Measure Applications Partnership

MAP Medicaid Adult and Child Task Forces In-Person Meeting

May 24-26, 2016

NATIONAL QUALITY FORUM

Welcome and Review of Meeting Objectives

Introductions of Task Force Members and Disclosures of Interest

Medicaid Adult Task Force Membership

Organizational Members

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

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Medicaid Adult Task Force Membership

Subject Matter Experts

Ann Marie Sullivan, MD
Kim Elliott, PhD, CPHQ

Federal Government Members

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

Meeting Objectives

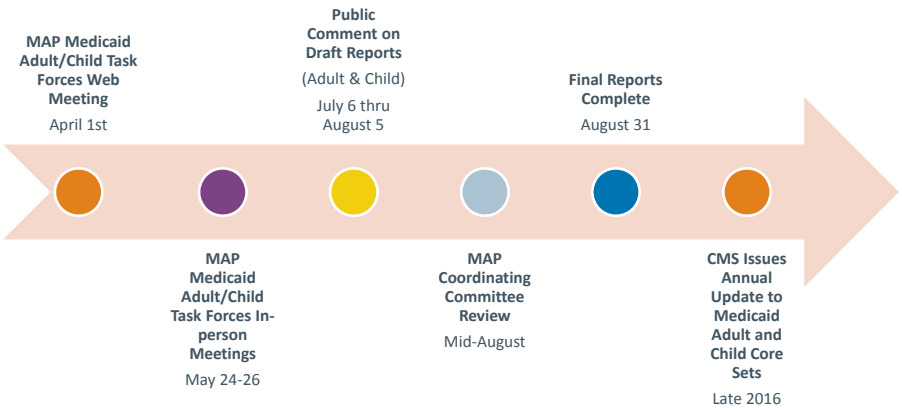
- Consider states' experiences implementing the Medicaid Child and Adult Core Sets
- Develop strategic recommendations for strengthening the Medicaid Child and Adult Core Sets through identification of:
  - Priority measure gaps and potential measures to address them
  - Measures found to be ineffective and or topped out, for potential removal
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals
- Overarching policy issues to help inform Core Set Updates

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.

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

2016 Timeline



Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Themes from April's Web Meeting

- Update Adult & Child Core Sets
- Consider Gap Areas
- Consider IOM Vital Signs themes of parsimony, harmonization and alignment with respect to measure when voting on adding measures
- Define Alignment
- Discuss operational roadblocks re: alignment

Key Points from Staff Review of Core Set

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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

Medicaid Adult Population Background

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

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

Additional information

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

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

Medicaid Adult Core Set

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

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

MAP 2015 Measure Recommendations

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

CMS– Adult Core Set Update for 2016 Reporting

Issued December 11, 2015

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

Medicaid Adult Core Set Measures for FFY 2016 Use

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

Medicaid Adult Core Set Measures for FFY 2016 Use - Continued

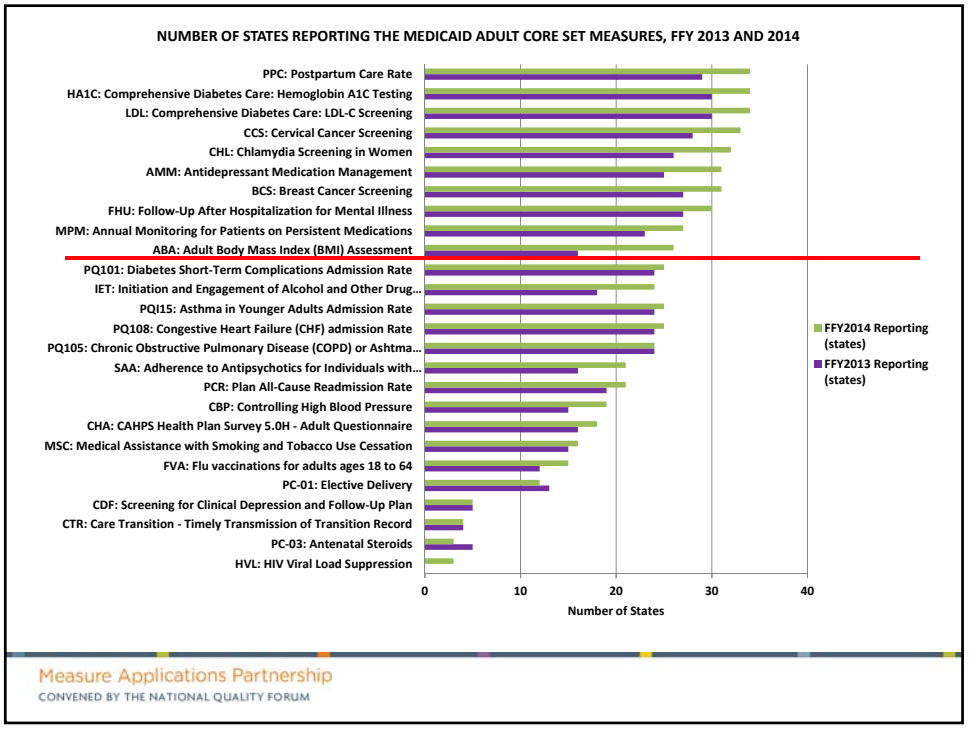
NQF #	Measure Name	Measure Steward
0418	Screening for Clinical Depression and Follow-Up Plan	CMS
0469	PC–01: Elective Delivery	Joint Commission
0476	PC–03 Antenatal Steroids	Joint Commission
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0648	Care Transition—Transition Record Transmitted to Health Care Professional	AMA-PCPI
1517	Prenatal and Postpartum Care: Postpartum Care Rate	NCQA
1768	Plan All-Cause Readmission Rate	NCQA
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)**	NCQA
2082	HIV Viral Load Suppression	HRSA
2371	Annual Monitoring for Patients on Persistent Medications	NCQA
2372	Breast Cancer Screening	NCQA
n/a	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA
n/a	Adult Body Mass Index (BMI) Assessment	NCQA
n/a	Use of Opioids from Multiple Providers or at High Dosage in Persons Without Cancer: Opioid High Dosage**	PQA

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

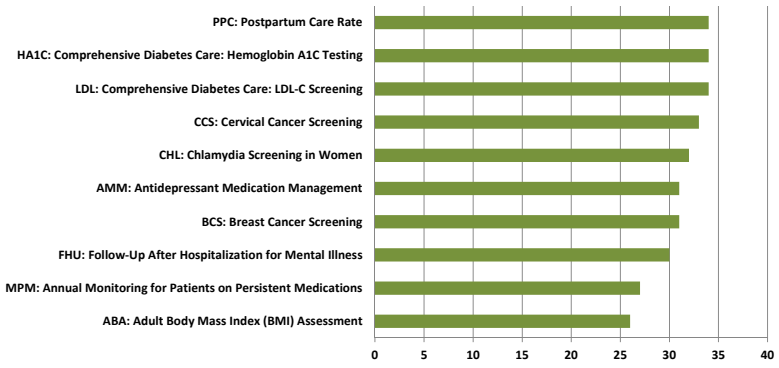
- Most frequently reported measures focused on:
  - Diabetes care management
  - Postpartum care visits
  - Women's preventive health care
- TA requests were submitted by 25 states-a total of 69 requests



Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Measures with High Levels of Reporting (10)

Measures with at least 25 states reporting, CMS publically reported

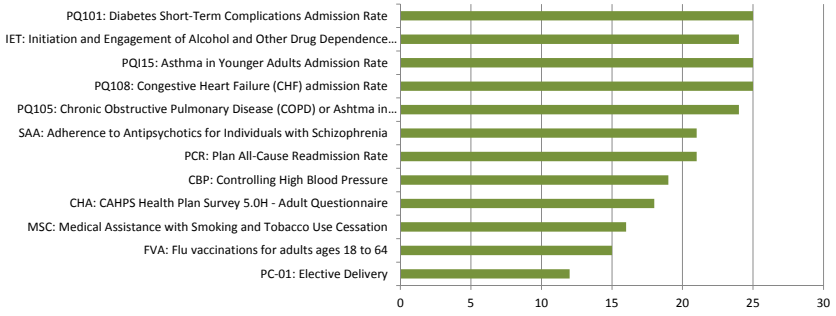


Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Measures with Medium Levels of Reporting (12)

Measures with 12-24 states reporting

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

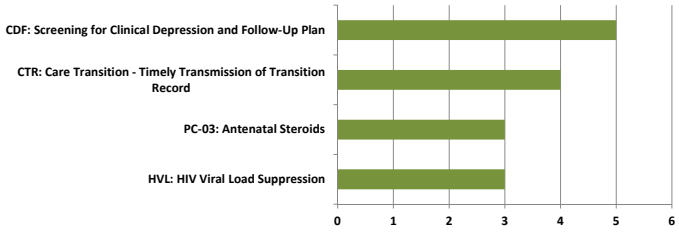


Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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
- Care Transition and Screening for Clinical Depression stayed the same in FFY 2013 and FFY2014



Staff Review: Reasons Given for Technical Assistance (TA) Requests

- TA requests were submitted by 25 states-a total of 69 requests
- Measures receiving the most TA requests(≥ 5 requests)
  - PQI 01 Diabetes Short-Term Complications Admission Rate (PQI01)
  - PQI 08 Heart Failure Admission Rate (PQI08)
  - PQI 05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)
  - PQI 15 Asthma in Younger Adults Admission Rate (PQI15)
  - HIV Viral Load Suppression (HVL)
  - Plan All-Cause Readmissions Rate (PCR)

Questions

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Updates from CMS

NQF Medicaid MAP In-Person Meeting
May 2016

Karen Matsuoka PhD, CMCS Chief Quality Officer and Director, Division of Quality and Health Outcomes

)

Overarching Policy Considerations

Policy Topics

- IOM Vital Signs themes:
  - Alignment
  - Care Coordination
  - Community Linkage
- Measurement and Considerations

Institute of Medicine's (IOM) Vital Signs

- Overview of strengths, weaknesses, opportunities, and threats (SWOT) analysis of the domains and key elements in the IOM report with the Adult and Child Core Set measures

SWOT Analysis Results: Adult Core Set

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

Resonant Themes

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

Policy Issues for Consideration

- Alignment of measure concepts and measurement
- Alignment across multiple programs
- Alignment through standardization of definitions
- *Alignment across different payors (CMS Quality Measure Development Plan)*

Definition of Alignment from MAP Coordinating Committee

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

Technical Definition of Alignment

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

  Note: Alignment is not synonymous to harmonization.

Themes from Policy Issues Home Work Assignment

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

Homework Assignment Themes: ***Alignment Definition***

- ***Alignment Benefits***:
  - Promotes comparability
  - Simplifies and improves reporting
  - Reduces reporting burden
  - Purpose is to facilitate comparison of data across states and across various payors
  - Across levels of measurement
  - Across measure/measure programs and payment models

- ***Alignment Challenges*** :
  - Voluntary nature of Medicaid reporting
  - Aligning with other commercial/private payors
  - Innovation and variation in the field

Homework Assignment Themes: ***Alignment Operational Considerations***

- Measure mandate
- Methodology mandate
- Balance goal of measurement and implementation flexibility
- Temporal considerations when aligning across ages: infancy, childhood, youth, adolescent, adulthood…etc.
- Appearance of Comparability versus Actual Comparability
  - *Example: Was HbA1c measured (yes/no) versus levels of HbA1c*

Homework Assignment Themes: ***Alignment Operational Considerations Contd.***

- **Measures are only as good as their design**

- Measurement development elements/concepts for discussion:
  - Exclusions
  - Risk adjustment (clinical and SDS factors)
  - Transitory nature of the Medicaid population
  - Resource
  - Data

Themes from Policy Issues Home Work Assignment

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

Homework Assignment Themes: ***Data Collection Feasibility and Considerations***

- Claims data as being the limit of feasibility-due to voluntary nature of Medicaid reporting
- Resource limitations
- Alignment versus other values (ex: purpose, comprehensiveness)
- Alignment level (full, partial…etc.)
- Streamlining data acquisition and collection
- Identifying and developing outcomes measures and patient-reported outcome measures

Homework Assignment Themes: ***Data Collection Considerations***

- Ability to track system and population level health improvements
- Interoperability
- Measure design and exclusions (simplify measure constructs)
- Survey data-functional status, patient reported outcomes surveys such as CAHPS surveys
- Provider Reporting Systems such as MDS, Nursing Home Compare
- Track NQF SDS project re: data stratification

Data Collection: 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?*

Homework Assignment Themes: ***Data Stratification Considerations***

- Goal is to assess disparities in care
- Caution not to penalize safety net providers
- Important stratification parameters: race/ethnicity, geography, individuals with multiple chronic conditions, individuals with specific conditions such as persistent mental illness, children with complex medical needs
- Track NQF SDS project re: data stratification

Care Coordination

- Medicaid Adults: Chronic Health Condition Management
- Disability (physical, mental and developmental) and Care Coordination

- *How can care coordination be optimized for Medicaid adult population?*
- *What are some essential elements of care coordination for this population?*
- *How can the current core set be used to capture care coordination?*

Community Integration: Relevance

- IOM Vital Signs report of 2015 recently listed Engaged People as a critical domain, including Individual and Community Engagement elements
  - Recognizes the interrelatedness of these elements with others such as health and wellbeing
  - Acknowledges involvement of range of stakeholders and wide variation in individual and community interests and resources

Community Linkage: Key Attributes

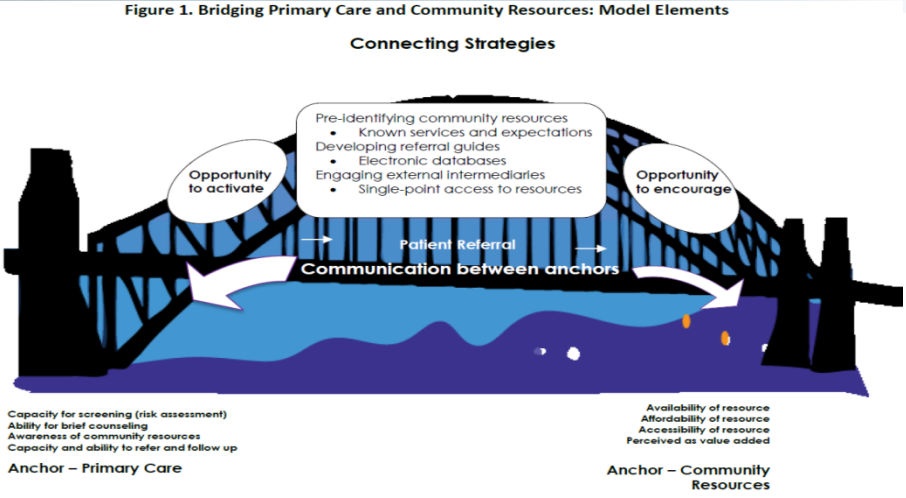
- Linking clinical care with resources in the community
- Linking clinical providers with social service providers
- Activating patient and encouraging patient participation
- Increasing awareness of community resources
- Referral follow-ups
- Addressing availability, affordability and accessibility of resources in the community

Discussion

- *How can community linkage be optimized for Medicaid adult population?*
- *How can data that is currently being collected be maximized and stretched to capture community linkages?*

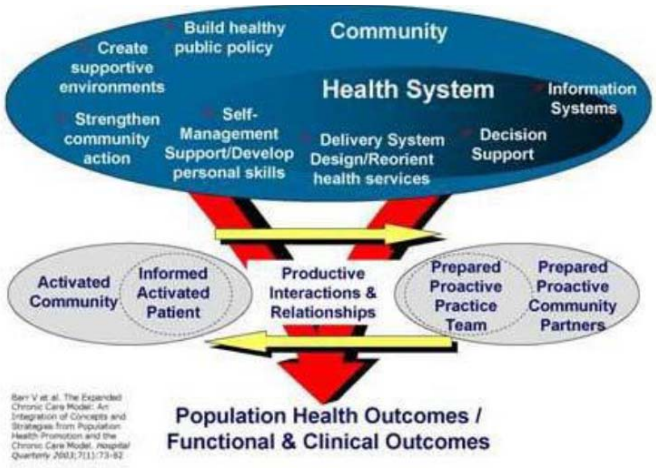
Community Linkage: *Bridging Clinical Care with Community Resources*

Figure 1. Bridging Primary Care and Community Resources: Model Elements



Minnesota Department of Health. Statewide Health Improvement Program. Clinical-Community Linkages for Prevention. Guide for Implementation FY2014-2015.

Community Linkage: *The Expanded Chronic Care Model*



Barr, V.J., Robinson, S., Marin-Link, B., et al. (2003). The Expanded Chronic Care Model: Integrating Population Health Promotion. Available at http://www.longwoods.com/content/16763. Accessed April 25, 2016.

Discussion

- How can care coordination and community linkage be fostered within the adult Medicaid population?
- What are the essential elements for such efforts to be successful?

Break

State Perspectives Panel

Julia Logan, MD, PhD
Chief Quality Officer, California Department of Health Care Services

Measurement and Reporting in California's Medicaid Program

JULIA LOGAN MD, MPH

CHIEF QUALITY OFFICER
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

55

Overview

1. Medi-Cal Demographics
2. Aiming for Alignment in California
3. Medi-Cal 2020: Care Coordination and Community Integration
4. Driving Quality at Medi-Cal
5. Measure Reporting Mechanisms: EAS and AMQG
6. Reporting and Measurement Challenges of the CMS Core Set
7. Priority Areas in Need of Practical and High-Quality Measures

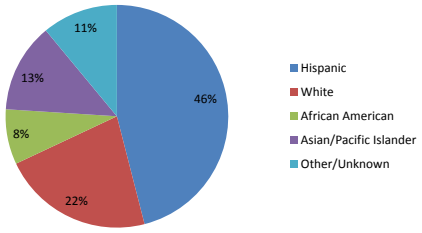
56

Medi-Cal's Demographics

- More than 13 million beneficiaries
- 10,000,000+ in Managed Care
- 23 Full-Scope Managed Care plans in all 58 counties
- Almost 90% in Managed Care

.

