NATIONAL QUALITY FORUM

Web Meeting Agenda

MAP Dual Eligible Beneficiaries Workgroup

Expedited Review of Initial Core Set of Measures for Medicaid-Eligible Adults

Friday, September 27, 2013

12:00-2:00 pm ET

Participant Instructions:

- Please log in 10 minutes prior to the scheduled start to allow time for troubleshooting
- Direct your browser to: http://nqf.commpartners.com for slides and streaming audio
- Under "Enter a Meeting," type in the meeting number **331070** and click "Enter"
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"
- Workgroup members dial **(877) 829-9898**; use conference ID code **51427334** to access the audio platform.
- Public participants dial (855) 226-0347; use conference code 51427334 to access the audio platform.

Meeting Objectives:

- Establish understanding of experience to date with the Initial Core Set of Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set)
- Evaluate the Medicaid Adult Core Set against the MAP Measure Selection Criteria
- Consider measure alignment opportunities and measure gaps to inform recommendations to the MAP Coordinating Committee

12:00 pm **Welcome and Review of Meeting Objectives**

Alice Lind, Workgroup Chair

12:05 pm **Background on the Initial Core Set of Measures for Medicaid-Eligible Adults**

Amaru Sanchez, Project Analyst, NQF
Allison Ludwig, Senior Project Manager, NQF

- Adult Medicaid population demographics
- Process used to identify the Medicaid Adult Core Set

12:20 pm **Program Experience to Date**

Karen LLanos, Technical Director, Center for Medicaid and CHIP Services, CMS
Margo Rosenbach, Vice President, Mathematica Policy Research

- CMS goals for Medicaid Adult Core Set reporting
- Known successes and challenges in program implementation for consideration by MAP

- Future direction
- Questions from workgroup members

12:45 pm **Evaluation of the Medicaid Adult Core Set with the MAP Measure Selection Criteria**

Megan Duevel Anderson, Project Analyst, NQF
Sarah Lash, Senior Director, NQF
Workgroup Members

- Review characteristics of measures in the Medicaid Adult Core Set
- Consider staff's draft recommendations based on MAP Measure Selection Criteria

1:30 pm **Strengthening the Medicaid Adult Core Set**

Alice Lind
Workgroup Members

- Short term: what actions, if any, would strengthen the measure set?
- Long term: what measures might CMS consider adding to or retiring from the set?

1:40 pm **Implementation Issues to Monitor Going Forward**

Alice Lind
Workgroup Members

- What information about the program implementation experience is needed to support MAP's future decision making?

1:50 pm **Public Comment**

1:55 pm **Next Steps**

2:00 pm **Adjourn**

Measure Applications Partnership

Dual Eligible Beneficiaries Workgroup Web Meeting

September 27, 2013

NATIONAL QUALITY FORUM

Welcome

Dual Eligible Beneficiaries Workgroup Membership

Chair: Alice Lind, MPH, BSN

Organizational Members

American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
Center for Medicare Advocacy	Alfred Chiplin, JD, M.Div.
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP, FACC, FCCP
L.A. Care Health Plan	**Jennifer Sayles, MD**
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

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Subject Matter Experts

Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members

Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

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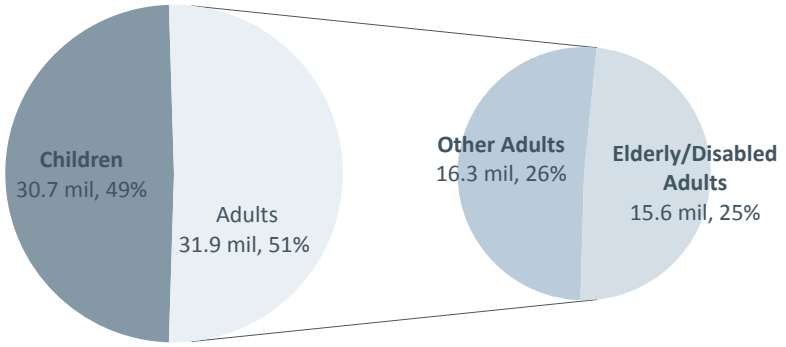
Meeting Objectives

- Establish understanding of experience to date with the Initial Core Set of Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set)
- Evaluate the Medicaid Adult Core Set against the MAP Measure Selection Criteria
- Consider measure alignment opportunities and measure gaps to inform recommendations to the MAP Coordinating Committee

Background on the Initial Core Set of Measures for Medicaid-Eligible Adults

Medicaid Enrollees
(2009, in millions)

