NATIONAL QUALITY FORUM

Measure Applications Partnership: 2014 Report on the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid

DRAFT REPORT FOR COMMENT

July 9, 2014

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I task order 11.

Contents

Introduction and Purpose

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

The charge of the MAP Medicaid Task Force is to advise the MAP Coordinating Committee on recommendations to HHS for strengthening and revising measures in the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set) as well as the identification of high priority measure gaps. The task force consists of MAP members from the MAP Coordinating Committee and MAP workgroups (Appendix B).

Guided by the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences implementing the Adult Core Set in making its recommendations. To inform MAP's review, CMS provided detailed summaries of the number of states reporting each measure, deviations from the published measure specifications, technical assistance requests, and actions taken in response to questions and challenges. This report summarizes select states' feedback on collecting and reporting measures. It also includes measure-specific recommendations, high-priority gaps, and potential gap-filling measures (Appendix D). In addition, MAP identified several strategic issues related to the programmatic context for the Adult Core Set. This report follows an Expedited Review MAP performed in 2013 and contains more detailed information.

Background on Medicaid and the Adult Core Set

Medicaid is the largest health insurance program in the US and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership; each state designs and operates its own program within federal guidelines.

Medicaid Adult Population

In 2013, 72.8 million individuals were enrolled in Medicaid at some point in time, of which about half were adults.[1] Before the enactment of the Affordable Care Act of 2010 (ACA), federal funding for Medicaid could only be used for specific categories of low-income individuals: children, pregnant women, parents of dependent children, individuals with disabilities, and people age 65 and older. In other words, most low-income non-elderly adults without dependent children were excluded from Medicaid. States now have the option to expand Medicaid eligibility to nearly all non-elderly adults with incomes at or below 138% of the federal poverty level (FPL).[2] In 2014, the 138% of FPL for an individual is $16,105 and $32,913 for a family of four.[3]

Each state will decide whether to expand their Medicaid eligibility.[4] To date, 27 states including the District of Columbia are implementing expansion in 2014, 3 states are still debating expansion, and 21 states are not moving forward with expansion at this time.[5] Enrollment data for April 2014 indicate enrollment growth in states that have expanded Medicaid to low-income adults has outpaced the national average and is significantly higher than growth in non-expansion states (15.3% vs.3.3%).[6]

Because nonelderly adults covered by Medicaid are more likely than uninsured adults to report receiving timely health care visits, the expansion offers an important opportunity to improve access and health outcomes.[7]

Because Medicaid expansion is a state decision, an eligibility "coverage gap" is created for adults in states that opt not to expand who would otherwise be eligible for the Medicaid expansion. Nearly 80% of the 4.8 million uninsured adults who fall into the coverage gap live in Southern states, and the coverage gap in the South disproportionately affects people of color.[8]

Due to the strong correlation between poverty and poor health, Medicaid beneficiaries have a poorer health profile compared with both the privately insured and the uninsured. [9] Among adults with similar income, those with Medicaid report both worse overall health, worse mental health, and also higher rates of both multiple chronic conditions and activity limitations.[10] A recent analysis by the Healthcare Cost and Utilization Project (HCUP) found that non-elderly Adult Medicaid beneficiaries experienced a total all-cause, 30 day hospital readmission rate of 14.6 per 100 admissions, totaling approximately 700,000 readmissions in 2011 at a cost of approximately $7.6 billion.[11]

Medicaid Adult Core Set

In addition to the expansion of Medicaid coverage to adults, ACA also called for the creation of a core set of health care quality measures to assess the quality of care for adults enrolled in Medicaid. While many states were already monitoring and seeking to improve quality in Medicaid, the core set of measures will standardize and align measurement efforts. HHS established the Adult Medicaid Quality Measurement Program to standardize the measurement of health care quality across state Medicaid programs, assist states who elect to collect and report on the measures, and facilitate the use of the measures for quality improvement.[12] HHS published the initial Adult Core Set of measures in 2012 and offered grant support for a two-year period to assist states in building capacity to participate in reporting. CMS' three-part goal for the Adult Core Set is:

1. Increase number of states reporting Adult 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

The measures in the Adult Core Set were compiled to address quality issues related to general adult health, maternal/reproductive health, complex health care needs, and mental health and substance use. The Statute also requires HHS to make annual updates to the Adult Core Set, starting in January 2014, and MAP's input directly informs these changes.[13]

ACA requires annual reports on the reporting of adult Medicaid quality information. The 2014 Report to Congress: HHS Secretary's Efforts to Improve the Quality of Health Care for Adults Enrolled in Medicaid highlights CMS's use of the National Quality Strategy (NQS) to guide health care improvement efforts and to measure progress toward achieving the goals of better care, healthy people/healthy communities, and affordable care. [14] This report also includes a summary of technical assistance and analytic support provided to states in the first year of reporting Adult Core Set measures.