Race/Ethnicity of Medi-Cal Beneficiaries, 9/2015



57

Aiming for Alignment in California

58

Aiming for Alignment in California

- Let's Get Healthy California
- Medi-Cal 2020: 1115 Waiver
- Statewide Workgroup on Overuse
- Statewide Workgroup on High-Cost Pharmaceuticals
- Measure alignment with 3 large purchasers
  - ➢Challenges and opportunities

DHCS
California Department of HealthCareServices

COVERED CALIFORNIA

CalPERS

59

Medi-Cal 2020

- Medi-Cal 2020 is the state's renewed 1115 waiver, approved on December 30, 2015.
- Waiver renewal extends through December 31, 2020. California received approval for four major initiatives:
  - Public Hospital Redesign and Incentives in Medi-Cal (PRIME)
  - Whole Person Care (WPC) Pilots
  - Global Payment Program (GPP)
  - Dental Transformation Initiative (DTI)
- The waiver establishes a foundation to support the transition to value-based purchasing.
- Opportunities to test innovative measures

60

Key Medi-Cal Programs

Whole-Person Care	Health Homes	Coordinated Care Initiative	PRIME
• Voluntary, county-based initiative. • Coordination of health, behavioral health, and social services for Medi-Cal beneficiaries who are high utilizers. • A five-year program. Pilot applications are expected to be due on July 1, 2016.	• Led by Medi-Cal managed care plans in counties scheduled for implementation. • Supports the development of a network of providers to integrate and coordinate primary, acute, and behavioral health care for high risk Medi-Cal beneficiaries. • First implementation phase in January 2017.	• Pilot program in seven counties, led by Cal MediConnect plans and Medi-Cal managed care plans. • Promotes coordinated care for dual eligibles by combining a beneficiary's Medi-Cal and Medicare benefits into one health plan. • A three-year pilot with authority through 2017.	• Funding for Designated Public Hospitals (DPH) and District/Municipal Public Hospitals (DMPH)throughout the state. • Provides incentives to improve the way care is delivered and to transition to Alternative Payment Models (APMs). • A five-year program. Five-year plans will be approved by June 3, 2016.

61

Driving Quality at Medi-Cal

- Managed Care Plan Quality requirements:
  - Performance Improvement Plans
  - PDSA Cycles
- Ongoing QI Projects/Initiatives:
  - Immunizations
  - Opioid Overuse and Misuse
  - Obesity Prevention
  - Medicaid Incentives to Quit Smoking
  - Million Hearts Initiative
  - Maternal Health: Postpartum Care and Improving C-Section rates

62

Measure Reporting Mechanisms

Program-wide reporting to CMS via Adult Medicaid Quality Grant

Reporting required for the Managed Care plans via the External Accountability Set (EAS)

- EAS set of quality measures that support the DHCS Quality Strategy and the Managed Care Quality Strategy Report
- EAS Committee utilizes NQF criteria

63

2015 Medi-Cal Managed Care Adult External Accountability Set

CMS Adult Core Set	Measure Name
Yes-modified	**All-Cause Readmissions**
No	Ambulatory Care: Outpatient Visits
No	Ambulatory Care: ED Visits
Yes	**Annual Monitoring for Patients on Persistent Medications**
No	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis
Yes	**Cervical Cancer Screening**
No	Comprehensive Diabetes Care: Retinal Exam
Yes	**Comprehensive Diabetes Care: HgA1c Testing**
Yes	**Comprehensive Diabetes Care: Poor Control (HgA1c >9%)**
No	Comprehensive Diabetes Care: Control (HgA1c <8%)
No	Comprehensive Diabetes Care: Medical Attention for Nephropathy
No	Comprehensive Diabetes Care: Blood Pressure Control
Yes	**Controlling High Blood Pressure**
No	Medical Management for Asthma
Yes	**Postpartum Care**
No	Use of Imaging Studies for Low Back Pain

64

Adult Medicaid Quality Grant

In 2015, California reported 16 of the 26 Adult Core Measures.

- 11 were based on administrative data
- 4 were based on administrative + MCP reporting
- 1 was based on MCP reporting

Over the course of the grant, California was able to report on HIV Viral Load suppression, Elective delivery, and Antenatal steroids.

65

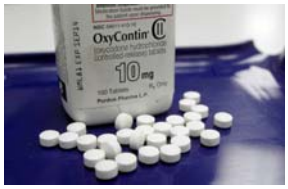
Reporting and Measurement Challenges within CMS Core Set

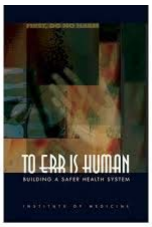
1. Dually Eligible:
   - Medi-Cal only has portion of the claims
   - Measures that focus on hospital events are challenging to produce with admin data
2. Encounter Data Quality issues
3. Clinical data not available in Medi-Cal data set
4. Lack of Provider data available
5. Look-Back required (Cervical Cancer Screening measure) difficult with enlarging enrollment
6. PQI measures: Dually Eligible and Limited Scope Benefits
7. CAHPS survey: Low response rate

66

Areas in Need of High Quality and Practical Measures

- Promoting Outpatient Safety
- Controlling the Opioid Epidemic
- Implementing Choosing Wisely
- Integrating Behavioral Health
- Implementing Palliative Care Services
- Ensuring Access





Choosing Wisely
An initiative of the ABIM Foundation

67

68

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?
- What are states experiences with policy-level issues such as alignment, care coordination and community linkage?
- Which policy issues have been the most challenging for states? Please consider alignment, care coordination and community linkage during this discussion.
- What are states' most notable successes related to quality measurement? How are they using the measures?

State Perspectives Panel

Charles Gallia PhD
Senior Policy Advisor for Research and Evaluation, Oregon Health Authority

Measures Applications Partnership

Medicaid Child and Adult Task Forces

May, 2016, Charles Gallia

Healthcare Quality Measurement

A snapshot of different perspectives

- National
- Multi-state
- State, Plan, Clinic, and Physician

National view

- CHIPRA
  - 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, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children*
- AHRQ SNAC 1st round of review
  - Lots great measures through the PQMP and COEs
  - Few added

Some T-CHIC Lessons

Initial Core Measure	Alaska		Oregon		West Virginia	
	2012	2014	2012	2014	2012	2014
Timeliness of Prenatal Care			63.2%	82.9%	89.0%	82.3%
Frequency of Ongoing Prenatal Care (≥81%)			11.4%		78.3%	79.1%
Percentage of Live Births <2500 grams	7.4%	6.8%	6.5%	5.6%		
Cesarean rate for nulliparous singleton vertex	15.2%		24.2%		36.9%	34.6%
Childhood Immunization (Combination 2)			85.8%	67.8%	64.9%	69.1%
Immunizations for Adolescent (Combination)			48.7%	55.1%	71.5%	74.0%
Weight Assessment and Counseling			0.8%*	0.4%	31.8%	34.2%
Developmental Screening by 12 months	9.2%	6.6%	18.5%	42.6%	40.1%	43.5%
Chlamydia Screening for Women	37.0%	44.7%	47.8%	43.2%	37.5%	
Well-Child Visits First15 Months of Life (6+ visits)	43.4%	67.0%	55.4%	50.2%	69.2%	77.2%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years	46.7%	48.1%	54.8%	76.1%	67.3%	72.6%
Adolescent Well-Care Visits	25.9%	30.6%	25.9%	38.2%	46.1%	47.0%
Received Preventive Dental	43.4%	45.6%		43.2%	41.6%	35.5%
Access to PCPs	85.1%	84.4%	86.7%	89.8%	88.8%	88.0%
Pharyngitis: Appropriate Testing	66.0%		71.5%			
Otitis Media with Effusion						
Received Dental Treatment	27.4%			37.4%		
ED Visits per 1000 member months	47.2%	41.6%	38.2%	44.1%	7.0%	
Pediatric Catheter-Associated Blood Stream Infection						
Asthma: ED Visits	12.9%		8.5%	14.8%		
ADHD Follow-up (Initiation phase)	55.7%	59.3%	52.3%	57.7%	100.0%	99.1%
Hemoglobin A1C Testing			74.5%	86.7%		
Follow-up after mental illness related hospitalization (7-day)	30.3%	13.9%	53.5%	26.3%	57.2%	65.6%
CAHPS [T-CHIC Modified Version] (submission yes or no)	Y	Y	Y	Y	Y	N

Core Set Lessons

- State Medicaid/CHIP measures require modifications from the technical specification provided by NCQA.
- Stratifying measures by any population characteristic, such as race or special heath care needs, makes the denominators produces too small an N for analysis, especially at a practice level let alone the numerators, are often too small for statistical analysis.
  - This same limitation impacts trending
- Knowing what measures are being developed at the federal level for states' use is not as clear as it should be. States need lead to making plans to incorporate the measures. The new measures are often improvements the states are seeking but don't know about.

Core Set Lessons

- Medicaid population characteristic considerations
  - Measures that require coverage and provider stability are more difficult to produce.
  - Measures do not emphasize the programmatic eligibility groups- medically fragile children or those who became impoverished as a result of medical costs, or demographics of the Medicaid population and are more limited to health systems rather than population health over time.
  - Measures that span more than one year are difficult to produce because encounter data is reliant on claims submitted while covered by Medicaid/CHIP.
  - Population instability and mobility may mean we are missing the population that is 'most vulnerable' and most in need of care, yet omitted from quality of care assessments
  - Age segmentations in measures, even adult versus child, may not make programmatic or clinical sense. Smoking, alcohol and drug use, and pregnancy happen before age 18.

Core Set Lessons

- State Medicaid/CHIP measures require modifications from the technical specification provided by NCQA.
- Stratifying measures by any population characteristic, such as race or special heath care needs, makes the denominators produces too small an N for analysis, especially at a practice level let alone the numerators, are often too small for statistical analysis.
  - This same limitation impacts trending
- Knowing what measures are being developed at the federal level for states' use is not as clear as it should be. States need lead to making plans to incorporate the measures. The new measures are often improvements the states are seeking but don't know about.
- Medicaid population characteristic considerations
  - Measures that require coverage and provider stability are more difficult to produce.
  - Measures do not emphasize the programmatic eligibility groups- medically fragile children or those who became impoverished as a result of medical costs, or demographics of the Medicaid population and are more limited to health systems rather than population health over time.
  - Measures that span more than one year are difficult to produce because encounter data is reliant on claims submitted while covered by Medicaid/CHIP.
  - Population instability and mobility may mean we are missing the population that is 'most vulnerable' and most in need of care, yet omitted from quality of care assessments
  - Age segmentations in measures, even adult versus child, may not make programmatic or clinical sense. Smoking, alcohol and drug use, and pregnancy happen before age 18.
-

Core Set Lessons

- Measures that are more general, for example, general ambulatory care and emergency department use, are not as 'actionable' or easy to understand in terms of what constitutes good or optimal performance, as more discrete measures such as immunizations.
- The current roster of measures has some value and importance to providers, but their practical utility is not necessarily obvious.
- The most compelling information for practices, oftentimes, was formally presented patient feedback, through the C&G survey or patients' participation on panels and boards helping to guide interpretation of results. Patients like those measures more than anything.

Core Set Lessons

- No time : practices or at state
  - The overwhelming number of measures physicians are asked to produce results in them not going through the process to validate them, which, in turn, means they are easy to discount. This issue surfaced with the immunization registry information several times.
  - Yet, run-charts and registries frequently were seen by the clinicians as more worthwhile time investments than retrospective assessments of clinical performance.
  - The state has little time to analyze results. The cycle between starting each measure round leaves little or no staff time to examine the results, assess the implications, and develop courses of action.
  - There is little or no opportunity to examine relationships between measures.
- No path of action or resources
- No state staff
- Change expectations unclear
  - There is little knowledge about performance sensitivity or basis for knowing when variations from year to year are of concern, or when similar measures show conflicting results.

Core Set Lessons

- Notice: the term *burden* has not been used

Two examples of changes & needs Health Equity Index and CAHPs

Charles Gallia
Rusha Grinstead

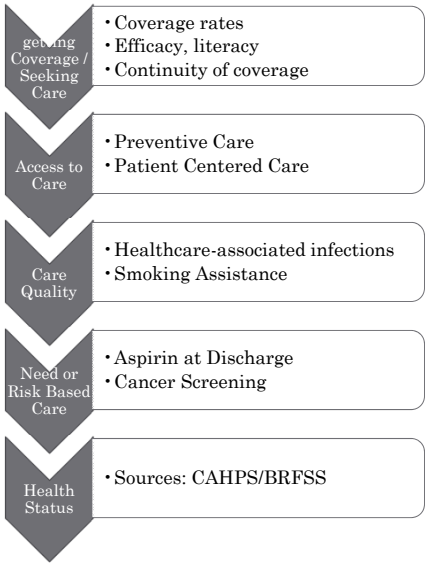
For the Index

Initial concept for the health equity index was based on several key documents:

- National Quality Forum's National Voluntary Consensus Standards for Ambulatory Care – Measuring Healthcare Disparities (2008)
- Institute of Medicine. Access to Health Care in America: A Model for Monitoring Access (1993)
- Institute of Medicine. Unequal Treatment: What Healthcare Providers Need to Know about Racial and Ethnic Disparities in Health Care (2002)

82

Disparities Framework



83

Process: Parameters for the Index

MUST

- address the Medicaid population
- use available data
- be statistically feasible
- address multiple factors (beyond race/ethnicity)

IDEALLY

- based on current Incentive, Performance Improvement Topic, or State performance metrics
- generate meaningful results
- be understandable
- allow for tracking over time

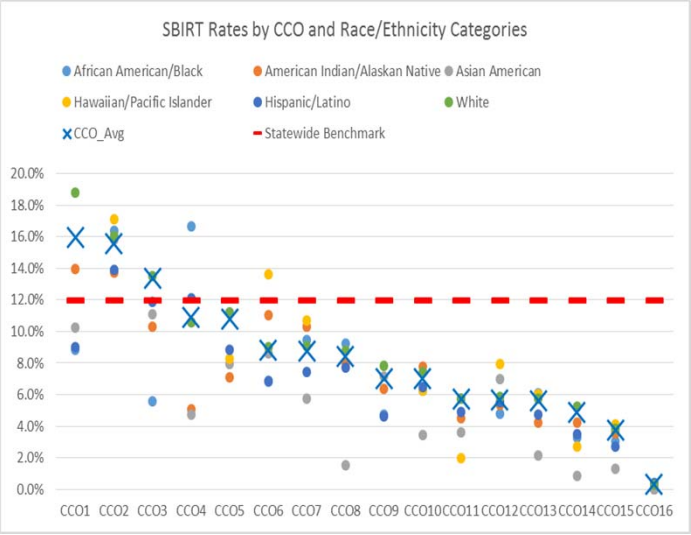
84

Issues We Expected to Encounter

- Small numbers
- Missing data measurement
- Equity vs Disparities
  - Relative versus absolute
- Measuring change and encouraging improvement
- Differences in CCO populations
- Statistical soundness versus ease of use
- Useable for language, gender, disability, & special health care needs

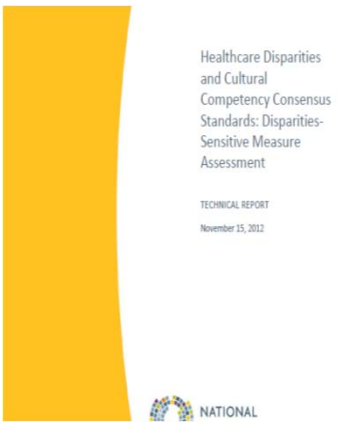
85

Many options and implications



86

Then we turned the NQF report



Report identified set of 76 measures that are "disparities-sensitive," based on

- Prevalence of conditions
- Gaps in quality of care
- Community impact
- Communication challenges
- Clinical discretion
- Social determinants of health

http://www.qualityforum.org/Publications/2012/11/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards__Disparities-Sensitive_Measure_Assessment.aspx

87

CAHPs – Issues and limitations

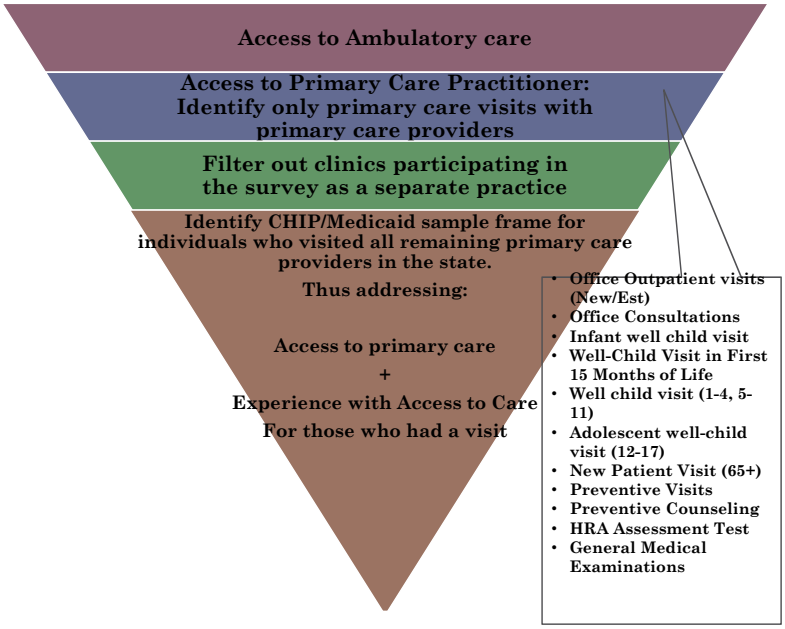
- The health plan version is designed to compare health insurance companies, not fee for service providers.
- Even in states with managed care, results are not often shared nor relevant to practices.
- The health plan version asks about getting care and services, even if there was no primary care visit
- The Clinician and Group version requires a visit, so everyone who is surveyed has had access.
- CMS seeks assurance about access and quality for whom they provide FFP, with priority on children with special health care needs, C&G does neither.

