# Measure Applications Partnership: Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults

*DRAFT FOR PUBLIC COMMENT*

*September 30, 2013*

# I. Introduction

The Measure Applications Partnership (MAP) is a multi-stakeholder group of public- and private-sector organizations and experts convened by the National Quality Forum (NQF). The Department of Health and Human Services (HHS) recently engaged MAP to provide input on the Initial Core Set of Measures for Medicaid-Eligible Adults (Medicaid Adult Core Set or Core Set). The MAP Dual Eligible Beneficiaries Workgroup reviewed the Core Set and provided its input to the MAP Coordinating Committee, which will issue final MAP input to HHS (see Appendices A and B for workgroup and committee rosters).

In its review of the measures, MAP identified opportunities to revise and strengthen the Medicaid Adult Core Set. MAP offers a mix of measure-specific and general recommendations to improve the accuracy, breadth, and feasibility of reporting the Medicaid Adult Core Set. This report also includes information that was provided to the workgroup as background to inform its review of the Core Set, specifically an overview of the population of adults enrolled in Medicaid and the purpose and history of the Adult Medicaid Quality Reporting Program.

HHS will use MAP's findings to inform an update of the Medicaid Adult Core Set required by statute to occur in 2014. A MAP Medicaid Task Force will convene in 2014 to provide additional input on future revisions.

# II. The Adult Medicaid Population

Since 1965, Medicaid has been an important source of health coverage for low-income adults and children. Following Medicaid expansion under the Affordable Care Act (ACA), enrollment is projected to rise from 15 percent of the country's population in 2010 to 25 percent in 2020.[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]

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

MAP considered the overall health status of adult Medicaid enrollees and conditions that are common in the population to ensure that measures in the Adult Core Set were appropriately tailored. Overall, it is important to note that approximately one in five adults younger than 65 on Medicaid reports fair or poor physical health; approximately one in seven reports fair or poor mental health.[4,5] In addition, Medicaid plays a dominant role in covering reproductive health services. Nearly two in three adult women on Medicaid are in their reproductive years (19-44) and an estimated 48 percent of births in the U.S. were paid for by Medicaid in 2010.[6] Finally, an estimated 57% of adults covered by Medicaid are overweight, diabetic, hypertensive, have high cholesterol, or a combination of these conditions.[7]

New adult Medicaid enrollees have a slightly different profile, and MAP also considered this in its review. Potentially eligible adults under ACA expansion are projected to have better or equal health status than current enrollees, with lower rates of obesity and depression.[8] However, the prevalence of

other behavioral health conditions may be higher. In addition, 49% of potentially eligible adults report using tobacco and 22% report high or moderate alcohol use.[9] These use rates are significantly higher among new enrollees than current enrollees and underline the importance of addressing these and other modifiable risk factors.

MAP also considered demographic factors and social determinants of health. Adults covered by Medicaid tend to be non-white, unmarried, and to have less than a high school level of education.[10] Medicaid enrollees are affected by disparities in health and healthcare, often facing barriers to accessing needed services.

# III. Overview of the Medicaid Adult Core Set Program

## Statutory Authority

The Affordable Care Act (ACA, section 1139B) requires that the Secretary of HHS identify and publish for public comment a recommended initial core set of health care quality measures for Medicaid-eligible adults.[11] 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."[12]

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 of care 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.[13]

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

In 2010, the Centers for Medicare & 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 who also serve on 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. Starting from approximately 1,000 measures drawn 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) re-examining the appropriateness of some proposed measures, and 4) including measures related to the topics of patient safety and rehabilitation. Additionally, comments

cumulatively suggested that 43 measures be considered for addition to the set, many of which had been previously considered.

Following public comment, CMS considered how to reduce the size of the measure set utilizing five criteria identified 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. In January 2012, CMS published the final rule 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.[14]

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

CMS has identified a three-part goal for this quality reporting program: increasing the number of states reporting Medicaid Adult Core Set measures, increasing the number of measures reported by each state, and increasing the number of states using Core Set measures to drive quality improvement.

