the Medicaid Adult Core Set

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

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

Strategy for Filling High Priority Measure Gaps

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

Next Steps

Important Dates

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

Adjourn

Thank You for Participating!

MEASURE APPLICATIONS PARTNERSHIP

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

EXPEDITED REVIEW

NOVEMBER 14, 2014

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

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

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

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

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

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

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

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

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

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

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

6. #0480 PC-05 Exclusive Breast Milk Feeding is part of a set of five measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns) and complements other perinatal measures in the Child and Adult Core Sets.

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

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

INTRODUCTION AND PURPOSE

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

The MAP Medicaid Child Task Force advises the MAP Coordinating Committee on recommendations to HHS for strengthening and revising measures in the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (Child Core Set), with a focus on addressing high-priority measure gaps. The task force consists of MAP members from the MAP Coordinating Committee and MAP workgroups (Appendix B).

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

BACKGROUND ON MEDICAID AND THE CHILD CORE SET

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

Medicaid and CHIP Benefits for Children

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

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

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

Health Issues for Children in Medicaid and CHIP

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

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

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

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

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

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

Child Core Set

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

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

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

Characteristics of the Child Core Set

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

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

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

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

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

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

STATE EXPERIENCE COLLECTING AND REPORTING THE CORE SET

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

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

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

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

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

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

MAP REVIEW OF THE CHILD CORE SET

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

High Priority Gaps

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

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

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

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

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

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

Measure-Specific Recommendations

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

Measures for Removal from the Child Core Set

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

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

Measures for Phased Addition to the Child Core Set

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

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

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

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

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

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

Use of NQF measure #0477 and NQF measure

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

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

STRATEGIC ISSUES

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

Feasibility of Reporting and Electronic Data Infrastructure

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

Pipeline of Measures in Development

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

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

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

Alignment of Measures

When making recommendations about measures for the Child Core Set, MAP considered the relationship between the selected measures and those contained in the Adult Core Set. Though the two measurement programs are separate, both CMS and States regard them as working together to provide an overall picture of quality within Medicaid and CHIP. Additionally, MAP's 2014 review of the Adult Core Set noted this inter-relationship. Comments noted that alignment efforts for the Medicaid quality reporting programs also advances alignment and harmonization of measures being used across states.

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

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

CONCLUSION

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

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

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

ENDNOTES

1 Department of Health and Human Services (HHS). *2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP*. Washington, DC:HHS;2013.

2 CMS. Medicaid by population: pregnant women website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Pregnant-Women/Pregnant-Women.html. Last accessed October 2014.

3 Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer – Key Information on the Nation's Health Coverage Program for Low-Income People.* Menlo Park, CA: Henry J. Kaiser Family Foundation;2013. Available at http://kff.org/medicaid/issue-brief/medicaid-a-primer/. Last accessed October 2014.

4 Centers for Medicare & Medicaid Services (CMS). Medicaid by population: children website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Children/Children.html. Last accessed October 2014.

5 Department of Health and Human Services (HHS). *2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP*. Washington, DC:HHS;2013.

6 CMS. Medicaid by population: pregnant women website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Pregnant-Women/Pregnant-Women.html. Last accessed October 2014.

7 CMS. Medicaid by population: children website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Population/Children/Children.html. Last accessed October 2014.

8 HHS, Office of the Assistant Secretary for Planning and Evaluation. 2014 Poverty Guidelines. Available at http://aspe.hhs.gov/POVERTY/14poverty.cfm. Last accessed October 2014.

9 Kaiser Commission on Medicaid and the Uninsured. *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults as of April 1, 2014.*Menlo Park, CA: Henry J. Kaiser Family Foundation;2014. Available at http://kaiserfamilyfoundation.files.wordpress.com/2014/06/7993-05-where-are-states-today-fact-sheet-june-2014.pdf. Last accessed October 2014.

10 CMS. Medicaid by topic: benefits: early and periodic screening, diagnostic, and treatment website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html. Last Accessed October 2014.

11 CMS. Medicaid by topic: benefits: prescription drugs website. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Prescription-Drugs.html. Last Accessed October 2014.

12 CMS. Children's Health Insurance Program (CHIP) website. Available at http://www.medicaid.gov/CHIP/CHIP-Program-Information.html. Last Accessed October 2014.

13 Bloom B, Jones LI, Freeman G. Summary health statistics for U.S. children: National Health Interview Survey, 2012. *Vital Health Stat*. 2013;10(258):1-81. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_258.pdf. Last accessed September 2014.

14 Children's Hospital Association. Optimizing health care for children with medical complexity, October 2013 website. Available at http://www.childrenshospitals.net/AM/Template.cfm?Section=Children_with_Medical_Complexity&template=/CM/ContentDisplay.cfm&ContentID=68420. Last accessed September 2014.

15 Wier LM, Hao Y, Owens P, et al. *Overview of Children in the Emergency Department, 2010*. HCUP Statistical Brief #157. Rockville, MD:Agency for Healthcare Research and Quality (AHRQ);2013. Available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb157.pdf. Last accessed September 2014.

16 Soni A. *The Five Most Costly Children's Conditions, 2011: Estimates for U.S. Civilian Noninstitutionalized Children, Ages 0–17*. Statistical Brief #434. Rockville, MD:AHRQ;2014. Available at http://www.meps.ahrq.gov/mepsweb/data_files/publications/st434/stat434.shtml. Last accessed October 2014.

17 AHRQ. Welcome to HCUPnet: quick national or state statistics. (Data from HCUPnet: Rank order of CCS principal diagnosis category by Cost using weighted national estimates from HCUP Nationwide Inpatient Sample (NIS), 2012). Available at http://hcupnet.ahrq.gov/. Last accessed October 2014.

18 National Center for Health Statistics (NCHS). Healthy People 2010 Final Review. Hyattsville, MD: NCHS; 2012. Available at http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_final_review.htm. Last accessed November 2014.

19 Gerritsen AE, Allen PF, Witter DJ, et al. Tooth loss and oral health-related quality of life: a systematic review and meta-analysis. *Health Qual Life Outcomes*. 2010; 8: 126.

20 Bloom B, Jones LI, Freeman G. Summary health statistics for U.S. children: National Health Interview Survey, 2012.. *Vital Health Stat*. 2013;10(258):1-81. Available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_258.pdf. Last accessed September 2014.

21 Wall, T., Nasseh K., Vujicic M. *U.S. Dental Spending Remains Flat through 2012. Health Policy Resources Center Research Brief*. Chicago, IL:American Dental Association;2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/HPRCBrief_0114_1.ashx. Last accessed November 2014.

22 CMS. Medicaid by topic: quality of care: CHIPRA initial core set of children's health care quality measures website. 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. Last accessed October 2014.

23 CMS. *January 2013 State Health Official Letter regarding 2013 Children's Core Set of Health Care Quality Measures*. Baltimore, MD:CMS;2013. Available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf. Last accessed November 2014.

24 Center for Medicaid & CHIP Services. *Informational Bulletin: 2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets*. Baltimore, MD:CMS; 2013. Available at http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf. Last accessed November 2014

25 CMS. *2014 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP*. Baltimore, MD: CMS;2014. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/ChildCoreMeasures.pdf. Last accessed November 2014.

26 CMS. *Health Insurance Marketplace. Quality Rating System Measure Technical Specifications Final 2015 Quality Rating System Beta Test Measure Set*. Baltimore, MD:CMS;2014. Available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html. Last accessed November 2014.

27 Dougherty D, Mistry KB, Lindly O, et al. Systematic evidence-based quality measurement life-cycle approach to measure retirement in CHIPRA. *Acad Pediatr*. 2014; 14(5S):S97-S103.

28 AHRQ. Pediatric quality measures program website. Available at http://www.ahrq.gov/policymakers/chipra/factsheets/factsheets2.html. Last accessed October 2014.

29 American Academy of Pediatrics Section on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics.* 2012;129(3):e827-e841. Available at http://pediatrics.aappublications.org/content/129/3/e827.full#content-block. Last accessed October 2014.

30 Information on measure specifications can be found via NQF's Quality Positioning System (QPS) at http://www.qualityforum.org/QPS/0480.

31 Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer – Key Information on the Nation's Health Coverage Program for Low-Income People.* Menlo Park, CA: Henry J. Kaiser Family Foundation;2013. Available at http://kff.org/medicaid/issue-brief/medicaid-a-primer/. Last accessed October 2014.

APPENDIX A:
MAP Background

Purpose

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

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

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

MAP's objectives are to:

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

2. Align performance measurement across programs and sectors to provide consistent and meaningful information that supports provider/clinician improvement, informs consumer choice, and enables purchasers and payers to buy based on value. MAP promotes the use of measures that are aligned across programs and between public and private sectors to provide a comprehensive picture of quality for all parts of the healthcare system.

3. Coordinate measurement efforts to accelerate improvement, enhance system efficiency, and reduce provider data collection burden. MAP encourages the use of measures that help transform fragmented healthcare delivery into a more integrated system with standardized mechanisms for data collection and transmission.

Coordination with Other Quality Efforts

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

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

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

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

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

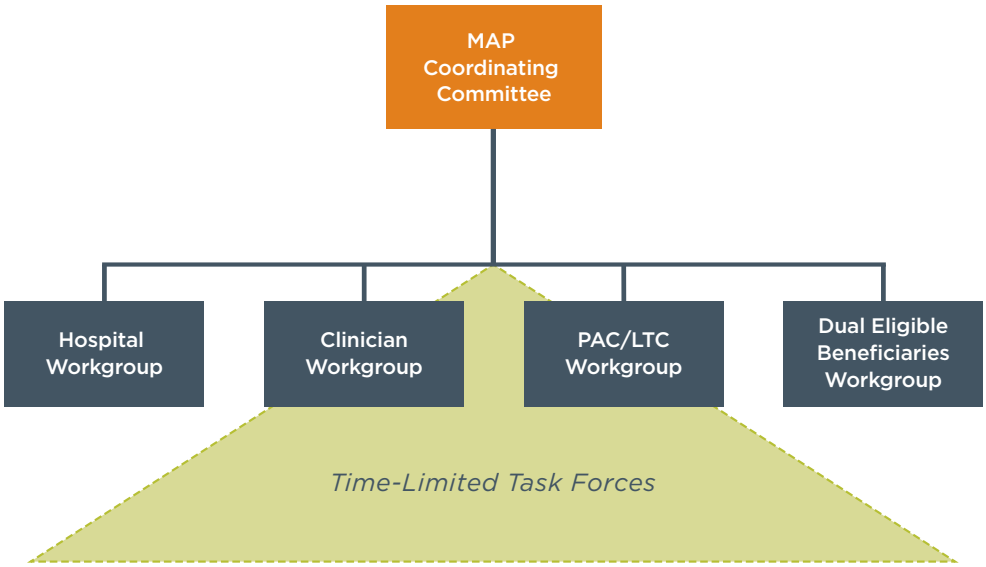
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Structure

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

EXHIBIT A1. MAP STRUCTURE



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

Timeline and Deliverables

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

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

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

ENDNOTE

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

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

Roster for the MAP Medicaid Child Task Force

CHAIR (VOTING)
Foster Gesten, MD, FACP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
Aetna	Sandra White, MD, MBA
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
American Academy of Pediatrics	Terry Adirim, MD, MPH, FAAP
American Nurses Association	Susan Lacey, RN, PhD, FAAN
America's Essential Hospitals	Beth Feldpush, DrPH
Children's Hospital Association	Andrea Benin, MD
Kaiser Permanente	Susan Fleischman, MD
March of Dimes	Cynthia Pellegrini
National Partnership for Women and Families	Carol Sakala, PhD, MSPH

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

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

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

Roster for the MAP Coordinating Committee

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

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

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

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

NQF Staff

Sarah Lash	Senior Director
Elizabeth Carey	Senior Project Manager
Nadine Allen	Project Analyst

APPENDIX C:
MAP Measure Selection Criteria

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

Criteria

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

APPENDIX D:
Child Core Set and MAP Recommendations

In February 2011, HHS published the initial core set of quality measures for children enrolled in Medicaid and CHIP. The authorizing legislation also requires HHS to publish annual changes to the Child Core Set beginning in January 2013. Exhibit D1 below lists the measures included in the current version of the Child Core Set along with their current NQF endorsement number and status. States voluntarily collect the Child Core Set measures using the 2014 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System. Exhibit D2 lists the measures supported by MAP for potential addition to the Child Core Set.

EXHIBIT D1. CURRENT CHILD CORE SET

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0024 Endorsed Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity	27 states reported FY 2012 Alignment: Meaningful Use (EHR Incentive Program) - Eligible Professionals (MU-EP), Physician Feedback, Physician Quality Reporting System (PQRS), Health Insurance Exchange–Quality Rating System (HIX-QRS)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0033 Endorsed Chlamydia Screening in Women (CHL) Measure Steward: National Committee for Quality Assurance	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	35 states reported FY 2012 Alignment: Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set), MU-EP, PQRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

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

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
0139 Endorsed National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure Measure Steward: Centers for Disease Control and Prevention	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations.	40 states reported FY 2012 Alignment: Hospital Acquired Condition Reduction Program, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-term Care Hospital Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting	Support continued use of this measure in the program. No significant implementation issues identified at this time.
0471 Endorsed PC-02 Cesarean Section Measure Steward: Joint Commission	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.

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

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1392 Endorsed Well-Child Visits in the First 15 Months of Life (W15) Measure Steward: National Committee for Quality Assurance	Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported: • No well-child visits • One well-child visit • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits	43 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1407 Endorsed Immunizations for Adolescents (IMA) Measure Steward: National Committee for Quality Assurance	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	32 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1448 Endorsed Developmental Screening in the First Three Years of Life Measure Steward: Oregon Health & Science University	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.	12 states reported FY 2012	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1516 Endorsed Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) Measure Steward: National Committee for Quality Assurance	Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	46 states reported FY 2012 Alignment: HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS and Alignment	MAP Recommendation and Rationale
1517 Endorsed Prenatal & Postpartum Care (PPC)* Measure Steward: National Committee for Quality Assurance *Child Core Set includes "Timeliness of Prenatal Care" rate only. "Postpartum Care" rate is evaluated in Medicaid Adult Core Set.	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.	31 states reported FY 2012 Alignment: Medicaid Adult Core Set, HIX-QRS	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1799 Endorsed Medication Management for People with Asthma (MMA) Measure Steward: National Committee for Quality Assurance	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.
1959 Endorsed Human Papillomavirus Vaccine for Female Adolescents (HPV) Measure Steward: National Committee for Quality Assurance	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	0 states reported FY 2012 (New)	Support continued use of this measure in the program. No significant implementation issues identified at this time.

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

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

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

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

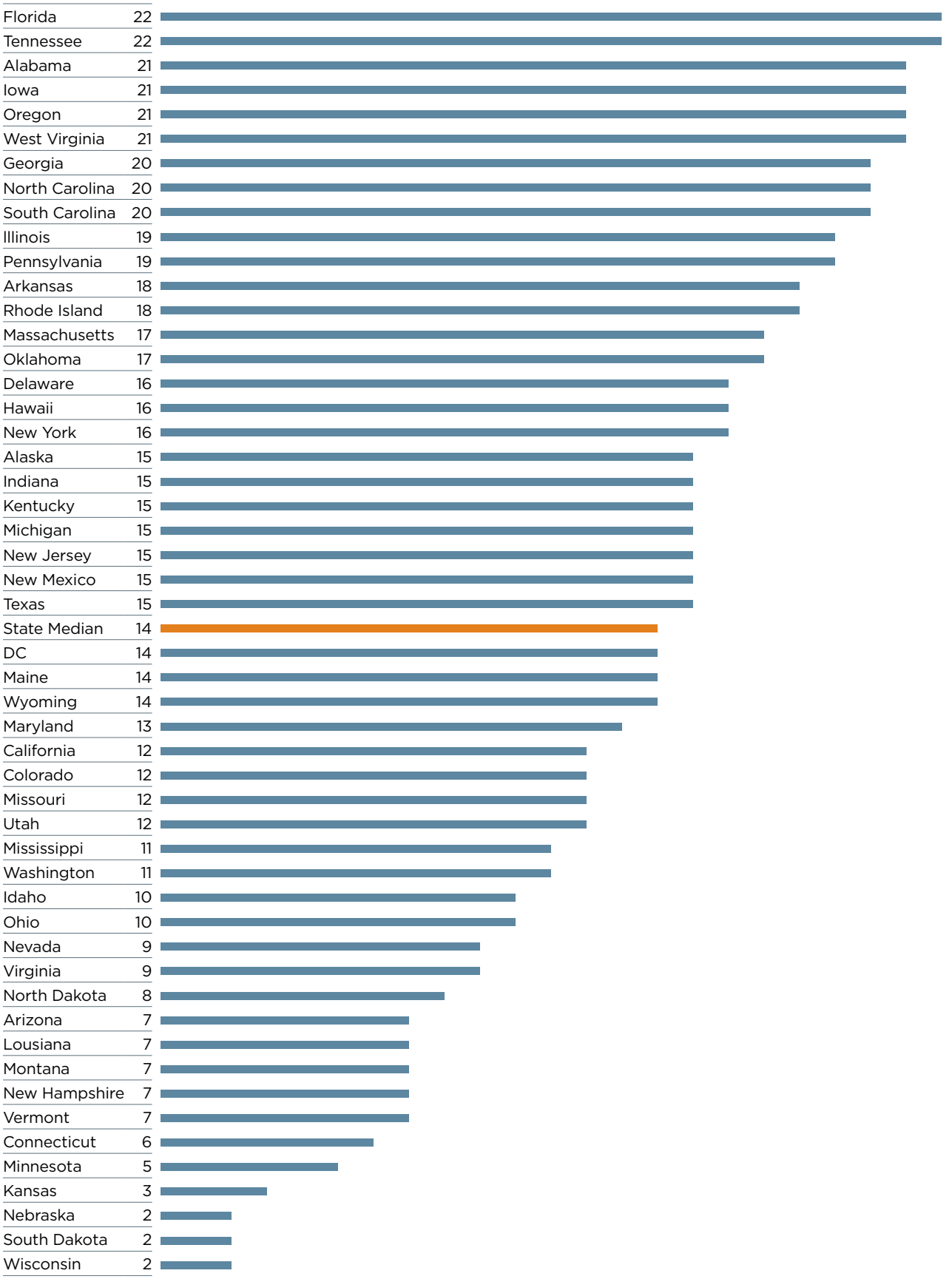
Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
2508 Endorsed Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk Measure Steward: American Dental Association on behalf of the Dental Quality Alliance	Percentage of enrolled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

Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
1365 Endorsed Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Quality Reporting System (PQRS)	Support addition of this measure to the program. Addresses gap in behavioral health.
0477 Endorsed Under 1500g infant Not Delivered at Appropriate Level of Care Measure Steward: California Maternal Quality Care Collaborative	The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant.		Support addition of this measure to the program. Enhances perinatal measures and would improve regional care coordination for high-risk pregnancies.
0480 Endorsed PC-05 Exclusive Breast Milk Feeding and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice Measure Steward: The Joint Commission	PC-05 assesses the number of newborns exclusively fed breast milk during the newborn´s entire hospitalization and a second rate, PC-05a which is a subset of the first, which includes only those newborns whose mothers chose to exclusively feed breast milk. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns).	Meaningful Use (EHR Incentive Program) - Hospitals, CAHs	Support addition of this measure to the program. Enhances perinatal measures and is associated with positive health outcomes for mother and child.