	CAHPS Health Plan 5.0 ADULT AND CHILD CORE MEASURE	Clinician and Group	C&G PCMH	T-CHIC **Revised** C&G- PCMH
Who is included?	Medicaid continuous enrolled in a Health Plan > 6 mo.	Had a visit in the last 12 months, no Insurance coverage	Had a visit in the last 12 months, no insurance coverage	Access to care: outpatient visits rate measure, narrowed to primary care, all payers-insurance coverage
How are they surveyed?	Both mailed and telephone	Mailing emphasis	Several choices, minor follow-up RR = <25%	Pre-notices, pre-work, Telephone emphasis in AK
Performance Benchmarks	CAHPS Database & NCQA	CAHPS Database & NCQA	NCQA emerging	T-CHIC plus new practices (n = 50)
Access	Access to: Emergency Care, Specialist Care, Special Equipment, Routine Care	Access: after hours, getting timely appointments, and to information	Same as C&G	Same as C&G (Sample frame can address overall access, specialty care and ED)
Special populations	Children with Chronic Conditions module and adults…race and ethnicity	none	none	*Includes both Children with Chronic Conditions and Adult chronic conditions*
Care Coordination	For Children working with schools, and provider awareness, for adults, provider awareness		Provider seemed informed and up-to-date about the care	*Expanded to include needing extra help coordinating care*
Shared Decision-making	Children with Chronic Conditions module and adults…	Related to Rx only	Related to RX only and for adults only	*Include for both, and several on shared goals, for those making health care choices*

CAHPs – Issues and Limitations

- Doesn't reflect perinatal care.
- Multiple versions and fielding methods.
- Annual- maybe
- Funding segmented by payer
- Analysis, reporting, and converting to action and improvement is very complex and states have limited capacity for analysis and interpretation.

One Solution



Discussion and recommendations

- Assess the sensitivity of measures to changes by number and time
- Identify those measures with added value-
  - Demonstrated that they reflect state Medicaid populations and their health priority areas
  - Are proven sensitive to disparities; including disability, gender, children with special health care needs
  - Are scalable and multi-purpose
- Rethink care-coordination
  - different between adults and children – provider to provider versus provider to community or school
- Rethink integration, from a patient's perspective
  - Systems and services, including 'reverse integration'

92

Discussion and recommendations continued

- Simplify the measures – e.g.. multiple well child visits only because of history
  - % of USPTF A&B for example, not single disease management but person centered, reflect provider, community and patient's priorities and values

  For monitoring and evaluations, a State responsibility, process measures are okay
- Start thinking more broadly about where and how care is provided- behavioral health home, birthing centers, 'retail' location.
- Different managed care organizations have different community relations. Multi-line, national insurers and education and social services relationships integration are not the same as more local health systems.
- Life course versus program criteria – get to a single comprehensive set that is parsimonious, and organic

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?
- What are states experiences with policy-level issues such as alignment, care coordination and community linkage?
- Which policy issues have been the most challenging for states? Please consider alignment, care coordination and community linkage during this discussion.
- What are states' most notable successes related to quality measurement? How are they using the measures?

Guidance for Future Medicaid Core Sets

- What changes to the reporting programs would assist states and CMS in meeting its goals?
- How should policy considerations be included in the selection and discussion of measures for the Core Sets?

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?

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

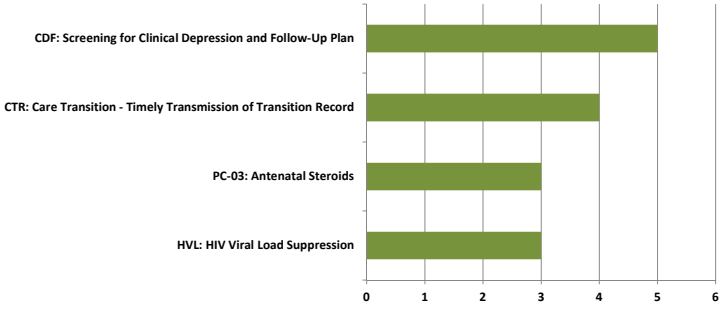
Decision Categories

- 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 by Measure Review: Measures with Five or Fewer States 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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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

Staff Review: Measures for Potential Removal

- 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?

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 and Break

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

MAP's 2015 Recommendations to Address High Priority Gaps

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

Note: An asterisk (*) denotes newly identified gap areas

MAP's 2015 Recommendations to Address High Priority Gaps

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Note: An asterisk (*) denotes newly identified gap areas

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 Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Gap Areas with Measures Currently Available

- Perinatal / Maternity Care (will be discussed tomorrow)
- Health Related Quality of Life (8)
- Behavioral health/Substance Use (24)
- Home and Community Based Service(s)(1)
- Engagement & Activation in Care (2)
- Workforce (1)
  - *Some measure gap areas may 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 one measure. TaskForce members have selected five measures that appear to be a good fit.*

Recommendations for Strengthening the Adult Core Set – Staff Pick

Available Measures

NQF #	Measure Name	Measure Steward
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling	AMA-PCPI

2152 – Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

NQF Endorsed – Steward: AMA-convened Physician Consortium for Performance Improvement

QPS Link: http://www.qualityforum.org/qps/2152

Description:	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Numerator Statement	Patients who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user
Denominator Statement	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two-year measurement period
Exclusions:	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)
Data Source:	Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry
Type:	Process

Recommendations for Strengthening the Adult Core Set - Results from the homework

Available Measures

NQF #	Measure Name	Measure Steward
0541	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Pharmacy Quality Alliance
0055	Comprehensive Diabetes Care: Eye Exam (performed)	National Committee for Quality Assurance
0027	Medical Assistance With Smoking and Tobacco Use Cessation (MSC)	National Committee for Quality Assurance
2111	Antipsychotic Use in Persons with Dementia	Pharmacy Quality Alliance
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	National Committee for Quality Assurance

0055 – Comprehensive Diabetes Care: Eye Exam (performed)

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0055

Description:	Patients 18-75 with diabetes type 1 or type 2 who had an eye exam performed
Numerator Statement	Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following: -a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year OR –a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. For exams performed in the year prior to the measurement year, a result must be available.
Denominator Statement	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Exclusions:	Exclusions (optional): -Exclude patients who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year. AND -Exclude patients who meet either of the following criteria: -A diagnosis of polycystic ovaries, in any setting, any time in the patient's history through December 31 of the measurement year. -A diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy
Type:	Process

0541 – Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

NQF Endorsed – Steward: Pharmacy Quality Alliance

QPS Link: http://www.qualityforum.org/qps/0541

Description:	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins. A higher score indicates better quality.
Numerator Statement	The number of patients who met the PDC threshold during the measurement year for each therapeutic category separately. Follow the steps below for each patient to determine whether the patient meets the PDC threshold.
Denominator Statement	Patients age 18 years and older who were dispensed at least two prescriptions in a specific therapeutic category on two unique dates of service during the measurement year.
Exclusions:	Exclusion criteria for the PDC category of Diabetes medications: Patients who have one or more prescriptions for insulin in the measurement period.
Data Source:	Administrative claims
Type:	Process

0027– Medical Assistance With Smoking and Tobacco Use Cessation (MSC)

NQF Endorsed – National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/0027

Description:	Assesses different facets of providing medical assistance with smoking and tobacco use cessation:
Numerator Statement	Component 1: Advising Smokers and Tobacco Users to Quit (ASTQ) Patients who received advice to quit smoking or using tobacco from their doctor or health provider Component 2: Discussing Cessation Medications (DSCM) Patients who discussed or received recommendations on smoking or tobacco cessation medications from their doctor or health provider Component 3: Discussing Cessation Strategies (DSCS) Patients who discussed or received recommendations on smoking or tobacco cessation methods and strategies other than medication from their doctor or health provider
Denominator Statement	Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the last 6 months for Medicaid and Medicare.
Exclusions:	none
Data Source:	Patient Reported Data/Survey
Type:	Process

2111 – Antipsychotic Use in Persons with Dementia

NQF Endorsed – Steward: Pharmacy Quality Alliance

QPS Link: http://www.qualityforum.org/qps/2111

Description:	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.
Numerator Statement	The number of patients in the denominator who had at least one prescription and > 30 days supply for any antipsychotic medication during the measurement period and do not have a diagnosis of schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome.
Denominator Statement	All patients 65 years of age and older continuously enrolled during the measurement period with a diagnosis of dementia and/or two or more prescription claims within the measurement year for a cholinesterase inhibitor or an NMDA receptor antagonist within the measurement year where the sum of days supply is >60.
Exclusions:	N/A
Data Source:	Administrative claims
Type:	Process

2607 – Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/2607

Description:	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA.
Numerator Statement	Patients whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year. The intermediate outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Denominator Statement	Patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2) during the measurement year or the year before.
Exclusions:	See Excel
Data Source:	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy
Type:	Outcome

Recommendations for Strengthening the Adult Core Set

Task Force Votes to Recommend Each Measure for Inclusion

- Vote to support (or conditionally support) inclusion of:
  - 2152 – Preventive Care and Screening: Unhealthy Alcohol
  - *0055 – Comprehensive Diabetes Care: Eye Exam (performed)
  - *0541 – Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category
  - *2607 – Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
  - *2111 – Antipsychotic Use in Persons with Dementia
  - * 0027 – Medical Assistance With Smoking and Tobacco Use Sensation
- Are there other measures Task Force members would propose for addition?

* Denotes measures recommended by TF members

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 2015
  - #2602: Controlling High Blood Pressure for People with Serious Mental Illness
  - #1927: Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
  - Use of Opioids from Multiple Providers in Persons Without Cancer (not NQF-endorsed)
  - Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer

Prioritizing Remaining Measure Gap Areas

Gaps in the Medicaid Adult Core Set

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

Note: Asterisk (*) denotes newly identified gap areas

Gaps in the Medicaid Adult Core Set – Cont'd

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

Note: Asterisk (*) denotes newly identified gap areas.

Strategy for Filling High Priority Measure Gaps

- Have any of the gap areas been satisfied?
- Do other gaps need to be added?
- 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
CONVENED BY THE NATIONAL QUALITY FORUM

Measure Applications Partnership

Joint Medicaid Adult and Child Task Forces In-Person Meeting

NATIONAL QUALITY FORUM

Day 2 - May 25, 2016

Welcome and Review of Meeting Objectives

Introductions of the Child Task Force Members and Disclosures of Interest

Medicaid Child Task Force Membership

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

Organizational Members (*Voting*)

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

Medicaid Child Task Force Membership

Subject Matter Experts (*Voting*)

Richard Antonelli, MD
Luther Clark, MD

Organizational Member (*Non-Voting*)

National Association of Medicaid Directors	Deidre Gifford, MD, MPH

Federal Government Members (*Non-voting*)

Agency for Healthcare Research and Quality (AHRQ)	Kamila Mistry, PhD, MPH
Centers for Medicare & Medicaid Services (CMS)	Laura de Nobel, JD, RN
Health Resources and Services Administration (HRSA)	Gopal Singh, PhD
Office of the National Coordinator for Health IT (ONC)	David Hunt, MD

In-Person Meeting Objectives

- Consider states' experiences implementing the Medicaid Adult and Child Core Set
- Develop strategic recommendations for strengthening the Medicaid Adult and Child Core Set through identification of:
  - Priority measure gaps and potential measures to address them
  - Measures found to be ineffective and or topped out, for potential removal
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals
- Overarching policy issues to help inform Core Set Updates

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

MAP Medicaid Child and Adult Task Forces Charge

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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

Highlights from Day #1

- Adult Core Set Updates
- Policy Discussion Highlights
- Gap Area Changes and Updates

Updates from CMS

NQF Medicaid MAP Web Meeting
April 2016

Marsha Lillie-Blanton
Center for Medicaid and CHIP Services (CMCS)

CMS Oral Health Initiative

NQF Medicaid MAP Meeting
Washington, D.C.
May 25, 2016

Laurie Norris, JD
Senior Policy Advisory for Oral Health
Division of Quality and Health Outcomes
Center for Medicaid and CHIP Services
laurie.norris@cms.hhs.gov

Oral Health Initiative

- Aim: Increase by 10 percentage points the proportion of children receiving a **preventive dental service (PDENT)**
- National Goal:
  - FFY 11 Baseline = 42%
  - FFY 14 Progress = 45%
  - FFY 18 Goal = 52%
- Each state has its own baseline and goal.

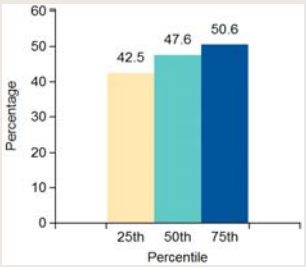
149

Snapshot of Current Performance - PDENT

Preventive Dental Services

Tooth decay, or dental caries, is one of the most common chronic diseases of children. The disease is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services. This measure assess the percentage of children ages 1 to 20 that received preventive dental services.

Percentage of Eligibles Who Received Preventive Dental Services, FFY 2014 (n = 51 states)



A median of

48 percent

of children ages 1 to 20 had a preventive dental service (51 states)

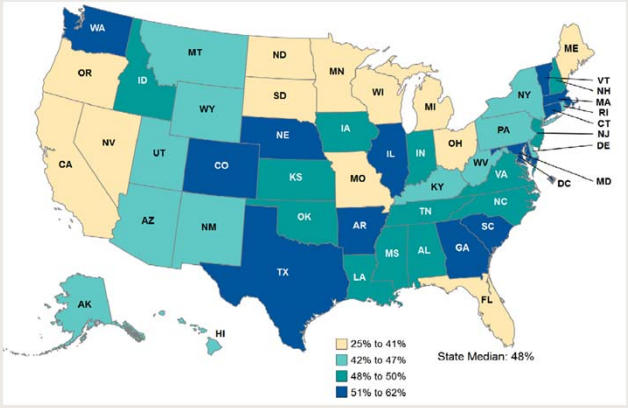
Source: Mathematica analysis of FFY 2014 Form CMS-416 reports as of September 29, 2015.
Note: This measure identifies the percentage of children ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.

Medicaid/CHIP Health Care Quality Measures

Snapshot of Current Performance - PDENT

Preventive Dental Services (continued)

Geographic Variation in the Percentage of Eligibles Who Received Preventive Dental Services, FFY 2014 (n = 51 states)



Source: Mathematica analysis of FFY 2014 Form CMS-416 reports as of September 29, 2015.

Medicaid/CHIP Health Care Quality Measures

Overview of Efforts: 2011-2015

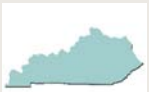
- 26 states submitted State Oral Health Action Plans
- 13 states participated in learning collaboratives
- CMS hosted 17 webinars
- CMS developed technical assistance tools:
  - Keep Kids Smiling compilation of promising approaches
  - Free "Think Teeth" consumer education materials
  - Oral health PIP template and handbooks
  - Online training modules for reporting 416 dental data
  - Medicaid Dental Contracting Toolkit (coming soon)
- Intensive work with individual states

152

Examples of Work in Three States

- **Florida 2013:** CMS used 1115 waiver approval process to get provisions in the STCs focused on improving stakeholder engagement and data quality, and requiring oral health Performance Improvement Projects.
- State placed PDENT improvement targets and sanctions in MCO contract.
- PDENT performance has improved from 19% in FY 11 to 31% in FY 15.

- **California 2015**: CMS used 1115 delivery system reform process to get $740M allocated to dental improvement over five years.
- Focus will be primarily on provider incentives for PDENT and continuity of care through provider incentives.
- At least 10 percentage points of improvement required by 2020; state can earn additional $10M by exceeding targets, up to 15 percentage points of improvement.



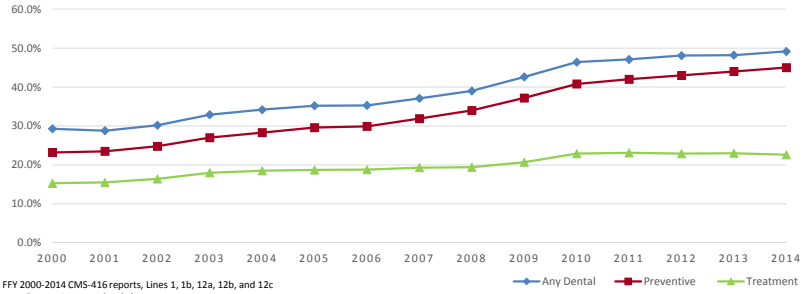
- **Kentucky 2015:** CMS hosted a 9-month learning collaborative for Kentucky Medicaid and their 5 MCOs to develop collaborative oral health PIPs.
- The aim is to increase the proportion of children age 3 and under who receive an oral health evaluation and a fluoride varnish treatment every six months.
- PDENT performance has improved from 44% in FFY 11 to 45% in FFY 15.

ORAL HEALTH Initiative

153

Steady Progress on Access to Dental Care

Proportion of Children, Age 1-20, Enrolled in Medicaid for at Least 90 Continuous Days Who Received Dental Services FFY 2000 – FFY 2014



Source: FFY 2000-2014 CMS-416 reports, Lines 1, 1b, 12a, 12b, and 12c
Note: Data reflect updates as of 10/2/15.
1 With the exception of FL and OH, the national FFY 2011 percentage used FFY 2011 data reported by states to CMS as of May 28, 2013. Due to errors in FL's FFY 2011 data that could not be corrected, the state's FFY 2012 data were used in the FFY 2011 national percentage. As FFY 2011 data for OH were reported after May 28, 2013, these data were not included in the FFY 2011 national percentage.
2 With the exception of CT and OH, the national FFY 2012 percentage used data reported by states to CMS as of April 10, 2014. FFY 2011 data for CT were used in the FFY 2012 national percentage because final FFY 2012 data for CT were not available as of April 10, 2014. As FFY 2011 data for OH were not used in the FFY 2011 national percentage, OH's FFY 2012 data were similarly excluded from the FFY 2012 national percentage.
3 With the exception of OH, the national FFY 2013 percentage used data reported by states to CMS as of December 15, 2014. As FFY 2011 data for OH were not used in the FFY 2011 national percentage, OH's FFY 2013 data were similarly excluded from the FFY 2013 national percentage.
4 With the exception OH, the national FFY 2014 percentage used data reported by states as of October 1, 2015. As FFY 2011 data for OH data were not used in the FFY 2011 national percentage, OH's FFY 2014 data were similarly excluded from the FFY 2014 national percentage.