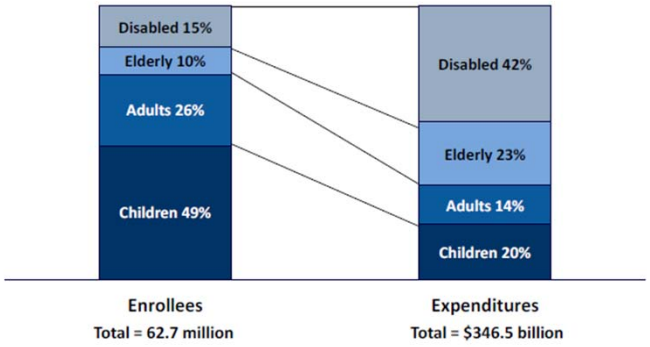


Since 1965, Medicaid has been the source of health coverage for low-income adults and children.

Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on the Nation's Health Coverage Program for Low-Income People.* March 2013.

Medicaid Expenditures for Adults

- In 2009, payments for non-disabled, working-age adults averaged $2,900 per enrollee
- Expenditures for this cohort are much lower, on average, than for individuals with LTSS needs, but still account for 14% of the total.



Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on the Nation's Health Coverage Program for Low-Income People.* March 2013.

Health Status of Current Adult Medicaid Enrollees

Adult enrollees under 65 have significant health conditions and risks.

- Approximately one in five adults on Medicaid reports being in fair or poor physical health.
- Approximately one in seven adults on Medicaid reports fair or poor mental health.
- An estimated 57% of adults ages 21-64 covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.

Kaiser Family Foundation: Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured, June 2009.
Government Office on Accountability: Study on Medicaid Preventive Services, August 2009.

Health Status of Current Adult Medicaid Enrollees

Medicaid is the dominant funder of reproductive health services.

- Nearly two of three adult women on Medicaid are in their reproductive years (19-44).
  - An estimated 48 percent of births were covered by Medicaid in 2010 (from a high of nearly 70 percent in Louisiana to less than 30 percent in New Hampshire and Massachusetts).
  - Medicaid covers approximately two of every three publically-funded family planning services including: prenatal and postpartum care, gynecological services, and testing/treatment of sexually transmitted infections.

Markus, Anne Rossier, et al. "Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues 23.5 (2013): e273-e280.
Kaiser Family Foundation: Health Reform: Implications for Women's Access to Coverage and Care, December 2009.
National Institute for Reproductive Health

Health Status of New/Potential Enrollees

Medicaid expansion under ACA is projected to enroll an additional 10 million adults

- Among *potentially eligible* non-elderly adults:
  - Better self-reported health status (40% "good" vs. 31.6%)
  - Lower prevalence of obesity (34% vs. 43%)
  - Lower prevalence of depression (15% vs. 22%)
  - Higher prevalence of smoking (49% vs. 38%)
  - Higher prevalence of high and moderate alcohol use (22% vs. 16%)
  - Similar levels of diabetes and hypertension

Chang T and Davis M. "Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared with Current Adult Medicaid Beneficiaries." Ann Fam Med September/October 2013 vol. 11 no. 5 406-411

Measure Set and Program Information

Authority Under the Affordable Care Act

ACA requires that the Secretary of HHS identify and publish a recommended initial core set of quality measures for Medicaid-eligible adults. The law calls for HHS to:

1. Develop a standardized reporting format for the core set of measures;
2. Establish an adult quality measurement program;
3. Issue an annual report by the Secretary on the reporting of adult Medicaid quality information; and
4. Publish updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures.

Process for Compiling the Initial Core Set

- In 2010, CMS partnered with AHRQ to form a subcommittee to the AHRQ National Advisory Council for Healthcare Research and Quality.
  - Focused on four measure categories: adult preventive health, maternal/reproductive health, complex health care needs, and mental health and substance use.
  - Reduced approximately 1000 possible measures to a set of 51 measures for public comment.
- Majority of public comments remarked upon the large size of set and suggested that it be aligned with existing programs.
- In January 2012, the final rule was published with a total of 26 measures for voluntary use by states.