Characteristics of the Medicaid Adult Core Set

The Adult Core Set used in FFY2013 contains 26 measures (Appendix D) that cover all six areas of the NQS and CMS Quality Strategy priorities (Exhibit 1).

Exhibit 1: NQS and CMS Quality Strategy Priorities

NQS and CMS Quality Strategy Priorities	Number of Measures in the Adult Core Set (n = 26)
Patient Safety	7
Person- and Family-Centered Experience of Care	1
Effective Communication and Care Coordination	6
Prevention and Treatment of Chronic Disease	2
Healthy Living and Well-Being	8
Affordability	1

It also contains a mix of structure, process, outcome, and patient experience of care measures. Six of the measures are sensitive to known healthcare disparities. Additionally, the Adult Core Set is well-aligned with other quality and reporting initiatives: 15 of the measures are used in one or more federal programs, 3 in the Medicaid Children's Core Set, and 12 are included in the Health Insurance Marketplace Quality Rating System Beta Test Measure Set.[15,16] Representing the diverse health needs of the adult Medicaid population, the Adult Core Set measures span clinical conditions (Exhibit 2).

Exhibit 2: Clinical Conditions Covered by Measures in the Medicaid Adult Core Set

Clinical Conditions	Number of Measures in the Adult Core Set (n = 26)
Preventive Screening and Care	6
Behavioral Health and Substance Use	5
Cardiovascular Disease and Diabetes	5
Care Coordination and Experience of Care	4
Maternal and Prenatal Health	3
Respiratory Care, COPD, and Asthma	2
HIV/AIDS	1

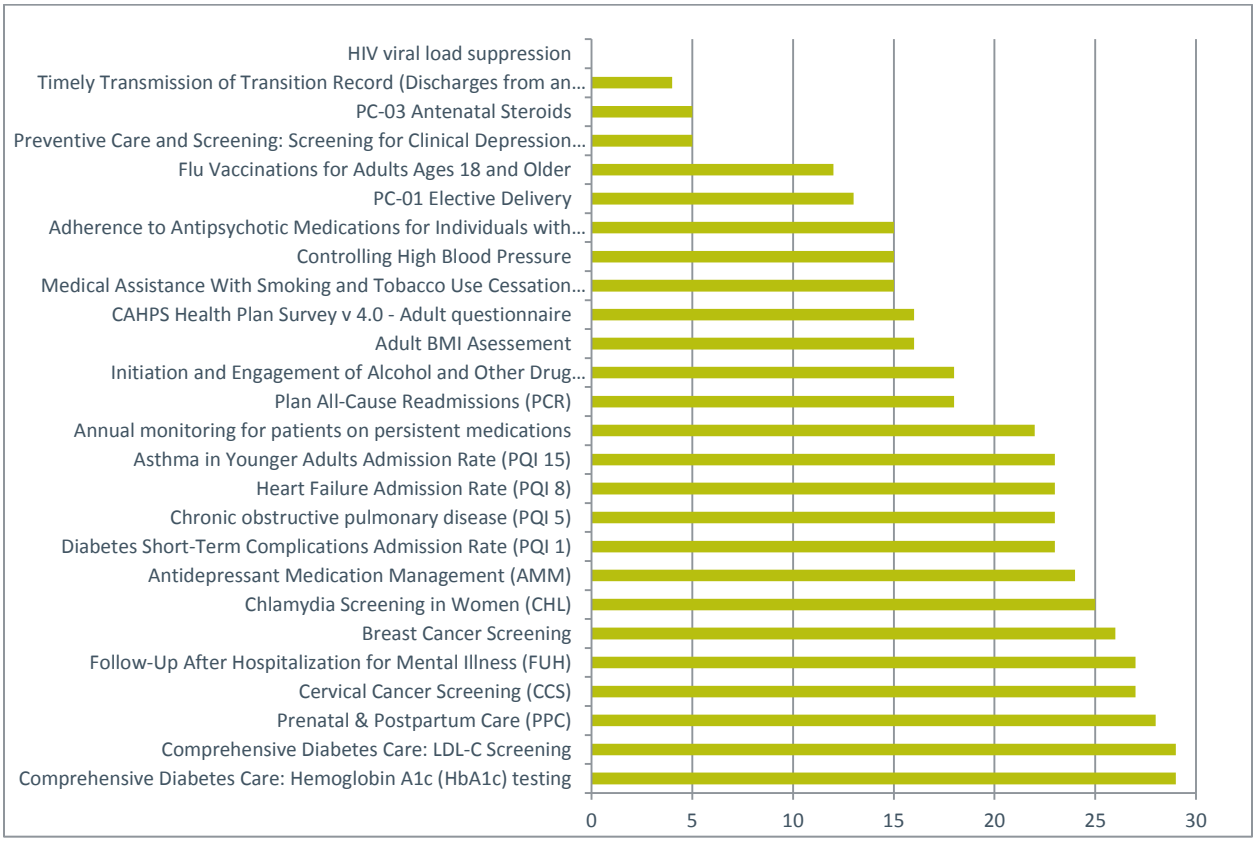
State Experience Collecting and Reporting the Core Set