ORAL HEALTH Initiative

154

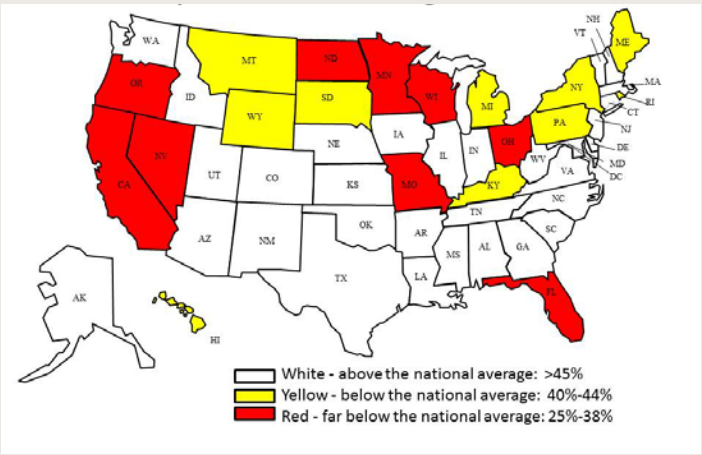
Oral Health Initiative 2.0: 2016 – 2018

Step	Action
1	Build on OHI 1.0: spread what works and use TA tools
2	Prioritize states; conduct assessments to identify components of high-performing delivery systems that are not already in place
3	Communicate with state Medicaid leadership; let states know what we've found; share data
4	Engage with states using CMS/state interactions; when the state comes to us, engage them in the context of their request; reach out to priority states; develop improvement targets and strategies
5	Document improvement targets and strategies where appropriate such as STCs, approval letters, etc.
6	State takes action

ORAL HEALTH Initiative

155

Prioritizing States Based on Performance on "Preventive Dental Services"



ORAL HEALTH Initiative

156

CMCS Maternal and Infant Health Initiative

In July 2014, CMCS launched a Maternal and Infant Health Initiative in collaboration with states to:

1) Increase the rate and content of postpartum visits; and
2) Increase the use of effective methods of contraception in Medicaid and CHIP.

This initiative builds on the work of an Expert Panel that identified strategies CMS and states could undertake to improve maternal and infant outcomes in Medicaid and CHIP.

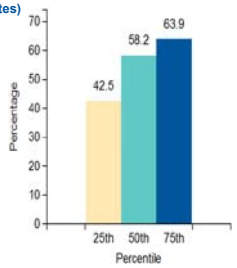
Centers for Medicare & Medicaid Services MATERNAL & INFANT HEALTH Initiative

157

Postpartum Care (PPC) Rate

Postpartum visits provide an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions, mental health status, and family planning. They also provide an opportunity for counseling on nutrition and breastfeeding and other preventive health issues. CMS's Maternal and Infant Health Initiative aims to increase by 10 percentage points the rate of postpartum visits among women in Medicaid and CHIP in at least 20 states over a 3-year period.

Percentage of Women Delivering a Live Birth with a Postpartum Care Visit on or Between 21 and 56 Days after Delivery, FFY 2014 (n = 34 states)



Source: Mathematica analysis of FFY 2014 Adult CARTS

Notes: This measure identifies 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 that had a postpartum visit on or between 21 and 56 days after delivery.

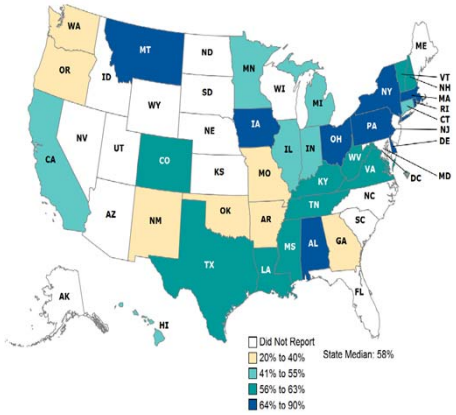
A median of 58 percent of women delivering a live birth had a postpartum care visit on or between 21 and 56 days after delivery (34 states)

Centers for Medicare & Medicaid Services MATERNAL & INFANT HEALTH Initiative

22

Postpartum Care (PPC) Rate

Geographic Variation in the Percentage of Women Delivering a Live Birth with a Postpartum Care Visit on or Between 21 and 56 Days after Delivery, FFY 2014 (n = 34 states)

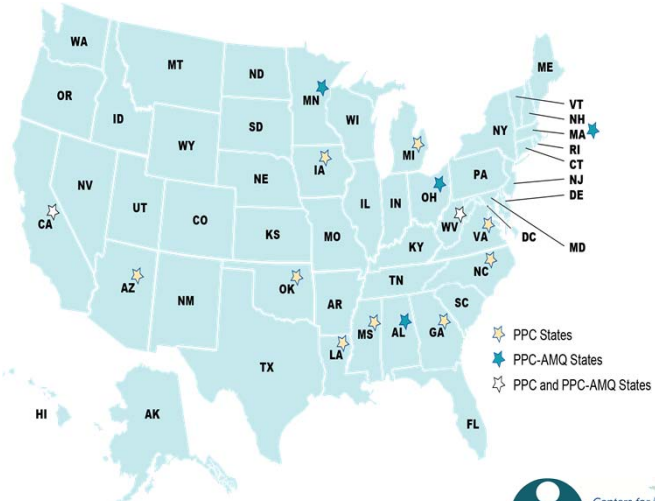


Source: Mathematica analysis of FFY 2014 Adult CARTS reports as of May 8, 2015.

Centers for Medicare & Medicaid Services MATERNAL & INFANT HEALTH Initiative

23

Improving Postpartum Care Action Learning Series Participating States



*PPC -- Postpartum Care Action Learning Series
*AMQ – Adult Medicaid Quality Grant

Centers for Medicare & Medicaid Services MATERNAL & INFANT HEALTH Initiative

160

Accomplishments

- Pilot sites were engaged in developing and/or implementing quality improvement projects to increase and improve the postpartum care visit.
- States identified a diverse range of opportunities to improve postpartum care, including care coordination, appointment reminders, home visits, provider education, clinical checklists, provider and/or staff incentives, transportation access, and policy changes such as removing postpartum care from global billing
- States focus on key aspects of health, such as contraception, chronic conditions, transitions to primary care, breastfeeding, and postpartum depression as part of the postpartum care visit
- States developed several useful tools related to improving postpartum care

Centers for Medicare & Medicaid Services MATERNAL & INFANT HEALTH Initiative

161

Challenges

- Global billing limits accountability for ensuring the PPC visit occurs since billing and payment for the maternity care episode occurs at time of delivery
- Tracking the PPC visit is burdensome for states with global billing payments
- The measure does not recognize the range of routine care the postpartum population requires outside of the timeframe defined in the measure
- The measure does not adequately address the content of visit

Centers for Medicare & Medicaid Services MATERNAL & INFANT HEALTH Initiative

162

Opportunities and Next Steps

- Tracking the PPC visit rate is an important mechanism to drive quality improvement
  - Using data to assess the effectiveness of tests of change is an important step in developing Medicaid and CHIP policies to drive improvement
- State Medicaid and CHIP programs can drive improvement in postpartum care visits in partnership with managed care organizations through their links to providers and to members
- Reforms in the payment methods for postpartum care require further modeling, testing, and evaluation

Centers for Medicare & Medicaid Services
MATERNAL & INFANT HEALTH Initiative

163

Issues of Shared Importance: Adult & Child Continuum of Care; Looking at Measures Across the Core Set

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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/0024)

Measure Alignment: Task Force and State Panelist Discussion

Opportunities for Alignment

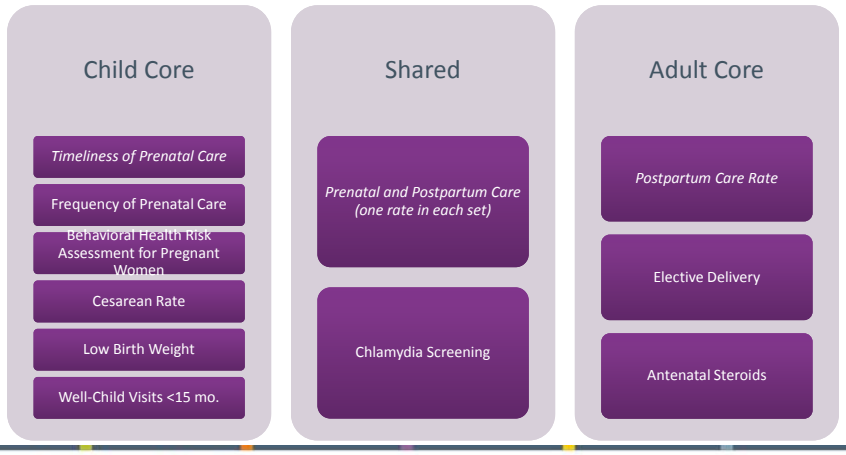
- Between Core Sets
  - Is further alignment of measures needed between the Adult and Child Core Sets?
- With Other Programs
  - Does it help states if measures selected for the Core Sets are used for other reporting requirements?
  - If so, which other measurement programs are most important for alignment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

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



Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Perinatal and Maternity Care Measures in Child/Adult Core Sets Submitted for Maintenance Review

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Potential Perinatal / Maternity Care Measures

- 23 total measures on perinatal/maternity care could be considered
  - 4 endorsed
  - 19 not endorsed, mostly from Pediatric Quality Measures Program
- Includes 3 measures recommended in 2015 and not yet added
- Topics include:
  - Capacity of facility to handle high-risk delivery
  - Temperature management
  - Safety / complications / obstetric trauma
  - Contraception access/use
  - Other
- There are no staff picks for this gap area.
- Updates on measures 1391 (included in child core set) and 1517 (included in both core sets)

1391 - Frequency of Ongoing Prenatal Care (FPC)

Steward: National Committee for Quality Assurance

The Perinatal Committee did not recommend this measure for continued endorsement because:

- Evidence indicates that outcomes are worse if a mother has no prenatal care, however….there is no empirical evidence that relates frequency of prenatal visits to outcomes for moms and babies. ACOG guidelines are based on opinion only.
- Measure is called a “proxy for access” but does not assess the capacity of a plan to provide prenatal care. The measure reflects the challenges women face - taking time off work, transportation, child care.
- Measure inhibits innovative strategies and new models of care.

1391 – Frequency of Ongoing Prenatal Care (FPC)

Steward: National Committee for Quality Assurance

- 28 states reported FFY 2014
  - All states reported the measure using the Child Core Set specifications.
- Reasons states did not report (n=23):
  - The data were not available (13)
  - Other reasons: Information was not collected because of budget constraints, staff constraints, data source not easily accessible (i.e., requires medical record review and data linkage), and information not collected.

1517 Prenatal and Postpartum Care (PPC)

Steward: National Committee for Quality Assurance

The Perinatal Committee did not reach consensus because:

- No evidence for the timing of visits – insufficient with exception
- Earlier postpartum visits often indicated: breastfeeding support; post-op wound check; follow-up for BP, depression
- Moms being seen in pediatrics for depression screening, breastfeeding support
- Concerns about validity: limited number of codes; nothing about the content of the visits;
- Usability: “Lots of effort against headwinds”; discourages earlier care; unclear whether quality is improving
- Reluctant to remove until something better is available

1517 – Prenatal and Postpartum Care (PPC)

Steward: National Committee for Quality Assurance

Timeliness of Prenatal Care (Child Core Set)

- 36 states reported FFY 2014
  - All states reported the measure using the Child Core Set specifications, which were based on HEDIS 2014 specifications.
- Reasons states did not report (n=15):
  - The data were not available (9)
  - Other reasons: Information was not collected because of staff constraints, data inconsistencies/accuracy, data source not easily accessible (i.e., requires medical record review and data linkage), and information not collected.

Postpartum Care (Adult Core Set)

- 34 states reported FFY 2014
  - All states reported the measure using the Adult Core Set specifications, which were based on HEDIS 2014 specifications.
- One state reported a reason for not reporting the measure, due to data inconsistencies/ accuracy, and staff constraints.
- TA request received by one state. Topic: Reporting of populations.

Measures for Discussion

- Based on updated endorsement information on measures 1391 and 1517, do any members of the Task Force have any thoughts for moving forward?

Recommendations for Strengthening the Core Sets – Child TF Member Recommendations

Available Measures

NQF #	Measure Name	Measure Steward
2902	Contraceptive Care - Postpartum	US Office of Population Affairs
0480	PC-05 Exclusive Breast Milk Feeding	The Joint Commission
2830	PC-05 Exclusive Breast Milk Feeding (e-measure)	The Joint Commission

2902 – Contraceptive Care - Postpartum

NQF N/A - Steward: US Office of Population Affairs

Description:	Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.
Numerator Statement	Primary measure: Women ages 15 through 44 who had a live birth and were provided a most (sterilization, intrauterine device, implant) or moderately (pill, patch, ring, injectable, diaphragm) effective method of contraception within 3 and 60 days of delivery. Sub-measure: Women ages 15 through 44 who had a live birth and were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.
Denominator Statement	Women ages 15 through 44 who had a live birth in a 12-month measurement year.
Exclusions:	The following categories are excluded from the denominator: (1) deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth or induced abortion); and (2) deliveries that occurred during the last two months of the measurement year.
Data Source:	Administrative claims
Type:	Intermediate Clinical Outcome

0480 – PC-05 Exclusive Breast Milk Feeding

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 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).
Numerator Statement	PC-05 Newborns that were fed breast milk only since birth PC-05a 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 PC-05a Single term newborns discharged alive from the hospital excluding those whose mothers chose not to exclusively breast feed 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:	Pleases refer to the Excel sheet
Data Source:	Administrative claims, Electronic Clinical Data, Paper Medical Records
Type:	Process

2830 – PC-05 Exclusive Breast Milk Feeding (e-measure)

NQF N/A – Steward: The Joint Commission

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). PC-05, Exclusive Breast Milk Feeding, is one of two measures in this set that have been reengineered as eCQMs and are included in the EHR Incentive Program and Hospital Inpatient Quality Reporting Program.
Numerator Statement	Newborns that were fed breast milk only since birth
Denominator Statement	Single term newborns discharged from the hospital who did not have a diagnosis of galactosemia, were not subject to parenteral nutrition, and had a length of stay of less than or equal to 120 days
Exclusions:	- Newborns who were admitted to the Neonatal Intensive Care Unit (NICU) - Newborns who were transferred to an acute care facility - Newborns who expired during the hospitalization
Data Source:	Electronic Clinical Data, Electronic Clinical Data: Electronic Health Record
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:
  - *2830 – PC-05 Exclusive Breast Milk Feeding (e-measure)
  - *0480 – PC-05 Exclusive Breast Milk Feeding
- Are there other measures Task Force members would propose for addition?

* Denotes measures recommended by TF members

Recommendations for Strengthening the Child Core Sets

Measures with Support for Addition

- New measures (TBD)

  and
- Measures recommended in 2015
  - #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care
  - #2902: Contraceptive Care - Postpartum
  - #2903: Contraceptive Care – Most & Moderately Effective Methods

Recommendations for Strengthening the Adult Core Sets

Measures with Support for Addition

- New measures (TBD)

  and

- Measures recommended in 2015
  - #2902: Contraceptive Care - Postpartum
  - #2903: Contraceptive Care – Most & Moderately Effective Methods

Measurement of Asthma Care

Asthma Is a Measurement Priority

- Asthma is a significant burden to patients, families and society.
- 2014 Asthma prevalence rates: 17.7 million (7.4%) adults and 6.3 million (8.6%) children have asthma
- Asthma prevalence increases with decreasing annual household income
- Measure #1799 was recommended for addition to the Adult Core Set in 2014 and 2015. It is currently a measure in the Child Core Set.

Potential Asthma Measures

- 10 total measures on asthma could be considered
  - 6 endorsed
  - 4 not endorsed, mostly from Pediatric Quality Measures Program
- Includes measure #1799: Medication Management for People with Asthma (MMA) currently in the Child Core Set. Also, this measure was recommended in 2014 and 2015 but not yet added in the Adult Core Set.
- Topics include:
  - Pharmacologic Therapy for Persistent Asthma
  - Asthma Medication Ratio
  - Asthma Admission Rate (PDI 14)
  - Rate of Emergency Department Visit
  - Other

Themes from Public Comments on Measure #1799: Medication Management for People with Asthma (MMA)

- MAP received comments that alternative asthma medication management measures, NQF #1800: Asthma Medication Ratio (AMR) and NQF #0548: Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT), may be superior.
- Because MAP did not have the opportunity to conduct a detailed review of the suggested measures prior to 2015 recommendations being due, it was determined that all of the asthma measures will be examined during this year's annual review of the Child and Adult Core Sets.

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

1799 – Medication Management for People with Asthma

NQF Endorsed – Steward: The Children's Hospital of Philadelphia

QPS Link: http://www.qualityforum.org/qps/1799

Description:	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.
Numerator Statement	Medication Compliance 50%: The number of patients who achieved a PDC* of at least 50% for their asthma controller medications during the measurement year. Medication Compliance 75%: The number of patients who achieved a PDC* of at least 75% for their asthma controller medications during the measurement year. *PDC is the proportion of days covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period.
Denominator Statement	Patients 5–64 years of age during the measurement year who were identified as having persistent asthma.
Exclusions:	1) Exclude patients who had any diagnosis of Emphysema (Emphysema Value Set, Other Emphysema Value Set), COPD (COPD Value Set), Chronic Bronchitis (Obstructive Chronic Bronchitis Value Set, Chronic Respiratory Conditions Due To Fumes/Vapors Value Set), Cystic Fibrosis (Cystic Fibrosis Value Set) or Acute Respiratory Failure (Acute Respiratory Failure Value Set) any time during the patient's history through the end of the measurement year (e.g., December 31). 2) Exclude any patients who have no asthma controller medications (Table ASM-D) dispensed during the measurement year.