State Experience in Collecting the Medicaid Adult Core Set

- The 2-year grant program launched in December 2012, with 26 state participants.
- Grantees are developing staff capacity to collect, report, and analyze the data related to Medicaid Adult Core Set.
- Grantees are also required to conduct two quality improvement projects using measures from the Medicaid Adult Core Set.
- Participating states receive technical assistance and analytic support.
- Non-grantee states can also chose to collect and report the Medicaid Adult Core Set measures

Future Program Activities

- Voluntary reporting of measure data to CMS is scheduled to begin in Fall 2013.
- By January 1, 2014, HHS will:
  - Annually publish recommended changes to the Medicaid Adult Core Set that reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.
  - Include information on adult health quality in the mandated report to Congress. This report must be published every 3 years thereafter in accordance with the statute.
- By September 30, 2014, HHS will:
  - Collect, analyze, and make publicly available the information reported by the States as required in section 1139B(d)(1) of the Act.

Program Experience to Date

CMS Goals for Medicaid Adult Core Set

The three-part goal for the Medicaid Adult Core Set is to continually increase:

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

Status of the Adult Core Set

- Reporting is just ramping up
  - Voluntary reporting for states; first reporting deadline January 20, 2014
- Grantees providing insight into feasibility of reporting Core Set
  - 26 grantee states are required to report at least 15 measures in 2014
  - Grantee progress reports indicate states are working on collecting data, testing programming specifications, and calculating the measures
- Developing TA resources to support states with FFY 2013 reporting
  - Amendments to specifications to add definitions, codes, and clarifications, where new information is available
  - Planning for training webinar to promote reporting of measures by grantee and non-grantee states

Challenges Encountered

- 59 TA requests/questions since release of technical specifications in February 2013
  - All requests from Adult Medicaid Quality Grantees
- Reporting physician-level and hospital-level measures at state level is a challenge
  - Also impacts measure stewards who are unsure how to provide guidance if measure was not originally intended for state-level reporting
  - Examples: PC-01: Elective Delivery, PC-03: Antenatal Steroids, and Screening for Clinical Depression and Follow-Up Plan
- Measures that require medical record review to determine the numerator, denominator, and/or exclusions
- Some measures need clearer technical specifications
  - Lack of NDC codes or diagnostic codes
  - Definition of additional data elements not included in original specifications

Measure-Specific Challenges

- Loss of endorsement affects several measures
  - Looking for MAP feedback on how to handle
- Loss of steward maintenance
  - Annual HIV Medical Visit
- Risk adjustment issues
  - Plan All Cause Readmissions
    - » CMS plans to work with NCQA to develop Medicaid risk-adjustment
    - » Discussions are also underway on whether Medicaid should align with Hospital-Wide All-Cause Unplanned Readmission Measure used by Inpatient Quality Reporting Program

Future Direction/Next Steps

- State health official letter to be released January 2014
- CMS required to publicly report state data
  - Report to Congress every three years (beginning January 2014)
  - Annual Secretary's Report (beginning September 30, 2014)
- Measure development to begin in FFY2014
  - Key gap areas from Core Set (such as care coordination, outcomes)
  - Managed long-term care services and supports
  - Health homes for people with chronic conditions

How CMS Will Use MAP Feedback

- MAP's input will be used to inform CMS's recommendations to strengthen the Core Set and in targeting measure development
- In future years, MAP will help CMS identify ways to strengthen the Medicaid Adult Core Set
  - Which measures to retire
  - Which measures to add
  - Ways to better align with other CMS/HHS programs

Evaluation of the Medicaid Adult Core Set with the Measure Selection Criteria

Medicaid Adult Core Set Measures

NQF #	Measure Name	Measure Steward
0039	Flu Shots for Adults Ages 50-64	NCQA
n/a	Adult BMI Assessment	NCQA
0031	Breast Cancer Screening	NCQA
0032	Cervical Cancer Screening	NCQA
0027	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA
0418	Screening for Clinical Depression and Follow-Up Plan	CMS
1768	Plan All-Cause Readmission	NCQA
0272	PQI 01: Diabetes, Short-Term Complications Admission Rate	AHRQ
0275	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	AHRQ
0277	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ
0283	PQI 15: Adult Asthma Admission Rate	AHRQ
0033	Chlamydia Screening in Women Ages 21-24	NCQA

NQF #	Measure Name	Measure Steward
0576	Follow-Up After Hospitalization for Mental Illness	NCQA
0469	PC–01: Elective Delivery	Joint Commission
0476	PC–03 Antenatal Steroids	Joint Commission
0403	Annual HIV/AIDS Medical Visit	NCQA
0018	Controlling High Blood Pressure	NCQA
0063	Comprehensive Diabetes Care: LDL–C Screening	NCQA
0057	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA
0105	Antidepressant Medication Management	NCQA
n/a	Adherence to Antipsychotics for Individuals with Schizophrenia	CMS
0021	Annual Monitoring for Patients on Persistent Medications	NCQA
0006/0007	CAHPS Health Plan Survey v 4.0—Adult Questionnaire with CAHPS Health Plan Survey v 4.0H—NCQA Supplemental	AHRQ, NCQA
0648	Care Transition—Transition Record Transmitted to Health Care Professional	AMA-PCPI
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA
1391	Prenatal and Postpartum Care: Postpartum Care Rate	NCQA