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.

Early feedback from the grantees has provided better understanding of the feasibility of implementing the measures in the Medicaid Adult Core Set. Specific challenges have included reporting physician-level and hospital-level measures at the state level, difficulties with measures that require medical record review, and the need for more detailed and straightforward technical specifications. Grantee feedback will continue to be monitored and shared with MAP for future decision-making.

### Future Activities

Voluntary reporting of Medicaid Adult Core Set measure data to CMS is scheduled to begin at the end of 2013.[15] By January 1, 2014, HHS will annually publish recommended changes to the Core Set that reflect the results of the testing, validation, and consensus process for the development of adult health quality measures. 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.[16] HHS will also include information on adult health quality in a mandated report to Congress, to be published every 3 years in accordance with the statute.

## IV. MAP Review of the Medicaid Adult Core Set

MAP considered the current version of the MAP Measure Selection Criteria (MSC) (Appendix C) to evaluate the strength of the Medicaid Adult Core Set. The MSC are intended to assist MAP with identifying characteristics that are associated with ideal measure sets used for public reporting and payment programs. MAP used the MSC to guide the evaluation of the program measure set and its ability to meet the program goals outlined by CMS.

Table 1 describes the properties of the 26 measures included in the Medicaid Adult Core Set. Some characteristics such as care setting and level of analysis are not mutually exclusive; measures are specified for more than one. Measures may also be in both one or more Federal program(s) and a State Dual Eligible Beneficiaries Integration Demonstration. Overall, the majority of measures in the Medicaid Adult Core Set are NQF-endorsed process measures; are most commonly applied to the ambulatory care setting; can be analyzed for health plans and populations; and align with other public and private programs.

**Table 1: Medicaid Adult Core Set Measure Properties**

| Measure Properties | Measure Sub-Properties | Measure Count (Total n=26) |
|---|---|---|
| NQF Endorsement | Endorsed | 21 |
| | Not Currently Endorsed | 5 |
| Measure Type | Outcome | 7 |
| | Process | 19 |
| Care Setting | Ambulatory Care | 21 |
| | Behavioral Health | 4 |
| | Hospital/Acute Care | 9 |
| | Post-Acute/Long-Term Care | 3 |
| | Other (e.g., Pharmacy) | 3 |
| Level of Analysis | Clinician | 12 |
| | Facility | 3 |
| | Health Plan | 17 |
| | Integrated Delivery System | 9 |
| | Population | 15 |
| Alignment | In Another Federal Program | 19 |
| | In a State Duals Integration Demonstration | 15 |
| | In one or more of MAP's Families of Measures | 12 |
| | In NCQA's HEDIS Program | 17 |

## General Recommendations

Application of the MAP MSC generated a series of general recommendations to strengthen the Medicaid Adult Core Set over time. In assessing the Core Set, MAP found that it is adequate to advance CMS' stated goals for the program. MAP judged the Core Set to have a satisfactory number of outcome measures, to give sufficient attention to the three aims and six priorities of the National Quality

Strategy, and to be sensitive to health disparities. The Medicaid Adult Core Set is particularly strong in its alignment with other program sets and its parsimonious number of measures.

MAP's other general recommendations primarily relate to the need for the measure set to evolve in parallel with advances in the field of health care quality measurement and encourage development of new measures in key areas. In selecting measures for the first iteration of the Medicaid Adult Core Set, CMS was limited to those that were currently available for immediate use. As revisions are published and additions are considered, MAP encourages CMS to consult MAP's families of measures for promising measures and measure concepts.

Though several measures in the Medicaid Adult Core Set relate to mental health, they are fairly narrow in scope. Behavioral health conditions are highly prevalent in the Medicaid population and affect both mental and physical wellness. Too often, these conditions are not diagnosed and treated. MAP suggests that development of a composite measure of mental health screening could help address this issue. Such a composite should include a wide variety of conditions, including depression, schizophrenia, and anxiety disorders.