1799 – Medication Management for People with Asthma

NQF Endorsed – Steward: The Children's Hospital of Philadelphia

- 27 states reported FFY 2014
  - All states reported the measure using the Child Core Set specifications, which were based on HEDIS 2014 specifications.
- Reasons states did not report (n=24):
  - The data were not available (15)
  - 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)

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

1800 – Asthma Medication Ratio

NQF Endorsed – Steward: National Committee for Quality Assurance

QPS Link: http://www.qualityforum.org/qps/1800

Description:	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Numerator Statement	The number of patients who had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Denominator Statement	All patients 5–64 years of age as of December 31 of the measurement year who have persistent asthma by meeting at least one of the following criteria during both the measurement year and the year prior to the measurement year: • At least one emergency department visit with asthma as the principal diagnosis • At least one acute inpatient claim/encounter with asthma as the principal diagnosis • At least four outpatient visits or observation visits on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events. Visit type need not be the same for the four visits. • At least four asthma medication dispensing events
Exclusions:	Exclude patients who had any of the following diagnoses any time during the patient's history through the end of the measurement year (e.g., December 31): COPD; Emphysema; Obstructive Chronic Bronchitis; Chronic Respiratory Conditions Due To Fumes/Vapors; Cystic Fibrosis; Acute Respiratory Failure Exclude any patients who had no asthma medications (controller or reliever) dispensed during the measurement year.
Data Source:	Administrative claims

Child Task Force Decision on Asthma Measures

- Is the addition of the following measures supported and or conditionally supported?
  - 1800 – Asthma Medication Ratio
- There may not be capacity to include multiple measures on the same topic, so MAP should weigh the pros and cons of retaining measure #1799 – Medication Management for People with Asthma and/or replacing with measure #1800.

Adult Task Force Decision on Asthma Measures

- Is the addition of the following measures supported and or conditionally supported?
  - 1799 – Medication Management for People with Asthma
  - 1800 – Asthma Medication Ratio
- There may not be capacity to include multiple measures on the same topic, so MAP should weigh the pros and cons of all proposed measures.

Prioritization of Adult Core Set Additions

- Today, the Adult Task Force voted on maternity care and asthma care measures.
- Does the Adult Task Force need to reconsider yesterday's prioritization of measures based on the discussion of maternity care and asthma care?

Recommendations for Strengthening the Adult Core Sets

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.
- Day 1 measures
- Maternity care measures
- Asthma measures

Opportunity for Public Comment

LUNCH

Measure Alignment Considerations

Policy Topics

Looking within and across Medicaid Adult & Child Core Sets

- IOM Vital Signs
  - Alignment
  - Care Coordination
  - Community Linkage

Institute of Medicine's (IOM) Vital Signs

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

SWOT Analysis Results: Child Core Set

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

Resonant Themes

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

Policy Issues for Consideration

- Alignment of measure concepts and measurement
- Alignment across multiple programs
- Alignment through standardization of definitions
- *Alignment across different payors (CMS Quality Measure Development Plan)*

Definition of Alignment from Coordinating Committee

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

Technical Definition of Alignment

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

  Note: Alignment is not synonymous to harmonization.

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

National Quality Forum (NQF), Guidance on Competing Measures, Washington, DC: NQF; 2011.

Themes from Policy Issues Home Work Assignment

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

Homework Assignment Themes: ***Alignment Definition***

- ***Alignment Benefits***:
  - Promotes comparability
  - Simplifies and improves reporting
  - Reduces reporting burden
  - Purpose is to facilitate comparison of data across states and across various payors
  - Across levels of measurement
  - Across measure/measure programs and payment models
- ***Alignment Challenges*** :
  - Voluntary nature of Medicaid reporting
  - Aligning with other commercial/private payors
  - Innovation and variation in the field

Homework Assignment Themes: ***Alignment Operational Considerations***

- Measure mandate
- Methodology mandate
- Balance goal of measurement and implementation flexibility
- Temporal considerations when aligning across ages: infancy, childhood, youth, adolescent, adulthood…etc.
- Appearance of Comparability versus Actual Comparability
  - *Example: Was HbA1c measured (yes/no) versus levels of HbA1c*

Homework Assignment Themes: ***Alignment Operational Considerations Contd.***

- **Measures are only as good as their design**

- Measurement development elements/concepts for discussion:
  - Exclusions
  - Risk adjustment (clinical and SDS factors)
  - Transitory nature of the Medicaid population
  - Resource
  - Data

Themes from Policy Issues Home Work Assignment

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

Homework Assignment Themes: ***Data Collection Feasibility and Considerations***

- Claims data as being the limit of feasibility-due to voluntary nature of Medicaid reporting
- Resource limitations
- Alignment versus other values (ex: purpose, comprehensiveness)
- Alignment level annotation (full, partial…etc.)
- Streamlining data acquisition and collection
- Identifying and developing outcomes measures and patient-reported outcome measures

Homework Assignment Themes: ***Data Collection Considerations***

- Ability to track system and population level health improvements
- Interoperability
- Measure design and exclusions (simply measure constructs)
- Survey data-functional status, patient reported outcomes surveys such as CAHPS surveys
- Provider Reporting Systems such as MDS, Nursing Home Compare
- Track NQF SDS project re: data stratification

Data Collection: 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?*

Homework Assignment Themes: ***Data Stratification***

- Goal is to assess disparities in care
- Caution not to penalize safety net providers
- Important stratification parameters: race/ethnicity, geography, individuals with multiple chronic conditions, individuals with specific conditions such as persistent mental illness, children with complex medical needs
- Track NQF SDS project re: data stratification

Care Coordination Definition

- Medicaid regulations do not define care coordination
- Care Coordination components:
  - Comprehensive assessment and periodic reassessment of needs (medical, educational, social and other)
  - Development and periodic reassessment of care plan based on beneficiary needs assessment
  - Referrals
  - Regular monitoring and follow-up

CMS. Making Connections: Strengthening Care Coordination in the Medicaid Benefit for Children and Adolescents. September 2014. Accessed on 4/3/16.

Care Coordination

- Medicaid Adults: Chronic Health Condition Management
- Disability (physical, mental and developmental) and Care Coordination
- Medicaid Child/Children: Care coordination services for children are markedly different than those for adults

- *What are some essential elements of care coordination for this population? How can care coordination be seamless and aligned across the child/adult care continuum?*

Discuss the Priority Measure Gap Areas in Community Integration

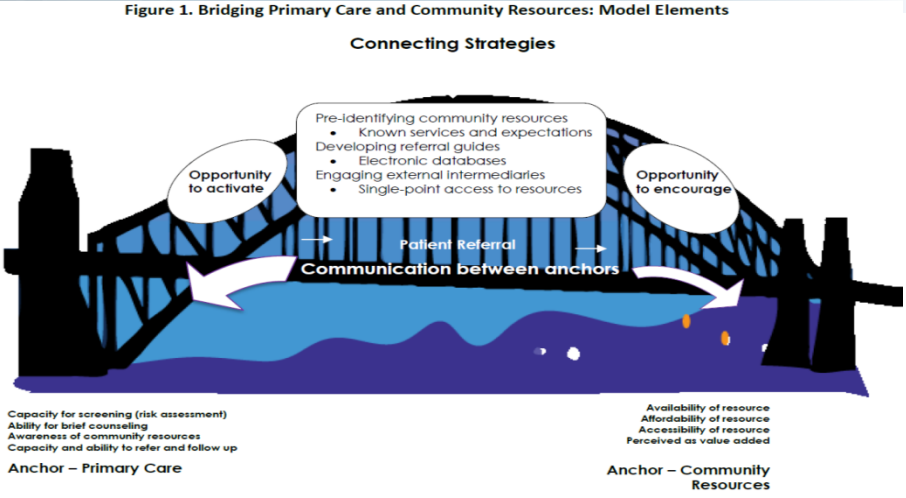
- IOM Vital Signs report of 2015 recently listed Engaged People as a critical domain, including Individual and Community Engagement elements
  - Recognizes the interrelatedness of these elements with others such as health and wellbeing
  - Acknowledges involvement of range of stakeholders and wide variation in individual and community interests and resources

Community Linkage: Key Attributes

- Linking clinical care with resources in the community
- Linking clinical providers with social service providers
- Activating patient and encouraging patient participation
- Increasing awareness of community resources
- Referral follow-ups
- Addressing availability, affordability and accessibility of resources in the community

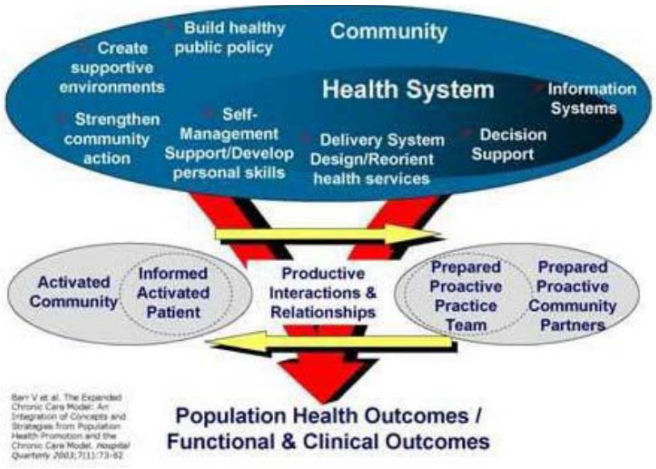
Community Linkage: *Bridging Clinical Care with Community Resources*

Figure 1. Bridging Primary Care and Community Resources: Model Elements



Minnesota Department of Health. Statewide Health Improvement Program. Clinical-Community Linkages for Prevention. Guide for Implementation FY2014-2015.

Community Linkage: *The Expanded Chronic Care Model*



Barr, V.J., Robinson, S., Marin-Link, B., et al. (2003). The Expanded Chronic Care Model: Integrating Population Health Promotion. Available at http://www.longwoods.com/content/16763. Accessed April 25, 2016.

Discussion

- What would community linkage look like for Medicaid populations?
- How can care coordination be enhanced through Community linkage in Medicaid populations?
- How can care coordination be seamless between child and adult Medicaid populations?
- How can current measures be used to address and capture community integration?

Issues of Shared Importance

Discussion Topics

- Data Collection Challenges-data availability and infrastructure versus workforce issues
- Balancing Process and Outcome measurement-resource, availability
- Quality Improvement Action-motivating factors, tipping point, regulatory actions, public reporting
- Managed care versus FFS and related data implications

Discussion Questions

- What are some real challenges from the group's perspective?
- What are some opportunities for change?
- What are some alignment issues that states can address in the near future?
- How can HHS/CMS address and facilitate alignment at the state level?

Opportunity for Public Comment

Break

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

Medicaid Trends

- Adult Medicaid expansion and access
- How to capture performance of new enrollees
- Effect of payment and delivery system reforms on data and reporting

Medicaid: New Enrollee Characteristics

- As with previously insured Medicaid adults age 19-64, roughly one-third of newly insured nonelderly Medicaid adults have income below 50% FPL.
- About 1 in 5 nonelderly adults in both Medicaid groups are Hispanic, and about 1 in 5 are Black/Non-Hispanic.
- 40% of newly insured Medicaid adults are male, compared to 30% of previously insured nonelderly Medicaid adults.
- The newly insured group is younger – individuals age 19-34 make up half of the newly insured Medicaid adults versus one-third of previously insured Medicaid adults age 19-64.

SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

New Enrollee Data and Measurement Needs

- Health status and health care needs of new enrollees
- Provider availability and accessibility
- Key measures of utilization (e.g., preventive/primary care, chronic care, avoidable hospital use)
- Unmet needs and reasons
- Cost barriers to access
- Patient experience (e.g., time/distance to care, linguistically/culturally appropriate care)
- System-level variables outside Medicaid's control (e.g., workforce maldistribution, poverty-related disparities in disease and disability rates)

SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

New Enrollee Data Challenges

- Voluntary and non-uniform state adoption of CMS Adult Core Set measures
- Gaps in Adult Core measures identified by NQF include access to primary, specialty and behavioral health care; care coordination; and others
- Availability and quality of MCO encounter data
- Appropriate standards/benchmarks
- Capability to analyze adult access by subgroup

SOURCE: 2014 Kaiser Survey of Low-Income Americans and the ACA.

Discussion

- How can data challenges be addressed?
- With increased access to care, how can data be used to capture and address public health from a population level?

Medicaid Payment and Delivery System Reforms

Important considerations and challenges:

- Do providers have the necessary technology, infrastructure and access to data to make the shift? If not, is it feasible? How about small providers?
- Is the payment system adequately adjusted for risk?
- Is the system transparent?
- Are accurate quality measures included?
- Are patients educated about the changes in the health care delivery system that are associated with payment reform?

Kaiser Family Foundation. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. Jun 22, 2015
Accessed 3 May2 016. Link: http://kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/

Medicaid: Delivery System Models

- **Medicaid Managed Care**
- Primary Care Case Management (PCCM)
- Risk-Based Managed Care/Managed Care Organization (RBMC/MCO)
- Prepaid Health Plan (PHP)
- Managed Long-Term Services and Supports (MLTSS)
- **Other Delivery System Models**
- Patient-Centered Medical Home (PCMH)
- Health Home (HH)
- Accountable Care Organization (ACO)

Medicaid: Payment Models

- Fee-for-Service (FFS)
- Capitation
- Care Management Fee
- Pay-for-Performance (P4P)
- Shared Savings Arrangements (Gain-Sharing)
- Shared Risk Arrangements (Risk-Sharing)
- Episode of Care (EOC) Payment
- Global Bundling
- Delivery System Reform Incentive Payment (DSRIP)

Kaiser Family Foundation. Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts. Jun 22, 2015 Accessed 3 May2 016. Link: http://kff.org/medicaid/fact-sheet/medicaid-delivery-system-and-payment-reform-a-guide-to-key-terms-and-concepts/

Discussion

- Current Core Sets and adequacy in facilitating new/alternative payment model implementation?
- Novel ways of stretching the measures in the current core set to accommodate APMs?

Summarize Progress

Important Dates

- **Tomorrow:** Task Force discussion of Child 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

Project Contact Info

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

Adjourn for the Day

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Measure Applications Partnership

Joint Medicaid Adult and Child Task Forces In-Person Meeting

NATIONAL QUALITY FORUM

Day 3 - May 26, 2016

In-Person Meeting Objectives

- Consider states' experiences implementing the Medicaid Child Core Set
- Develop strategic recommendations for strengthening the Medicaid Child Core Set through identification of:
  - Priority measure gaps and potential measures to address them
  - Measures found to be ineffective and or topped out, for potential removal
- Formulate strategic guidance to CMS about strengthening the measure set over time to meet program goals
- Overarching policy issues to help inform Core Set Updates

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Today's Action Items

- Review highlights from the previous day
- Share staff analysis of the 2015 Child 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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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

Medicaid and the Child Core Set

Background

- Medicaid and the Children's Health Insurance Program (CHIP) covered more than 43 million children in FFY 2014
- >40% of births in the US are financed by Medicaid
- Children with complex health needs
  - Account for 6% of the total number of children covered by Medicaid
  - Incur nearly 40% of total Medicaid costs

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

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

MAP 2015 Measure Recommendations

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

1/2 (tie). NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care

1/2 (tie). Use of Multiple Concurrent Antipsychotics in Children and Adolescents

3. Effective Postpartum Contraception Access

4 (tie). Use of Contraceptive Methods by Women Aged 15-20 Years

5/6 (tie). NQF #1360: Audiological Evaluation No Later Than 3 Months of Age

5/6 (tie). NQF #2393: Pediatric All-Condition Readmission Measure

CMS - Child Core Set Update for 2016 Reporting

Issued December 30, 2015

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Medicaid Child Core Set Measures for FFY 2016 Use

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Medicaid Child Core Set Measures for FFY 2016 Use - Continued

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

Staff Review of FFY 2014 State Reporting

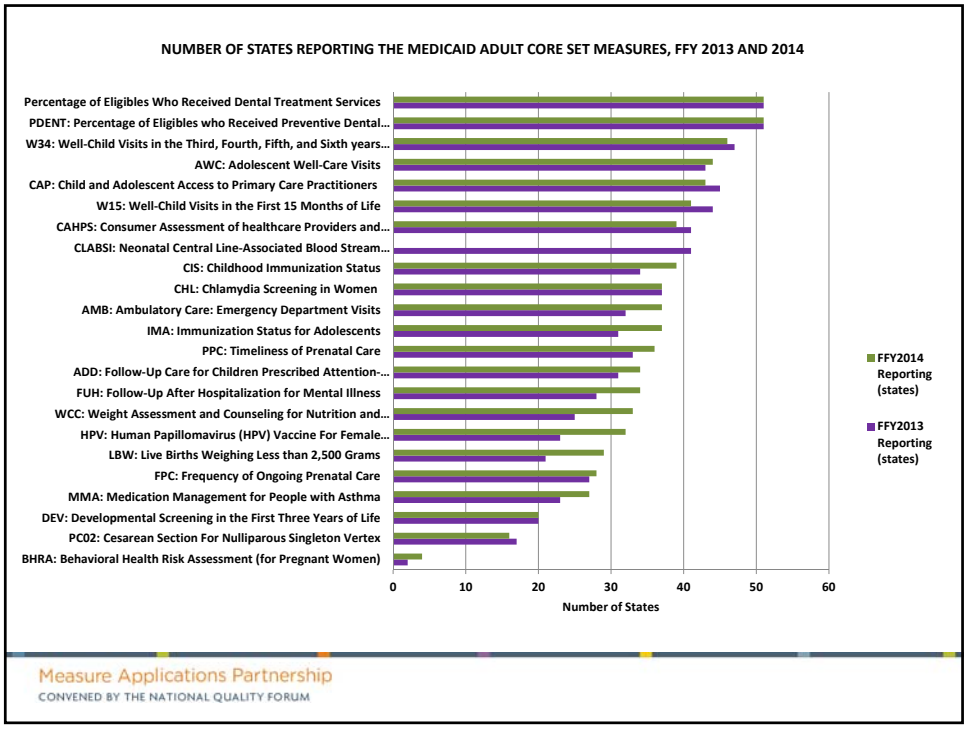
Overview of Medicaid Child Core Set FFY 2014 Reporting (most recent data available)