Properties of the Medicaid Adult Core Set Measures

Measure Properties	Measure Sub-Properties	Measure Count (Total n=26)
NQF Endorsement	Endorsed	22
	Endorsement Removed	4
Measure Type	Outcome	7
	Process	19
Care Setting	Ambulatory Care	22
	Behavioral Health	5
	Home Health	5
	Hospital/Acute Care	10
	Post-Acute/Long-Term Care	4
	Other (e.g., Pharmacy)	3
Alignment	Included in Another Federal Program	20
	Included in a State Duals Integration Demonstration	16

MAP Measure Selection Criteria (current)

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-centered care and services
6. Program measure set includes considerations for healthcare disparities and cultural competency
7. Program measure set promotes parsimony and alignment

Draft Recommendation #1

Challenge: There is not a risk adjustment methodology for the Medicaid population in the "Plan All Cause Readmissions" measure.

- Draft Recommendation:
  - Risk adjustment is necessary to fairly interpret measure results. Without it, one cannot determine if differences in performance are due to overall quality or the characteristics of the denominator population.
  - CMS should promptly proceed with planned effort to develop a risk adjustment model for the Medicaid population.

Draft Recommendation #2

Challenge: Measures #0647 and 0648 are *paired measures* designed to be used together but only #0648 is included.

- Draft Recommendation:
  - Communication upon discharge from a hospital is vital for safe and effective care transitions.
  - #0647 relates to provider-to-patient communication and #0648 relates to provider-to-provider communication.
  - CMS should consider adding #0647 "Transition Record with Specified Elements Received by Discharged Patients" to the measure set; doing so enhances person-centeredness and may also improve the feasibility of data collection for #0648.

Draft Recommendation #3

Challenge: #0031 "Breast Cancer Screening" has lost NQF endorsement since the Core Set was finalized

- Draft Recommendation:
  - MSC-1 states a requirement for the use of NQF-endorsed measures, if available, because of their recognized rigor.
  - However, measures undergo periodic updates by their developers and the most current versions may not have been reviewed by NQF at a particular point in time.
  - In cases when a measure has lost endorsement but the steward intends to resubmit an updated version, use of the most current version should proceed.
    - "Breast Cancer Screening" was updated in HEDIS specifications for 2014. NCQA will likely submit the revised measure at the next opportunity offered by NQF.

Draft Recommendation #4

Challenge: #0403 "Annual HIV/AIDS Medical Visit" has lost NQF endorsement since the Core Set was finalized

- Draft Recommendation:
  - Endorsement can be removed during the endorsement maintenance process or at the request of a measure steward.
  - In cases when a measure has lost endorsement and it is not updated or replaced with a superior measure, use of the measure should stop.
  - HIV/AIDS is a high-impact condition in the Medicaid population and CMS should consider a replacement, such as:
    - #0573 "HIV Screening: Members at High Risk of HIV"
    - #2082 "Viral Load Suppression"
    - #2083 "Prescription of HIV Antiretroviral Therapy Regardless of Age"

Draft Recommendation #5

Challenge: #0021 "Annual Monitoring for Patients on Persistent Medications" has lost NQF endorsement since the Core Set was finalized

- Draft Recommendation:
  - The measure was withdrawn by the steward during its most recent maintenance review. Though NCQA stated an intention to revise and resubmit the measure, it is not currently endorsed.
  - Similar to previous recommendations, the measure should be updated or replaced with a superior measure on the same topic.
  - Medication management is a vital quality indicator but currently endorsed measures tend to focus on single medications (e.g., warfarin) or an older population (65+) and are not appropriate for a broad-based program.

Draft Recommendation #6

Challenge: #0039 "Flu Shots for Adults Ages 50-64" excludes Medicaid enrollees 18-59

- Draft Recommendation:
  - CDC recommends that all adults receive annual vaccination against the flu. Moreover, pregnant women, older adults, and people with certain chronic conditions or disabilities are at higher risk.
  - CMS should consider a replacement measure that includes a broader denominator age range, such as #0041 "Influenza Immunization"
    - » #0041 aligns with other programs including Meaningful Use Stage 2, PQRS, and MSSP

Discussion: Strengthening the Measure Set

- **Short term**: what additional actions, if any, would strengthen the measure set?
- **Long term**: what measures might CMS consider adding to or retiring from the set?