APPENDIX E:
State Implementation and Participation in Reporting Measures

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

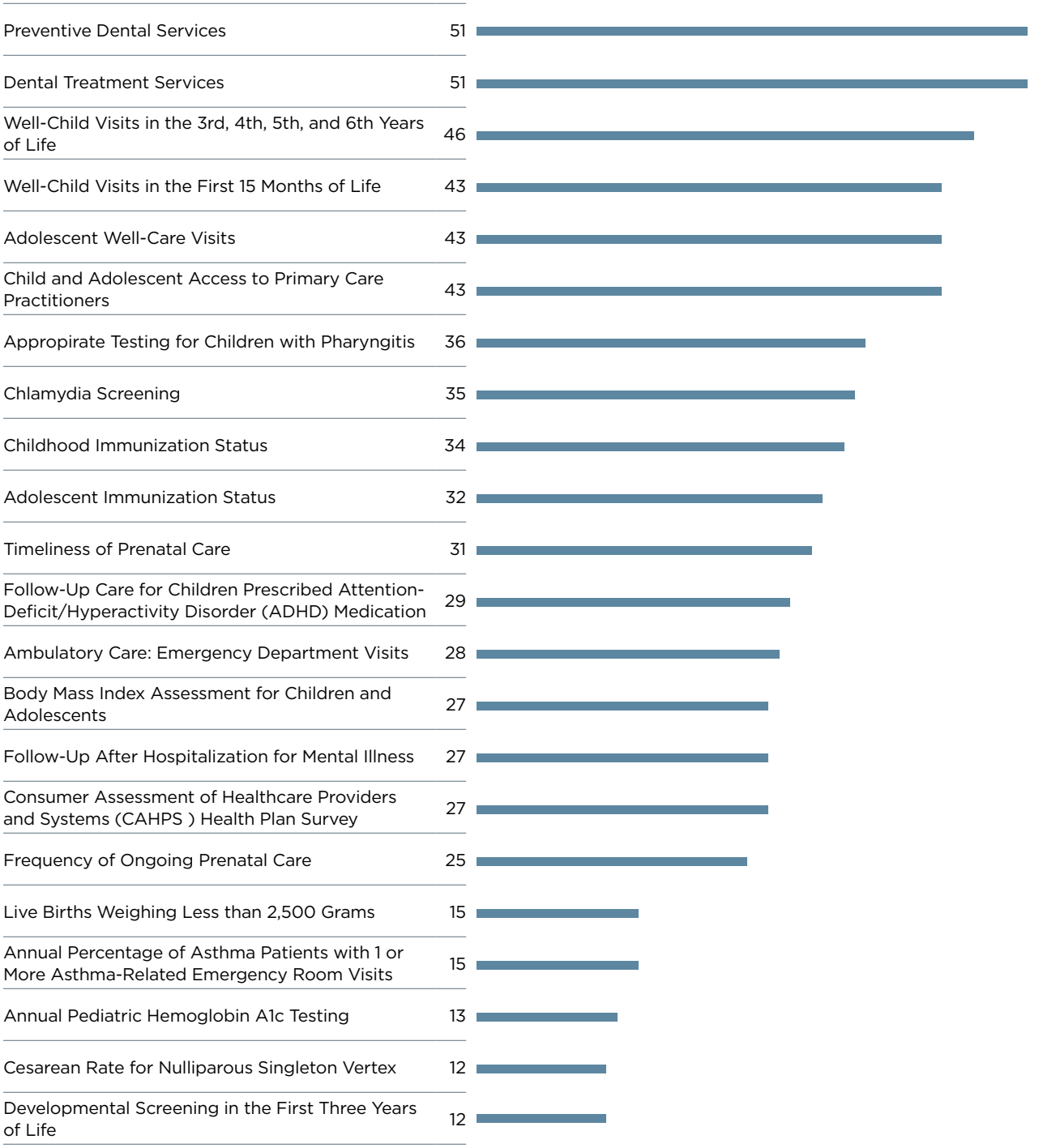
EXHIBIT E1. NUMBER OF MEDICAID/CHIP CHILD CORE SET MEASURES REPORTED BY STATES IN FY 2012



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

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

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



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

ENDNOTE

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

APPENDIX F:
NQF Member and Public Comments

General

Mount Sinai Hospital

Lawrence Kleinman

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

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

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

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

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

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

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

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

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

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

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

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

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

Children's Hospital Association

Ellen Schwalenstocker

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

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

America's Health Insurance Plans

Carmella Bocchino

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

The National Partnership for Women & Families

Alison Shippy

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

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

The many advantages of this measure include:

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

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

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

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

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

National Association of State Mental Health Program Directors

Stuart Gordon

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

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

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

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

AmeriHealth Caritas Family of Companies

Thomas James

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

National Initiative for Children's Healthcare Quality (NICHQ)

Charles Homer

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

Highmark, Inc

Nancy Mulvaney

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

AmeriHealth Caritas

Chelsea Newhall

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

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

Family Voices NJ/SPAN

Lauren Agoratus

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

Pharmacy Quality Alliance

Woody Eisenberg

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

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

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

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

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

Measure-Specific Recommendations

Children's Hospital Association

Ellen Schwalenstocker

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

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

America's Health Insurance Plans

Carmella Bocchino

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

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

National Association of State Mental Health Program Directors

Stuart Gordon

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

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

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

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

AmeriHealth Caritas Family of Companies

Thomas James

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

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

California Dept. of Health Care Services

Robert Isman

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

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

National Initiative for Children's Healthcare Quality (NICHQ)

Charles Homer

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

2. We endorse the measures for sealant use.

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

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

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

Highmark, Inc

Nancy Mulvaney

Percentage of Eligibles that Received Dental Treatment Services

Highmark comment: In agreement with removing this measure.

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

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

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

Highmark comment: See above for same comments #2508

NQF #0480 PC-05 Exclusive Breast Milk Feeding

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

AmeriHealth Caritas

Chelsea Newhall

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

the Core Child Set:

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

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

Family Voices NJ/SPAN

Lauren Agoratus

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

Measures for Phased Addition to the Child Core Set

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

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

Strategic Recommendations

Children's Hospital Association

Ellen Schwalenstocker

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

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

America's Health Insurance Plans

Carmella Bocchino

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

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

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

AmeriHealth Caritas Family of Companies

Thomas James

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

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

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

3. Need for Socioeconomic Risk Adjustment for outcomes measures.

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

National Initiative for Children's Healthcare Quality (NICHQ)

Charles Homer

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

Highmark, Inc

Nancy Mulvaney

New measures undergoing development and testing

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

Feasibility of reporting and electronic data

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

AmeriHealth Caritas

Chelsea Newhall

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

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

Family Voices NJ/SPAN

Lauren Agoratus

Feasibility of Reporting and Electronic Data Infrastructure

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

Pipeline of Measures in Development

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

Alignment of Measures

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

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

www.qualityforum.org

2015 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)
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)*
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 it as a measure in a future Child Core Set.

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

AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University.

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

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

CMCS Informational Bulletin

DATE: December 30, 2014

FROM: Cindy Mann
Director
Center for Medicaid and CHIP Services

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

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

Background

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

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

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

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

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

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

2015 Child Core Set

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

For the 2015 Child Core Set update, CMCS will:

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

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

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

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

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

[6] Measure steward: CMS, Not NQF Endorsed

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

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

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

2015 Adult Core Set

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

For the 2015 Adult Core Set update, CMCS will:

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

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

Next Steps

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

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

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

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

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

Report to Congress

HHS Secretary's Efforts to Improve Children's Health Care Quality in Medicaid and CHIP

Kathleen Sebelius
Secretary of the Department of Health and Human Services
2014

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CONTENTS

EXHIBITS

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GLOSSARY

ACF	Administration for Children and Families
ADHD	Attention-Deficit/Hyperactivity Disorder
Affordable Care Act	Patient Protection and Affordable Care Act of 2010
AHCA	Agency for Health Care Administration
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ARRA	American Recovery and Reinvestment Act
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control and Prevention
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CLABSI	Central Line-Associated Blood Stream Infection
CoIIN	Collaborative Improvement and Innovation Network
CMCS	Center for Medicaid and CHIP Services
CME	Care Management Entity
CMS	Centers for Medicare & Medicaid Services
COE	Center of Excellence
CPC	Comprehensive Primary Care
CUSP	Comprehensive Unit-based Safety Program
EHDI	Early Hearing Detection and Intervention
EHR	Electronic Health Record
ELE	Express Lane Eligibility
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment

FFY	Federal Fiscal Year
HCAC	Health Care-Acquired Condition
HEDIS	Healthcare Effectiveness Data and Information Set
HEN	Hospital Engagement Network
HHS	U.S. Department of Health and Human Services
HITECH	Health Information Technology for Economic and Clinical Health Act
HPV	Human Papillomavirus
HRSA	Health Resources and Services Administration
IHOC	Improving Health Outcomes for Children
Innovation Center	Center for Medicare & Medicaid Innovation
Learning Network	Medicaid Prevention Learning Network
MACBIS	Medicaid and CHIP Business Information Solutions
MHPAEA	Mental Health Parity and Addiction Equity Act
MSIS	Medicaid Statistical Information System
National Quality Strategy	National Quality Strategy for Quality Improvement in Health Care
NCQA	National Committee for Quality Assurance
NHSN	National Healthcare Safety Network
NICU	Neonatal Intensive Care Unit
NIPN	National Improvement Partnership Network
NOIP	National Outcomes Improvement Project
NTSV	Nulliparous Term Singleton Vertex
OB/GYN	Obstetrical/Gynecological Practitioner
OME	Otitis Media with Effusion
ONC	Office of the National Coordinator for Health Information Technology
OPPC	Other Provider-Preventable Condition
PCP	Primary Care Practitioner

PCPCH	Patient Centered Primary Care Home
PCPI	Physician Consortium for Performance Improvement
PfP	Partnership for Patients
PPC	Provider-Preventable Condition
PQMP	Pediatric Quality Measures Program
QI	Quality Improvement
SAHM	Society for Adolescent Health and Medicine
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHC	School-Based Health Center
SNAP	Supplemental Nutrition Assistance Program
SPA	State Plan Amendment
TA/AS	Technical Assistance and Analytic Support
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
YEHS!	Youth Engagement with Health Services

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EXECUTIVE SUMMARY

In federal fiscal year (FFY) 2012, Medicaid and the Children's Health Insurance Program (CHIP) covered more than 44 million children,[1] representing about one-third of all children in the United States and more than half of all low-income children.[2] Medicaid is also the largest provider of prenatal and delivery services for pregnant women, covering nearly half (48 percent) of all births in the United States.[3] The substantial reach of the Medicaid/CHIP programs underscores the importance of ongoing efforts to improve the quality of care for children in these programs.

The U.S. Department of Health and Human Services (HHS) is working closely with states, health care providers, and program enrollees to build high quality systems of care for children in Medicaid/CHIP. This report, required by Section 1139A(a)(6) of the Social Security Act, as amended by Section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), summarizes the ongoing efforts of HHS to improve the quality of care for children enrolled in Medicaid/CHIP. Since the first Report to Congress on Children's Health Care Quality in Medicaid and CHIP was submitted in 2010,[4] HHS and its federal, state, and private partners have made significant progress on initiatives related to improving stability of coverage and improving the quality of care for infants and children (including voluntary reporting of the children's core set of health care quality measures).

With standardized measurement and reporting tools now in place, HHS is working closely with its state partners to more thoroughly measure the care obtained by children covered by Medicaid/CHIP and to use the measures to assess and improve the quality of care provided to children in their states. Over the past three years, HHS has implemented a wide range of children's health care quality initiatives.

Highlights from this report include:

1. HHS's Efforts to Improve the Quality of Care for Children
    - Health care coverage and enrollment for children in Medicaid and CHIP have improved, with Medicaid/CHIP reaching a higher proportion of eligible children. HHS has conducted a national outreach campaign, issued a Secretarial challenge, and awarded more than $140 million in outreach grants to increase enrollment.

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[1] U.S. Department of Health and Human Services. "2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP." September 2013, Table 1. Available at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf.

[2] The Kaiser Commission on Medicaid and the Uninsured. "Medicaid: A Primer." March 2013. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.

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

[4] "Report to Congress on Children's Health Care Quality in Medicaid and CHIP." December 2010. Note: this report is due every three years. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_ChildHealthImprovement.pdf.

Further, evidence suggests that CHIPRA bonus payments have provided an impetus for some states to improve their outreach, enrollment simplification, and retention efforts.

- Multiple quality improvement efforts are well underway that cut across all domains of children's health care, with special attention to maternal and infant health, oral health, and prevention.
- Strong public-private partnerships, as demonstrated by the American Academy of Pediatrics and Childbirth Connections, have accelerated quality improvement initiatives.

2. Status of Voluntary Reporting by States

   - State reporting of the Child Core Set is more complete than in FFY 2010, the first year of voluntary reporting. All states reported two or more of the Child Core Set measures for FFY 2012.[5] The median number of measures reported by states for FFY 2012 was 14, up from 12 in FFY 2011. Altogether, 35 states reported at least 11 of the 22 core measures to the Centers for Medicare & Medicaid Services (CMS) in FFY 2012.[6] The most frequently reported measures in the Child Core Set assess children's access to primary care, well-child visits, and dental services.
   - CMS is partnering with states to improve the completeness and accuracy of the data to monitor state performance.
   - Although much of the technical assistance to states to improve performance has been made available to all states, CMS has tailored several efforts (such as quality improvement training series) to states with lower performance or with specific areas of interest.

The quality improvement efforts recently launched by CMS are helping to set the stage for the next generation of efforts designed to improve children's health care and health outcomes to continue to transform Medicaid/CHIP into a high quality system of coverage and care. In the FFY 2015 President's Budget, HHS proposed two changes relevant to Medicaid and CHIP quality: a one-year extension of the Performance Bonus Fund and permanently extending Express Lane Eligibility (ELE) for children beyond the end of FFY 2014.[7]

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

[6] The base of 22 measures excludes two core measures: (1) the central line-associated blood stream infections (CLABSI) measure, which was obtained from the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) beginning in FFY 2012; and (2) the otitis media with effusion (OME) measure, which was not collected for FFY 2012 and was retired in 2013 because it draws on CPT-II codes not commonly used by Medicaid/CHIP agencies.

[7] U.S. Department of Health and Human Services. "Fiscal Year 2015 Budget-in-Brief." Available at: http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf.

I. INTRODUCTION

Medicaid and the Children's Health Insurance Program (CHIP) covered more than 44 million children in federal fiscal year (FFY) 2012,[8] about one-third of all children in the United States and more than half of all low-income children.[9] From 2008–2010, Medicaid was the largest provider of prenatal and delivery services for pregnant women, covering nearly half (48 percent) of all births in the United States.[10] In recent years, Medicaid participation rates have increased as a result of outreach, enrollment simplification, and retention efforts, with 87 percent of eligible children enrolled in 2011.[11] The substantial reach of the Medicaid/CHIP programs underscores the importance of ongoing efforts to improve the quality of care for children.

The National Strategy for Quality Improvement in Health Care (National Quality Strategy), was established in 2011 as a national blueprint to align new and existing quality improvement efforts around three goals—better care; healthy people/healthy communities; and affordable care—and to measure progress toward achieving these goals.[12,13] Many initiatives are underway to promote continued improvement of children's health care quality under Medicaid/CHIP, as part of broader efforts to transform health care and create a higher-performing system. These include enhanced oversight and quality improvement efforts of managed care systems, quality measurement systems and value-based purchasing that promote high quality care over high volume, and electronic health records and other health information technology to improve care coordination and adherence to recommended care.

Many of these initiatives have been made possible by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA),[14] which provided funding and incentives to states to identify, enroll, and retain eligible children in Medicaid/CHIP, and supported various Medicaid/CHIP quality improvement efforts, including the development of a core set of children's health care quality measures, ongoing improvements to the core set and development of new quality measures, and establishment of a quality demonstration program. (See Exhibit 1

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[8] U.S. Department of Health and Human Services. "2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP." September 2013, Table 1. Available at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf.

[9] The Kaiser Commission on Medicaid and the Uninsured. "Medicaid: A Primer." March 2013. Available at: http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf.

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

[11] Kenney, G., N. Anderson, and V. Lynch. "Medicaid/CHIP Participation Rates Among Children: An Update." September 2013. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407769.

[12] The National Quality Strategy. "Guiding Principles." Available at: http://www.ahrq.gov/workingforquality/nqs/principles.htm.

[13] U.S. Department of Health and Human Services. "2013 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care." July 2013. Available at: http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm.

[14] "CHIP Reauthorization Act of 2009." Available at: http://www.gpo.gov/fdsys/pkg/PLAW-111publ3/html/PLAW-111publ3.htm.

for a list of the Child Core Set measures and Appendix A for a description of the CHIPRA quality demonstration projects.)

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), enacted under the American Recovery and Reinvestment Act (ARRA), provided incentives for the adoption of electronic health records and investment in health care technology infrastructure among providers nationwide;[15] and the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) is supporting testing of various innovations, such as value-based purchasing, primary care transformation, and efforts to speed the adoption of best practices among health care providers.[16]

Section 1139A(a)(6) of the Social Security Act, as amended by Section 401 of CHIPRA, directs the Secretary of HHS to report to Congress every three years on:

(A) The status of the Secretary's efforts to improve:

  (i) Quality related to the duration and stability of health insurance coverage for children under Titles XIX and XXI;

  (ii) The quality of children's health care under these titles, including preventive health services, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and

  (iii) The quality of children's health care under these titles across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;

(B) The status of voluntary reporting by states under Titles XIX and XXI, utilizing the initial core quality measurement set; and

(C) Any recommendations for legislative changes needed to improve the quality of care provided to children under Titles XIX and XXI, including recommendations for quality reporting by states.

Since the first Report to Congress on Children's Health Care Quality in Medicaid and CHIP was submitted in 2010, HHS and state partners have made significant progress on initiatives related to improving stability of coverage and improving the quality of care for infants and children (including voluntary reporting of the children's core set of health care quality measures).[17]

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[15] "American Recovery and Reinvestment Act of 2009." Available at: http://www.healthit.gov/sites/default/files/hitech_act_excerpt_from_arra.pdf.

[16] For more information on CMS Center for Medicare & Medicaid Innovation Models, see http://innovation.cms.gov/initiatives/index.html#views=models.

[17] "Report to Congress on Children's Health Care Quality in Medicaid and CHIP." December 2010. Note: this report is due every three years. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_ChildHealthImprovement.pdf.

II. HHS EFFORTS TO IMPROVE QUALITY OF CARE FOR CHILDREN

A. Efforts to Improve the Duration and Stability of Health Insurance Coverage for Children

Medicaid and CHIP provide health insurance coverage to more than one in three children in the United States. Nevertheless, more than four million children remain eligible but uninsured, and many children lose coverage at renewal despite continued eligibility. Ensuring access to continuous health care coverage is the foundation for creating a comprehensive health care system that is focused on improving health care quality. Over the past three years, HHS has continued its focus on streamlining Medicaid/CHIP enrollment and retention procedures and enhancing outreach efforts. This section describes selected HHS efforts to raise awareness of Medicaid/CHIP coverage, simplify enrollment, and facilitate retention.

1. Efforts to Enhance Outreach

Over the past four years, CHIPRA and the Affordable Care Act authorized $140 million to support national, state, and local outreach and enrollment efforts, including a national campaign; grants to Indian tribes and providers that serve tribes; and grants to states, community-based organizations, schools, health care provider groups, and others.[18] In 2009, the HHS Secretary announced a new enrollment challenge called "Connecting Kids to Coverage," to encourage public and private partners to enroll five million eligible but uninsured children in Medicaid/CHIP. The "Insure Kids Now" website is one of the vehicles used to support the outreach and enrollment campaign, a public–private partnership established to reach eligible but uninsured children, enroll them in Medicaid/CHIP, and maintain their coverage as long as they are eligible.

In July 2013, the most recent grant cycle, HHS awarded 41 grants in 22 states totaling $32 million. These grants had five general aims:[19]

1. Engaging schools in outreach, enrollment, and retention activities
2. Bridging health coverage disparities by reaching out to subgroups of children with below-average health coverage rates
3. Designing and implementing targeted enrollment strategies to streamline health coverage enrollment for individuals participating in Supplemental Nutrition Assistance Program (SNAP); Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); or other public benefit programs

[18] For more information, see the Insure Kids Now website at http://www.insurekidsnow.gov/professionals/outreach/grantees/.

[19] Centers for Medicare & Medicaid Services. "Connecting Kids to Coverage Outreach and Enrollment Grants." Available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-02.html.

4. Developing application assistance resources to provide high quality, reliable Medicaid/CHIP enrollment and renewal services in local communities
5. Conducting training programs to equip communities to help families understand the new application and enrollment system and to deliver effective assistance to families with children eligible for Medicaid and CHIP

With the implementation of the Affordable Care Act, coordination between Medicaid/CHIP and the Marketplaces (both state-based exchanges and the federally facilitated marketplace) will be essential to minimize confusion and coverage disruptions among families with children currently enrolled in Medicaid/CHIP and ensure that newly eligible family members obtain coverage. HHS will continue to work with states and their partners to support efforts to extend health coverage to those who are uninsured and to maintain coverage among those who already have it.

2. Efforts to Streamline Enrollment and Retention Procedures

CHIPRA established a Performance Bonus Program for states that implemented at least five of eight enrollment simplifications and achieved Medicaid enrollment increases.[20,21] Program simplification included:

- Continuous eligibility
- Elimination/liberalization of asset and resource requirements
- Use of same forms in both Medicaid and CHIP for application and renewal
- Administrative renewals
- Presumptive eligibility
- Express lane eligibility
- Premium assistance subsidies

In FFY 2009, 10 states received bonuses for implementing at least five of these practices and achieving Medicaid enrollment targets. More states followed, with 16 states receiving bonuses in FFY 2010, 25 states in FFY 2011, and 23 states in FFY 2012.[22] Performance bonuses amounted to $37 million in FFY 2009, and reached more than $307 million in FFY 2013.[23]

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[20] "Health Policy Brief: Enrolling More Kids in Medicaid and CHIP." Health Affairs, January 27, 2011. Available at: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_39.pdf.