MAP values implementation and impact information about measures and uses this feedback to inform its decisionmaking. MAP received feedback on the implementation of the Adult Core Set from CMS and states in three formats: FFY 2013 Medicaid Adult Core Set Implementation information, presentations from reporting states, and communication of barriers from non-reporting states. These valuable inputs informed the measure-specific and strategic recommendations for the Adult Core Set to achieve CMS' three-part goal.

Participation in Reporting Measures

During the first year of data collection and reporting, CMS recorded feedback from states on the implementation experience of each Adult Core Set measure. The number of states that reported each measure ranged from a low of four to a high of 29 states (Exhibit 3). The most common reason given for not reporting a measure was that the information was not collected because the measure was not identified as a key priority this year. MAP considered the number of states that were able to report each measure and sought to understand states' priorities to inform its recommendations.

Exhibit 3: Number of States Reporting Measures in Medicaid Adult Core Set in FFY 2013



In the January 2014 update to the measure set. CMS replaced the measure Annual HIV/AIDS Medicaid Visit with NQF #2082 HIV Viral Load Suppression.[17] MAP recommended this substitution because the original measure had NQF endorsement removed and its process focus was thought to be less important that the intermediate outcome of viral load suppression. As a result, FFY 2014 is the first year in which the measure of viral load suppression will be reported. No other additions, deletions, or substitutions were made in this first update.[18*]

[*] MAP also previously recommended measures #2372 Breast Cancer Screening (formerly #0031), #2371 Annual Monitoring for Patients on Persistent Medications (formerly #0021), and #0039 Flu Shots for Adults be updated and resubmitted for NQF endorsement. Since that time, the measure stewards have completed and submitted updates to NQF. At the time of this report, measures #2371 and #2372 received support in the early stages of the endorsement process and are currently available for comment.

Implementation Feedback from Reporting States

Three states–Louisiana, New Hampshire, and Virginia–shared their implementation experiences collecting and reporting measures to CMS to inform the MAP review of the Adult Core Set. These voices are a sample and not representative of all state Medicaid programs. This dialogue was highly informative and MAP will continue to pursue opportunities to receive direct feedback from users of measures to guide decisionmaking.

Louisiana

In the state of Louisiana nearly 500,000 adults received Medicaid services in 2010.[19] Until 2011, Louisiana Medicaid operated in a fee-for-service model; since 2012 almost all beneficiaries have been enrolled in a Managed Care benefit with one of the five participating health plans across the state. Louisiana is a recipient of an Adult Medicaid Quality Grant and reported 19 of the 26 measures in the core set. Prior to the grant program, Louisiana Medicaid collected 18 HEDIS measures and 10 Children's Core Set measures.

Facilitated by the grant, the State is collecting nine additional measures. When selecting measures, Louisiana selected those that matched their interests and purposefully avoided those requiring medical record review. From the state perspective, medical record review is thought to be labor intensive, require a specific skill set, and relatively costly. To collect and report additional measures from the Adult Core Set, Louisiana built new capacities, partnered with others in the state, and demonstrated successful innovations that will be useful across the state Medicaid programs.