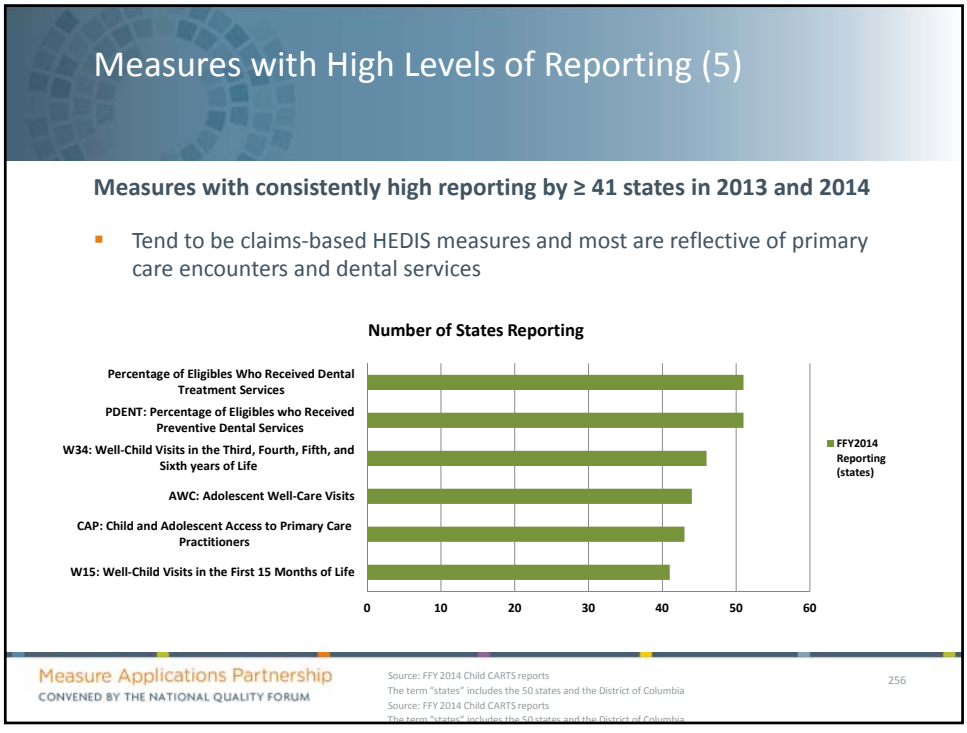
All states voluntarily reported two or more of the Child Core Set measures

- Data completeness improved; 44 states now report measures for both Medicaid and CHIP enrollees
- Most frequently reported measures assess children's access to primary care, well-child visits, use of dental services, receipt of childhood immunizations, and satisfaction with care received

Overview of Medicaid Child Core Set FFY 2014 Reporting

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

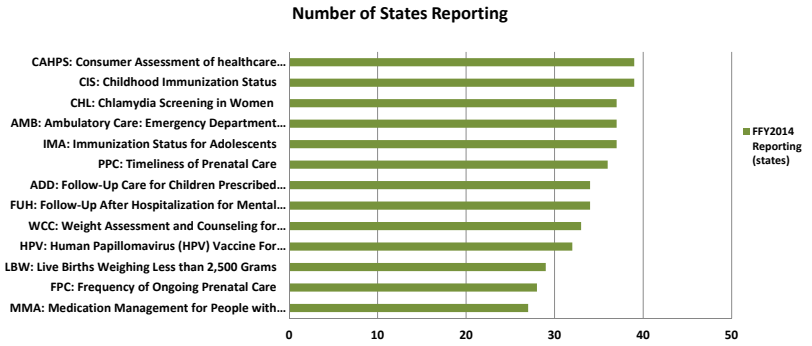

NUMBER OF STATES REPORTING THE MEDICAID ADULT CORE SET MEASURES, FFY 2013 AND 2014
Percentage of Eligibles Who Received Dental Treatment Services
PDENT: Percentage of Eligibles who Received Preventive Dental...
W34: Well-Child Visits in the Third, Fourth, Fifth, and Sixth years...
AWC: Adolescent Well-Care Visits
CAP: Child and Adolescent Access to Primary Care Practitioners
W15: Well-Child Visits in the First 15 Months of Life
CAHPS: Consumer Assessment of healthcare Providers and...
CLABSI: Neonatal Central Line-Associated Blood Stream...
CIS: Childhood Immunization Status
CHL: Chlamydia Screening in Women
AMB: Ambulatory Care: Emergency Department Visits
IMA: Immunization Status for Adolescents
PPC: Timeliness of Prenatal Care
ADD: Follow-Up Care for Children Prescribed Attention-...
FUH: Follow-Up After Hospitalization for Mental Illness
WCC: Weight Assessment and Counseling for Nutrition and...
HPV: Human Papillomavirus (HPV) Vaccine For Female...
LBW: Live Births Weighing Less than 2,500 Grams
FPC: Frequency of Ongoing Prenatal Care
MMA: Medication Management for People with Asthma
DEV: Developmental Screening in the First Three Years of Life
PC02: Cesarean Section For Nulliparous Singleton Vertex
BHRA: Behavioral Health Risk Assessment (for Pregnant Women)
0
10
20
30
40
50
60
Number of States
FFY2014 Reporting (states)
FFY2013 Reporting (states)
Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM


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 and dental services
Number of States Reporting
Percentage of Eligibles Who Received Dental Treatment Services
PDENT: Percentage of Eligibles who Received Preventive Dental Services
W34: Well-Child Visits in the Third, Fourth, Fifth, and Sixth years of Life
AWC: Adolescent Well-Care Visits
CAP: Child and Adolescent Access to Primary Care Practitioners
W15: Well-Child Visits in the First 15 Months of Life
0
10
20
30
40
50
60
FFY2014 Reporting (states)
Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia
Source: FFY 2014 Child CARTS reports
256

Measures Reported More Frequently in FFY 2014 (13)

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

- Most measures have increased uptake by three or more states

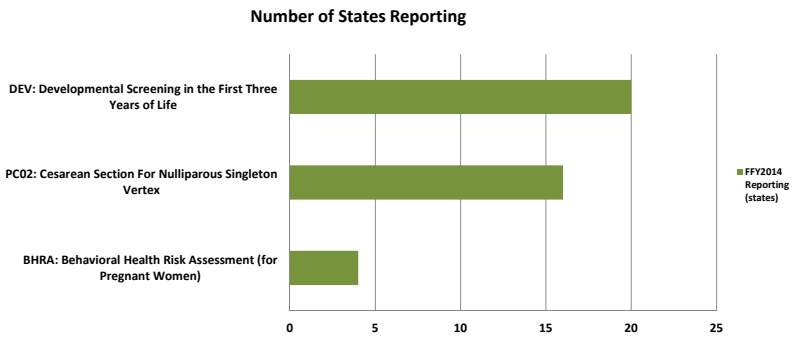


Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia
Source: FFY 2014 Child CARTS reports
The term "states" includes the 50 states and the District of Columbia

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



Staff Review: Reasons Given for Technical Assistance (TA) Requests

- TA requests were submitted by 22 states-a total of 40 requests.
- Measures receiving the most TA requests(≥ 3 requests)
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items) (CPC)
  - Human Papillomavirus Vaccine for Female Adolescents (HPV)
  - Medication Management for People with Asthma (MMA)
  - PC-02: Cesarean Section (PC02)
  - Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)

Questions

Status of PQMP Measure Development and Endorsement

MAP's 2014 Input

- In 2015 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.

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)

- 16 NQF-endorsed measures:
  - 2393 Pediatric All-Condition Readmission Measure
  - 2414 Pediatric Lower Respiratory Infection Readmission
  - 2789 Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care
  - 2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia
  - 2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics
  - 2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
  - 2803 Tobacco Use and Help with Quitting Among Adolescents
  - 2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Pediatric Quality Measures Program (PQMP) : Measures (NQF Endorsed)

- 2842 Family Experiences with Coordination of Care (FECC)-1 Has Care Coordinator
- 2843 Family Experiences with Coordination of Care (FECC) -3: Care coordinator helped to obtain community services
- 2844 Family Experiences with Coordination of Care (FECC) -5: Care coordinator asked about concerns and health
- 2845 Family Experiences with Coordination of Care (FECC) -7: Care coordinator assisted with specialist service referrals
- 2846 Family Experiences with Coordination of Care (FECC)-8: Care coordinator was knowledgeable, supportive and advocated for child's needs
- 2847 Family Experiences with Coordination of Care (FECC) -9: Appropriate written visit summary content
- 2849 Family Experiences with Coordination of Care (FECC)-15: Caregiver has access to medical interpreter when needed
- 2850 Family Experiences with Coordination of Care (FECC)-16: Child has shared care plan

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Pediatric Quality Measures Program (PQMP) : Measures (Available and in Development) - Continued

- 79 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

State Perspectives Panel

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
May 26, 2016
NQF Measurement Application Partnership

"Give shy people the strength to stand up and do what needs to be done."

What are we trying to impact?

Decisions guided by the purpose of measurement

- Measurement for accountability – state, MCO, ACO
- Measurement for accountability - quality improvement at the provider/ community level
- Measurement to compare populations/ identify and improve disparities
- Measurement to develop policy

Medicaid levers

- MCO contracting
- Changes to payment models to providers
- Focused policy/payment initiatives

Real levers at the provider level

- Financial
- Disenrollment
- Competitive spirit
- Reporting burden
- PATIENT / FAMILY CARE RELATIONSHIP

Measurement for accountability at the health plan level

- Minnesota Prepaid Medical Assistance withhold measures
  - ER rate
  - Hospital admission rate
  - Hospital readmission rate
  - Well visit under age 15 months
  - Child and teen visit referral code
  - Annual dental visit

Legislative language for withhold

…**a reduction in the plan's emergency room utilization rate** for state health care program enrollees by a measurable **rate of five percent** from the plan's utilization rate for the previous calendar year. To earn the return of the withhold **the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent** of the plan's utilization rate for medical assistance and MinnesotaCare enrollees

Measurement for accountability at the health plan level

- Withhold 1% vs. 5%
- Partial credit
  - For moving to the goal

Measurement for accountability - quality improvement - Opioids

- Data to create policy
- Process
  - New guidelines and communication tools
  - New measures - Vetted internally and in the state
    - Acute use / Post-acute use / Chronic use
  - New levers
    - Quality reporting – peer review protected
    - Required quality improvement – peer review protected
    - Disenrollment – public
- Support by Legislature/Medical association/Steve Rummler Foundation
- No other financial incentive

Measurement for accountability - quality improvement

- Strategic goal
- Existing infrastructure
  - Measurement clear and timely
  - QI clear and supported
    - Clear process map
- Community adoption of the goal
  - Legislature
  - Agencies
  - Providers
  - Patients
- Funding and staff to execute project

To the CORE set:

- Increase the number we report without increasing provider burden
- Assure quality of measure submission
- Link of measures to state quality goals

Minnesota DHS Core Set reporting

Access and Preventive Care

1. Child and adolescent's access to Primary Care
2. Childhood immunization status
3. Well-child visits in the First 15 months
4. Immunizations for adolescents
5. Adolescent well visit

Minnesota DHS Core Set reporting

Maternal and Perinatal Health
6. Live births <2500 grams
7. Prenatal and postpartum care
Behavioral Health
8. Follow up after hospitalization for Mental illness
Care of Acute and Chronic Conditions
9. Medication Management for People with Asthma
10. Ambulatory Care – ED visits
Oral Health
11. Sealants 6-9 year olds
12. Percentage of eligible who receive a dental visit

Minnesota's Suggestions to Increase the Reporting of Child & Adult Core Set Measures

1. Invest the time and resources to find the right State people responsible for reporting.
2. Technical Assistance must be proactive, not reactive.
3. Respect the state reporting effort and commitment necessary to report.
4. Provide timely and precise measurement technical specifications.
5. Motivate greater reporting by providing a return on the reporting investment.

Minnesota SQRMS

State Quality and Measurement Reporting System

- Used by Health Care Homes
- Integrated Health Partnerships (Medicaid ACO)
- Quality Incentive Payment System
- More…

Burden

Doctor burnout is a rising problem in Minnesota medicine

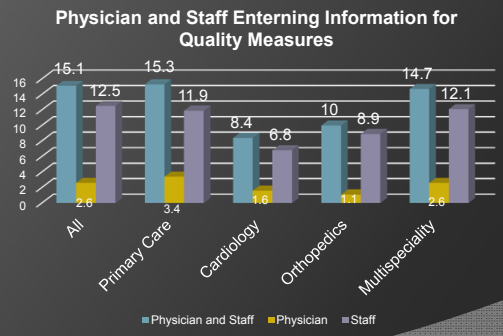
Epidemic of burned-out doctors threatens care.

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

ILLUSTRATION BY ROB DOBI, SPECIAL TO THE STAR TRIBUNE

Burden of External Quality Measures Reporting is Expanding

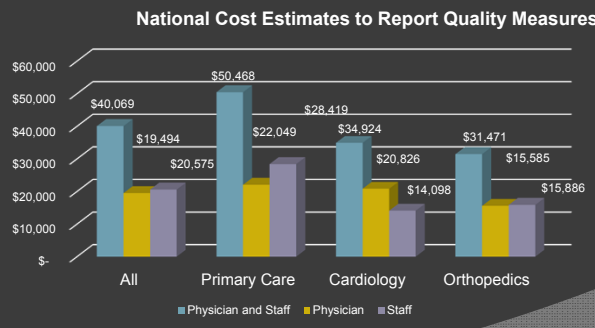
- Survey of US physicians found that 15.1 hours per physician per week of physicians and staff time was used to deal with external quality measures.
- The average physician spent 2.6 hours per week and their staff spent 12.5 hours per physician per week.



The Population Value of Quality Indicator Reporting: A Framework for Prioritizing Health Care Performance Measures. David O. Meltzer and Jeanette W. Chung, Health Affairs 33, no.1 (2014): 132-139.

US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures

- Based on survey times estimates the average practice cost was $40,069 per physician per year.



The Population Value of Quality Indicator Reporting: A Framework for Prioritizing Health Care Performance Measures. David O. Meltzer and Jeanette W. Chung, Health Affairs 33, no.1 (2014): 132-139.

Results of the Annual Estimated $15.4 Billion Reporting Cost

- 81% of practices reported their quality reporting effort has increased in the past three years.
- 27% of the practices believed the current measures were moderately or strongly representative of the quality of care provided.
- 28% used their quality scores to focus their quality improvement activities.

- Common survey comment themes;
  - ✓ Burden of current measurement requirements on small practices;
  - ✓ Have measures that are uniform across entities;
  - ✓ Need for specialty-specific measures;
  - ✓ Measures should better represent quality, and
  - ✓ Need to easily and accurately extract data from EHRs

The Population Value of Quality Indicator Reporting: A Framework for Prioritizing Health Care Performance Measures. David O. Meltzer and Jeanette W. Chung, Health Affairs 33, no.1 (2014): 132-139.

Going deeper in Minnesota

Minnesota Department of Human Services

Too Many & Not Enough:

"DHS What Matters Most" Care Quality Measures

Implementing the IOM Vital Signs Core Metrics

Blueprint for a DHS What Matters Most Core Set - JOB 1 – too many

Measure what matters the most. As public purchaser of health care services- WHAT MATTERS THE MOST is purchasing and delivering health care services that meet the public program (Medicaid) population's health care needs and valued by enrollees.

Measurement must have purpose. A measure may have one or more of the following types of purposes demonstrating: organizational compliance (DHS, MCOs, Medical Groups) with state plan, waiver, or contract requirements, access to services, quality of services, satisfaction with services, or change/improvement.

Measurements must be clinically relevant. Selected measures will be relevant in clinical practice and link to current quality improvement project interventions

Use what you have. DHS uses FFS claims, managed care encounters, Medicare cross-over claims and Medicaid enrollment data to annually calculate HEDIS and PQI performance measures.

Too Many & Not Enough

6

Parsimonious Set of Measures

The IOM Vital Signs Report recommends a set of health and well-being measures totaling 54; the 15 best measures and an additional 39 related priority measures across four domains, key elements, and core measure foci.

More measures do not exhibit better outcomes or quality, and often lead to confusion.

Reducing the number of measures can lead to a sharpen focus, consolidate improvement efforts, improve comparability and reduce the measurement burden.

Harmonizing and aligning measurement sets "minimizes redundancies and unnecessary customizations".