[21] CMS State Health Official Letter: "CHIPRA Performance Bonus Payments." December 16, 2009. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho09015.pdf.

[22] Kaiser Family Foundation. "CHIPRA Performance Bonus Awards, FY 2009–FY 2012." Available at: http://kff.org/other/state-indicator/chipra-performance-bonuses/.

[23] CMS and the Center for Medicaid and CHIP Services (CMCS). "CMCS Informational Bulletin: FY 2013 CHIPRA Performance Bonuses." December 30, 2013. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-30-2013.pdf.

Evaluation results suggest that ELE, one of the eight enrollment simplifications, yields administrative savings for states as well as a more streamlined application process for families.[24] Through ELE, states can use eligibility findings from other public benefit programs, such as SNAP to determine eligibility for Medicaid and CHIP. Since 1997, states have had the option to guarantee a full year of coverage to children in their Medicaid and CHIP programs by providing 12 months of continuous eligibility, another of the eight simplifications. Under this option, children retain coverage for 12 months regardless of changes in most family circumstances, such as income or household size. For children and states, the option can mitigate the problems associated with "churning", the enrollment and re-enrollment of eligible people when they lose coverage for procedural reasons or because of slight fluctuations in income. As of April 2014, 33 states have adopted 12-month continuous eligibility in their Medicaid or CHIP programs for children, compared to 30 states with such a program in January 2009.[25] In 2013, 23 states implemented the option in both Medicaid and CHIP programs, compared to 18 states in 2009 with a coordinated policy.[26]

The Affordable Care Act also included multiple provisions designed to streamline the eligibility and enrollment process. CMS developed regulations, guidance, and multiple tools to assist states in the implementation of these provisions. Eligibility is determined based on modified adjusted gross income, simplifying the determination and bringing consistency to the way income is counted across the country. These new laws and policies are designed to create coordination and alignment across Medicaid, CHIP, and the Health Insurance Marketplace, so beneficiaries and families can have a more seamless experience enrolling in health coverage and less confusion about coverage options.

For example, the Affordable Care Act mandates states to use a single streamlined application to allow applicants to apply for coverage using one application and receive an eligibility determination for all insurance affordability programs, including Medicaid, CHIP, and coverage in a qualified health plan with advance premium tax credits, cost-sharing reductions, or both. Applications are accepted online, over the phone, via mail, and in person. The eligibility procedures used by states were also simplified by updating ways to verify eligibility, moving from paper-based verification to electronic verifications, and increasing reliance on self-attestation. Administrative efficiencies were also gained by changing the process used for renewing a person's eligibility for the program, requiring states to rely on information known to the system, before requesting additional information from enrollees.

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[24] Mathematica Policy Research. "CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings." December 2013. Available at: http://aspe.hhs.gov/health/reports/2013/ELE/ELE%20Final%20Report%20to%20ASPE%2012%2011%2013.pdf.

[25] Insure Kids Now. "Continuous Eligibility for Medicaid and CHIP Coverage." Available at: http://www.insurekidsnow.gov/professionals/eligibility/continuous.html.

[26] Georgetown University Health Policy Institute, Center for Children and Families. "Program Design Snapshot: 12-Month Continuous Eligibility." Available at: http://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf.

In May 2013, CMS issued a State Health Official letter describing other strategies states can use to increase Medicaid/CHIP enrollment and promote more continuous enrollment once enrolled.[27] These strategies often require Medicaid systems enhancements. CMS is offering enhanced federal matching funds (at a 90 percent rate for development and a 75 percent rate for operations) for state Medicaid systems changes, as long as those systems meet applicable requirements.[28]

These opportunities will help to ensure that eligible individuals obtain access to Medicaid coverage in a simple, streamlined manner and that, by aligning coverage policies for parents and children, coverage is better coordinated for families. Although some of these options apply to coverage for parents rather than children, evidence suggests that a parent's health insurance status is strongly associated with a child's health insurance coverage.[29] Research shows that, when coverage is extended to parents, more children enroll in Medicaid/CHIP; they stay covered longer; and they are more likely to access health care, including preventive care. Thus, when many parents gain coverage in 2014 as a result of the Affordable Care Act, children's access and coverage may improve as well.

3. Effects of HHS Outreach, Enrollment, and Retention Efforts on Children's Health Coverage

Although it is not possible to isolate the impact of specific efforts on the duration and stability of children's coverage, recent evidence suggests that these efforts, taken together, contributed to a significant increase in Medicaid/CHIP participation rates. Between 2008 and 2011, Medicaid/CHIP participation rates increased more than five percentage points (from 81.7 percent to 87.2 percent) and the number of eligible-but-uninsured children fell by nearly 1 million (from 4.9 million to 4.0 million). In 2011, nineteen states (Alabama, Arkansas, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Mexico, New York, Rhode Island, Tennessee, Vermont, West Virginia, and Wisconsin) and the District of Columbia had participation rates of 90 percent or higher. In contrast, in 2008 four states and the District of Columbia had rates at or above 90 percent and fifteen states had rates below 80 percent.[30]

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[27] CMS State Health Official Letter: "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014." May 17, 2013. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf.

[28] "Affordable Care Act: State Resources FAQ." April 25, 2013. Available at: http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Affordable-Care-Act-FAQ-enhanced-funding-for-medicaid.pdf.

[29] U.S. Government Accountability Office. "Medicaid and CHIP: Given the Association Between Parent and Child Insurance Status, New Expansions May Benefit Families." GAO-11-264, February 2011. Available at: http://www.gao.gov/products/GAO-11-264.

[30] Kenney, G., N. Anderson, and V. Lynch. "Medicaid/CHIP Participation Rates Among Children: An Update." September 2013. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407769.

Despite significant progress, additional efforts are required to continue to reduce the number of children who are eligible but uninsured. Nationally, four million eligible children have yet to be covered. About half of all eligible-but-uninsured children live in six states: Texas, California, Florida, Georgia, New York, and Arizona. In response, HHS targeted half of the Connecting Kids to Coverage Outreach and Enrollment grants awarded in July 2013 to organizations in these six states.

B. Efforts to Improve Health Care Quality

1. The Quality Roadmap

In 2013, HHS and its partner states continued to build on and advance efforts to improve the quality of health care for children in Medicaid/CHIP. Over the past two years, CMS has used the HHS National Strategy for Quality Improvement in Health Care (National Quality Strategy) as the roadmap for improving the delivery of health care services, patient health outcomes, and population health. The National Quality Strategy aims to align new and existing health care improvement efforts around three goals (better care, healthy people/healthy communities, and affordable care) and to measure progress toward achieving these goals. As Medicaid covers about 44 million children in the United States, it is critical that the quality improvement efforts of the Medicaid program align with and reflect the priorities of the nation as a whole. CMS has a responsibility to implement the six goals of the National Quality Strategy:

1. Make care safer by reducing harm caused in the delivery of care
2. Ensure that each person and family are engaged as partners in their care
3. Promote effective communication and coordination of care
4. Promote effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
5. Work with communities to promote wide use of best practices to enable healthy living
6. Make quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models

The following sections of this report provide a broad overview of these activities.

2. Preventive Health Care

HHS is leading a number of efforts to improve the health and well-being of children and adults through primary and secondary prevention initiatives. These efforts include both programmatic efforts and population-based efforts. Within the Medicaid program, CMS offered a technical assistance webinar series entitled Promoting Prevention in Medicaid and CHIP in spring 2013. This series featured presentations on the activities of several state Medicaid programs and their collaborations with federal prevention initiatives, managed care organizations, public health

departments, and other stakeholders to improve access to preventive care.[31] Additionally, CMS launched the Medicaid Prevention Learning Network (Learning Network) in late fall 2013, to help states increase access to and use of preventive services and improve reporting and performance on CMS's prevention-related quality measures. The Learning Network will also provide enhanced technical assistance to states and facilitate exchange of information about promising practices of high-impact, effective preventive care delivery. CMS is also partnering with the Centers for Disease Control and Prevention (CDC) on efforts related to the Vaccines for Children Program, which provides vaccines at no cost to parents of children under age 19 who are enrolled in Medicaid, uninsured, underinsured, or American Indian/Alaskan Native.[32]

Several HHS initiatives focus on promoting healthy communities. The National Prevention Strategy provides evidence-based recommendations to increase the health of Americans in seven major areas: (1) tobacco use, (2) drug and alcohol use, (3) healthy eating, (4) active living, (5) injury and violence prevention, (6) reproductive and sexual health, and (7) mental and emotional well-being.[33] Other wide-scale prevention initiatives address specific health issues and health disparities. These include (1) the President's Teen Pregnancy Prevention Initiative, in which the CDC has partnered with the federal office of the Assistant Secretary for Health to fund community-wide initiatives to reduce rates of teen pregnancy and births, with a focus on reaching African American and Latino young adults;[34] and (2) the Surgeon General's Call to Action to Support Breastfeeding, which identifies 20 key actions that can be taken by the health care sector, employers, child care providers, and others to increase rates of breastfeeding.[35] In addition, the 2012 Report of the Surgeon General on Preventing Tobacco Use Among Youth and Young Adults presents updated evidence on the epidemiology and health consequences of tobacco use among youth, along with evidence-based interventions to address tobacco use among this population.[36] More information on HHS's efforts to improve preventive health care for children in Medicaid and CHIP is available in a 2014 Report to Congress on Preventive Services and Obesity-related Services.[37]

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[31] For more information on the CMS webinar series Promoting Prevention in Medicaid and CHIP, see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prevention.html.

[32] For more information on the Vaccines for Children Program, see http://www.cdc.gov/vaccines/programs/vfc/index.html.

[33] U.S. Department of Health and Human Services. "National Prevention Strategy." Available at: http://www.surgeongeneral.gov/initiatives/prevention/strategy/index.html.

[34] For more information, see "Teen Pregnancy Prevention 2010–2015. Integrating Services, Programs, and Strategies through Communitywide Initiatives: The President's Teen Pregnancy Prevention Initiative." Available at: http://www.cdc.gov/TeenPregnancy/PreventTeenPreg.htm.

[35] For more information, see "The Surgeon General's Call to Action to Support Breastfeeding." Available at: http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html.

[36] For more information, see "Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General." Available at: http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/exec-summary.pdf.

[37] The Report to Congress is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC-Preventive-Obesity-Related-Services2014.pdf

3. Obesity-Related Initiatives

Nearly 18 percent of children and adolescents are obese, and many more are overweight.[38] Because obese children are at increased risk for adverse health outcomes, the obesity epidemic presents an urgent public health challenge.[39] Medicaid and CHIP play an integral role in anti-obesity efforts by providing access to screenings and interventions to prevent and reduce obesity, and promoting healthy eating and physical activity.

Section 4004(i) of the Affordable Care Act requires HHS to provide guidance to states and health care providers regarding preventive and obesity related-services, such as screening and counseling, available to Medicaid and CHIP enrollees. States are also required to design public awareness campaigns to educate Medicaid beneficiaries about the availability and coverage of these services. To help meet these requirements, in 2013 CMS hosted a webinar series on Promoting Prevention in Medicaid and CHIP, which included information about successful obesity interventions developed by state Medicaid managed care plans. CMS has also posted information and resources related to obesity on the Medicaid.gov website, and provided individualized technical assistance to states as needed.[40] More information on HHS's Medicaid and CHIP-specific activities related to obesity can be found in the 2014 Report to Congress on Preventive Services and Obesity-related Services.[41]

4. Efforts to Improve Maternal and Infant Health

Nearly two out of every three women enrolled in Medicaid are of childbearing age (19 to 44 years) and Medicaid currently finances about 48 percent of all births in the United States.[42] States, CMS, federal partners, and other stakeholders and experts are engaged in numerous activities to improve the health of mothers and newborns. At the heart of these efforts is an ongoing emphasis on measuring and reporting the quality of maternal and infant health care. CMS's work in this area began several years ago through the Neonatal Outcomes Improvement Project (NOIP) and was further solidified in June 2011 when CMS and the Center for Medicare & Medicaid Innovation (Innovation Center) hosted a Perinatal Symposium to convene thought leaders to discuss opportunities for CMS to improve perinatal care outcomes. The following are examples of the activities underway at HHS to improve maternal and child health:

- **Strong Start for Mothers and Newborns.** Led by the Innovation Center, the Strong Start for Mothers and Newborns Initiative includes two primary strategies: (1)

[38] For more information, see "CDC Childhood Obesity Facts." Available at: http://www.cdc.gov/healthyyouth/obesity/facts.htm.

[39] For more information, see "Basics About Childhood Obesity." Available at: http://www.cdc.gov/obesity/childhood/basics.html.

[40] For more information, see "Reducing Obesity." Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Reducing-Obesity.html.

[41] The Report to Congress is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC-Preventive-Obesity-Related-Services2014.pdf

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

testing ways to encourage best practices for reducing the number of early elective deliveries that lack medical indication across all payer types; and (2) a cooperative agreement program to test and evaluate four models of enhanced prenatal care across three settings to reduce preterm births and decrease the cost of medical care during pregnancy, delivery, and the first year of life. In February 2013, 27 recipients received awards to support the testing of enhanced prenatal care in three settings: (1) group or centering visits, (2) birth centers, and (3) maternity care homes.[43]

- **Expert Panel on Improving Maternal and Infant Outcomes in Medicaid and CHIP.** CMS's contractor, Provider Resources Incorporated, convened this expert panel quarterly between June 2012 and July 2013 to explore policy and reimbursement opportunities for Medicaid programs to provide better care, improve birth outcomes, and reduce the costs for mothers and infants. In August 2013, the expert panel presented strategies to CMS leadership for consideration as CMS develops implementation plans to improve birth outcomes based on potential impact, available resources, and partnership opportunities. These strategies included enhanced maternal care management, reproductive health, perinatal payment, data measurement, and reporting. Over the next several months, CMS will develop implementation plans for the policy opportunities identified.
- **Collaborative Improvement and Innovation Network (CoIIN).** The CoIIN is a public–private partnership comprised of HRSA, CMS, CDC, state leaders, and others focused on identifying and sharing innovations and evidence-based practices to improve maternal and infant health outcomes. CoIIN teams working in 13 southern states are currently seeking to reduce infant mortality by providing inter-conception care management services to women who had an adverse pregnancy outcome. They are also focused on improving data linkages across Medicaid agencies and departments of public health to facilitate sharing vital statistics information.

CMS has undertaken other efforts to improve infant health outcomes. In 2011, CMS provided guidance to states on coverage of comprehensive tobacco cessation services for pregnant women through Medicaid.[44] In 2012, CMS produced an issue brief on Medicaid Coverage of Lactation Services and collaborated with the Association of Women's Health, Obstetric and Neonatal Nurses to disseminate the brief.[45] Currently, CMS has several efforts in place to reduce early elective delivery, including working with the Medicaid Medical Directors Learning Network to support quality improvement efforts focused on reducing early elective deliveries and enhancing

[43] The fourth model, home visiting, implemented by the Health Resources and Services Administration (HRSA), will also be evaluated along with the other three enhanced models of care.

[44] Section 4107 of the Patient Protection and Affordable Care Act (Affordable Care Act), P.L. 111-148, which amended Title XIX (Medicaid) of the Social Security Act (the Act) to provide for Medicaid coverage of comprehensive tobacco cessation services for pregnant women, including both counseling and pharmacotherapy, without cost sharing. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11-007.pdf.

[45] Centers for Medicare & Medicaid Services. "Lactation Services Issue Brief." 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Lactation_Services_IssueBrief_01102012.pdf.

state data capacity using matched vital records and Medicaid eligibility/claims data. Additionally, CMS launched the following other maternal- and infant-related quality improvement and demonstration projects:

- Under the Adult Medicaid Quality grants, 10 states are implementing quality improvement projects related to maternal and infant health; of these, five states are implementing projects to reduce early elective deliveries, and all states are working to improve measures of maternal health, such as prenatal and postpartum care visits.[46]
- Under the CHIPRA Quality Demonstration Grants, two states (Florida and Illinois) are working to reduce early elective deliveries to improve maternal and infant outcomes.[47]
- In August of 2013, CMS launched a Quality Improvement (QI) Learning Series (QI 201), building on the successful QI 101 webinar series attended by nearly 500 people. The QI 201 Series involves 10 teams focused on developing and implementing specific maternal and infant health projects tailored to their own state needs. The QI 201 Series takes a deeper dive into the topics covered in the QI 101 Series, such as creating aims statements, identifying interventions and measures, and implementing tests of change designed to improve maternal and infant health care quality.

5. Oral Health

Tooth decay remains one of the most common preventable chronic childhood diseases and can cause pain, missed school days, infections, and even death.[48] Although considerable progress in pediatric oral health care has been achieved in recent years,[49] CMS continues to work with state partners and other stakeholder groups to increase the number of dental professionals participating in Medicaid and increase awareness of the need for dental care among beneficiaries. In April 2010, CMS launched the Oral Health Initiative to: (1) increase by 10 percentage points (from FFY 2011 to FFY 2015) the percentage of children ages 1 to 20 enrolled in Medicaid for at least 90 continuous days who received a preventive dental service; and (2) increase by 10 percentage points the percentage of children ages 6 to 9 enrolled in Medicaid for at least 90 continuous days

[46] For more information about the Medicaid Adult Quality Grants, see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Medicaid-Quality-Grants.html.

[47] In February 2010, CMS awarded CHIPRA Quality Demonstration Grants to 10 grantees (involving a total of 18 states across the 10 grantees). Descriptions of the grantees' projects are in Appendix A.

[48] Centers for Medicare & Medicaid Services. "Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs: CMS Oral Health Strategy." April 11, 2011. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf.

[49] From 2007 to 2011, almost half (24) of all states achieved at least a 10 percentage point increase in the proportion of enrolled children who received a preventive dental service during the reporting year. For more information on the CMS Oral Health Initiative, see http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-18-13.pdf.

who received a sealant on a permanent molar.[50] CMS launched an educational campaign in September 2013 targeting oral health education for pregnant women.[51] CMS, through its Health Care Innovation Awards, is funding a children's oral health initiative focused on children enrolled in Medicaid and the Indian Health System in South Dakota. The goal of the initiative is to improve oral health care for American Indian mothers, their children, and American Indians with diabetes. By coordinating community-based oral care with other types of care or social services, the model is expected to reduce the high incidence of oral health problems in the area; improve patient access, monitoring, and overall health; and lower cost through prevention.[52]

The ability to accurately measure dental services provided to children is critical to assessing progress toward these goals. To improve the completeness and accuracy of the data being used to set baselines and track progress, CMS developed a data quality improvement process for the annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) report, which includes information on dental services provided to children under age 21 enrolled in Medicaid. In addition, the Child Core Set includes two measures related to children's access to dental care.[53] Beginning in FFY 2012, to minimize state burden, the two dental measures were calculated using data reported by all 50 states and the District of Columbia on Form CMS-416. As a result, CMS was able to profile all states' performance on these oral health measures in the 2013 Annual Secretary's Report on Children's Health Care Quality in Medicaid and CHIP.[54]

6. National EPSDT Improvement Workgroup

The EPSDT benefit is vital for Medicaid-enrolled children because it ensures coverage of a comprehensive range of preventive services and all medically necessary health care services prescribed by a physician to treat a condition diagnosed under this benefit, even if the services are not covered under a state's Medicaid plan.[55] Recognizing the importance of this benefit, CMS convened a National EPSDT Improvement Workgroup from December 2010 through February 2013 to identify areas for improvement of EPSDT, including increasing the number of

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[50] Centers for Medicare & Medicaid Services. "Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs: CMS Oral Health Strategy." April 11, 2011. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf.

[51] For more information, see http://www.insurekidsnow.gov/professionals/dental/index.html.

[52] CMS Health Care Innovation Awards: South Dakota. "Improving the care and oral health of American Indian mothers and young children and American Indian people with diabetes on South Dakota reservations." Available at: http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/South-Dakota.html.

[53] Two of the measures in the Child Core Set focus on oral health: total eligibles who received a preventive dental service (ages 1–20); and total eligibles who received a dental treatment service (ages 1–20). U.S. Department of Health and Human Services. "2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP." September 2013.

[54] U.S. Department of Health and Human Services. "2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP." September 2013. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf.

[55] Centers for Medicare & Medicaid Services. "Early and Periodic Screening, Diagnostic, and Treatment." Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

children accessing services under EPSDT and improving quality of data reporting on EPSDT to better evaluate performance. Soon-to-be-released EPSDT strategy guides focus on improving care coordination, adolescent well-care visits, and oral health under EPSDT, as well as outreach and education to families.