Linking Claims Data and Vital Records: Louisiana celebrated the creation of a link between vital records and claims data for the collection and reporting of #0469 PC-01 Elective Delivery. This method has been validated by the National Perinatal Information Center/Quality Analytic Services (NPIC/QAS) and has the potential to eliminate the need to review medical records for this measure.

Medical Record Review: Though challenging from the outset, Louisiana selected and successfully reported #1517 Prenatal and Postpartum Care (Postpartum care rate only). This measure was collected through hybrid data collection. The state selected this measure because administrative claims data was already available, but later observed it produced inaccurate results due to the clinical importance of timing of care for this measure and missing data due to bundled payments including postpartum care. Therefore, Louisiana Medicaid formed a new partnership with the Louisiana Office of Public Health Nursing Services to implement a new medical record review process.

This new process, developed over several months, uses administrative claims data that is highly familiar to the state for HEDIS reporting to streamline data collection and improve the efficiency of medical record review. The ultimate result was improved measurement accuracy. The state hopes to use this method for other measurement efforts and to share this best practice with other states. Despite successfully developing methods to reduce the burden of medical record review, the state recommends the set contain measures that use automated methods such as claims and e-measures.

Measurement Driving Improvement: Representatives from Louisiana identified several avenues through which Adult Core Set measures are helping drive improvement. As a result of the grant program, Louisiana has enhanced capacity for analyzing and reporting quality measures across all

Medicaid programs. The results are used to steer state-level Medicaid policy and interventions to improve outcomes in the population.

Other recommendations from Louisiana's representatives to CMS and MAP for the core set focused on reducing burden. CMS and MAP are encouraged to consider alignment of the measures in the Adult Core Set with other measurement programs. Representatives also suggested including additional measures to address needs of large segments of the population, such as asthma, appropriateness of care, access to preventive care and ambulatory care, and emergency department utilization.

New Hampshire

The State of New Hampshire provided Medicaid-funded health care services to approximately 68,000 adults in 2010.[20] In 2014, New Hampshire chose to expand Medicaid coverage through provisions in ACA. Beginning July, 2014, the effective lower income limit for tax credits in New Hampshire will be 138% of poverty for adults.[21] As a result, 30% of the currently uninsured adult population is expected to gain Medicaid eligibility. During the first year of participation in the quality reporting program, New Hampshire submitted 16 measures in the Adult Core Set to CMS. To select and report these measures, state officials balanced political, logistical, and financial realities. Three key features influenced the selection of measures to report: feasibility, efficiency, and capacity building.

Feasibility: The state preferred measures that did not present significant challenges in collecting or reporting the data. The state sought measures that had clear specifications; unclear specifications increase the resources required to collect and report a measure. Representatives encouraged the continued availability of clear, thorough manuals to improve the data collection process, accuracy, and ability to eventually compare results between states.

Efficiency: Related to feasibility, measurement imposes a burden of cost. Measures with relative high-cost of reporting, and potentially less efficient, compared to others in the Adult Core Set were not reported. Specifically, measures collected through administrative claims data were heavily favored over medical record review. In the future, understanding the efficiency and return on investment of measurement and identification of the measures best available to drive improvement would be highly valuable in state measure selection.

Capacity Building: The state appreciated the flexibility to use grant funds to explore linking data sets to collect data for measures. Once established, this infrastructure and knowledge could improve the feasibility and efficiency of future collection. Linked data sets were pursued for measures #0576 Follow-up After Hospitalization for Mental Illness, and #0469 PC-01 Elective Delivery, and ultimately successful for the former. The state identified value in formally linking data sets, which yielded techniques that may contribute to other state-wide quality improvement efforts. The measures not reported this year were thought to be important, though the state lacked capacity to collect them all. Over time, the state will build additional capacity to report additional measures.

Overall, New Hampshire representatives communicated their appreciation for the new reporting program and the associated grant opportunity. They support the structure of the program and its voluntary nature, the common core set, and the ability for states to select measures from the core to report. Over time, representatives encouraged CMS to make the results of the measures transparent to allow for comparisons between states that would drive improvement. Important measure gaps were

identified in long-term supports and services, beneficiary and consumer experience, and quality of Medicaid administration and services.

Virginia

The Commonwealth of Virginia Department of Medical Assistance Services funds Medicaid services for more than 350,000 adults.[22] Enrollees receive services through managed care health plans, all of which are required to maintain National Committee for Quality Assurance (NCQA) accreditation. This full-risk model for health plans provides budgetary certainty for the state and opportunities for marketplace competition and innovation. Virginia was not a recipient of the grant and voluntarily reported 8 measures in the Adult Core Set.