Too Many & Not Enough

Domain	Key Element	Focus	Measures (best & related)
Healthy People	Length of Life	Life expectancy	1. Life expectancy at birth
			2. Infant mortality
			3. Maternal mortality
			4. Violence & injury mortality
	Quality of Life	Wellbeing	5. Self-reported health
			6. Multiple chronic conditions
			7. Depression
	Healthy Behaviors	Overweight & obesity	8. Body mass index
			9. Activity levels
			10. Healthy eating patterns
		Addictive behaviors	11. Addiction death rate
			12. Tobacco use
			13. Drug dependence/illicit use
			14. Alcohol dependence/misuse
		Unintended pregnancy	15. Teen pregnancy rate
			16. Contraceptive use
	Healthy Social Circumstances	Healthy communities	17. High school graduation rate
			18. Childhood poverty rate
			19. Childhood asthma
			20. Air quality index
			21. Drinking water quality index
Care Quality	Prevention	Preventive services	22. Childhood immunizations
			23. Influenza immunization
			24. Colorectal cancer screening
			25. Breast cancer screening
	Access to Care	Care access	26. Unmet care need
			27. Usual source of care
			28. Activity of medical care
	Safe Care	Patient safety	29. Hospital-acquired infection rate
			30. Wrong-site surgery
			31. Pressure ulcers
			32. Medication reconciliation
	Appropriate Treatment	Evidence based care	33. Preventable hospitalization rate
			34. Cardiovascular risk reduction
			35. Hypertension control
			36. Diabetes control composite
			37. Heart attack therapy protocol
			38. Stroke therapy protocol
			39. Unnecessary care composite
	Person-centered Care	Care matched with patient goals	40. Patient-clinician communication satisfaction
			41. Patient experience
			42. Shared decision making
			43. End-of-life advanced care planning
Care Cost	Affordability	Personal spending burden	44. High spending relative to income
			45. Health care-related bankruptcies
	Sustainability	Population spending burden	46. Per capita expenditures on health care
			47. Total cost of care
			48. Health care spending growth
Engaged People	Individual Engagement	Individual engagement	49. Health literacy rate
			50. Involvement in health initiatives
	Community Engagement	Community engagement	51. Social support
			52. Availability of healthy food
			53. Volunteerism
			54. Community health benefit agenda

3

County Health and Vital Sign Models

The six County Health factors are common to approximately half of the Vital Signs measure set.

County Health Ranking Data Model Health Factors

1. Tobacco Use
2. Diet & Exercise
3. Alcohol & Drug Use
4. Sexual Activity
5. Access to Care
6. Quality of Care

Limit DHS' initial measurement transformation focusing on measures of health care instead of the broader slate of health and well being measures.

Too Many & Not Enough

Vital Signs Core Measure Set

Domain	Key Element	Focus
Healthy People	Length of Life	Life expectancy
	Quality of Life	Wellbeing
	Healthy Behaviors	Overweight & obesity
		Addictive behaviors
		Unintended pregnancy
	Healthy Social Circumstances	Healthy communities
Care Quality	Prevention	Preventive services
	Access to Care	Care access
	Safe Care	Patient safety
	Appropriate Treatment	Evidence based care
	Person-centered Care	Care matched with patient goals
Care Cost	Affordability	Personal spending burden
	Sustainability	Population spending burden
Engaged People	Individual Engagement	Individual engagement
	Community Engagement	Community engagement

5

Expectations for DHS' What Matters Most Core Set

The initial DHS Health Care Core Set will:

Domain	Key Element	Focus	Measures
Healthy People	Healthy Behaviors	Overweight & obesity	
		Addictive behaviors	
Care Quality	Prevention	Preventive services	
	Access to Care	Care access	
	Safe Care	Patient safety	
	Appropriate Treatment	Evidence based care	
	Person-centered Care	Care matched with patient goals	

- Utilize Vital Signs Model the "healthy people & care quality domains, key elements and focus categories,
- Include structure, process, outcome & satisfaction (grievance) types of measures,
- Selected measures will include HEDIS, SQRMS, and PQI, measures to accommodate CMS core set requirements,
- Need to be coordinated measurement logistics with: required technical report process, and MDH SQRMS collections, production and reporting limitations, and
- Not match CMS Core Sets, DHS will be required to request an exception to the future CMS required measurement set.

Too Many & Not Enough

9

Prototype of DHS Core Set Measures for Adults & Association with CMS Core Sets and MN SQRMS

Adults: Screening/ Treatment

Domain	Key Element	Focus	Measure	Core Set	MDH SQRMS
Healthy People	Healthy Behaviors	Overweight & obesity			
		Addictive behaviors	1. Use of Opioids 2. CAHPS Medical Assistance with Smoking/Tobacco Use Cessation	Adult Adult	
Care Quality	Prevention	Preventive services	1. Cervical CA Screening 2. Breast CA Screening	Adult Adult	X X
	Access to Care	Care access	1. Initiation/Engagement Alcohol & Drug Tx 2. F/U After Hospitalization for Mental Illness	Adult Adult	
	Safe Care	Patient safety	1. PQI 91 Acute Composite 2. PQI 92 Chronic Composite		
	Appropriate Treatment	Evidence based care	1. Optimal Diabetes Care 2. Optimal Vascular Care 3. Optional Asthma Care 4. Depression 6 Remission		X X X X
	Person-centered Care	Care matched with patient goals			

10

What Matters Most Model

Paradigm for the selection of a parsimonious core metrics set

WHAT MATTERS THE MOST is purchasing and delivery of health care services that meet the population's health care needs and valued by enrollees.

- Purchasing and delivery of health care services purpose:
  1. Access to health care services
  2. Quality of health care services
  3. Satisfaction with health care services
  4. Change/Improvement accountability

"Strawman" Illustration

- DHS Populations and Health Care Priority Elements:
  1. Children: Prevention & Screening
  2. Adults: Screening & Treatment
  3. Seniors: Treatment and Transitions
  4. Special Needs: Accommodation and Adaptive Services

"A core metrics set is a parsimonious set of measures that provides a quantitative indication of current status on the most important elements in a given field and can be used as a standardized and accurate tool for informing, comparing, focusing, monitoring and reporting change."

7

Matching DHS Purpose, Populations & Elements with Available Measures

EXAMPLE

	Access	Quality	Satisfaction	Change/ Improvement
Children: Prevention/Screening				
1. Childhood Immunizations – HEDIS Combo 10	●			
2. Annual Dental Visit	●			
3. Dental Fluoride Tx.		●		●
4. CAHPS Question X			●	
Adults: Screening/ Treatment				
1. SQRMS Optimal Diabetes Care		●		
2. SQRMS Optimal Vascular Care		●		
3. SQRMS Optimal Asthma Control		●		
4. CAHPS Medical Assistance with Smoking and Tobacco Use Cessation	●			
5. PQI 91/92 Acute & Chronic Composites		●		
Seniors: Treatment/Transitions				
1. HEDIS Potentially Harmful Drug-Disease Interactions in the Elderly		●		
2. Grievance System Data	●		●	
3. HEDIS Care of Older Adults				
SNP: Accommodation/Adapting Services				
1. Annual Dental Visit	●			●
2. HEDIS/Core Set Follow-up After Hospitalization for Mental Illness		●		
3. Other existing or placeholder measures				

8

The Aspirational Stuff

Not Enough – JOB 2

- Patient reported outcomes
- Patient reported experience of care
- EMR derived measures

Interface with our cultural and ethnic communities to get patient/recipient

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

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

Family and social risk factors

What measures to standardize (per the Minnesota State Improvement Model)

- Mental health and substance use disorder
- Race/ethnicity/language
- Transportation
- Social services being received
- Housing
- Food insecurity

Family and Social Risk Factors

https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7079-ENG

Can we develop a payment structure

- What are the social risk factors that impact health?
- Which of these can be impacted effectively by the health care system?
- How much should it cost to provide this intervention?

Measurement Infrastructure

- EMR/ personal health record
- Text/app reported outcomes
- Feedback mechanisms to providers

Opportunities – state infrastructure

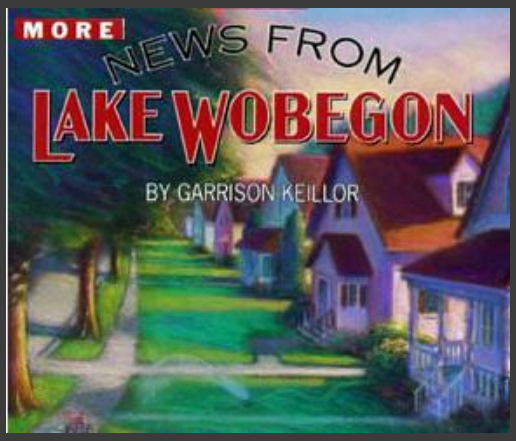
- Assess capacity
  - To report – AQM
  - To do quality improvement – AQM
  - To sustain systems
- Value proposition for legislators and policy makers
  - Link measures to quality improvement and policy

National Infrastructure

Medicaid Medical Director Network

Sustainable national structure to promote state level quality improvement

- 65% of us (N=37) ran or participated in state Quality Measurement and Performance
- Know both measurement and improvement
- Can use the same comparative peer relationship to influence the MMDs as we would use in states
- Could leverage other state level partners (professional societies and public health)



"... Lake Wobegon, where all the women are strong, all the men are good-looking, and all the children are above average."

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?
- What are states experiences with policy-level issues such as alignment, care coordination and community linkage?
- Which policy issues have been the most challenging for states? Please consider alignment, care coordination and community linkage during this discussion.
- What are states' most notable successes related to quality measurement? How are they using the measures?

Break

State Perspectives Panel

Charles Gallia PhD
Senior Policy Advisor for Research and Evaluation, Oregon Health Authority

Measures Applications Partnership

Medicaid Child and Adult Task Forces

May, 2016, Charles Gallia

Healthcare Quality Measurement

A snapshot of different perspectives

- National
- Multi-state
- State, Plan, Clinic, and Physician

National view

- CHIPRA
  - 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, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children*
- AHRQ SNAC 1st round of review
  - Lots great measures through the PQMP and COEs
  - Few added

Some T-CHIC Lessons

Initial Core Measure	Alaska		Oregon		West Virginia	
	2012	2014	2012	2014	2012	2014
Timeliness of Prenatal Care			63.2%	82.9%	89.0%	82.3%
Frequency of Ongoing Prenatal Care (≥81%)			11.4%		78.3%	79.1%
Percentage of Live Births <2500 grams	7.4%	6.8%	6.5%	5.6%		
Cesarean rate for nulliparous singleton vertex	15.2%		24.2%		36.9%	34.6%
Childhood Immunization (Combination 2)			85.8%	67.8%	64.9%	69.1%
Immunizations for Adolescent (Combination)			48.7%	55.1%	71.5%	74.0%
Weight Assessment and Counseling			0.8%*	0.4%	31.8%	34.2%
Developmental Screening by 12 months	9.2%	6.6%	18.5%	42.6%	40.1%	43.5%
Chlamydia Screening for Women	37.0%	44.7%	47.8%	43.2%	37.5%	
Well-Child Visits First15 Months of Life (6+ visits)	43.4%	67.0%	55.4%	50.2%	69.2%	77.2%
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years	46.7%	48.1%	54.8%	76.1%	67.3%	72.6%
Adolescent Well-Care Visits	25.9%	30.6%	25.9%	38.2%	46.1%	47.0%
Received Preventive Dental	43.4%	45.6%		43.2%	41.6%	35.5%
Access to PCPs	85.1%	84.4%	86.7%	89.8%	88.8%	88.0%
Pharyngitis: Appropriate Testing	66.0%		71.5%			
Otitis Media with Effusion						
Received Dental Treatment	27.4%			37.4%		
ED Visits per 1000 member months	47.2%	41.6%	38.2%	44.1%	7.0%	
Pediatric Catheter-Associated Blood Stream Infection						
Asthma: ED Visits	12.9%		8.5%	14.8%		
ADHD Follow-up (Initiation phase)	55.7%	59.3%	52.3%	57.7%	100.0%	99.1%
Hemoglobin A1C Testing			74.5%	86.7%		
Follow-up after mental illness related hospitalization (7-day)	30.3%	13.9%	53.5%	26.3%	57.2%	65.6%
CAHPS [T-CHIC Modified Version] (submission yes or no)	Y	Y	Y	Y	Y	N

Core Set Lessons

- State Medicaid/CHIP measures require modifications from the technical specification provided by NCQA.
- Stratifying measures by any population characteristic, such as race or special heath care needs, makes the denominators produces too small an N for analysis, especially at a practice level let alone the numerators, are often too small for statistical analysis.
  - This same limitation impacts trending
- Knowing what measures are being developed at the federal level for states' use is not as clear as it should be. States need lead to making plans to incorporate the measures. The new measures are often improvements the states are seeking but don't know about.

Core Set Lessons

- Medicaid population characteristic considerations
  - Measures that require coverage and provider stability are more difficult to produce.
  - Measures do not emphasize the programmatic eligibility groups- medically fragile children or those who became impoverished as a result of medical costs, or demographics of the Medicaid population and are more limited to health systems rather than population health over time.
  - Measures that span more than one year are difficult to produce because encounter data is reliant on claims submitted while covered by Medicaid/CHIP.
  - Population instability and mobility may mean we are missing the population that is 'most vulnerable' and most in need of care, yet omitted from quality of care assessments
  - Age segmentations in measures, even adult versus child, may not make programmatic or clinical sense. Smoking, alcohol and drug use, and pregnancy happen before age 18.

Core Set Lessons

- State Medicaid/CHIP measures require modifications from the technical specification provided by NCQA.
- Stratifying measures by any population characteristic, such as race or special heath care needs, makes the denominators produces too small an N for analysis, especially at a practice level let alone the numerators, are often too small for statistical analysis.
  - This same limitation impacts trending
- Knowing what measures are being developed at the federal level for states' use is not as clear as it should be. States need lead to making plans to incorporate the measures. The new measures are often improvements the states are seeking but don't know about.
- Medicaid population characteristic considerations
  - Measures that require coverage and provider stability are more difficult to produce.
  - Measures do not emphasize the programmatic eligibility groups- medically fragile children or those who became impoverished as a result of medical costs, or demographics of the Medicaid population and are more limited to health systems rather than population health over time.
  - Measures that span more than one year are difficult to produce because encounter data is reliant on claims submitted while covered by Medicaid/CHIP.
  - Population instability and mobility may mean we are missing the population that is 'most vulnerable' and most in need of care, yet omitted from quality of care assessments
  - Age segmentations in measures, even adult versus child, may not make programmatic or clinical sense. Smoking, alcohol and drug use, and pregnancy happen before age 18.
-

Core Set Lessons

- Measures that are more general, for example, general ambulatory care and emergency department use, are not as 'actionable' or easy to understand in terms of what constitutes good or optimal performance, as more discrete measures such as immunizations.
- The current roster of measures has some value and importance to providers, but their practical utility is not necessarily obvious.
- The most compelling information for practices, oftentimes, was formally presented patient feedback, through the C&G survey or patients' participation on panels and boards helping to guide interpretation of results. Patients like those measures more than anything.

Core Set Lessons

- No time : practices or at state
  - The overwhelming number of measures physicians are asked to produce results in them not going through the process to validate them, which, in turn, means they are easy to discount. This issue surfaced with the immunization registry information several times.
  - Yet, run-charts and registries frequently were seen by the clinicians as more worthwhile time investments than retrospective assessments of clinical performance.
  - The state has little time to analyze results. The cycle between starting each measure round leaves little or no staff time to examine the results, assess the implications, and develop courses of action.
  - There is little or no opportunity to examine relationships between measures.
- No path of action or resources
- No state staff
- Change expectations unclear
  - There is little knowledge about performance sensitivity or basis for knowing when variations from year to year are of concern, or when similar measures show conflicting results.

Core Set Lessons

- Notice: the term *burden* has not been used

Two examples of changes & needs Health Equity Index and CAHPs

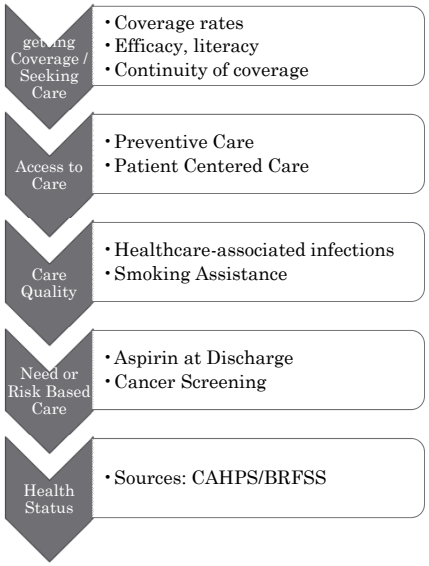
Charles Gallia
Rusha Grinstead

For the Index

Initial concept for the health equity index was based on several key documents:

- National Quality Forum's National Voluntary Consensus Standards for Ambulatory Care – Measuring Healthcare Disparities (2008)
- Institute of Medicine. Access to Health Care in America: A Model for Monitoring Access (1993)
- Institute of Medicine. Unequal Treatment: What Healthcare Providers Need to Know about Racial and Ethnic Disparities in Health Care (2002)

Disparities Framework



327

Process: Parameters for the Index

MUST

- address the Medicaid population
- use available data
- be statistically feasible
- address multiple factors (beyond race/ethnicity)

IDEALLY

- based on current Incentive, Performance Improvement Topic, or State performance metrics
- generate meaningful results
- be understandable
- allow for tracking over time

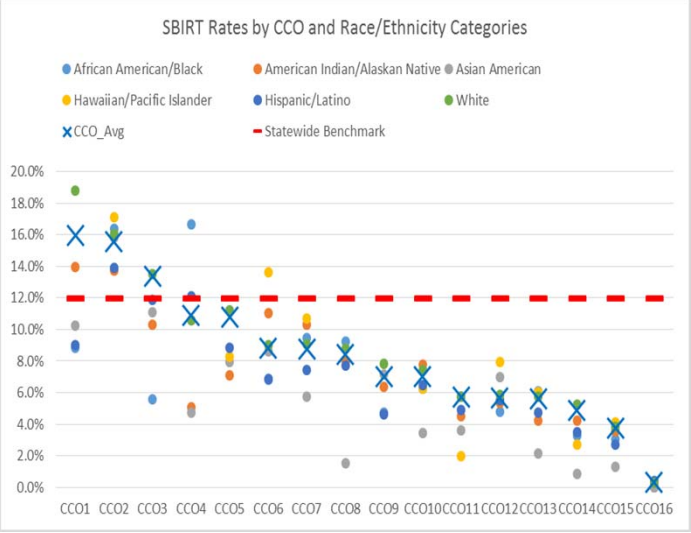
328

Issues We Expected to Encounter

- Small numbers
- Missing data measurement
- Equity vs Disparities
  - Relative versus absolute
- Measuring change and encouraging improvement
- Differences in CCO populations
- Statistical soundness versus ease of use
- Useable for language, gender, disability, & special health care needs