7. CHIPRA Quality Demonstration Grants

In February 2010, CMS awarded 10 grants funding 18 states to improve health care quality and delivery systems for children enrolled in Medicaid/CHIP. The Quality Demonstration Grant Program aims to identify effective, replicable strategies for enhancing quality of care for children. Many states are using these funds to support the collection and reporting of the Core Set of Children's Health Care Quality Measures, in addition to various quality improvement projects. As described in Appendix A, the states are engaging in a wide array of quality improvement activities targeted to special populations, such as children with special health care needs, underserved children, and foster care children.

With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) is overseeing a national evaluation team comprised of Mathematica Policy Research, AcademyHealth, and the Urban Institute to evaluate the CHIPRA Quality Demonstration Program. The goals of the national evaluation are to determine the demonstration's effectiveness in improving the quality of health care provided to children in Medicaid and CHIP and to assess if and how the demonstration increases transparency and consumer choice. The team released five Evaluation Highlights in 2013 focusing on interim findings from the first three years of the Demonstration. The Highlights examined a diversity of topics including (1) how demonstration states are approaching practice-level quality measurement; (2) how selected grantee projects are measuring medical homeness; and (3) how demonstration states worked together to improve adolescent health. Other evaluation activities have included site visits to each of the demonstration states, provision of technical assistance to state-sponsored evaluation teams, and preparation for a survey of parents and child-serving physicians about their perceptions of quality initiatives. More information on the national evaluation is available on AHRQ's website.[56]

8. Behavioral Health Initiatives

HHS supports various initiatives to promote behavioral health among children and adolescents, prevent youth substance abuse and violence, and prevent suicide. Over the past several years, CMS released the following Informational Bulletins and State Medicaid Director letters designed to inform and support state Medicaid and CHIP agencies to improve mental health and prevent substance use among youth:

[56] For more information on the evaluation of CMS's CHIPRA Quality Demonstrations, see http://www.ahrq.gov/policymakers/chipra/demoeval/index.html.

- Informational Bulletin: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations[57]
- State Medicaid Director's Letter: Trauma Informed Care[58]
- State Health Official Letter: Application of the Mental Health Parity and Addiction Equity Act (MHPAEA)[59]
- Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions[60]
- Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions[61]

In addition to the activities noted above, CMS, through its Health Care Innovation Awards, is funding behavioral health initiatives for children in Medicaid/CHIP. CMS also partners with the Administration for Children and Families (ACF) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to strengthen state systems of prescribing and monitoring psychotropic medication use among children in foster care.[62] CMS activities include disseminating information and resources on the extent of the problem; promoting the use of the core set of children's health care quality measures to monitor the quality of Medicaid behavioral health care; and convening directors of Medicaid, state child welfare, and mental health authorities to develop action plans for addressing this issue.[63]

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[57] CMS and the Center for Medicaid and CHIP Services (CMCS). "CMCS Informational Bulletin: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations." August 24, 2012. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-08-24-12.pdf.

[58] CMS State Director Letter. "Use of Trauma-Focused Screening, Functional Assessments and Evidence-Based Practices in Child-Serving Settings." July 11, 2013. Available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf.

[59] CMS State Health Official Letter. "Application of the Mental Health Parity and Addiction Equity Act to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans." January 16, 2013. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[60] CMS and the Center for Medicaid and CHIP Services. "CMCS Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions." May 7, 2013. Available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

[61] CMS and the Center for Medicaid and CHIP Services. "CMCS Informational Bulletin: Prevention and Early Identification of Mental Health and Substance Use Conditions." May 27, 2013. Available at: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-27-2013.pdf.

[62] CMS State Director Letter. November 23, 2011. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf.

[63] Medicaid Medical Directors Learning Network (MMDLN)/Rutgers CERTs, "Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide From a 16-State Study." Publication No. 1, June 2010. Available at: http://rci.rutgers.edu/~cseap/MMDLNAPKIDS/Antipsychotic_Use_in_Medicaid_Children_Report_and_Resource_Guide_Final.pdf.

In 2012 and 2013, SAMHSA awarded grants and cooperative agreements to cities, states, and tribal organizations across a variety of areas related to community mental health services for children with emotional disturbances, community-level interventions to promote child wellness, and effective treatment and support systems for youth with substance use and/or mental health disorders.[64,65,66,67]

9. Health Homes for Children and Adults with Chronic Conditions

Section 2703 of the Affordable Care Act created an optional Medicaid State Plan benefit for states to establish health homes to coordinate care for child and adult Medicaid enrollees with chronic conditions.[68] The health home service delivery model is intended to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to create a person-centered system of care that achieves improved outcomes for beneficiaries and improved value for state Medicaid programs. CMS is collaborating with federal partners, including SAMHSA and the HHS Assistant Secretary for Planning and Evaluation, to ensure an evidence-based approach and consistency in implementing this statutory provision.[69] As of June 2014, 15 states have at least one approved Health Home State Plan Amendment (SPA), and 12 others have submitted a SPA or a planning request to CMS.[70]

The impact of the health homes provision will be monitored by CMS. A forthcoming 2014 Report to Congress will provide more detailed information about this program. Section 1945(f) of the Social Security Act requires states that implement health homes to track avoidable hospital readmissions, calculate cost savings that result from improved coordination of care and chronic disease management, and monitor the use of health information technology to improve service delivery and coordination across the care continuum. States are also expected to track emergency room visits and skilled nursing facility admissions for the evaluation.[71]

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[64] "Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and Their Families." Available at: http://www.samhsa.gov/grants/2013/sm-13-001.aspx.

[65] "Press Release: Planning Grants for Expansion of the Comprehensive Community Mental Health Services for Children and Their Families." July 15, 2013. Available at: http://www.samhsa.gov/newsroom/advisories/1307150448.aspx.

[66] "FY 2013 Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination." Available at: http://www.samhsa.gov/grants/2013/ti-13-014.aspx.

[67] "Safe Schools/Healthy Students State Planning, Local Education Agency, and Local Community Cooperative Agreements." Available at: http://www.samhsa.gov/grants/2013/sm-13-006.aspx.

[68] For more information on health homes, see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html.

[69] CMS State Medicaid Director Letter. "Health Homes for Enrollees with Chronic Conditions." November 16, 2010. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

[70] CMS. "State Health Home CMS Proposal Status (effective June 2014)." Available at: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-MAP_v32.pdf.

[71] CMS State Medicaid Director Letter. "Health Homes for Enrollees with Chronic Conditions." November 16, 2010. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

10. The Pediatric Quality Measures Program

CHIPRA (Pub. L. 111-3) added Section 1139A(a) to the Social Security Act, which requires the development of a Pediatric Quality Measures Program (PQMP) to (1) improve and strengthen the initial core set of measures to make them more broadly applicable to Medicaid, CHIP, and other programs; and (2) develop additional quality measures that address dimensions of care where standardized measures do not currently exist. The AHRQ-CMS PQMP, funded by CMS and managed by AHRQ, comprises seven CHIPRA Centers of Excellence (CoEs) and two CHIPRA quality demonstration project grantees (Illinois and Massachusetts) focused on developing measures that could be considered as improvements to the initial core set measures. Measures being developed under the PQMP by each CoE encompass topics related to duration of enrollment, availability of services, family experiences of care, identification of children with special health care needs, continuum of care, transitions and care coordination, hospital readmissions, person-reported outcomes, quality of care for children in the child welfare system, quality to cost, prevention and health promotion, and management of acute and chronic conditions.[72] New research from some of the CoEs on readmission and mental health measures has been published in the Journal of the American Medical Association and Pediatrics.[73] CMS also is working with the Office of the National Coordinator for Health Information Technology (ONC) to develop new pediatric measures that can be collected through an electronic health record and to electronically specify measures from the initial core set.

C. Quality of Children's Health Care Across the Domains of Quality

HHS is undertaking multiple efforts to improve the quality of health care delivered to children enrolled in Medicaid and CHIP through various domains, including clinical quality, innovation, health care safety, family experience with health care, and elimination of health care disparities.[74]

1. Clinical Quality

CMS's clinical quality strategy is pursued through six priorities: (1) making care safer; (2) strengthening person and family engagement; (3) promoting effective communication and coordination of care; (4) promoting effective prevention and treatment; (5) working with communities to provide best practices of healthy living; and (6) making care affordable. These aims and priorities are reflected in the range of activities CMS currently is pursuing to improve the quality of health care for children in Medicaid and CHIP.

As discussed in greater detail in Section 2, the National Quality Strategy relies on accurate, comprehensive measurement and monitoring of clinical quality, which CMS supplements through the implementation of the core set of children's health care quality measures (Exhibit 1).

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[72] "CHIPRA Measures by CHIPRA Categories." Rockville, MD: Agency for Healthcare Research and Quality, May 2012. Available at: http://www.ahrq.gov/policymakers/chipra/pqmpmeasures.html.

[73] Berry, Jay G., et al. "Pediatric Readmission Prevalence and Variability Across Hospitals Pediatric Readmissions and Hospital Variability." JAMA, vol. 309, no. 4, 2013, pp. 372–380.

[74] An additional domain, health care in the most integrated setting, is discussed throughout the report.

In partnership with other agencies, HHS is pursuing numerous initiatives to improve the clinical quality of care for mothers and children: CHIPRA Quality Demonstration Grants; the Neonatal Outcomes Improvement Project;[75] Strong Start for Mothers and Newborns;[76] the Maternal, Infant, and Early Childhood Home Visiting Program;[77] Early Hearing Detection and Intervention (EHDI) programs;[78] and a pilot project on delivery of educational messages through mobile health technology to pregnant and postpartum women. In addition, CMS launched the Oral Health Project in April 2010 with a focus on improving access to and utilization of preventive dental services for children.[79]

Another national clinical quality improvement project, led by AHRQ and part of the HHS National Plan to Prevent Healthcare-Associated Infections and the Partnership for Patients, involved reducing neonatal central line-associated bloodstream infections (CLABSIs) in Neonatal Intensive Care Units (NICUs).[80] CLABSI is a significant contributor to morbidity and mortality for infants in NICUs because of these patients' immature immune systems.[81] Beginning in August 2011, 100 NICUs in nine states implemented a Comprehensive Unit-based Safety Program (CUSP) and saw a reduction in their overall infection rates.[82,83] As part of its Children's Core Set measures reporting, CMS is also tracking CLABSI data reported by

[75] For more information, see CMS Issue Brief, "Reducing Early Elective Deliveries in Medicaid and CHIP." Detailed descriptions of NOIP Grantee projects and outcomes are on pp. 3–4. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EED-Brief.pdf.

[76] For more information, see "Strong Start for Mothers and Newborns Initiative: General Information." Available at: http://innovation.cms.gov/initiatives/strong-start.

[77] For more information, see the CMS Fact Sheet, "Strong Start for Mothers and Newborns: Testing Approaches to Prenatal Care." February 15, 2013. Available at: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2013-Fact-sheets-items/2013-02-15.html?DLPage=7&DLSort=0&DLSortDir=descending.

[78] For more information, see "Improving Hearing Screening and Intervention Systems." Available at: http://www.nichq.org/our_projects/newborn_hearing.html.

[79] For more information, see "CMS Oral Health Strategy: Improving Access to and Utilization of Oral Health Services for Children in Medicaid and CHIP Programs." April 11, 2011. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CMS-Oral-Health-Strategy.pdf.

[80] "Intensive Care Units for Newborns in Nine States See Sharp Drop in Bloodstream Infections." Rockville, MD: Agency for Healthcare Research and Quality, January 2013. Available at: http://www.ahrq.gov/news/newsroom/press-releases/2013/nclabsipr.html.

[81] "Eliminating CLABSI, A National Patient Safety Imperative: Neonatal CLABSI Prevention: A Progress Report on the National On the CUSP: Stop BSI Project, Neonatal CLABSI Prevention." Rockville, MD: Agency for Healthcare Research and Quality, January 2013. Available at: http://www.ahrq.gov/professionals/quality-patient-safety/cusp/using-cusp-prevention/clabsi-neonatal/index.html.

[82] The nine states are: Colorado, Florida, Hawaii, Massachusetts, Michigan, New Jersey, North Carolina, South Carolina, and Wisconsin.

[83] "Intensive Care Units for Newborns in Nine States See Sharp Drop in Bloodstream Infections." Rockville, MD: Agency for Healthcare Research and Quality, January 2013. Available at: http://www.ahrq.gov/news/newsroom/press-releases/2013/nclabsipr.html.

hospitals to the CDC National Healthcare Safety Network. The measure includes all neonatal CLABSI events, not just those for infants covered by Medicaid/CHIP.[84]

2. Innovations

The Innovation Center supports initiatives that test new models for delivering and paying for health care, with the ultimate goal of creating systems that offer high quality care at lower costs to Medicare, Medicaid, and CHIP beneficiaries.[85] Three of the current initiatives target Medicaid and/or CHIP populations with the potential to provide higher quality care to child beneficiaries. The Comprehensive Primary Care (CPC) initiative provides funding to states to offer additional reimbursements to Medicaid providers who provide comprehensive care management, with the goal of increasing the quality of primary care available to Medicaid beneficiaries.[86] Strong Start for Mothers and Newborns is testing methods to reduce early elective deliveries, and offering funding to providers, states, and others to test three prenatal care approaches to reduce preterm births for Medicaid beneficiaries.[87] The State Innovation Models initiative funds state efforts to design and test multi-payer payment and delivery models that will improve the quality of health care, particularly for Medicare, Medicaid, and CHIP beneficiaries.[88]

3. Health Care Safety

CMS established the Partnership for Patients (PfP) in 2011. It is a different type of quality improvement intervention. It represents a full-court press, combining the efforts of multiple partners and federal and non-federal programs, in an aligned effort to improve patient safety by reducing Hospital Acquired Conditions by 40 percent and readmissions by 20 percent. The PfP partnership is a consortium of more than 3,700 participating hospitals distributed throughout all 50 states which has committed to improve care by participating with one of 26 hospital engagement networks (HENs). To facilitate this effort, the HENs have established the infrastructure to support these hospitals in improvement, measurement, engaging with patients and families, learning, reporting and generating results. The goals of the PfP initiative include reducing inpatient adverse events, such as adverse drug events, CLABSIs, catheter-associated urinary tract infections, and obstetric events such as early elective deliveries, as well as reducing readmissions through better care transitions and reducing obstetric adverse events.[89]

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[84] U.S. Department of Health and Human Services. Appendices to the "2013 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP." September 2013. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept-App.pdf.

[85] "CMS Health Care Innovation Awards." Available at: http://www.medicaid.gov/State-Innovations.html.

[86] "Comprehensive Primary Care Initiative Fact Sheet." August 22, 2012. Available at: http://innovation.cms.gov/Files/fact-sheet/CPCI-Fact-Sheet.pdf.

[87] "CMS State Innovations." Available at: http://www.medicaid.gov/State-Innovations.html.

[88] "CMS State Innovation Models Initiative: General Information." Available at: http://innovation.cms.gov/initiatives/state-innovations/index.html.

[89] "CMS Partnership for Patients: What the Partnership is About." Available at: http://partnershipforpatients.cms.gov/about-the-partnership/what-is-the-partnership-about/lpwhat-the-partnership-is-about.html.

In June 2011, CMS published a final rule implementing Section 2702 of the Affordable Care Act, which prohibits federal Medicaid payments to states for care provided to treat health care-acquired conditions. The final rule required states to implement non-payment policies for a range of provider-preventable conditions (PPCs), which include health care-acquired conditions (HCACs) (applicable to any inpatient hospital settings in Medicaid), as well as other provider-preventable conditions (OPPCs) (applicable to any health care setting).[90] This policy is intended to provide an incentive for providers to apply best practices in order to prevent secondary conditions and prevent adverse outcomes.

4. Family Experience with Health Care

An important dimension of quality is the patient's or family's experience with care. Experience can be measured globally (such as overall satisfaction with the health plan or ability to get needed care), or in relation to a specific event or encounter (such as a medical visit, hospitalization, or nursing home stay). The most commonly used set of tools to measure experiences with health care are AHRQ's Consumer Assessment of Healthcare Provider System (CAHPS) family of surveys.[91] Two key HHS efforts to promote the understanding of patient and family experiences with health care are as follows:

1. Section 402(a)(2) of CHIPRA requires all Title XXI (CHIP) programs to provide "data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the state child health plan" in their annual reports. Since the children's CAHPS survey tool is part of the CMS Child Core Set, many states plan to use CAHPS surveys to fulfill the requirement.
2. One of the AHRQ-CMS Pediatric Centers of Excellence, The Boston Children's Hospital, developed the Child Hospital Consumer Assessment of Healthcare Providers and Systems Survey (Child HCAHPS).[92] Many of the survey items are taken from the original HCAHPS instrument and are being adapted for pediatric care, though several new domains have been proposed, including those covering the admission process, care coordination, family involvement, cultural competence, child-appropriateness, privacy, safety, and age-specific items (for example, for adolescents). The survey was completed in 2014.

5. Health Care Disparities

Health disparities have been defined as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage."[93] Disparities are documented

[90] "Medicaid Program; Payment Adjustments for PPCs Including HCACs; Final Rule," 76 FR 108 (June 6, 2011), pp. 32816–32838. Available at: http://www.gpo.gov/fdsys/pkg/FR-2011-06-06/pdf/2011-13819.pdf.

[91] For more information, see the Agency for Healthcare Research and Quality, Consumer Assessment of Healthcare Provider and Systems Survey (CAHPS) overview. Available at: http://cahps.ahrq.gov/about.htm.

[92] For more information, see http://www.childrenshospital.org/research-and-innovation/research-labs/center-of-excellence-for-pediatric-quality-measurement-cepqm/cepqm-measures/pediatric-hcahps.

[93] Healthy People 2020. Available at: http://www.healthypeople.gov/2020/about/DisparitiesAbout.aspx.

in many conditions and in access to health care for adults and children. A number of HHS initiatives seek to eliminate racial, ethnic, and socioeconomic disparities in health and health care, and to ensure more accurate data collection across population subgroups.

The Affordable Care Act includes several provisions to address health and health care disparities, including provisions focused on workforce development, quality of care, prevention and health promotion, and data collection and analysis. One of the key provisions relates to improving data collection and analysis, which will enable a better understanding of the needs, gaps, and opportunities for quality improvement to eliminate health disparities. Section 4302(a) of the Affordable Care Act required HHS to develop data collection standards for five demographic categories—race, ethnicity, sex, primary language, and disability status—and requires that any federally conducted or supported health care or public health program, activity, or survey collect and report data on these categories to the extent practicable. The final data standards apply to the collection of data in HHS-sponsored population surveys where person-level data are collected either via self-report or from a respondent who serves as a knowledgeable household representative.[94] Section 4302(b) also required that the Secretary evaluate approaches for collecting and evaluating data on health care disparities in Medicaid/CHIP. This evaluation has already led CMS to make changes in the collection and analysis of Medicaid and CHIP data, including:

- Integrating many of the section 4302 data elements into the single, streamlined application that is used to determine eligibility in the new insurance marketplaces
- Updating the data dictionary for the Medicaid Statistical Information System (MSIS), CMS's primary, claims-based data system, to include the section 4302 data elements
- Integrating the racial and ethnic categories from the section 4302 standards into CMS's Statistical Enrollment Data System

Further complementing these activities is the HHS Disparities Action Plan, which builds upon the Affordable Care Act, and outlines goals and actions HHS will take to reduce health disparities among racial and ethnic minority groups.[95] CMS is the lead agency for a number of actions in the HHS Disparities Action Plan, and several of the overarching Secretarial priorities are specific to CMS, including an initiative focused on improving access to dental care for children in Medicaid and CHIP.

[94] U.S. Department of Health and Human Services, Office of Minority Health. "OMB Standards for Data on Race and Ethnicity." Available at: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=172.

[95] "HHS Disparities Action Plan: A Nation Free of Disparities in Health Care." Available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

III. STATUS OF VOLUNTARY REPORTING BY STATES

As discussed previously, CHIPRA directed the Secretary of HHS to (1) identify and publish an initial core set of children's health care quality measures for voluntary use by state programs administered under Medicaid (Title XIX) and CHIP (Title XXI);[96] (2) develop a standardized reporting vehicle for the core set of children's health care quality measures;[97] and (3) annually report state-specific information on the quality of children's health care in Medicaid/CHIP.[98] CHIPRA also called for the establishment of a national technical assistance program, the Medicaid/CHIP Technical Assistance and Analytic Support (TA/AS) Program, to support states in consistently collecting, reporting, and using the core set of children's health care quality measures.[99] This chapter summarizes the status of voluntary reporting by states and discusses progress over the past three years.