Quality Strategy: Virginia maintains a Medicaid Managed Care Quality Strategy with a population health focus. The Quality Strategy defines the quality measures required by all participating health plans and prioritizes HEDIS to align with NCQA accreditation requirements. The state currently requires health plans to report 18 HEDIS measures. The Quality Strategy will be updated over the course of the next year to identify the priority quality measures for performance improvement and consider the demographics of Medicaid enrollees and medical trends.

Performance Measure Incentive Program: Virginia is implementing a financial incentive program for quality and cost containment outcomes. The program will reward health plan performance and phase in over three years. The state program focus is on quality through the assessment of three HEDIS measures and three health plan administration process metrics. Fiscal awards will be proportionate to the achievements of the health plan against the benchmark for each measure.[23]

In the first year of reporting, Virginia submitted 8 of the HEDIS measures from the Adult Core Set to CMS. State representatives identified participation in the Adult Core Set as a valuable opportunity because it is the first national core measure set for Medicaid programs for adults. The representatives recommend that the measures' results be available for valid benchmarking and comparisons through consistent the collection across states. To enable this, they advocate the measure specifications in the data entry system be clear and up to date with HEDIS, NQF endorsement, clinical practice guidelines, and other nationally recognized standards. They also recommend that the Adult Core Set continue to align across public and private measurement programs and focus on improving population health.

Non-Reporting States

Roughly half of Medicaid programs did not submit data on measures in the Adult Core Set to CMS for this voluntary reporting program. A primary goal of CMS is to increase the number of states participating in reporting measures in the Adult Core Set. To inform its recommendations, MAP sought feedback from non-reporting states to identify barriers to reporting and avenues to overcome them. Representatives from two states shared their reasoning with MAP. While not identified for purposes of confidentiality, their perspectives added helpful insights to inform measure-specific and general recommendations. MAP encouraged subsequent reviews of the Adult Core Set to be informed by additional discussions with non-reporting Medicaid programs. Several themes arose from non-reporting state feedback, some of which are congruent with feedback from reporting states:

- Broad factors influence state decisions to report, including political, feasibility, and financial concerns;

- Stakeholders were uncertain about the reporting requirements and use of data for comparisons or public reporting in the new program;
- Ability of the measures to compare states' performance may be compromised due to differences in benefit structures, payment models, diverse populations, or other factors;
- Some states have already invested in tailored quality measurement programs that have longitudinal results comparing providers within the state and externally to national benchmarks;
- Measurement priorities include access to care, primary care, and preventative care and should be aligned with other programs.

MAP Review of the Medicaid Adult Core Set

MAP reviewed the measures in the Adult Core Set and provides the following recommendations to strengthen the measure set and support CMS' stated goals for the program. To conduct this review, MAP applied the measure selection criteria (MSC) and feedback from the first year of state implementation to carefully evaluate and identify opportunities to improve the Adult Core Set. MAP also identified priority measure gap areas to address health care quality for the Adult Medicaid population.[24]

The 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. The criteria favor the selection of high-quality measures that optimally address the NQS, fill critical measurement gaps, and increase alignment across programs. In the application of the MSC to the Adult Core Set, MAP noted the following:

- The Adult Core Set is adequate to advance CMS' stated goals for the program;
- The Adult Core Set's strong alignment with other program sets and parsimonious number of measures should continue;
- While the mix of measure types is satisfactory, MAP encourages the inclusion of relevant outcome measures in future iterations of the set;
- MAP strongly prefers the set contain the most current NQF-endorsed measures to ensure validity and reliability.
    - MAP observed changes had been made to several measures to enable state-level reporting, including the use of a more restricted age range, setting a specific date for age calculation, and changing denominator populations from 'enrollees' to 'member-months.'
    - An observed modification that constitutes a significant change is use of a different risk adjustment methodology.
    - For measures that have not been endorsed or have had endorsement removed, CMS should consider updates or substitutions.

MAP recognized the investment made in the initial version of the Adult Core Set measures as well as the need for states and CMS to gain experience with their use. As such, making drastic changes to the measures in the first two years of program implementation would be premature. Such changes could have the unintended consequence of discouraging states' participation in quality measurement and

quality improvement. Therefore, the most important efforts for CMS to undertake now to achieve the program goals are to address known challenges in data collection and reporting, monitor the program's continuing development, and consider the measure-specific recommendations in this report.