MAP noted an additional gap area related to structural measures of access to care. These are important because of their relationship to health care disparities and providers' and systems' cultural competency. Measuring variability in states' provision of wrap-around support services may illustrate marked differences in beneficiaries' ability to access needed supports. These include enrollment assistance and benefit navigation, specialized services for individuals with disabilities, transportation, and translation services.

Finally, and perhaps most importantly, the field lacks performance measures that evaluate goal-directed, person-centered care and outcomes that matter to individuals enrolled in Medicaid. MAP members remarked on the clinical orientation of the measure set and its inability to gauge fundamental concepts such as functional status and community integration. MAP strongly encourages CMS to pursue development activities in these topic areas.

## Measure-Specific Recommendations

Application of the MAP MSC also generated a series of measure-specific recommendations to immediately strengthen the Medicaid Adult Core Set. Several relate to MSC #1 and the general principle that the best available NQF-endorsed measures are strongly preferred for use in program measure sets. For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or possible substitutions as detailed below.

### *NQF #0031: Breast Cancer Screening*

**Discussion:** Breast Cancer Screening has lost NQF endorsement since the Medicaid Adult Core Set was published. Since that time, the measure steward, the National Committee on Quality Assurance (NCQA), has completed an update of the measure that incorporates new clinical practice guidelines and has included new specifications in the 2014 HEDIS manual. NCQA plans to submit the revised measure at the next endorsement review opportunity offered by NQF.

**Recommendation:** MAP requires the use of NQF-endorsed measures in program sets, if available, because of their recognized rigor. While this measure is not currently endorsed, MAP supports

continued focus on breast cancer screening. MAP recommends that CMS use the most current version of the measure in the Medicaid Adult Core Set and encourages NCQA to submit the updated measure for NQF endorsement.

### *NQF #0403: Annual HIV/AIDS Medical Visit*

**Discussion:** Annual HIV/AIDS Medical Visit has lost NQF endorsement since the Medicaid Adult Core Set was published. Endorsement was removed during the measure's most recent maintenance review. The measure steward, NCQA, has no intention to edit and resubmit the measure.

**Recommendation:** In cases when a measure has lost endorsement and it is not updated or replaced, use of the measure should stop. Such a measure should be replaced in the program set by a superior measure on the same topic. HIV/AIDS is a high-impact condition in the Medicaid population and MAP recommends that CMS consider another NQF-endorsed HIV/AIDS measure as a replacement. MAP strongly supports use of measure #2082: Viral Load Suppression because it is a highly meaningful and regularly collected clinical indicator that is predictive of overall outcomes. This measure is also perceived as relatively less burdensome for data collection because it can be drawn from administrative data. The workgroup also supported #2083: Prescription of HIV Antiretroviral Therapy Regardless of Age as a possible alternative.

### *NQF #0021: Annual Monitoring for Patients on Persistent Medications*

**Discussion:** Annual Monitoring for Patients on Persistent Medications has lost NQF endorsement since the Medicaid Adult Core Set was published. The steward, NCQA, withdrew this measure from consideration during its most recent maintenance review. NCQA has not yet determined whether they will revise and resubmit the measure.

**Recommendation:** The measure should be updated or replaced with an endorsed measure on the same topic. Medication management is a vital quality indicator. However, currently endorsed measures tend to focus on single medications (e.g., warfarin) or an older population (65+) and are not as appropriate for a broad-based program like the Medicaid Adult Core Set. MAP recommends that CMS retain the measure in the set for the time being, monitor measure development in this topic area, and update or replace the measures as soon as a suitable alternative is available.

### *NQF #0039: Flu Shots for Adults Ages 50-64*

**Discussion:** Flu Shots for Adults Ages 50-64 excludes Medicaid enrollees 18-49, a large portion of the Medicaid population. The Centers for Disease Control and Prevention (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 of poor outcomes if they become infected.