Discussion: Implementation Issues to Monitor

- What information about the program implementation experience is needed to support MAP's future decision-making?
  - Feasibility of data collection
  - Testing scientific properties of measures altered after endorsement
  - Others?

Opportunity for Public Comment

Important Dates

- **October 1-11:** NQF Member and Public comment on draft recommendations
- **October 3:** Review of draft recommendations by MAP Coordinating Committee
- **October 15:** Final MAP recommendations due to HHS

Save the Date for Workgroup's Next Web Meeting: November 21, 1:00-3:00 ET

Thank you for participating

Adult Medicaid Enrollees: Population Profile

Since 1965, Medicaid has been an important source of health coverage for low-income adults and children. Enrollment is projected to rise from 15 percent of the country's population in 2010 to 25 percent in 2020, further increasing the influence of Medicaid coverage on health outcomes.[1] At last count (2009), 62.7 million people were covered by Medicaid, including 30.7 million children, 16.3 million adults, and 15.6 million elderly or disabled individuals.[2]

Medicaid spending per enrollee varies sharply by eligibility group. In 2009, average payments for were $2,300 per child, $2,900 per non-elderly adult, $15,840 per disabled enrollee, and $13,150 per elderly enrollee.[3] Non-elderly, non-disabled adults consume relatively fewer resources than individuals who receive long-term supports and services, but their healthcare needs can still be significant. Adults' access to high-quality preventive care and chronic disease management services greatly affects their overall health.

- Approximately one in five adults on Medicaid reports fair or poor physical health.[4]
- Approximately one in seven adults on Medicaid reports fair or poor mental health.[5]
- Nearly two of three adult women on Medicaid are in their reproductive years (19-44).
    - An estimated 48 percent of births were covered by Medicaid in 2010 (from a high of nearly 70 percent in Louisiana to less than 30 percent in New Hampshire and Massachusetts).[6]
    - Medicaid covers approximately two of every three publically-funded family planning services including: prenatal and postpartum care, gynecological services, and testing/treatment of sexually transmitted infections.[7]
- An estimated 57% of adults covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.[8]
- Adults covered by Medicaid tend to be non-white, unmarried, and to have less than a high school level of education.[9]

Medicaid expansion under the Affordable Care Act is projected to enroll an additional 10 million adults who differ from current beneficiaries in numerous ways:[10]

- Better self-reported health status (40% "good" vs. 31.6%)
- Lower prevalence of obesity (34% vs. 43%) and depression (15% vs. 22%)
- Higher prevalence of smoking (49% vs. 38%) and of high and moderate alcohol use (22% vs. 16%)

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[1] Center for Health Care Strategies. *Toward 2014: Perspectives on Shaping Medicaid's Future*. May 2013.
[2] Kaiser Commission on Medicaid and the Uninsured. *Medicaid Primer: Key Information on the Nation's Health Coverage Program for Low-Income People*. March 2013.
[3] *Ibid.*
[4] Medicaid and CHIP Payment and Access Commission (MACPAC). *Report to Congress on Medicaid and CHIP*. June 2012.
[5] Kaiser Family Foundation: Low-Income Adults Under Age 65-Many are Poor, Sick, and Uninsured, June 2009.
[6] Markus, Anne Rossier, et al. "Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform." Women's Health Issues 23.5 (2013): e273-e280.
[7] Kaiser Family Foundation: Health Reform: Implications for Women's Access to Coverage and Care, December 2009.
[8] Kaiser Family Foundation: Low-Income Adults Under Age 65 — Many are Poor, Sick, and Uninsured,
June 2009. Government Office on Accountability: Study on Medicaid Preventive Services, August 2009.
[9] Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid and CHIP. June 2012.
[10] Chang T and Davis M. "Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared with Current Adult Medicaid Beneficiaries." Ann Fam Med September/October 2013 vol. 11 no. 5 406-411

Program Information:

Initial Core Set of Adult Health Care Quality Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set)

Statutory Authority

The Affordable Care Act (ACA, section 1139B) requires that the Secretary of Health and Human Services (HHS) identify and publish for public comment a recommended initial core set of health care quality measures for Medicaid-eligible adults.[i] The statute requires the initial core set to be comprised of "existing adult health care quality measures in use under public and privately sponsored health care coverage arrangements or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time and that may be applicable to Medicaid-eligible adults."[ii]