Measure-Specific Recommendations

MAP supported the majority of the measures in the Adult Core Set for continued use in the program. Appendix D provides further details on MAP's measure-specific recommendations and decision rationale. Although MAP discussed concerns about the feasibility of reporting complex measures that require hybrid specifications, medical record review, or data linkages, members were comfortable retaining them in the set to pose a challenge to states. As previously discussed, it is important that the measure set remain stable to enable states to gain experience and build capacity for reporting.

Measures for Phased Addition to the Adult Core Set

MAP recommends that CMS consider three measures for phased addition to the Adult Core Set. Their use would strengthen the measure set, but MAP is aware that additional resources are required for each new measure and grants CMS the flexibility to add the measures gradually and only if they are found to be feasible to implement at the state level.

1. First, MAP prioritized the addition of #0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) to the Adult Core Set to address the highly prevalent condition of diabetes and facilitate state efforts to drive quality improvement on the risk factor of poor HbA1c control. A measure of HbA1c testing is currently a part of the measure set, but MAP is more interested in measuring the intermediate outcome than the process.
2. Second, MAP recommended the addition of #1799 Medication Management for People with Asthma as a complement to #0283 Asthma in Younger Adults Admission Rate (PQI 15) because it focuses on upstream activities to control asthma symptoms. There is thought to be a relatively low incidence of asthma admissions in the Medicaid adult population.
3. Third, consistent with prior recommendations, #0647 Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) was supported for addition to the Adult Core Set. This measure is paired and intended to be used with #0648 Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care), which had relatively low levels of reporting by states because of data collection challenges. Care coordination is an important topic area and using these measures together may improve the feasibility of the measures.

Measures with Conditional Support for Continued Use in the Adult Core Set

MAP conditionally supported the continued use of three measures.

Medication Management and NQF#2371 Annual Monitoring for Patients on Persistent Medications

Medication management is critical to achieving high quality care and positive health outcomes; measures of this topic are very important quality indicators. The set contains NQF#2371 Annual

Monitoring for Patients on Persistent Medications.[†] This measure had NQF endorsement removed at one point in time but has now been updated and gained the approval of the Safety Standing Committee. MAP conditionally supported the continued use of this measure if its endorsement is renewed but considers it to be narrowly designed. As is the case with this measure, the focus on a single point in time, condition, or prescription fail to reflect the overall quality of medication management. MAP would prefer the inclusion of a measure of adherence or shared decision-making about medication choices.

MAP suggests further review of issues related to medication management and inclusion of a more comprehensive measure. However, the group did not reach consensus on the addition of a specific measure that is presently available. MAP remains sensitive to the need to maintain a relatively stable measure set and the cost of adding new measures. Exhibit 4 identifies potential measures to address medication management and will further consider input from the MAP Coordinating Committee and public comment on the matter of whether the current measure should be replaced or supplemented with another.

Exhibit 4: Medication Management Measures for Potential Addition or Substitution

Measure and Steward	Description	Data Source	Alignment and Level of Analysis
0097 Endorsed Medication Reconciliation Steward: National Committee for Quality Assurance	Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist who had reconciliation of the discharge medications with the current medication list in the outpatient medical record documented. This measure is reported as two rates stratified by age group: 18-64 and 65+.	Administrative claims, Electronic Clinical Data	Alignment: Medicare Shared Savings Program, PQRS Level of Analysis: Clinician: Individual and Clinician: Group/Practice
0419 Endorsed Documentation of Current Medications in the Medical Record Steward: Centers for Medicare & Medicaid Services	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration	Administrative claims, Electronic Clinical Data: Registry	Alignment: Meaningful Use Stage 2 – Eligible Professionals, PQRS Level of Analysis: Clinician: Individual and Population: National
0541 Endorsed Proportion of Days Covered (PDC): 3 Rates by	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	Electronic Clinical Data: Pharmacy	Alignment: Meaningful Use Stage 2 – Eligible Professionals, PQRS

[†] For HEDIS 2015, NCQA retired the Anticonvulsant-Monitoring rate; revised the numerator for angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin and Diuretics rates to remove blood urea nitrogen as a substitute for serum creatinine; and revised the Digoxin rate to include serum digoxin monitoring. These updates would take effect in the Medicaid Adult Core Set as part of updated Technical Specifications to be released in 2015.