**Recommendation:** MAP recommends that the measure be expanded to include all adults. The measure steward, NCQA, has completed an update of the measure that broadens the denominator age group to include all individuals age 18 and older and has included new specifications in the 2014 HEDIS manual. MAP strongly encourages NCQA to submit the new specifications to NQF during the measure's annual update process. MAP further recommends that CMS use the most current, expanded version of the measure in the Medicaid Adult Core Set.

### *NQF# 1690: Adult Body Mass Index (BMI) Assessment*

**Discussion:** Adult Body Mass Index (BMI) Assessment has not been NQF-endorsed. The steward, NCQA, withdrew this measure from consideration and intends to revise and re-submit the measure for future NQF review.

**Recommendation:** The measure should be updated or replaced with an endorsed measure on the same topic. Obesity is common in the Medicaid population, and MAP recommends that CMS consider an NQF-endorsed measure as a replacement if NCQA's update is not forthcoming. MAP specifically supports use of measure #0421: Preventive Care and Screening: BMI Screening and Follow-Up, as an alternative. This NQF-endorsed measure complies with the current USPSTF recommendations. It is possible to collect measure #0421 from administrative claims data or electronic medical records, an important consideration for the feasibility of implementing this measure in the Medicaid Adult Core Set.

### *NQF #1768: Plan All-Cause Readmissions*

**Discussion:** There is not a risk adjustment methodology for the Medicaid population in Plan All-Cause Readmissions. 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. The health of the adult Medicaid population has been shown to be significantly different than the general population and justifies use of an appropriate risk adjustment methodology.

**Recommendation:** MAP stressed the importance of risk adjustment for the Medicaid population and strongly supports CMS' planned effort to work with the measure steward to develop a Medicaid-specific methodology. MAP also encourages CMS to consider other potential applications of this work to other measurement programs for the Medicaid population.

### *NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)*

**Discussion:** Transition Record with Specified Elements Received by Discharged Patients and Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) are paired measures; however, only #0648 is included in the Medicaid Adult Core Set. Safe and effective care transitions after discharge from a hospital environment are highly dependent upon many levels of communication. Transition records need to be effectively shared with providers receiving the hand-off as well as individuals being discharged and their families and caregivers. Participants in the review noted that these measures are specified for the facility level of analysis and therefore are more challenging to collect than those designed for populations or health plans. CMS noted that they are aware of the difficulties and view Timely Transmission of Transition Record as a "stretch" measure but want to encourage states to build the relationships with providers that are necessary to collect and report this measure.

**Recommendation:** CMS should consider adding Transition Record with Specified Elements Received by Discharged Patients to the measure set. Doing so would enhance person-centeredness and may also improve the feasibility of data collection for Timely Transmission of Transition Record. MAP noted that these paired measures do not fully address the important issue of care coordination, however Timely Transmission of Transition Record is the only measure in the Medicaid Adult Core Set that directly assess care coordination, and so it should be preserved.

## V. Future Activities

In the coming months, CMS and its technical assistance team will work with participating states to complete the first submission of performance measure data to CMS. This data is scheduled to be made publicly available by September 30, 2014. CMS is also planning to begin measure development activities in 2014, moving one step closer to making new measures available to fill key gaps in the Core Set.

MAP will have the opportunity to conduct a second review of the Medicaid Adult Core Set in mid-2014. NQF and MAP will continue to work closely with CMS and its technical assistance providers to monitor implementation challenges and further opportunities for strengthening the Core Set. At the request of MAP members, NQF will support future deliberations by gathering information on the feasibility of data collection at the state level, monitoring the testing of scientific properties of any measures altered after endorsement, understanding data collection methodologies, and how states are acting on the performance data they collect.