A. Core Set of Children's Health Care Quality Measures

For the past three years, states have continued to break new ground with standardized reporting on CMS's core set of children's health care quality measures (referred to as the Child Core Set). The 2010 Secretary's Report signaled the first time CMS released state-specific information from voluntary reporting on the Child Core Set, an important milestone in CMS's efforts to uniformly measure and report on the quality of care obtained by children covered by Medicaid/CHIP. Over the next two years, states continued to improve the quality and completeness of the data they collected and reported for the Child Core Set measures. CMS's FFY 2012 goals for quality measurement and improvement were to:

- Increase the number of states 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)
- Streamline data collection and reporting processes, to the extent possible

[96] For more information on the initial core set measures, see the February 2011 CMS State Health Official letter at http://www.cms.gov/smdl/downloads/SHO11001.pdf.

[97] CARTS is a web-based data submission tool, which serves as the standardized reporting vehicle for the Child Core Set. States are asked to submit and certify core set measure data in CARTS on an annual basis.

[98] The 2010–2013 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.

[99] The CMS TA/AS contract is led by Mathematica Policy Research and supported by subcontracts with the National Committee for Quality Assurance, the Center for Health Care Strategies, and the National Initiative for Children's Healthcare Quality. Through the TA/AS Program, CMS works with states to improve the completeness and accuracy of the data reported, and to support states' efforts to build internal capacity to conduct quality improvement projects. Resources 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.

- Support states to drive improvements in health care quality at the local level using data from the Child Core Set

B. Measurement and Voluntary Reporting Using the Child Core Set

CMS continues to gain experience and insight in ways to facilitate state reporting of CMS's Child Core Set of measures, including streamlining state reporting of the Child Core Set data and evaluating measures for retirement.[100] Additionally, CMS and states have made great strides in reporting since the 2010 Report to Congress,[101] most notably:

- All states reported two or more of the Child Core Set measures for FFY 2012 (Exhibit 2). The median number of measures reported by states for FFY 2012 was 14, up from 7 in FFY 2010 and 12 in FFY 2011. Altogether, 35 states reported at least 11 of the 22 core measures to CMS for FFY 2012.[102] Two states, Florida and Tennessee, reported 22 of the core measures for FFY 2012.
- CMS continues to encourage states to report data on the Child Core Set that include both Medicaid and CHIP populations. The completeness of Child Core Set data reported by states improved for FFY 2012. For example, 38 states now include both Medicaid and CHIP populations in one or more measures, up from 23 states for FFY 2010 and 34 states for FFY 2011.
- The most frequently reported measures in the Child Core Set assess children's access to primary care, well-child visits, and dental services (Exhibit 3).

C. State Performance on the Child Core Set for FFY 2012

The increase in the number of measures reported by states for FFY 2012 has allowed CMS, for the first time, to conduct deeper analysis on 16 Child Core Set measures reported by 25 or more states. These measures reflect a continuum of quality measures within the maternal and child health population, including overall access to primary care and use of well-child care, timeliness and frequency of prenatal care, management of acute and chronic conditions, and use of dental and oral health services. Detailed findings for these measures (including percentiles, trends, and geographic variation) are featured in the Appendix to the 2013 Secretary's Report.[103]

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[100] The 2010–2013 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.

[101] U.S. Department of Health and Human Services. "2011 Report to Congress on the Quality of Children's Health Care in Medicaid and CHIP." December 2010. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_ChildHealthImprovement.pdf.

[102] The base of 22 measures excludes two core measures: (1) the central line-associated blood stream infections (CLABSI) measure, which was obtained from the CDC's NHSN beginning in FFY 2012; and (2) the otitis media with effusion (OME) measure, which was not collected for FFY 2012 and was retired in 2013 because it draws on CPT-II codes not commonly used by Medicaid/CHIP agencies.

[103] U.S. Department of Health and Human Services. "2013 Annual Secretary's Report on the Quality of Healthcare for Children in Medicaid and CHIP." September 2013. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf.

D. Updates to the Core Set of Children's Health Care Quality Measures

Section 1139A(b)(5) of the Social Security Act provides that, beginning January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the Initial Child Core Set. 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 decision-making.[104] Three measures were added as a result of this process and one of the measures was retired due to reporting challenges cited by state Medicaid and CHIP agencies.[105] States choosing to voluntarily report these new measures can submit data to CMS during the FFY 2013 reporting cycle.

In order to ensure that measures reflect updates to clinical guidelines and current approaches to health care delivery, it is necessary to continue to evolve the pediatric measurement field. As noted in previous sections of this report, the AHRQ-CMS Pediatric Quality Measures Program is developing measures that will be considered for inclusion in future versions of the Child Core Set. Additionally, CMS continues to work with ONC to develop pediatric-focused measures that can be collected through an electronic health record. These measures are currently under development and, once completed, will be considered for inclusion in stage three of the Electronic Health Record Medicaid Incentive Program.

As with the measures themselves, the data systems and sources used to collect information and monitor progress are also subject to periodic adjustments. Learning from the experiences of the past three years of reporting, CMS has made additional refinements to the CMS CARTS reporting system, the vehicle states use to report the children's quality measures to CMS. CMS has also continued to make 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 CMS's quality reporting and performance measurement capacities for Medicaid and CHIP. CMS expects that these efforts will (1) help ensure that the information is more accurate, complete, and uniform; (2) reduce burden on our state partners; and (3) have the potential to strengthen quality reporting for children, reduce health care costs associated with inefficiencies in the health care delivery system, and ultimately facilitate better health outcomes for children.

[104] CMS State Health Official Letter. "2013 Children's Core Set of Health Care Quality Measures." January 24, 2013. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf.

[105] The three measures added to the Child Core Set in 2013 are: (1) Medication Management for People with Asthma, (2) Human Papilloma Virus (HPV) Vaccination for Female Adolescents, and (3) Behavioral Health Risk Assessment (for Pregnant Women). One measure was retired: Otitis Media with Effusion (OME) – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2–12).

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IV. RECOMMENDATIONS

Over the past three years HHS has continued to identify and implement multifaceted ways to measure, monitor, and improve the quality of health care for children in Medicaid and CHIP. Using a variety of mechanisms, including efforts to expand eligibility to the Medicaid/CHIP program, standardized measurement, and quality-focused demonstration grants, tangible improvements to the quality of health care received by children are just beginning to emerge.

Section 1139A(a)(6) of the Social Security Act, as amended by section 401 of CHIPRA, directs the Secretary of HHS to include in the report to Congress any recommendations for legislative changes needed to improve the quality of care provided to children under Titles XIX and XXI, including recommendations for quality reporting by states. In the FFY 2015 President's Budget, HHS proposed two changes relevant to Medicaid and CHIP quality: one year extension of the Performance Bonus Fund and permanent extension of the ELE for children beyond the end of FFY 2014.[106] These two recommendations are intended to support state efforts to assure comprehensive, continuous coverage of children, while also encouraging reporting on quality of care.

[106] U.S. Department of Health and Human Services. "Fiscal Year 2015 Budget-in-Brief." Available at: http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf.

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V. CONCLUSION

With standardized measurement and reporting tools now in place, HHS is working closely with its state partners to more thoroughly measure the care obtained by children covered by Medicaid/CHIP and use the measures to assess and improve the quality of care provided to children in their states. The efforts described in this report are a snapshot of the activities underway across HHS and state Medicaid and CHIP agencies designed to improve the quality of health care provided to children. HHS has implemented activities across a wide range of children's health care quality domains including:

- Health care coverage and enrollment for children in Medicaid and CHIP have improved, with Medicaid/CHIP reaching a higher proportion of eligible children. Further, evidence suggests that CHIPRA bonus payments have provided an impetus for some states to improve their outreach, enrollment simplification, and retention efforts.
- Multiple quality improvement efforts are well underway that cut across all domains of children's health care, with special attention to maternal and infant health, oral health, and prevention.
- State reporting of the Child Core Set is more complete than in FFY 2010, the first year of voluntary reporting of these measures. CMS is working with its state partners to improve the completeness and accuracy of the data to monitor state performance. In addition, the measures are being used to set priorities for child health quality improvement initiatives at both the national and state levels.
- Public–private partnerships support and have helped to accelerate quality improvement initiatives.

Moving forward, HHS will continue to strengthen existing partnerships and build new ones among states, HHS agencies (that is, CMS, HRSA, CDC, SAMHSA, and ACF), health care providers, and program enrollees to continue on the path toward nationally standardized quality measurement and expansion of quality improvement efforts. Among the varied efforts underway, CMS will be focusing on aligning managed care requirements in a way that supports states in the voluntary reporting of the Child and Medicaid Adult Core Set measures.

The quality improvement efforts recently launched by CMS are helping to set the stage for the next generation of efforts designed to improve children's health care and health outcomes to continue to transform Medicaid/CHIP into a high quality system of coverage and care.

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Exhibit 1. 2013 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP

Measure	Measure Steward	Description	Data Source
Human Papillomavirus (HPV) Vaccine for Female Adolescents	National Committee for Quality Assurance (NCQA)/Healthcare Effectiveness Data and Information Set (HEDIS)	Percentage of female adolescents that turned 13 years old during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday	Administrative or hybrid
Body Mass Index Assessment for Children and Adolescents	NCQA/HEDIS	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender	Administrative or hybrid
Child and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS	Percentage of children and adolescents ages 12 months to 19 years that had a visit with a primary care practitioner (PCP), including four separate percentages: Children ages 12 to 24 months and 25 months to 6 years that had a visit with a PCP during the measurement year Children ages 7 to 11 years and adolescents ages 12 to 19 years that had a visit with a PCP during the measurement year or the year prior to the measurement year	Administrative
Childhood Immunization Status	NCQA/HEDIS	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday	Administrative or hybrid
Immunization Status for Adolescents	NCQA/HEDIS	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday	Administrative or hybrid
Frequency of Ongoing Prenatal Care	NCQA/HEDIS	Percentage of 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 ≥ 81 percent of expected visits	Administrative or hybrid
Timeliness of Prenatal Care	NCQA/HEDIS	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester or within 42 days of enrollment	Administrative or hybrid

Exhibit 1 (continued)

Measure	Measure Steward	Description	Data Source
Live Births Weighing Less Than 2,500 Grams	Centers for Disease Control and Prevention (CDC)	Percentage of live births that weighed less than 2,500 grams in the state during the reporting period	State vital records
Cesarean Rate for Nulliparous Singleton Vertex	California Maternal Quality Care Collaborative	Percentage of women that had a cesarean section among women with first live singleton births (also known as nulliparous term singleton vertex [NTSV] births) at 37 weeks of gestation or later	State vital records alone or merged with discharge diagnosis data
Behavioral Health Risk Assessment (for Pregnant Women)	American Medical Association (AMA) – Physician Consortium for Performance Improvement (PCPI)	Percentage of women, regardless of age, that 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: depression, alcohol use, tobacco use, drug use, and intimate partner violence	Electronic health records
Developmental Screening in the First Three Years of Life	Oregon Health and Science University	Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday	Administrative or hybrid
Annual Pediatric Hemoglobin A1c Testing	NCQA	Percentage of children ages 5 to 17 with diabetes (type 1 and type 2) that had a Hemoglobin A1c (HbA1c) test during the measurement year	Administrative or hybrid
Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS	Percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life	Administrative or hybrid
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA/HEDIS	Percentage of children ages 3 to 6 that had one or more well-child visits with a primary care practitioner during the measurement year	Administrative or hybrid
Adolescent Well-Care Visits	NCQA/HEDIS	Percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrical/gynecological (OB/GYN) practitioner during the measurement year	Administrative or hybrid
Chlamydia Screening	NCQA/HEDIS	Percentage of women ages 16 to 20 that were identified as sexually active and had at least one test for Chlamydia during the measurement year	Administrative
Preventive Dental Services	Centers for Medicare & Medicaid Services (CMS)	Percentage of individuals ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received preventive dental services	Form CMS-416

Exhibit 1 (continued)

Measure	Measure Steward	Description	Data Source
Dental Treatment Services	CMS	Percentage of individuals ages 1 to 20 eligible for Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received dental treatment services	Form CMS-416
Medication Management for People with Asthma	NCQA/HEDIS	Percentage of children ages 5 to 20 that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period Two rates are reported: • Percentage of children that remained on an asthma controller medication for at least 50 percent of their treatment period • Percentage of children that remained on an asthma controller medication for at least 75 percent of their treatment period. This measure is reported using the following age ranges: 5 to 11 years; 12 to 18 years; 19 to 20 years; and total	Administrative
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	Percentage of discharges for children ages 6 to 20 that were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder Medication	NCQA/HEDIS	Percentage of children newly prescribed medication for attention-deficit/ hyperactivity disorder (ADHD) that had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase	Administrative
Pediatric Central Line-Associated Blood Stream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	CDC	Rate of central line-associated blood stream infections (CLABSI) in pediatric and neonatal intensive care units during periods selected for surveillance	National Healthcare Safety Network (NHSN)
Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS	Percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode	Administrative
Annual Percentage of Asthma Patients 2 through 20 Years Old with One or More Asthma-Related Emergency Room Visits	Alabama Medicaid	Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits	Administrative

Exhibit 1 (continued)

Measure	Measure Steward	Description	Data Source
Ambulatory Care: Emergency Department Visits	NCQA/HEDIS	Rate of emergency department (ED) visits per 1,000 member months among children up to age 19	Administrative
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey	NCQA/HEDIS	Survey on parents' experiences with their children's care	Survey

Source: Centers for Medicare & Medicaid Services. "Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting." May 2013. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-and-CHIP-Child-Core-Set-Manual.pdf.

Notes: The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

Beginning in FFY 2012, data for the CLABSI measure were obtained from the National Healthcare Safety Network and data for the two core set dental measures were obtained from the Form CMS-416. The OME measure was not collected for FFY 2012 and was retired in 2013.

Exhibit 2. Overview of State Reporting of the Core Set of Medicaid/CHIP Children's Health Care Quality Measures, FFY 2012

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Adolescent Immunization Status	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with 1 or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey
Total	14 (Median)	38	31	25	15	12	34	32	27	12	35	43	46	43	51	43	36	51	28	15	29	13	27	27
Alabama	21	-	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Alaska	15	X	-	-	X	X	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	-	X	-
Arizona	7	-	-	-	-	-	X	X	-	-	-	-	X	X	X	X		X	-	-	-	-	-	-
Arkansas	18	X	X	X	X	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	12	X	X	-	-	-	X	X	X	-	X	X	X	X	X	X	-	X	X	-	-	-	-	-
Connecticut	6	X	-	-	-	-	-	-	-	X	X	-	-	-	X	X	-	X	-	-	X	-	-	-
Delaware	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	-	X	X
D.C.	14	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	-	-	X	-
Florida	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Georgia	20	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	-
Hawaii	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-
Idaho	10	X	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	-	-	-	-
Illinois	19	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X	-
Indiana	15	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	3	X	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	X
Kentucky	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	-	-	-	X
Louisiana	7	X	-	-	-	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	-	X
Maine	14	X	-	-	-	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Maryland	13	X	X	X	-	-	X	X	-	-	X	X	X	X	X	X	X	X	-	-	-	-	-	X
Massachusetts	17	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	X	X	X
Michigan	15	-	X	-	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	-	X
Minnesota	5	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	-	X	-	-	-	-	-	-
Mississippi	11	-	-	-	-	-	-	-	-	-	X	-	X	X	X	X	X	X	X	-	X	-	X	X

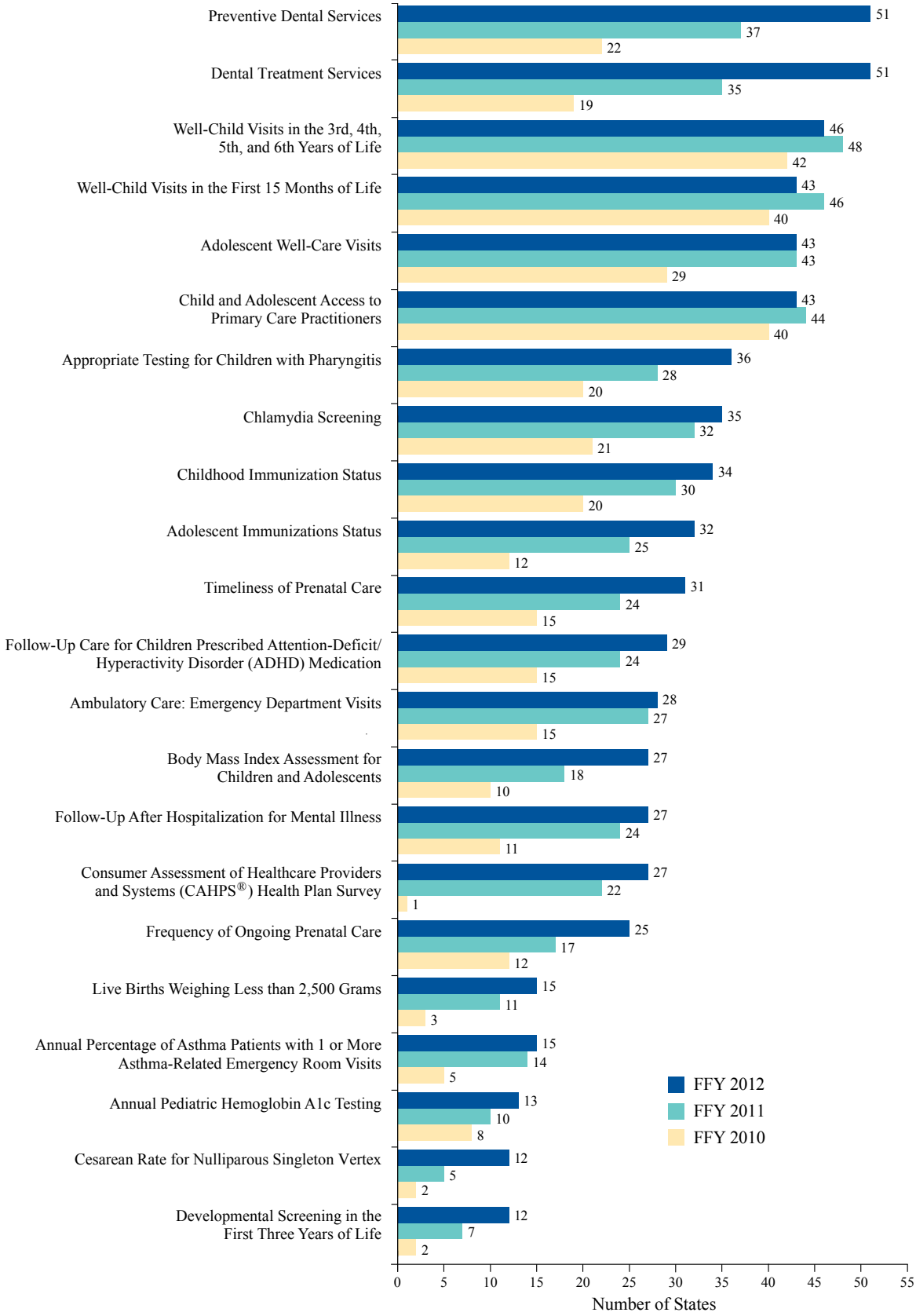
Exhibit 2 (continued)

	Number of Measures Reported	State Reported at Least One Measure for Both Medicaid and CHIP Populations	Timeliness of Prenatal Care	Frequency of Ongoing Prenatal Care	Live Births Weighing Less than 2,500 Grams	Cesarean Rate for Nulliparous Singleton Vertex	Childhood Immunization Status	Adolescent Immunization Status	Body Mass Index Assessment for Children and Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Preventive Dental Services	Child and Adolescent Access to PCPs	Appropriate Testing for Children with Pharyngitis	Dental Treatment Services	Ambulatory Care: Emergency Department Visits	Asthma Patients with 1 or More Asthma-Related Emergency Room Visits	Follow-Up Care for Children Prescribed ADHD Medication	Annual Pediatric Hemoglobin A1c Testing	Follow-Up After Hospitalization for Mental Illness	CAHPS Health Plan Survey
Missouri	12	X	X	-	-	-	X	X	-	-	X	X	X	X	X	-	-	X	X	-	-	-	X	X
Montana	7	-	-	-	-	-	-	-	-	-	-	X	X	-	X	X	X	X	X	-	-	-	-	-
Nebraska	2	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	-
Nevada	9	-	-	-	-	-	X	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	X	X
New Hampshire	7	X	-	-	-	-	-	-	-	-	-	X	X	-	X	X	X	X	-	-	-	-	X	-
New Jersey	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	-	X	X	-	-	X	-	X	X
New Mexico	15	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	-	-	X	-		X
New York	16	X	X	X	-	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	-
North Carolina	20	X	X	-	X	X	X	X	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	10	X	X	X	-	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	X	-	-	X
Oklahoma	17	X	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-	X
Oregon	21	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	-
Pennsylvania	19	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	X	X	X	X	X	-	-	X
Rhode Island	18	X	X	X	X	-	X	X	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	X
South Carolina	20	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	22	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Texas	15	-	X	X	-	-	-	-	X	-	X	X	X	X	X	X	X	X	X	-	X	-	X	X
Utah	12	-	-	-	-	-	X	X	X	-	-	X	X	X	X	X	X	X	-	-	X	-	-	X
Vermont	7	X	-	-	X	-	-	-	-	-	-	X	X	X	X	X	-	X	-	-	-	-	-	-
Virginia	9	X	X	-	X	-	X	-	-	-	-	X	X	X	X	-	-	X	-	-	-	-	-	X
Washington	11	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	2	-	-	-	-	-	-	-	-	-	-	-	-	-	X	-	-	X	-	-	-	-	-	-
Wyoming	14	-	-	-	-	-	X	X	X	X	X	X	X	X	X	X	X	X	X	-	-	X	-	-

Source: Based on Mathematica analysis of FFY 2012 CARTS reports.