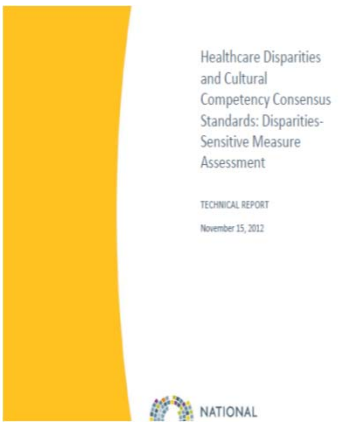
329

Many options and implications



330

Then we turned the NQF report



Report identified set of 76 measures that are "disparities-sensitive," based on

- Prevalence of conditions
- Gaps in quality of care
- Community impact
- Communication challenges
- Clinical discretion
- Social determinants of health

http://www.qualityforum.org/Publications/2012/11/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards__Disparities-Sensitive_Measure_Assessment.aspx

331

CAHPs – Issues and limitations

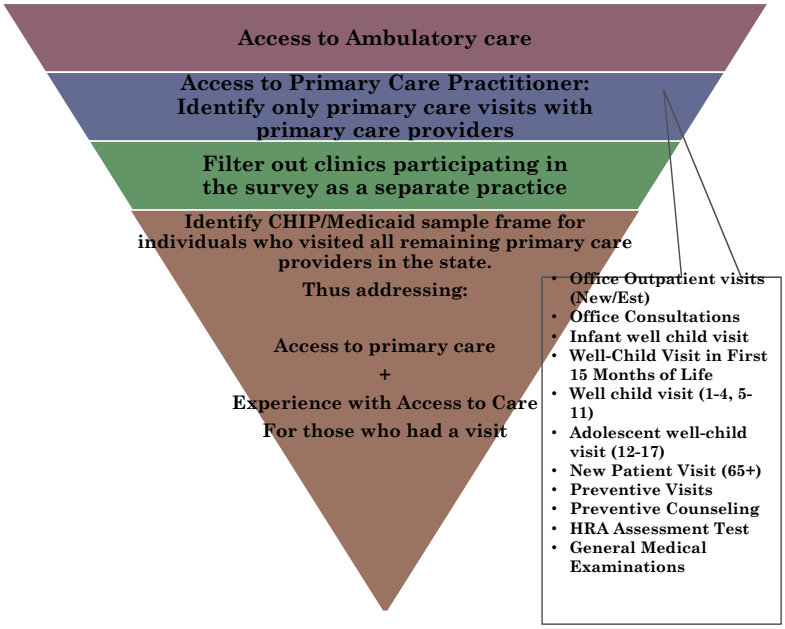
- The health plan version is designed to compare health insurance companies, not fee for service providers.
- Even in states with managed care, results are not often shared nor relevant to practices.
- The health plan version asks about getting care and services, even if there was no primary care visit
- The Clinician and Group version requires a visit, so everyone who is surveyed has had access.
- CMS seeks assurance about access and quality for whom they provide FFP, with priority on children with special health care needs, C&G does neither.

	CAHPS Health Plan 5.0 ADULT AND CHILD CORE MEASURE	Clinician and Group	C&G PCMH	T-CHIC **Revised** C&G- PCMH
Who is included?	Medicaid continuous enrolled in a Health Plan > 6 mo.	Had a visit in the last 12 months, no Insurance coverage	Had a visit in the last 12 months, no insurance coverage	Access to care: outpatient visits rate measure, narrowed to primary care, all payers-insurance coverage
How are they surveyed?	Both mailed and telephone	Mailing emphasis	Several choices, minor follow-up RR = <25%	Pre-notices, pre-work, Telephone emphasis in AK
Performance Benchmarks	CAHPS Database & NCQA	CAHPS Database & NCQA	NCQA emerging	T-CHIC plus new practices (n = 50)
Access	Access to: Emergency Care, Specialist Care, Special Equipment, Routine Care	Access: after hours, getting timely appointments, and to information	Same as C&G	Same as C&G (Sample frame can address overall access, specialty care and ED)
Special populations	Children with Chronic Conditions module and adults…race and ethnicity	none	none	*Includes both Children with Chronic Conditions and Adult chronic conditions*
Care Coordination	For Children working with schools, and provider awareness, for adults, provider awareness		Provider seemed informed and up-to-date about the care	*Expanded to include needing extra help coordinating care*
Shared Decision-making	Children with Chronic Conditions module and adults…	Related to Rx only	Related to RX only and for adults only	*Include for both, and several on shared goals, for those making health care choices*

CAHPs – Issues and Limitations

- Doesn't reflect perinatal care.
- Multiple versions and fielding methods.
- Annual- maybe
- Funding segmented by payer
- Analysis, reporting, and converting to action and improvement is very complex and states have limited capacity for analysis and interpretation.

One Solution



Discussion and recommendations

- Assess the sensitivity of measures to changes by number and time
- Identify those measures with added value-
  - Demonstrated that they reflect state Medicaid populations and their health priority areas
  - Are proven sensitive to disparities; including disability, gender, children with special health care needs
  - Are scalable and multi-purpose
- Rethink care-coordination
  - different between adults and children – provider to provider versus provider to community or school
- Rethink integration, from a patient's perspective
  - Systems and services, including 'reverse integration'

336

Discussion and recommendations continued

- Simplify the measures – e.g.. multiple well child visits only because of history
  - % of USPTF A&B for example, not single disease management but person centered, reflect provider, community and patient's priorities and values

  For monitoring and evaluations, a State responsibility, process measures are okay
- Start thinking more broadly about where and how care is provided- behavioral health home, birthing centers, 'retail' location.
- Different managed care organizations have different community relations. Multi-line, national insurers and education and social services relationships integration are not the same as more local health systems.
- Life course versus program criteria – get to a single comprehensive set that is parsimonious, and organic

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?
- What are states experiences with policy-level issues such as alignment, care coordination and community linkage?
- Which policy issues have been the most challenging for states? Please consider alignment, care coordination and community linkage during this discussion.
- What are states' most notable successes related to quality measurement? How are they 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
- Focus on 2015 recommendation: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- 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?

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

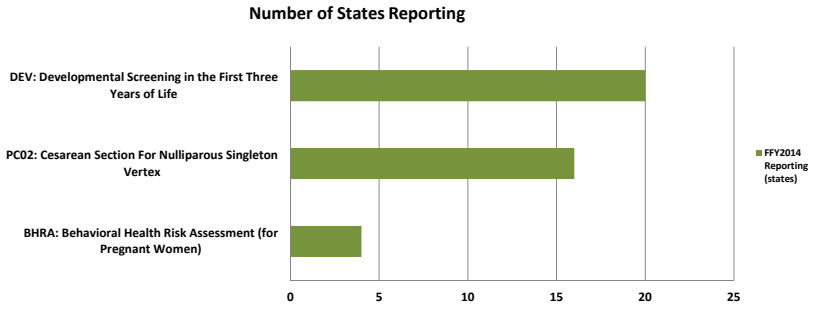
Decision Categories

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

Measures with 4 to 20 states reporting

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



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.

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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).

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

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), and information not collected.

Staff Review: Measures for Potential Removal

- 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?

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?

2015 MAP Recommendation to Include Measure #2799: Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Not NQF Endorsed: Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Not NQF Endorsed: Use of Multiple Concurrent Antipsychotics in Children and Adolescents

- During its 2015 review, MAP recommended that CMS add the measure Use of Multiple Concurrent Antipsychotics in Children and Adolescents to the Child Core Set upon completion of NQF endorsement.
- For the 2016 Child Core Set update, CMCS added the Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure to the 2016 Child Core Set.
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (now measure #2799) was submitted for NQF endorsement.

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Not NQF Endorsed (Measure #2799): Use of Multiple Concurrent Antipsychotics in Children and Adolescents

- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (now measure #2799) was submitted for NQF endorsement, however the Pediatric Measures Steering Committee did not recommend this measure for endorsement because.
  - Importance to measure and report *(must-pass)*: Lack of empirical evidence to support this measure, particularly the specification of 2 antipsychotic medications versus more than 2 antipsychotic medications. No evidence-based threshold or goal for percent of patients on 2 or more antipsychotics exists, only that the percentage should be low. Due to insufficient empirical evidence, this measure did not pass Evidence, but moved forward on Insufficient Evidence with Exception, given the Committee's concern about the importance of the measure focus.
  - Reliability and Validity-scientific acceptability of measure properties *(must-pass)*:
    - Reliability Criterion: While reliability was good at the state level, the measure was not as reliable for Medicaid plans, except those that are large; it was not reliable at the commercial plan level. Because the measure assesses a relatively rare event, a large sample size/population is needed to produce statistically significant results; the Committee found this to be a limitation of the measure. The Committee did not reach consensus on the Reliability criterion.
    - Validity Criterion: Concerns about the consistency of the measure specifications with the evidence. Specifically, the goal of the measure is to assess inappropriate prescribing of antipsychotic medication to children and adolescents, however, the specifications do not measure inappropriate prescribing of antipsychotic medications but use quantity as a proxy. Since the measure did not assess inappropriate prescribing, the Committee agreed #2799 did not meet the Validity criterion.
  - Overall Suitability for Endorsement: Overall, the Committee felt the measure did not get to the specificity of the individual practitioner's problem with prescribing, and did not adequately address situations for which it would be appropriate to prescribe more than 1 antipsychotic at a time. Since #2799 did not pass the must-pass criterion of Validity, it did not move forward and is not endorsed.

Questions

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Measure by Measure Review: Measures for Potential Addition

High-Priority Gaps in Child Core Set

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

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

High-Priority Gaps in Child Core Set - Continued

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

Gap Areas with Measures Currently Available

- Perinatal / Maternity Care (discussed yesterday)
- Asthma (discussed yesterday)
- Care coordination (9)**
- Injuries and Trauma (3)*
- Mental and behavioral health measures (12)**
- Overuse (6)**
- Sickle-cell disease measure (18)**
- Patient-reported outcome measures (10)**
- Dental care measures (10)**
  - *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.*

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

Recommendations for Strengthening the Child Core Set – Staff Picks

Available Measures

NQF #	Measure Name	Measure Steward
2800	Metabolic screening for children and adolescents newly on antipsychotics	NCQA
2797	Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia	Q-METRIC – University of Michigan
2789	Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care	CEPQM

2800 – Metabolic screening for children and adolescents newly on antipsychotics

NQF Endorsed – Steward: National Committee on Quality Assurance

QPS Link: http://www.qualityforum.org/qps/2800

Description:	The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Numerator Statement	Children and adolescents who received glucose and cholesterol tests during the measurement year.
Denominator Statement	Children and adolescents who had ongoing use of antipsychotic medication (at least two prescriptions).
Exclusions:	No exclusions
Data Source:	Administrative claims
Type:	Process

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

2797 – Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia

NQF Endorsed – Steward: Q-METRIC – University of Michigan

QPS Link: http://www.qualityforum.org/qps/2797

Description:	The percentage of children ages 2 through 15 years old with sickle cell anemia (Hemoglobin SS) who received at least one transcranial Doppler (TCD) screening within a year.
Numerator Statement	The numerator is the number of children ages 2 through 15 years old with sickle cell anemia who received at least one TCD screening within the measurement year.
Denominator Statement	The denominator is the number of children ages 2 through 15 years with sickle cell anemia within the measurement year.
Exclusions:	There are no denominator exclusions.
Data Source:	Administrative claims
Type:	Process

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

2789 – Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care

NQF Endorsed – Steward: CEPQM

QPS Link: http://www.qualityforum.org/qps/2789

Description:	The Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care measures the quality of preparation for transition from pediatric-focused to adult-focused health care as reported in a survey completed by youth ages 16-17 years old with a chronic health condition. The ADAPT survey generates measures for each of the 3 domains: 1) Counseling on Transition Self-Management, 2) Counseling on Prescription Medication, and 3) Transfer Planning.
Numerator Statement	The ADAPT survey consists of 26 questions assessing the quality of health care transition preparation for youth with chronic health conditions, based on youth report of whether specific recommended processes of care were received. The ADAPT survey generates measures for each of 3 domains: 1) Counseling on Transition Self-Management, 2) Counseling on Prescription Medication, and 3) Transfer Planning. ADAPT measure scores are calculated using the sum of the proportions of positive responses to between 3 and 5 individual items. Complete instructions for measure score calculations are provided in the Detailed Measure Specifications (Appendix A).
Denominator Statement	The target population of the survey is 16- or 17-year-old adolescents with a chronic health condition who are either (a) receiving health care services in a clinical program or (b) enrolled in a health plan or similar defined population. The denominator for each measure is the number of respondents with valid responses for all of the questions in the measure.
Exclusions:	See excel spreadsheet for full details.
Data Source:	Patient Reported Data/Survey
Type:	PRO

Recommendations for Strengthening the Child Core Set - Results from the homework

Available Measures

NQF #	Measure Name	Measure Steward
n/a	Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Disease	Q-METRIC
n/a	Informed coverage (IC)	The Children's Hospital of Philadelphia (CHOP)
n/a	Duration of first observed enrollment	The Children's Hospital of Philadelphia (CHOP)

n/a – Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Disease

Steward: Q-METRIC

Description:	This measure assesses the percentage of children between the ages of 3 months and 5 years diagnosed with sickle cell disease (SCD) who receive appropriate antibiotic prophylaxis during the measurement year. Preventive (prophylactic) antibiotics markedly reduce the risk of life-threatening infections for children with SCD in this age group. This measure is implemented with administrative claims data and is calculated as two rates: (1) the percentage of children who received preventive antibiotics for at least 300 days and (2) the percentage who received antibiotics for 350 days or more.
Numerator Statement	The numerator is the number of children between the ages of 3 months and 5 years with SCD who receive appropriate preventive antibiotics during the measurement year. Two rates are reported: 1. The percentage of eligible children who received antibiotics for at least 300 days, as determined by administrative record review. 2. The percentage of eligible children who received antibiotics for at least 350 days, as determined by administrative record review.
Denominator Statement	The eligible population consists of children aged 90 days or older on January 1 of the measurement year but younger than 5 years on December 31 of the measurement year who are continuously enrolled in Medicaid and received an appropriate SCD-related ICD-9 code on three or more separate health care encounters during the measurement year (Table 1).
Exclusions:	Claims in the administrative records for any of the SCD variants listed in Table 3 do not count toward the “three or more separate health care encounters” criteria.
Data Source:	Administrative Data
Type:	Process

n/a – Informed coverage (IC)

Steward: The Children’s Hospital of Philadelphia (CHOP)

Description:	
Numerator Statement	For Medicaid/CHIP standalone programs—Summation of covered months for all children over an 18-month observation window. Calculated for Medicaid and CHIP separately. Does not reflect transitions between programs. A month is considered "covered" if a child has greater than 14 enrolled days in that month. this measure. may also be calculated as a program specific measure, taking into account transitions between programs. For jointly administered programs—Summation of covered months for all children in either Medicaid or CHIP program, over an 18-month observation window. Reflects transitions between Medicaid and CHIP. A month is considered "covered" if a child has greater than 14 enrolled days in that month.
Denominator Statement	For Medicaid/CHIP standalone programs—The denominator is the summation of eligible months over an 18-month observation window. The definition of "eligible months" for Informed Coverage is dependent upon whether the natural experiment estimate most closely reflects Coverage Presumed Eligible, Presumed Ineligible, or the average of the two. For jointly administered programs—The denominator is the summation of eligible months over an 18-month observation window.
Exclusions:	
Data Source:	Administrative data
Type:	Process

n/a – Duration of first observed enrollment

Steward: The Children's Hospital of Philadelphia (CHOP)

Description:	
Numerator Statement	For Medicaid / CHIP standalone programs—total number of children continuously enrolled in Medicaid at 6 months, 12 months, and 18 months after initial enrollment during a pre-specified observation period. For jointly administered Medicaid and CHIP programs or programs with the ability to link data across independent programs—total number of children continuously enrolled in Medicaid and CHIP at 6 months, 12 months, and 18 months after initial enrollment during a pre-specified observation period.
Denominator Statement	For Medicaid / CHIP standalone programs—total number of children newly enrolled in Medicaid during a 6, 12, or 18 month pre-specified observation period. Calculated for CHIP separately. For jointly administered Medicaid and CHIP programs or programs with the ability to link data across independent programs—total number of children newly enrolled in Medicaid or CHIP during a 6, 12, or 18 month pre-specified observation period.
Exclusions:	Children 16 years and 5 months or older. This exclusion ensures that children do not reach age 18 or older before the end of the 18-month measurement period and lose age eligibility for Medicaid and CHIP programs. Children previously enrolled in Medicaid or CHIP within 1 month of the beginning of the observation window. Second period of enrollment within the observation window.
Data Source:	Administrative data
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:
  - *#2800 Metabolic Monitoring for Children and Adolescents on Antipsychotics*
  - *#2789 Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care*
  - *#2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia*
  - *n/a – Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Disease*
  - *n/a – Informed coverage (IC)*
  - *n/a – Duration of first observed enrollment*
- 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.
- Maternity Care and Asthma Care measures
- New measures (TBD)

  and
- Measures recommended in 2014 and 2015
  - NQF #2393: Pediatric All-Condition Readmission Measure
  - NQF #2509 Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk
- Measure under pilot testing since 2013
  - NQF #2548: The Consumer Assessment of Healthcare Providers and Systems Hospital Survey – Child Version (Child HCAHPS)

Prioritizing Remaining Gap Areas

High-Priority Gaps in Child Core Set

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

High-Priority Gaps in Child Core Set - Continued

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

Strategy for Filling High Priority Measure Gaps

- Have any of the gap areas been satisfied?
- Do others need to be added?
- Are you aware of specific measures that address identified gaps 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?

Opportunity for Public Comment

Next Steps

Important Dates

- July 6 – August 5: 30-day public comment period on draft reports
- August, Date TBD: MAP Coordinating Committee review of draft reports
- August 31: Final reports due to HHS and made available to the public

Project Contact Info

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

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM

Thank You for Participating!

Measure Applications Partnership
CONVENED BY THE NATIONAL QUALITY FORUM