## Appendix A: Roster for the MAP Dual Eligible Beneficiaries Workgroup

| CHAIR (VOTING) |
|---|
| Alice Lind, MPH, BSN |

| ORGANIZATIONAL MEMBERS (VOTING) | REPRESENTATIVE |
|---|---|
| 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 |
| America's Essential Hospitals | Steven Counsell, MD |
| Center for Medicare Advocacy | Alfred J. Chiplin, JD, MDiv |
| Consortium for Citizens with Disabilities | E. Clarke Ross, DPA |
| Humana, Inc. | George Andrews, MD, MBA, CPE |
| L.A. Care Health Plan | Jennifer Sayles, MD, MPH |
| 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 |

| EXPERTISE | INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING) |
|---|---|
| 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 (NON-VOTING, EX OFFICIO) | REPRESENTATIVE |
|---|---|
| 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, MPP |

| FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO) | REPRESENTATIVE |
| --- | --- |
| Substance Abuse and Mental Health Services Administration | Lisa Patton, PhD |
| Veterans Health Administration | Daniel Kivlahan, PhD |

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

## Appendix B: Roster for the MAP Coordinating Committee

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

| ORGANIZATIONAL MEMBERS (VOTING) | REPRESENTATIVES |
| --- | --- |
| AARP | Joyce Dubow, MUP |
| Academy of Managed Care Pharmacy | Marissa Schlaifer, RPh, MS |
| AdvaMed | Steven Brotman, MD, JD |
| AFL-CIO | Representative to be determined |
| America's Health Insurance Plans | Aparna Higgins, MA |
| American College of Physicians | David Baker, MD, MPH, FACP |
| American College of Surgeons | Frank Opelka, MD, FACS |
| American Hospital Association | Rhonda Anderson, RN, DNSc, FAAN |
| American Medical Association | Carl Sirio, MD |
| American Medical Group Association | Sam Lin, MD, PhD, MBA |
| American Nurses Association | Marla Weston, PhD, RN |
| Catalyst for Payment Reform | Suzanne Delbanco, PhD |
| Consumers Union | Lisa McGiffert |
| Federation of American Hospitals | Chip Kahn |
| LeadingAge | Cheryl Phillips, MD, AGSF |
| Maine Health Management Coalition | Elizabeth Mitchell |
| National Alliance for Caregiving | Gail Hunt |
| National Association of Medicaid Directors | Foster Gesten, MD, FACP |
| National Business Group on Health | Shari Davidson |
| National Partnership for Women and Families | Representative to be determined |
| Pacific Business Group on Health | William Kramer, MBA |
| Pharmaceutical Research and Manufacturers of America (PhRMA) | Christopher Dezii, RN, MBA,CPHQ |

| EXPERTISE | INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING) |
| --- | --- |
| Child Health | Richard Antonelli, MD, MS |
| Population Health | Bobbie Berkowitz, PhD, RN, CNAA, FAAN |
| Disparities | Marshall Chin, MD, MPH, FACP |
| Rural Health | Ira Moscovice, PhD |
| Mental Health | Harold Pincus, MD |
| Post-Acute Care/ Home Health/ Hospice | Carol Raphael, MPA |

| FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO) | REPRESENTATIVES |
| --- | --- |
| Agency for Healthcare Research and Quality (AHRQ) | Nancy Wilson, MD, MPH |
| Centers for Disease Control and Prevention (CDC) | Gail Janes, PhD, MS |
| Centers for Medicare & Medicaid Services (CMS) | Patrick Conway, MD, MSc |
| Health Resources and Services Administration (HRSA) | John E. Snyder, MD, MS, MPH (FACP) |
| Office of Personnel Management/FEHBP (OPM) | Edward Lennard, PharmD, MBA |
| Office of the National Coordinator for HIT (ONC) | Representative to be determined |

| ACCREDITATION/CERTIFICATION LIAISONS (NON-VOTING) | REPRESENTATIVES |
| --- | --- |
| American Board of Medical Specialties | Lois Margaret Nora, MD, JD, MBA |
| National Committee for Quality Assurance | Peggy O'Kane, MHS |
| The Joint Commission | Mark Chassin, MD, FACP, MPP, MPH |

## Appendix C: MAP Measure Selection Criteria

*(Version used at time of Workgroup Review)*

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- and family-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 outcomes that matter to patients, including patient- and caregiver-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- and family-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-criterion 5.3** Measure set enables assessment of the person's care and services across providers, settings, and time

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

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

**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)

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