Notes: This table excludes the OME and CLABSI measures. The OME measure was not collected for FFY 2012 and was retired in 2013. Beginning in FFY 2012, data for the CLABSI measure were obtained from CDC's National Healthcare Safety Network.

Exhibit 3. Changes in the Number of States Reporting the Medicaid/CHIP Children's Health Care Quality Measures, FFY 2010–2012



Source: Based on Mathematica analysis of FFY 2010–2012 CARTS reports.

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

The FFY 2010 and 2011 counts for the two dental measures reflect the number of states reporting the dental measures in CARTS, whereas the FFY 2012 count reflects the number of states reporting data on Form CMS-416. In FFY 2012, to minimize state burden, CMS began calculating the two dental measures on behalf of states using data reported on Form CMS-416.

Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network. The OME measure was not collected for FFY 2012 and was retired in 2013.

APPENDIX A

OVERVIEW OF THE CHIPRA QUALITY DEMONSTRATION GRANTS

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The CHIPRA Quality Demonstration Program includes 10 lead grantees and 8 collaborating states that are implementing multi-dimensional projects in the following five areas to improve the quality of children's health care: (1) use of quality measures; (2) use of health information technology; (3) implementation of provider-based delivery models; (4) use of a model format for pediatric electronic health records (EHRs); and (5) implementation of other innovative approaches to improve quality. This appendix summarizes activities of the 18 Demonstration states.[107] The lead grantee is shown first (followed by collaborating states).

1. Colorado (New Mexico)

Colorado and New Mexico have developed an initiative focusing on improving adolescent health through school-based health centers (SBHCs). The SBHCs receive training in disease prevention and management; data collection; consultation, referral, and coordination of care; interacting with adolescents; and enabling them to direct their own health care as they mature. To monitor the quality of health in school-age adolescents, Colorado and New Mexico have developed the Youth Engagement with Health Services (YEHS!) survey. The YEHS! instrument was recently evaluated, and results presented at the Society for Adolescent Health and Medicine (SAHM) Annual Meeting in March 2013. Initial results indicate that the YEHS! is a feasible and reliable measure of youth engagement and the quality of care delivered at SBHCs.

2. Florida (Illinois)

Florida and Illinois are collaborating on efforts to improve maternal and infant health outcomes, with a common focus on reducing early elective deliveries using improvement science and evidence-based practices to improve quality. Florida has also been using the CHIPRA demonstration grant to support and expand its Pediatric Medical Home Demonstration Project, known as Change for Kids. In January 2013, Florida's Agency for Health Care Administration (AHCA) announced that 16 pediatric primary care practices serving more than 100,000 children across Florida graduated from AHCA's quality improvement initiative aimed at strengthening medical homes and fostering patient-centered health care. The program has demonstrated improvement in the percentage of medically complex children with an updated care plan at each visit and the number of children receiving screenings during their checkups to assess their needs for specialty follow-up care. In addition to reducing early elective deliveries, Illinois's maternal health project is focused on various quality initiatives surrounding maternal care, including development of a prenatal electronic data set to improve quality of labor and delivery care and reduce system duplication; a prenatal risk assessment tool; and maternity care coordination guidelines for care transitions.

[107] The website for the national evaluation of CMS's CHIPRA Quality Demonstration is available at http://www.ahrq.gov/policymakers/chipra/demoeval/index.html.

3. Maine (Vermont)

Maine and Vermont are investing in interventions to improve the health of all Medicaid- and CHIP-eligible children, with a particular focus on children in foster care, through information technology enhancement and the development of a pediatric medical home model. The University of Southern Maine surveyed pediatric and family practices about how they use data, clinical guidelines, and office systems to monitor and improve children's health care quality as part of the grant's "Improving Health Outcomes for Children" (IHOC) initiative. In 2014, a follow-up survey will be conducted to assess how quality improvement has changed in child-serving practices statewide over time in areas targeted for improvement by IHOC (for example, use of Bright Futures and state registries) and within subgroups, including practices participating in IHOC learning sessions. In addition, the CHIPRA grant funds the National Improvement Partnership Network (NIPN), a Vermont-led network of 27 states that have developed Improvement Partnerships to advance quality and transform health care for children and their families.

4. Maryland (Georgia and Wyoming)

These three states are implementing innovative care models to improve the quality of care for children with serious behavioral health challenges. Maryland is implementing a Care Management Entity (CME) model to improve crisis intervention services. Maryland convened a workgroup to design a comprehensive and statewide behavioral health crisis system for children and adolescents. The aims are to reduce inpatient psychiatric hospitalizations, reach children in the least restrictive setting, and reduce behavioral health care costs. The work group conducted an assessment and recommended a robust crisis system that involves a continuum of services, from hotlines to stabilization services. Within Maryland's landscape, the workgroup determined what core crisis components and services are required to increase rapid and competent community access to youth and families in crisis. In addition to implementing the CME model for high-utilizing children, Wyoming is integrating a total health record for health home and electronic health record functions into CME practices. Georgia's approach involves developing and implementing a statewide network of certified parent and youth Peer Support Specialists.

5. Massachusetts

Massachusetts is leveraging its CHIPRA demonstration grant to improve care, focusing on high-impact conditions such as attention deficit hyperactivity disorder, asthma, and childhood obesity, through expansion of a medical home model of care and practice-level quality reporting for children enrolled in Medicaid, CHIP, and commercial insurance plans. The state believes that this comprehensive reporting will provide practices with more complete information about their performance, which may help with planning quality improvement efforts. Massachusetts has addressed various challenges in its effort to implement comprehensive reporting, including identifying a patient-provider attribution methodology and minimizing administrative burden by collecting data from state-level systems.

6. North Carolina

North Carolina is expanding the patient-centered medical home model to improve the health of children with special health care needs, as well as developing a pediatric EHR model that is

applicable to all children. Most recently, the state has been testing and expanding quality measurement and improvement projects through its medical home network, Community Care of North Carolina (CCNC). Fourteen participating networks have received a half-time quality improvement specialist to provide quality measurement and feedback data to providers, identify quality improvement goals, and connect practices to resources and training.

7. Oregon (Alaska and West Virginia)

These three states are targeting low-income rural populations by testing the impact of patient-centered care models and health information technology on pediatric care quality. Oregon has created a Patient Centered Primary Care Home (PCPCH) recognition program to promote their development, and encourage populations covered by the Oregon Health Authority to receive care in this new model. Across the state, more than 170 clinics have been recognized as an official PCPCH model of care. Recognized primary care homes offer a team-based approach to care focused on care coordination and keeping people healthy. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Primary care homes reduce costs and improve care by catching problems earlier and focusing on prevention, wellness, and community-based management of chronic conditions. Alaska's approach involves adapting the medical home model to the state's rural and frontier practices, while West Virginia is using a virtual learning collaborative approach to assist practices in implementing quality improvement processes.

8. Pennsylvania

Pennsylvania is using the CHIPRA demonstration grant to implement a pediatric EHR model and enhance health information technology-based care coordination efforts for children with developmental delay, behavioral issues, and complex medical conditions. The state established a pay-for-performance system that rewards pediatric practices in seven health systems for extracting and reporting eight of the Child Core Set quality measures from EHRs and either maintaining good performance or improving performance. Providers in Pennsylvania indicated they are initiating new quality improvement efforts as a result of CHIPRA practice-level reports. To increase well-child visits, for example, clinics are redesigning reminder letters and completing reminder calls earlier in the month when parents are more likely to have available cell phone minutes.

9. South Carolina

Through its CHIPRA Quality Demonstration Grant, South Carolina is implementing the medical home model for pediatric practices, and enhancing health care quality for children through provider quality data feedback loops. The state is hosting a learning collaborative for pediatric practices to improve their performance on the core set of children's health care quality measures. The state recently found that all 18 participating practices improved on some measures since baseline reporting began.

10. Utah (Idaho)

Utah and Idaho are supporting the development of medical home models in pediatric practices by embedding Medical Home Coordinators in primary care practices and conducting learning collaboratives to implement multiple quality improvement projects. These projects focus on improving collaboration among pediatric generalists and specialists; implementing care and self-care plans for children with chronic conditions; facilitating care transitions for children with special health care needs; and identifying ways to sustain overall quality improvement efforts.

NATIONAL QUALITY FORUM

Meeting Summary

HHSM-500-2012-00009I – Task Order HHSM-500-T0011

Joint Web Meeting of the MAP Medicaid Adult and Child Task Forces

April 27, 2015 | 12:00pm – 2:00pm ET

The National Quality Forum (NQF) convened a web-based meeting of the Measure Applications Partnership (MAP) Adult and Child Medicaid Task Forces on Monday, April 27, 2015. An online archive of the meeting is available.

Task Force Members in Attendance

Task Force	Name	Organization
Child	Foster Gesten, MD - *Task Force Chair*	
Adult	Harold Pincus, MD - *Task Force Chair*	
Child	Terry Adirim, MD, MPH, FAAP	American Academy of Pediatrics
Adult	George Andrews, MD, MBA, CPE, FACP	Humana, Inc.
Child	Andrea Benin, MD	Children's Hospital Association
Child	Luther Clark, MD	Subject Matter Expert
Child/Adult	Anne Cohen, MPH	Subject Matter Expert
Child	Jeff Convissar, MD	Kaiser Permanente
Child	Denise Cunill, MD, FAAP	American's Essential Hospitals
Adult	Kirstin Dawson	America's Health Insurance Plans
Child	Carole Flamm, MD, MPH	Blue Cross and Blue Shield Association
Child	Amy Gibson	Patient-Centered Primary Care Collaborative
Adult	Sue Kendig	American Academy of Nurse Practitioners
Child	Susan Lacey, RN, PhD, FAAN	American Nurses Association
Child	Kevin Larsen	Office of the National Coordinator for Health IT
Child/Adult	Marc Leib, MD, JD	Subject Matter Expert
Adult	Daniel Lessler, MD, MHA, FACP	National Association of Medicaid Directors
Adult	Lisa Patton	Substance Abuse and Mental Health Services Administration
Child/Adult	Cynthia Pellegrini	March of Dimes
Adult	Ruth Perry, MD	Subject Matter Expert
Child	Carol Sakala, PhD, MSPH	National Partnership for Women and Families
Adult	Marissa Schlaifer	Academy of Managed Care Pharmacy
Child/Adult	Alvia Siddiqi, MD, FAAFP	American Academy of Family Physicians
Adult	Brock Slabach, MPH, FACHE	National Rural Health Association
Adult	Marsha Smith, MD, MPH, FAAP	Centers for Medicare and Medicaid Services
Child	Sandra White, MD, MBA	Aetna

Welcome and Review of Meeting Objectives

Dr. Harold Pincus and Dr. Foster Gesten, chairs of the Adult and Child Task Forces respectively, welcomed the task force members and members of the public to the web meeting. Ann Hammersmith, NQF's General Counsel, led the Committee's introductions and disclosures of interest. The meeting objectives were to:

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

Dr. Gesten reviewed the MAP Medicaid Adult and Child Task Forces' charge to remind members of the purpose and structure of this year's review, which is to provide input on the Adult and Child Core Sets by August 2015.

CMS Overview of the Child and Adult Quality Measurement Programs

Marsha Lillie-Blanton and Karen LLanos, Centers for Medicare & Medicaid Services (CMS), conveyed their appreciation of the Task Forces' work and expressed CMS' support of MAP's effort to combine the work of both the Adult and Child Core Sets during the 2015 review. Ms. LLanos provided background on how the Core Sets operate and fit together. She discussed CMS' three-part goal for both the Child and Adult Core Sets, the statutory requirements for annual updates, changes in both Core Sets as a result of annual measure updates, and the role that MAP plays in strengthening the Core Sets by informing CMS.

CMS provides technical assistance and analytic support to both of these voluntary state-level reporting programs. The Child Core Set is the older of the two reporting programs. CMS and states have five years of experience working with the Child Core Set, compared to two years of experience working with the Adult Core Set. The Core Sets are governed by two separate pieces of legislation. CHIPRA requires annual updates to the Child Core Set and the Affordable Care Act section 2701 requires annual improvements to the Adult Core Set.

CMS stressed the value of multi-stakeholder perspectives and encouraged MAP to strengthen the Child and Adult Core Sets by recommending measures that can fill key gap areas and promote better alignment with other CMS/HHS programs while focusing on incremental changes. CMS reviews MAP's feedback with various internal and external stakeholders and will release annual updates to both Core Sets by January 2016.

Task Force remarks during the discussion included:

- While the majority of the measures in both Core Sets are claims-based measures, eMeasures and hybrid measures have been included. Experience shows that fewer states report on measures that are not claims-based.
- There are some PQMP Centers of Excellence measures that are ready to be or are being considered for NQF endorsement. CMS is open to including those measures in the Core Sets and encourages the Task Forces to consider them, if they fill critical gap areas. Behavioral Risk for

Pregnant Women, a PQMP measure, was added to the Core Set two years ago but has not yet been endorsed.

Child Core Set: Recent Changes and Properties of the Measures

Shaconna Gorham, Senior Project Manager, NQF, reviewed the current measures, properties, and the characteristics of the Child Core Set. Ms. Gorham highlighted that measures are concentrated in the National Quality Strategy (NQS) priority area of Healthy Living and Well-Being and in the clinical areas of Maternal and Perinatal Care and Preventive Care.

Dr. Gesten reviewed MAP's 2014 measure and gap recommendations for the Child Core Set and noted recent changes based on CMS updates for FFY 2015. He remarked that MAP identified numerous gaps in measures in the 2014 Child Core Set during its expedited review. MAP reviewed available NQF-endorsed® measures for potential addition to the measure set, however for some areas, such as screening for abuse and neglect, trauma, and DME, no NQF-endorsed measures were found. MAP also noted measures (i.e., care coordination, behavior health, and inpatient care) in various stages of development under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP) that could enhance the Child Core Set. These areas and potential measures will be revisited during this year's annual review process. Dr. Gesten noted that MAP recommendations included the removal of one measure and the phased addition of six measures to the Child Core Set. He highlighted CMS's responsiveness to MAP's recommendations exemplified by their updates to the 2015 Child Core Set.

Dr. Gesten provided an overview of the Medicaid Child Core Set FFY 2013 reporting results. In 2013, all states and the District of Columbia reported two or more of the Child Core Set measures. The measures most frequently reported by states include access to primary care, well-child visits, and use of dental services. A full report, published annually by HHS, is available: 2014 Annual Report on the Quality of Care for Children in Medicaid and CHIP.

Dr. Gesten also facilitated a discussion related to opportunities to further strengthen the Child Core Set. Members suggested leveraging the Centers of Excellence measures and revisiting MAP's previous recommendations that were not added to the 2015 Child Core Set.

Adult Core Set: Recent Changes and Properties of the Measures

Sarah Lash, Senior Director, NQF, reviewed the current composition of the Medicaid Adult Core Set, measure properties, and recent changes to the Core Set. Most of the Task Force's 2014 recommendations are well-represented on the 2015 Core Set, in particular its strong alignment with other program sets and parsimonious number of measures. Measures in the Adult Core Set are primarily process measures, with 23 of the 26 currently in use in one or more federal programs and three measures also included in the Child Core Set. Changes to the Core Set reflect the need to enable greater state-level reporting.

Dr. Pincus reviewed MAP's 2014 measure and gap recommendations for the Adult Core Set and noted recent changes based on CMS updates for FFY 2015. He led the discussion on gap areas identified by the Task Force during last year's deliberations, with an emphasis on topics particularly relevant to the Medicaid population such as maternal/child health, behavioral health, and access to primary care. Dr. Pincus noted that MAP recommended the continued use of 25 of the 26 measures to provide stability

and the opportunity to gain additional experience. MAP recommendations included the removal of one measure and the phased addition of three measures to the Adult Core Set.

Dr. Pincus provided an overview of the Medicaid Adult Core Set FFY 2013 reporting results. In 2013, 30 states reported a median of 16.5 measures. The most frequently reported measures focused on: diabetes care management, postpartum care visits, mental health treatment, and women's preventive health care. A full report, published annually by HHS, is available: 2014 Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid.

Discussions between the task force members and CMS representatives focused on opportunities to fill gap areas and further strengthening the Adult Core Set by possibly revisiting measures previously recommended but not included in the Core Set, further aligning measures with other programs, and ensuring that measures recommended for addition or removal limit states' burden.

Looking Ahead to the In-Person Meeting

Dr. Pincus and Ms. Lash presented a preview of the meeting objectives for the Task Forces' June convening. They led the discussion on additional information needed to support the Task Forces' deliberations. In addition to the presented planned sources of information, the Task Force members requested information to gain a better understanding of States' use of measures and their challenges, along with other factors influencing measure reporting.

Opportunity for Public Comment

Several public comments were received during the meeting, most of them reinforcing the task forces' earlier discussion on measure alignment in several programs, filling gaps in critical areas in the Child Core Set in particular, and information on availability of measure utilization by state.

Next Steps

NQF staff noted important upcoming events for the Task Forces included:

- June 9- 10: In-person meeting of Medicaid Child Task Force
- June 10- 11: In-person meeting of Medicaid Adult Task Force
- July 6- August 5: 30-day public comment period on draft reports
- August, Date TBD: MAP Coordinating Committee review of draft reports
- August 31: Final reports due to HHS and made available to the public

Ms. Gorham thanked the Task Forces, presenters, and public for their participation, and the web meeting was adjourned.

Measure (Developmental)
Use of Contraceptive Methods by Women Aged 15-20 Years

A. DESCRIPTION

The percentage of women aged 15-20 years who are at risk of unintended pregnancy and who:

1) Adopt or continue use of the *most* effective or *moderately* effective FDA-approved methods of contraception.

2) Adopt or continue use of a long-acting reversible method of contraception (LARC).

The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods (e.g., by calculating the median and focusing on those providers/entities that are performing well below the mean).

NOTE: *This is a developmental measure, and feedback obtained from state Medicaid programs over the first year of its use will lead to refinements and the development of additional guidance for reporting.*

B. DEFINITIONS

At risk of unintended pregnancy	Women are considered at risk of unintended pregnancy if they have ever had sex, are fecund, and are not pregnant or seeking pregnancy.
Use of a most effective method of contraception	Use of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS)
Use of a long-acting reversible method of contraception (LARC)	Use of contraceptive implants, intrauterine devices or systems (IUD/IUS)
Use of a moderately effective method of contraception	Use of injectables, oral pills, patch, ring, or diaphragm
Measurement year	The most recent calendar year for which data is available, and after the grace period within which providers must submit claims. This is typically within 12 months of the data of service.

C. ELIGIBLE POPULATION

Age	Women ages 15 through 20 who are enrolled in Medicaid as of December 31 of the measurement year
Continuous enrollment	The measurement year

Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year
Benefit	Medical
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATIONS

Denominator for both measures

The eligible population that is at risk of unintended pregnancy.

Exclusions

Women who are not capable of getting pregnant;

1. Omit from the data set any woman with a code for hysterectomy, bilateral oophorectomy, natural menopause (or premature menopause due to surgery, radiation or other factors) as those women are not capable of getting pregnant.

   Table 1. ICD-9-CM Codes for Infertility due to non-contraceptive reasons

Code	Description
V88.01	Hysterectomy
65.5x, 58720, 58150, 58940, 58700	Oophorectomy (bilateral; salpingo-partial or total, unilateral or bilateral) Total Abdominal Hysterectomy, w/w-o removal of tubes and/or ovaries
256.2, 256.31	Premature menopause due to surgery, radiation or other factors
V49.81, 627.0-627.9	Natural menopause

2. Omit from the dataset any women who were pregnant and/or received prenatal care or delivery care at any point in the 12-month reporting period as listed.