To assess the quality of care for adults enrolled in Medicaid, the law calls for HHS to:

1. Develop a standardized reporting format for the core set of measures;
2. Establish an adult quality measurement program;
3. Issue an annual report by the Secretary on the reporting of adult Medicaid quality information and a Report to Congress every three years; and
4. Publish updates to the initial core set of adult health quality measures that reflect new or enhanced quality measures.[iii]

Process for Compiling the Initial Core Set of Measures for Medicaid-Eligible Adults

In 2010, the Centers for Medicare and Medicaid Services (CMS) partnered with the Agency for Healthcare Research and Quality (AHRQ), and developed a subcommittee to the National Advisory Council for Healthcare Research and Quality. The subcommittee was charged with considering the health care quality needs of adults ages 18 and older enrolled in Medicaid. Members represented a broad range of experts and stakeholders, including multiple individuals serving on the NQF-convened Measure Applications Partnership (MAP).

The subcommittee focused on four dimensions of health care related to adults enrolled in Medicaid: adult health, maternal/reproductive health, complex health care needs, and mental health and substance use. From a starting place of approximately 1,000 measures from nationally recognized sources, the group deliberated and identified 51 measures for public comment.

Public comments commonly remarked upon the large size of the measure set and suggested that it be aligned with existing reporting programs to reduce data collection and reporting burden. Other, less frequent comments suggested: 1) avoiding measures that require medical record review, 2) using only measures endorsed by NQF, 3) the appropriateness of some proposed measures, and 4) including measures related to the topics of patient safety and rehabilitation. Additionally, commenters cumulatively suggested that 43 measures be considered for addition to the set, many of which had been previously considered.

Following public comment, the subcommittee considered how to reduce the size of the measure set utilizing five criteria identified by AHRQ and CMS that were based on NQF's endorsement criteria: importance, scientific evidence supporting the measure, scientific

soundness of the measure, current use in and alignment with existing Federal programs; and feasibility for state reporting. CMS further refined the core measure set. In January 2012, the final rule was published with a total of 26 measures for voluntary use by states as the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set).[iv]

State Experience in Collecting the Medicaid Adult Core Set Measures: Adult Medicaid Quality Grants

To assist in understanding how well the Medicaid Adult Core Set measures and their technical specifications could be collected by states, CMS launched a two-year grant program in December 2012. As part of this grant program, 26 Medicaid agencies are developing staff capacity to collect, report, and analyze data on the Medicaid Adult Core Set. In addition, the grantees are required to conduct two quality improvement projects using measures from the Core Set. States receive technical assistance and analytic support as part of the grant program.

Through this grant program, states' Medicaid agencies will be able to identify opportunities for improving health care quality for the Medicaid population, while CMS will be better able to understand the value and potential uses of the Medicaid Adult Core Set measures.

Future Activities

Voluntary reporting of measure data to CMS is scheduled to begin at the end of 2013.[v]

By January 1, 2014, HHS will:

- Annually publish recommended changes to the Medicaid Adult Core Set that reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.
- Include information on adult health quality in the mandated report to Congress. This report must be published every 3 years thereafter in accordance with the statute.

By September 30, 2014, HHS will:

- Collect, analyze, and make publicly available the information reported by the states as required in section 1139B(d)(1) of the Act.[vi]

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[i] Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults. *Fed Regist*. 2012;77(2):286-291. Available at http://www.gpo.gov/fdsys/pkg/FR-2012-01-04/html/2011-33756.htm. Last accessed September 2013.

[ii] *Fed Regist*. 2012;77(2):286-291.

[iii] Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Service (CMS)s. *Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2013*. Baltimore, MD:CMS; 2013. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93PM-Adult-Health-Care-Quality-Measures.html. Last accessed September 2013.

[iv] *Fed Regist*. 2012;77(2):286-291.

[v] Quality of Care. Medicaid.gov. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Adult-Quality-Grants-FAQ.pdf. Last accessed September 2013.

[vi] *Fed Registr*. 2012;77(2):286-291.

MAP Measure Selection Criteria

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

Criteria

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

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

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

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

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

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

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

Sub-criterion 2.3 Affordable care

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

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

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

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

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

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

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

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

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

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

Sub-criterion 4.2 Public reporting program measure sets should emphasize measures of patient experience and patient-reported outcomes

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

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

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

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

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

Sub-criterion5.3 Measure set enables assessment of the person's care and services across providers, settings, and time

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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