   Table 2. ICD-9-CM Codes for pregnancy

Code	Description
V72.42	Pregnancy test/exam positive
V61.7	Unwanted pregnancy
V22.x	Pregnancy

Table 3. CPT Codes to identify prenatal care visits

59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, 59425, 59426

The denominator includes all adolescents 15-20 years of age, but preliminary National Survey of Family Growth (NSFG) estimates show that 47.5% of this population is not at risk of unintended pregnancy because they have never had sex, are infecund, or are trying to get pregnant. Hence, the highest level of performance expected for the first measure may be 52.5% in many primary care settings. However, in reproductive health programs such as a state Medicaid family planning expansion or Title X-funded service sites a higher proportion of the client population is likely to be at risk for unintended pregnancy.

Numerator for measure 1

The eligible population that is using a most or moderately effective method of contraception.

1. Use the codes in Table 4 to identify women who adopted or continued use of one of the following methods of contraception in the measurement year among the population of clients identified for the denominator: sterilization IUD, implant, contraceptive injection, contraceptive pills, patch, ring or diaphragm; among the population of clients identified for the denominator.

2. Take the following two steps to adjust for some unique characteristics of the most effective methods of contraception:

    a. The most effective contraceptive methods (sterilization, IUD, implant) are either permanent or last many years, so adjustments must be made to estimate the number of women who received the most effective method in the year(s) preceding the measurement year. To do this, reassign to the most effective method 1.4% of the women who are using a least effective or no method of contraception.

    b. LARC methods (IUD, implant) can be removed at the client's request so adjustments must be made to reflect this. To do so, use the codes in Table 5 to identify women who had their IUD or implant removed at any point during the measurement year. Check to see if they had an IUD or implant reinserted on the same or a subsequent date. If there is no code indicating reinsertion, reassign them as using the next most effective method reported. If a subsequent method is not identified, reassign the client as a non-user of contraception.

3. Sum the number of women identified in steps 1-2 above to determine the numerator.

Numerator for measure 2

The eligible population that is using a LARC method.

1. Use the codes in Table 6 to identify women who adopted or continued use of the contraceptive implant or IUD/IUS; among the population of clients identified for the denominator.

2. Take the following two steps to adjust for some unique characteristics of the most effective methods of contraception:

    a. LARC methods (IUD, implant) last many years, so adjustments must be made to estimate the number of women who received the method in the year(s) preceding the measurement year. To do this, reassign as using a LARC method 1.4% of the women who are using a least effective or no method of contraception.

    b. LARC methods (IUD, implant) can be removed at the client's request so adjustments must be made to reflect this. To do so, use the codes in Table 5 to identify women who had their IUD or implant removed at any point during the measurement year. Check to see if they had an IUD or implant reinserted on the same or a subsequent date. If there is no code indicating reinsertion, reassign them as using the next most effective method reported. If a subsequent method is not identified, reassign the client as a non-user of contraception.

3. Sum the number of women identified in steps 1-2 above to determine the numerator.

E. ADDITIONAL NOTES

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy. However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention, history of sexual activity, and receipt of sterilization or LARC in the year(s) preceding the measurement year. This document proposes a way to create a denominator that more accurately represents all women at risk of unintended pregnancy by using estimates from the National Survey of Family Growth (NSFG) to adjust the claims data. The NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men 15-44 years of age. Approximately 5000 individuals are interviewed each year, and data files are released every two years (http://www.cdc.gov/nchs/nsfg.htm). The preliminary estimates in this document come from the NSFG conducted in 2006-2010, among women who were enrolled in Medicaid for at least 11 months of the previous year (n=2062). The percentage of women who were pregnant/seeking pregnancy came from the following publication: Frost J et al (2013). Contraceptive Needs and Services, 2010: Methodological Appendix, Guttmacher Institute, NY,NY. The NSFG estimates used in this measure specifications document will be revised over the coming year as more experience is gained with applying the NSFG data in the context of these

The measure is focused on outpatient delivery of contraceptive services, for the most part in primary care settings. As such, it does not consider use of postpartum contraception. This is due to the complexity of measuring postpartum contraception using claims data, and that the most appropriate denominator would be all women with a recent live birth. Additionally, a measure focused exclusively on postpartum contraception has been proposed and may be approved in the near future; omitting data about postpartum contraception from this measure will facilitate any future harmonization of the two measures.

Table 4. Codes used to identify use of most or moderately effective contraceptive methods

Description	ICD-9	CPT	HCPCS	NDC codes
Female Sterilization	**V25.2**, Sterilization **V26.51**, Tubal ligation status **66.2**	**58565, 58600, 58605, 58615, 58611, 58670, 58671, 58340, 74740**	**A4264, 58340, 74740**	
Intrauterine device (IUD/IUS)	***V25.1,*** *Encounter for insertion or removal of intrauterine* contraceptive device **V25.11,** Encounter for insertion of intrauterine contraceptive device **V25.13**, Encounter for removal and reinsertion of intrauterine contraceptive device **V25.42,** Surveillance of previously prescribed contraceptive method, intrauterine device **V45.51,** Post-surgical presence of intrauterine contraceptive device **996.32, 996.65,** Mechanical complication due to intrauterine contraceptive device or infection **V45.59,** contraceptive device **69.7**, Insertion	**58300,** Insertion of IUD	**J7300,** Intrauterine copper contraceptive **J7302,** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg **S4989,** Contraceptive intrauterine device (e.g. progestacertiud), including implants and supplies **Q0090,** Skyla (2013) **S4981**, Insertion of levonorgestrel-releasing intrauterine system	
Hormonal implant	**V25.5,** Encounter for contraceptive management, insertion of implantable subdermal contraceptive, **V25.43**, Surveillance of previously prescribed contraceptive method; implantable subdermal	**11981**,Insertion, non-biodegradable drug delivery implant, Implanon or Nexplanon **11983**,Removal with reinsertion, non-biodegradable drug delivery implant, Implanon or Nexplanon	**J7306**, Levonorgestrel (contraceptive) implant system, including implants and supplies **J7307**,Etonogestrel [contraceptive] implant system, including implant and supplies (A4260, Levonrgesterol implant system, code expired 2006 S0180, Etonogesterol	

	contraceptive. This code is reported for checking, reinsertion, or removal of the implant. **V45.52**, Post-surgical presence of subdermal contraceptive implant **996.30**, Mechanical complication of unspecified genitourinary device, implant, and graft **V45.59,** contraceptive device		implant system, code expired 2008)	
Injectable (1-month/ 3-month)	***V25.9****, Start other hormonal method: Unspecified contraceptive management ***V25.40****, Follow up other hormonal method: Contraceptive surveillance; unspecified	**96372** **90772,** before 2009	**J1050, 1051, 1055, 1056,** Injection, medroxyprogesterone acetate, 1 mg (J1051, Injection, medroxyprogesterone acetate, 50 mg, code expired 2013 J1055,Injection, medroxyprogesterone acetate for contraceptive use, 150 mg, code expired 2013 J1056, Injection, medroxyprogesterone acetate / estradiol cypionate, 5mg / 25mg, code expired 2013)	**54569370100** **54569490400** **54569552700** **54569561600** **54569621900** **54868361300** **54868410000** **54868410001** **54868525700** **55045350501** **59762453701** **59762453702** **59762453801** **59762453802** **59762453809**
Oral contraceptive	**V25.01**, Counseling and prescription of oral contraceptives **V25.41**, Surveillance of contraceptive pill ***V25.9****,* Start other hormonal method: Unspecified contraceptive management ***V25.40****,* Follow up other hormonal method: Contraceptive surveillance; unspecified		**S4993,** Contraceptive pills for birth control	**52544063128** **52544084728** **52544084828** **52544089228** **52544093628** **52544094028** **52544094928** **52544095021** **52544095121** **52544095328** **52544095428** **52544095931** **52544096691** **52544096728** **52544098131** **52544098231** **54569067900**

				54569068500 **54569068501** **54569068900** **54569068901** **54569143900** **54569384400** **54569422200** **54569422201** **54569426900** **54569427301** **54569481700** **54569487800** **54569487801** **54569489000** **54569498400** **54569499700** **54569499800** **54569516100** **54569534300** **54569534900** **54569549300** **54569549302** **54569579600** **54569579700** **54569579800** **54569581600** **54569582600** **54569603200** **54569612800** **54569614400** **54569627200** **54569628000** **54569628100** **54868042800** **54868044300** **54868050200** **54868050700** **54868050801** **54868050901** **54868051600** **54868151200** **54868156400** **54868231600** **54868260600** **54868270100** **54868377200** **54868386300** **54868394800** **54868409300** **54868423900** **54868436900** **54868453800** **54868459000** **54868460700** **54868473000** **54868473100**

				54868474200 **54868474500** **54868475400** **54868477600** **54868481400** **54868482800** **54868485100** **54868486000** **54868491100** **54868502800** **54868528600** **54868532600** **54868535600** **54868582600** **54868582800** **54868594200** **55045348506** **55045349701** **55045349801** **55045378106** **55045378206** **55289024708** **55289088704** **55887005228** **55887028628** **58016474701** **58016482701** **66993061128** **66993061528** **68180084313** **68180084413** **68180084613** **68180084813** **68180085413** **68180087611** **68180087613** **68180089713** **68180089813** **68180090213** **68462030329** **68462030529** **68462030929** **68462031629** **68462031829** **68462038829** **68462039429** **68462055629** **68462056529**
Patch	***V25.9*,*** Start other hormonal method: Unspecified contraceptive management ***V25.40*,*** Follow up other hormonal method:		**J7304,** Contraceptive supply, hormone containing patch, each	**54569541300** **54868467000**

	Contraceptive surveillance; unspecified			
Vaginal ring	***V25.9*,*** Start other hormonal method: Unspecified contraceptive management ***V25.40*,*** Follow up other hormonal method: Contraceptive surveillance; unspecified		**J7303,** Contraceptive supply, hormone containing vaginal ring, each	**54569586500** **54868483201** **55887075401**
Diaphragm		**57170**	**A4266,** Diaphragm for contraceptive use	

Table 5. Codes used to identify removal/discontinued use of LARC

Table DU-A: Codes to Identify Removal/Discontinued Use of LARC

Description	ICD-9	CPT
Discontinue Intrauterine device (IUD)	**V25.12**, Encounter for removal of intrauterine contraceptive device (97.71, Removal)	**58301**, Encounter for removal of intrauterine contraceptive device
Discontinue Implant		**11976,** Removal, non-biodegradable drug delivery implant, Norplant **11982,** Removal, non-biodegradable drug delivery implant, Implanon or Nexplanon

Table 6. Codes used to identify use of a long-acting reversible contraceptive method (LARC)

Description	ICD-9	CPT	HCPCS
Intrauterine device (IUD/IUS)	***V25.1,*** *Encounter for insertion or removal of intrauterine* contraceptive device **V25.11,** Encounter for insertion of intrauterine contraceptive device **V25.13**, Encounter for removal and reinsertion of intrauterine contraceptive device **V25.42,** Surveillance of previously prescribed contraceptive method, intrauterine device **V45.51,** Post-surgical presence of intrauterine contraceptive device **996.32, 996.65,** Mechanical complication due to intrauterine contraceptive device or infection **V45.59,** contraceptive device **69.7,** Insertion	**58300,** Insertion of IUD	**J7300,** Intrauterine copper contraceptive **J7302,** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg **S4989,** Contraceptive intrauterine device (e.g. progestacertiud), including implants and supplies **Q0090,** Skyla (2013) **S4981**, Insertion of levonorgestrel-releasing intrauterine system
Hormonal implant	**V25.5,** Encounter for contraceptive management, insertion of implantable subdermal contraceptive, **V25.43**, Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive. This code is reported for checking, reinsertion, or removal of the implant. **V45.52**, Post-surgical presence of subdermal contraceptive implant **V45.59,** contraceptive device **996.30**, Mechanical complication of unspecified genitourinary device, implant, and graft	**11981**,Insertion, non-biodegradable drug delivery implant, Implanon or Nexplanon **11983**,Removal with reinsertion, non-biodegradable drug delivery implant, Implanon or Nexplanon	**J7306**, Levonorgestrel (contraceptive) implant system, including implants and supplies **J7307**,Etonogestrel [contraceptive] implant system, including implant and supplies (A4260, Levonrgesterol implant system, code expired 2006 S0180, Etonogesterol implant system, code expired 2008)

Effective Postpartum Contraception Access
Measure Work-Up

Measure Description

The percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the utilization of postpartum contraception.

- *Highly effective postpartum contraception access*. The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing.
- *Moderately effective postpartum contraception access*. The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.

Eligible Population

Product lines	Report the following tables for each applicable product line. Commercial, Medicaid (report each product line separately).
Member months	For each product line and table, report all member months for the measurement period.
Ages	None specified. Report two age stratifications and a total rate for each numerator. • Less than 18 years. • Greater than or equal to 18 years. • Total.
Continuous enrollment	43 days prior to delivery through 99 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of live birth.
Benefit	Medical.
Event/diagnosis	*Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Include women who delivered in a birthing center. Refer to Tables PPC-A and PPC-B for codes to identify live births.

Administrative Specification

Denominator	Follow the first two steps below to identify the eligible population.
Step 1	Identify live births. Use Method A and and Method B below to identify all women with alive birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. Organizations must use both methods to identify the eligible population, but a member only needs to be identified by one to be included in the measure.
Method A	Codes listed in Table PPC-A identify a delivery *and* indicate the outcome of the delivery was a live birth. Women who are identified through the codes listed in Method A are automatically included in the eligible population and require no

further verification of the outcome.

Table PPC-A: Codes to Identify Live Births

Description	Codes	Codes	Codes

Method B Identify deliveries and verify live births. Codes in Table PPC-B, step A, identify deliveries but do not indicate the outcome. Organizations must use step B to eliminate deliveries that did not result in a live birth.

Table PPC-B: Codes to Identify Deliveries and Verify Live Births

Description	Codes	Codes	Codes

Step 2 Identify continuous enrollment. For women identified in step 1, determine if enrollment was continuous between 43 days prior to delivery and 99 days after delivery, with no gaps.

Numerator

Highly Effective Postpartum Contraception Effectiveness The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing.

Step 1 Identify the codes for highly effective postpartum contraception.

Table XXX: Codes to Identify Highly Effective Postpartum Contraceptive Methods

Description	
CPT	**11981** Insertion, non-biodegradable drug delivery implant **11983** Removal with reinsertion, non-biodegradable drug delivery implant **58300** Insertion of IUD 58600 Ligation or transection of fallopian tubes, abdominal or vaginal approach (sterilization) 58605 Ligation or transection of fallopian tubes, postpartum, unilateral or bilateral, during same hospitalization 58611 Ligation or transection of fallopian tubes when done at the time of cesarean delivery or intra-abdominal surgery. 58615 Occlusion of fallopian tubes by device (eg, band, clip, Falope ring) 58670 Laparoscopy with fulguration of oviducts 58671 Laparoscopy with occlusion of oviducts by device
ICD-9	**V25.5** Encounter for contraceptive management, insertion of implantable subdermal contraceptive **V25.43** Surveillance of previously prescribed contraceptive method; implantable subdermal contraceptive. This code is reported for checking, reinsertion, or removal of the implant. **V25.11** Insertion of intrauterine contraceptive device **V25.13** Removal and reinsertion of intrauterine contraceptive device **V25.42** Surveillance of previously prescribed contraceptive method, intrauterine device
ICD-10	Z30.0 Encounter for contraceptive management Z30.01 Encounter for initial prescription of contraceptives

	Z30.013 injectable Z30.014 IUD Z97.5 device intrauterine (in situ) Z30.019 initial prescription Z30.019 subdermal implantable Z30.431 IUD Z30.49 specified type NEC Z30.49 subdermal implantable Z30.9 Management Z30.8 specified type NEC Z30.019 prescription Z30.40 repeat Z30.2 Encounter for sterilization Z30.4 Encounter for surveillance of contraceptives Z30.40 Encounter for surveillance of contraceptives, unspecified Z30.42 Encounter for surveillance of injectable contraceptive Z30.43 Encounter for surveillance of IUD Z30.430 Encounter for insertion of UID Z30.431 Encounter for routine checking of IUD Z30.433 Encounter for removal and reinsertion of IUD Z30.49 Encounter for surveillance of other contraceptives Z30.8 Encounter for other contraceptive management Z30.9 Encounter for contraceptive management, unspecified
HCPCS	**J7307** Etonogestrel [contraceptive] implant system, including implant and supplies **J7300** Intrauterine copper contraceptive **J7302** Levonorgestrel-releasing intrauterine contraceptive system, 52 mg S4981 Insertion of levonorgestrel-releasing intrauterine system S4989 Contraceptive intrauterine device (eg, progestacert IUD), including implants and supplies
ICD-10-PCS	0U2DXHZ, 0UHC, 0JH8, 0JH6, 0JHH, 0JHG, 0JHP, 0JHN, 0JHF, 0JHD, 0JHM, 0JHL, 0UH9, 0JWW, 0JWT, 0JWV, 0UWD

Step 2 Report each woman's postpartum contraceptive utilization in the appropriate category in Table XXX: Highly Effective Postpartum Contraception

- Less than 18 years.
- Greater than or equal to 18 years.
- Total.

Table XXX: Highly Effective Postpartum Contraception

Age	0-7 days postpartum	8-33 days postpartum	34-66 days postpartum	67-99 days postpartum	0-99 days postpartum
Less than 18 years	_____	_____	_____	_____	_____
18-29 years	_____	_____	_____	_____	_____
30-39 years	_____	_____	_____	_____	_____

Greater than 40 years	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____

Moderately Effective Postpartum Contraception Effectiveness

The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing.

Step 1 Identify the codes for moderately effective postpartum contraception.

Table XXX: Codes to Identify Moderately Effective Postpartum Contraceptive Methods

Description	Codes
HCPCS	H1010 Nonmedical Family Planning Education, per session S4993 Contraceptive Pills for birth control
CPT	57170 Diaphragm or cervical cap fitting with instructions
ICD-10	Z30.011 pills Z30.018 encounter for initial prescription of other contraceptives, specified type NEC Z30.019 Encounter for initial prescription of contraceptives, unspecified Z30.02 Counseling and instruction in natural family planning to avoid pregnancy Z30.41 Encounter for surveillance of contraceptive pills

Step 2 Report each woman's postpartum contraceptive effectiveness in the appropriate category

- Less than 18 years.
- Greater than or equal to 18 years.
- Total.

Table XXX: Moderately Effective Postpartum Contraception

Age	0-7 days postpartum	8-33 days postpartum	34-66 days postpartum	67-99 days postpartum	0-99 days postpartum
Less than 18 years	_____	_____	_____	_____	_____
18-29 years	_____	_____	_____	_____	_____
30-39 years	_____	_____	_____	_____	_____
Greater than 40 years	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____

Topic Overview

Importance and Prevalence

Health importance

Effective Postpartum Contraception Access Measure Work-Up

In the United States, almost half of all pregnancies are unintended and one-third of all pregnancies are conceived within 18 months of a previous birth (Healthy People 2020). In 2001, 49% of births were unintended and 21% of women gave birth within 24 months of a previous birth (CDC MMWR, 2009). In 2006, the rate of unintended pregnancies remained at 49%, accounting for some 3.2 million pregnancies. Among women aged 19 years and younger, more than 4 out of 5 pregnancies were unintended. Between 2001 and 2006, the proportion of pregnancies that were unintended declined from 89% to 79% among teens aged 15–17 years but increased from 79% to 83% among women aged 18 and 19 years and from 59% to 64% among women aged 20–24 years (Finer and Zolna, 2011).

Unwanted and mistimed pregnancies lead to delayed prenatal care, poorer intra-partum health and adverse pregnancy behaviors with negative consequences for both the mother and the fetus including later entry into prenatal care, decreased likelihood of smoking cessation, increased incidence of low birth weight babies and decreased breastfeeding (Gipson et al, 2008). Children from unintended pregnancies have a higher risk of experiencing poor mental and physical health during childhood and have higher risk of behavioral problems than their planned peers. Even after controlling for socioeconomic and demographic factors, there is a strong association between both mistimed and unplanned pregnancies and behavioral problems at age 5 and 7 (Carson et al, 2013). Unintended pregnancy is a significant source of social and economic hardship for women and families in the United States and the U.S. has been unable to reduce the rate of unintended pregnancies or unintended births. Postpartum contraception is important to prevent both unintended pregnancies and short birth intervals, defined by the World Health Organization as a birth-to-pregnancy interval of less than 24 months (WHO, 2006). Short birth intervals are associated with adverse health outcomes for both the mother and the infant, including increased risks for low birth weight and preterm births (Zhu et al, 1999; Conde-Agudelo and Belizán, 2000). Compared to women with inter-pregnancy intervals of 18-23 months, those with inter-pregnancy intervals of 5 months or less have been shown to have a 70% increased risk of third trimester bleeding and premature rupture of membranes and a 30% increased risk of anemia and puerperal endometritis. These women also had a significantly greater risk of maternal death (adjust OR 2.54 95% CI 1.22 – 5.38) (Conde-Agudelo and Belizán, 2000). A large meta-analysis was conducted in 2006 including 20 studies conducted in the United States as well as a large number of women from populations around the world. The analysis showed that birth to conception intervals shorter than 18 months and longer than 59 months is associated with increased risk of poor perinatal outcomes including preterm birth, low birth weight, and small for gestational age babies. Meta-regression curves also suggested that inter-pregnancy intervals shorter than 6 months are associated with increased risk of fetal and early neonatal death. (Conde-Agudelo et al, 2006)

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

Financial importance & cost-effectiveness

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

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

Effective Postpartum Contraception Access Measure Work-Up

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

Not included in these cost estimates are the ongoing costs of children's medical care beyond their first year of life and other government or social programs utilized to support the families through pregnancy and birth as well as housing, food and other support. Ongoing social and psychological impacts to women and families of unintended pregnancies, losses, terminations and births should not be underestimated.

Evidence Supporting Postpartum contraception

While it is widely known and accepted that effective birth control is important in preventing unintended pregnancies, many women and their partners do not use effective contraception or use contraception ineffectively. Public health advocates believe that the post-partum period is an important time to educate patients about the effective use of contraceptives and discuss a contraceptive plan. During this period, women may have increased motivation to avoid another pregnancy. Those women who were receiving pre-natal care were having multiple contacts with health care providers and, ideally, several opportunities to discuss post-partum contraception and optimal birth spacing. For those women who did not have pre-natal care, it is an opportunity to plug them into care. At least one post-partum visit is generally scheduled for 4-8 weeks postpartum, earlier for any women with problems requiring closer follow-up, and presents another opportunity to emphasize the importance of post-partum contraception and begin contraception as previously planned or further any discussions that were postponed per patient preference. Some methods, such as the IUD, subdermal implant, and injectables can be initiated before discharge after birth if the patient desires.

Though it is known that long-acting reversible contraception (LARC) such as IUD and hormonal implants are the most effective form of contraception and that intra-uterine contraceptives are significantly easier to place in the post-partum period, most women are not utilizing LARCs. Instead, the majority of women use user-dependent forms of birth control such as oral contraceptive pills and condoms which depend on consistent, proper use.

In one large study of postpartum women enrolled in MediCal, 55% of women used user-dependent hormonal contraception as their most common contraceptive method and one third of women had no contraceptive claim. Women who used LARC had 3.89 times the odds of achieving an optimal birth interval compared with women who used barrier methods only. Women who used user-dependent hormonal methods had 1.89 times the odds and those with no method had 0.66 times the odds of achieving an optimal birth interval (Thiel de Bocanegra et al, 2014). Therefore women without a method of contraception have 0.34 times the odds of becoming pregnant without adequate birth interval spacing.

Contraceptive methods

Of the 50% of pregnancies that are unintended in the United States, about 60% of them occur in women who are using some form of contraceptive during the month of conception (Hurt et al, 2011). Of the many reversible contraceptive methods available to women and their partners, only the pill, patch, ring, injectable, implant and intrauterine devices and sterilization are moderate and highly effective.

Table 1

		% with Unintended Pregnancy	% Actual Effectiveness Rate
Method	**Perfect Use**	**Typical Use**	**(100-Typical Use)**
No method	85	85	15
Spermicides	18	29	71
Withdrawal	4	27	73

Periodic Abstinence			
Calendar	9	25	75
Standard days method	5	12	88
Ovulation method	3	25	75
Symptothermal	2	25	75
Postovulation	1	25	75
Diaphragm with spermicide	6	16	84
Condom			
Female	5	21	79
Male	2	15	85
Pill (combined)	0.3	8	92
Mini-pill (progestin only)	1.1	13	87
Patch	0.3	8	92
Vaginal Ring	0.3	8	92
Depo Provera	0.3	3	97
Subdermal hormonal Implant	0.05	0.05	99.95
IUD			
Copper T	0.6	0.8	99.2
Levonorgestrel IUS	0.2	0.2	99.8
Female sterilization	0.5	0.5	99.5
Male sterilization	0.10	0.15	99.85

Values are the percentage of women who experience an unintended pregnancy within the first year of typical use and the first year of perfect use for each listed method. From Hanson SJ and Burke AE. Fertility Control: Contraception, Sterilization, and Abortion. In Hurt KJ, Guile MW, Bienstock JL, Fox HE, Wallach EE., eds. *The Johns Hopkins Manual of Gynecology and Obstetrics: Fourth Edition.* Philadelphia, PA: Lippincott Williams & Wilkins, 2011.

Contraceptive methods that are dependent on consistent and correct use by the individual users are more likely to result in unintended pregnancies due to user error. LARCs such as the IUD and subdermal hormonal implant are

not user-dependent and are the most effective forms of reversible contraception. LARCs require provider training and an office visit for placement. However, they are extremely cost-effective and long-lasting. The copper-T can be left in place for 10 years, the Levonorgestrel IUS 5 years and the subdermal implant 3 years allowing for fewer clinical visits. All forms can be removed early if desired and do not have lasting effects on fertility after removal. In fact, these forms of contraception have the quickest return to fertility. These hormonal birth control methods do not increase risk for venous thromboembolism and can be used immediately after delivery, including post-cesarean delivery, unlike combined oral contraceptive pills (CDC, 2010).

Combined hormonal contraceptives can increase the risk for VTE in all women and post-partum women are at increased risk due to their already hypercoagulable state. The CDC recommends that post-partum women should not use combined hormonal contraceptives during the first 21 days postpartum for this reason. During postpartum days 21-42, women with risk factors for VTE or post-cesarean delivery should not use combined hormonal contraceptives. After 42 days, there are no restrictions based on post-partum status (CDC, 2010).

Progestin-only forms of contraception including progestin-only pills, the subdermal implant and depot medroxyprogesterone acetate injections are all considered safe for postpartum women, do not interfere with breastfeeding and can be started immediately postpartum. Progestin-only contraceptive pills require that the user take the pill at the same time every day with more than a 3-hour delay considered a missed pill. This method therefore has greater risk for user error, making it far less effective with typical use (Hanson SJ and Burke AE, 2011).

Gaps in care

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

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

Health care disparities

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

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

References

Carson C, et al. *Effects of pregnancy planning, fertility, and assisted reproductive treatment on child behavioral problems at 5 and 7 years: evidence from the Millennium Cohort Study*. Fertility and Sterility 2013;99(2):456-463

CDC*, Contraceptive use among postpartum women – 12 states and New York City, 2004-2006*. MMWR 2009; 58:821-6

CDC. [Accessed 2014 February 27] U S medical eligibility criteria for contraceptive use. 2010. [online]. Available from URL: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr59e0528a1.htm

Effective Postpartum Contraception Access Measure Work-Up

Conde-Agudelo A, Belizán J. *Maternal morbidity and mortality associated with interpregnancy interval: cross sectional study*. BMJ 2000; 321: 1255-1259

Conde-Agudelo A, Rosas-Bermúdez A, Kafury-Goeta AC*. Birth spacing and risk of adverse perinatal outcomes: A meta-analysis.* JAMA 2006;295:1809-1823

Finer LB, Jerman J, Kavanaugh ML. *Changes in use of long-acting contraceptive methods in the United States, 2007-2009.* Fertility and Sterility, 2012 October; 98(4):893-897.

Finer LB, Zolna MR*. Unintended pregnancy in the United States: incidence and disparities, 2006*. Contraception. 2011 November; 84(5):478-485

Frost JJ, Zolna MR and Frohwirth L, *Contraceptive Needs and Services, 2010,* New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/win/contraceptiveneeds-2010.pdf>, accessed March 1, 2014.

Gipson JD, Koenig MA, Hindin MJ. *The effects of unintended pregnancy on infant, child and prenatal health: a review of the literature*. Stud Family Plann 2008;39:18-38.

Hanson SJ and Burke AE. Fertility Control: Contraception, Sterilization, and Abortion. In Hurt KJ, Guile MW, Bienstock JL, Fox HE, Wallach EE., eds. *The Johns Hopkins Manual of Gynecology and Obstetrics: Fourth Edition.* Philadelphia, PA: Lippincott Williams & Wilkins, 2011.

Sonfield A and Gold RB, *Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2010,* New York: Guttmacher Institute, 2012, <http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf>, accessed March 1, 2014.

Sonfield A and Kost K, *Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy and Infant Care: Estimates for 2008.*

Speroff L and Michell DR, The postpartum visit: it's time for a change in order to optimally initiate contraception. Contraception, 2008; 78: 90-98.

Thiel de Bocanegra H, Chang R, Howell M, et al. Interpregnancy intervals: impact of postpartum contraceptive effectiveness and coverage. Am J Obstet Gynecol 2014 epub ahead of print.

Thiel de Bocanegra H, Chang R, Menz M, Howell M, Darney P. Postpartum contraception in publicly-funded programs and interpregnancy intervals. Obstetrics and Gynecology, 2013. 122(2): 296-303.

Trussell J. *The cost of unintended pregnancy in the United States*. Contraception 2007;75:168–70.

Trussell et al. *Burden of unintended pregnancy in the United States: potential savings with increased use of long-acting reversible contraception.* Contraception 2013:87:154-161

US Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId¼13. Accessed March 6, 2014

World Health Organization. Report of a WHO Technical Consultation on Birth Spacing: Geneva Switzerland, June 13-15, 2005. Available at: http://www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf. Accessed March 10, 2014

Zhu BP, Rolfs RT, Nangle BE, Horan JM. *Effect of the interval between pregnancies on perinatal outcomes*. N Engl J Med 1999;340: 589–94.

Zhu B, Haines K, Le T, McGrath-Miller K, Boulton M. *Effect of the interval between pregnancies on perinatal outcomes among black and white women.* Am J Obstet Gynecol 2001;185: 1403-10.

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Recommendations for Contraception

Organization (Guideline Date)	Population	Recommendation	Type/ Grade
World Health Organization	Women after live birth	After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes	
	Women after abortion	After a miscarriage or induced abortion, the recommended minimum interval to next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes.	
American College of Obstetricians and Gynecologists (2011)		Routine antibiotic prophylaxis to prevent pelvic infection is not recommended before intrauterine device (IUD) insertion	Level A
		Insertion of a copper IUD is the most effective method of postcoital contraception when inserted up to 5 days after unprotected intercourse	Level A
		IUDs may be offered to women with a history of ectopic pregnancy	Level B
		Insertion of the implant is safe at any time in nonbreastfeeding women after childbirth	Level B
		Implants may be offered to women who are breastfeeding and more than 4 weeks after childbirth	Level B
		Insertion of an IUD or implant immediately after either an abortion or miscarriage is safe and effective	Level B
		Immediate postpartum IUD insertion, which is an insertion within 10 minutes of placental separation, appears safe and effective.	Level B
		The *U.S. Medical Eligibility Criteria for Contraceptive Use* classifies placement of an implant in breastfeeding women less than 4 weeks after childbirth as Category 2 because of theoretic concerns regarding milk production and infant growth and development.	Level C
		Nulliparous women and adolescents can be offered long-acting reversible contraceptive (LARC) methods, including IUDs.	Level C
		Long-acting reversible contraceptive methods have few contraindications, and almost all women are eligible for implants and IUDs.	Level C
		Insertion of an IUD or an implant may occur at any time during the menstrual cycle as long as pregnancy may be reasonably excluded.	Level C
		For women at high risk of sexually transmitted infections (STIs) (e.g., aged 25 years or younger or having multiple sex partners), it is reasonable to screen for STIs and place the IUD on the same day (and administer treatment if the test results are positive) or when the test results are available.	Level C
		Long-acting reversible contraceptive methods have an effect on menstrual bleeding, and patients should be given anticipatory guidance about these effects.	Level C
		An endometrial biopsy may be performed without removing the IUD. Cervical colposcopy, cervical ablation or excision, or endometrial sampling, may be performed with an IUD left in place.	Level C
		The U.S. Food and Drug Administration (FDA) and the World Health Organization (WHO) recommend that IUDs be removed from pregnant women when possible without an invasive procedure.	Level C
Update to CDC's U.S. Medical Eligibility Criteria for Contraceptive Use, 2010: Revised Recommendations for the Use of Contraceptive	All Women		
	<21 days Postpartum	In women who are <21 days postpartum, use of combined hormonal contraceptives represents an unacceptable health risk and should not be used	Category 4
	<4 weeks after delivery of the placenta (Including	Levonorgestrel-releasing IUD - the advantages generally outweigh the risks, and they can usually be used. Although IUD expulsion rates are somewhat higher when insertion occurs within 28 days of delivery, continuation rates at 6 months are similar among women who receive an IUD postpartum and those who plan for delayed insertion.	Category 2

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Organization (Guideline Date)	Population	Recommendation	Type/ Grade
Methods During the Postpartum Period	post-cesarean delivery)		
	>4 weeks after delivery of the placenta (including post-cesarean delivery)	Levonorgestrel-releasing IUD – No restrictions	Category 1
	<10 min after delivery of the placenta (including post-cesarean delivery)	Copper-bearing IUD – No restrictions	Category 1
	10 min to <4 weeks after delivery of the placenta (including post-cesarean delivery)	Copper-bearing IUD - the advantages generally outweigh the risks, and they can usually be used.	Category 2
	>4 weeks after delivery of the placenta (including post-cesarean delivery)	Copper-bearing IUD – No restrictions	Category 1
	Puerperal sepsis	IUDs – Copper-bearing and Levonorgestrel-releasing IUD's are an unacceptable health risk and should not be used	Category 4
	Non-breastfeeding Women		
	21--42 days postpartum with other risk factors for VTE	CHC - In women who are 21--42 days postpartum and have other risk factors for VTE in addition to being postpartum, the risks for combined hormonal contraceptives usually outweigh the advantages and therefore combined hormonal contraceptives generally should not be used	Category 3
	21--42 days postpartum without other risk factors for VTE	CHC - In women who are 21--42 days postpartum, in the absence of other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they can usually be used	Category 2
	>42 days postpartum	CHC - In women who are >42 days postpartum, no restriction applies for the use of combined hormonal contraceptives because of postpartum status. Nonetheless, any other medical conditions still should be taken into consideration when determining the safety of the contraceptive method.	Category 1
	Any time	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants, are safe for postpartum women and can be initiated immediately postpartum	Category 1
	Breastfeeding Women		
	<21 days postpartum	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants – The advantages generally outweigh the risks, and they can usually be used.	Category 2

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Organization (Guideline Date)	Population	Recommendation	Type/ Grade
	21 to < 30 days postpartum with other risk factors for VTE	CHC - For women with other risk factors for VTE, these risk factors might increase the classification to a "4"; for example, smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy.	Category 3/4
	21 to < 30 days postpartum without other risk factors for VTE	CHC – For women without other risk factors for VTE, the risks for combined hormonal contraceptives usually outweigh the advantages and therefore combined hormonal contraceptives generally should not be used	Category 3
	All women 21 to < 30 days postpartum	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants – The advantages generally outweigh the risks, and they can usually be used.	Category 2
	30-42 days postpartum with other risk factors for VTE	CHC - For women with other risk factors for VTE, these risk factors might increase the classification to a "4"; for example, smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy.	Category 3/4
	30-42 days postpartum without other risk factors for VTE	CHC – For women without other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they can usually be used.	Category 2
	>42 days postpartum	CHC – For women without other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they can usually be used.	Category 2
	All women ≥30 days postpartum	Progestin-only hormonal methods, including progestin-only pills, depot medroxyprogesterone acetate injections, and implants, are safe and can be initiated immediately postpartum	Category 1
Faculty of Sexual and Reproductive Healthcare (2009)		Health professionals should find opportunities during both the antenatal and postnatal period to discuss all methods of contraception	Good practice point
		Health professionals should assess a woman's postpartum contraceptive needs by taking account of her personal beliefs/preferences, cultural practices, sexual activity, breastfeeding pattern, menstruation, medical and social factors	Good practice point
		The benefits of long-acting reversible contraception (LARC) methods in terms of efficacy should be highlighted to all postpartum women	Good practice point
	Breastfeeding women	Women can be informed that available evidence suggests that use of progestogen-only contraception while breastfeeding does not affect breast milk volume	Grade B
	Breastfeeding women	Women can be informed that there is currently insufficient evidence to prove whether or not combined hormonal contraception (CHC) affects breast milk volume	Grade C
	Breastfeeding women	Women can be informed that progestogen-only contraception has been shown to have no effect on infant growth	Grade A
		CHC should not be commenced before Day 21 due to the increased risk of thrombosis. Non-breastfeeding women may start CHC from Day 21 postpartum	Grade C
	Breastfeeding women	Breastfeeding women should avoid CHC in the first 6 weeks postpartum as there is insufficient evidence to prove the safety of CHC use while establishing breastfeeding	Grade C

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Organization (Guideline Date)	Population	Recommendation	Type/ Grade
	Breastfeeding women	Use of CHC between 6 weeks and 6 months should not be recommended in fully breastfeeding women unless other methods are not acceptable or available. In partially or token breastfeeding women the benefits of CHC use may outweigh the risks	Good practice point
		Postpartum women (breastfeeding and non-breastfeeding) can start the POP at any time postpartum	
	Non-breastfeeding women	Non-breastfeeding women can start a progestogen-only injectable method at any time postpartum	Grade C
	Breastfeeding women	Breastfeeding women should not start a progestogen-only injectable method before Day 21 unless the risk of subsequent pregnancy is high	Grade C
		Women should be advised that troublesome bleeding can occur with use of depot medroxyprogesterone acetate (DMPA) in the early puerperium	Grade C
		If more convenient, breastfeeding and non-breastfeeding women can choose to have a progestogen-only implant inserted before Day 21, although this is outside the product licence for Implanon	Good practice point
		Unless a copper-bearing intrauterine device (Cu-IUD) can be inserted within the first 48 hours postpartum (breastfeeding and non-breastfeeding women), insertion should be delayed until Day 28 onwards. No additional contraception is required	Grade C
		An LNG-IUS can be inserted from Day 28 postpartum (breastfeeding and non-breastfeeding women). Women should avoid sex or use additional contraception for 7 days after insertion unless fully meeting LAM criteria	Grade C
		Women who choose a diaphragm or cervical cap should be advised to wait at least 6 weeks postpartum before attending for assessment of size requirement	Grade C

Grading System Key

American College of Obstetricians and Gynecologists

Level A Recommendations are based on good and consistent scientific evidence; *Level B* Recommendations are based on limited or inconsistent scientific evidence.; *Level C* Recommendations are based primarily on consensus and expert opinion.

CDC

Categories: 1 = a condition for which there is no restriction for the use of the contraceptive method, 2 = a condition for which the advantages of using the method generally outweigh the theoretical or proven risks, 3 = a condition for which the theoretical or proven risks usually outweigh the advantages of using the method, 4 = a condition that represents an unacceptable health risk if the contraceptive method is used.

Faculty of Sexual and Reproductive Healthcare

A: Evidence based on randomised controlled trials (RCTs)
B: Evidence based on other robust experimental or observational studies
C: Evidence is limited but the advice relies on expert opinion and has the endorsement of respected authorities
Good Practice Point where no evidence exists but where best practice is based on the clinical experience of the multidisciplinary group

References for Recommendations

American College of Obstetricians and Gynecologists (ACOG). Long-acting reversible contraception: implants and intrauterine devices. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2011 Jul. 13

Centers for Disease Control and Prevention (CDC). Update to CDC's U.S. medical eligibility criteria for contraceptive use, 2010: revised recommendations for the use of contraceptive methods during the postpartum period. MMWR Morb Mortal Wkly Rep. 2011 Jul 8;60(26):878-83.

Effective Postpartum Contraception Access Measure Work-Up

Clinical Effectiveness Unit. Postnatal sexual and reproductive health. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2009 Sep. 23

World Health Organization. Report of a WHO Technical Consultation on Birth Spacing: Geneva Switzerland, June 13-15, 2005. Available at: http://www.who.int/maternal_child_adolescent/documents/birth_spacing.pdf. Accessed March 10, 2014