Measure and Steward	Description	Data Source	Alignment and Level of Analysis
Therapeutic Category Steward: Pharmacy Quality Alliance	following medication categories: Beta-Blockers (BB), Renin Angiotensin System (RAS) Antagonists, Calcium-Channel Blockers (CCB), Diabetes Medications, Statins		Level of Analysis: Clinician: Group/Practice and Clinician: Team/Health Plan

Hospital Readmission and NQF #1768 Plan All-Cause Readmissions (PCR)

NQF has endorsed two measures related to all-cause hospital readmissions. The two measures differ in their approach and underlying specifications due to the purposes for which they were designed. Measure #1768 Plan All-Cause Readmissions (PCR) is currently included in the Medicaid Adult Core Set. However, CMS is considering whether measure #1789 Hospital-Wide All-Cause Unplanned Readmission Measure would offer greater fit-for-purpose in the program. MAP urges CMS to consider the many potential uses of the measurement information and determine which one is primary because different "use cases" lead to different conclusions about which measure would be superior in this context. In particular, issues of alignment with other programs and the feasibility of data collection

Unless CMS makes a determination that #1789 better fits the needs of the program, MAP supports the continued use of #1768 Plan All-Cause Readmission in the Adult Core Set to address the critical quality issue of hospital readmission. However, MAP remains concerned about the lack of risk adjustment methodology available for the Medicaid adult population. Without an appropriate risk-adjustment methodology, one cannot determine if differences in performance are due to overall quality, the characteristics of the denominator population, or randomness due to availability of data and collection methods and extrapolation for analysis. 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. MAP supports CMS' planned effort to work with the measure steward to address this. MAP will gather additional input from the MAP Coordinating Committee and public comment on how CMS should approach the choice of the most appropriate all-cause readmission measure for use in the Adult Core Set.

NQF#2372 Breast Cancer Screening

Measure #2372 Breast Cancer Screening had NQF endorsement removed at one point in time but has been re-submitted, approved by the standing committee, and is currently in the Public and Member Commenting Phase of the Consensus Development Process. The measure is expected to regain endorsement. MAP supports its continued use contingent upon endorsement.

Measures for Removal from the Adult Core Set

NQF#0063 Comprehensive Diabetes Care: LDL-C Screening

MAP noted that clinical guidelines for lipid management have recently changed; as such, the continued use of #0063 Comprehensive Diabetes Care: LDL-C Screening may no longer be appropriate. NCQA is the steward of this measure and decided to retire the measure from the 2015 version of HEDIS. MAP recommends that CMS remove the measure from the Adult Core Set.

Recommendations to Address High Priority Gaps

MAP identified numerous gaps in the Adult Core Set from state feedback, the review of current measures, and data on conditions associated with hospital readmissions. They include:

- Access to care
- Beneficiary-reported outcomes
- Cultural competency
- Care Coordination
- Efficiency
- Inappropriate emergency department utilization
- Integration of health and human services
- Inter-conception health
- Long-term supports and services
- Poor birth outcomes (e.g., premature birth, low birth weight)
- Post-partum care and complications
- Primary care and behavioral health integration
- Primary prevention and wellness
- Treatment outcomes for behavioral health conditions and substance use disorders
- Workforce

Although the Adult Core Set includes measures pertaining to some of these topics, they were not perceived as sufficient. For example, several measures in the Adult Core Set relate to the conditions causing hospital readmissions, but others are available and could be considered for future addition to the set (Appendix E). MAP placed particular emphasis on three gap areas for future action: maternal health relating to risks for poor birth outcomes, behavioral health and substance abuse, and access to primary care.

Maternal Health

Pregnancy is among the eligibility criteria for adults to qualify for Medicaid benefits and nearly half of all births in the United States are covered by Medicaid. MAP identified reproductive, maternal, and prenatal care as an essential area for measurement to drive positive population health outcomes. MAP specifically suggested measures related to progesterone use to prevent premature birth, low birth weight, inter-conception health, contraception (e.g., LARC insertions), and maternal mortality.

Behavioral Health

In addition to the Medicaid adult population reporting high rates of poor mental health, 4 of the 10 most common conditions for readmission are behavioral health and/or substance use disorder (SUD) diagnoses. These conditions are often undiagnosed and/or untreated. One member suggested routinely integrating mental health screening in primary care visits and routine follow-up as a prime measurement opportunity.

MAP learned of joint efforts of the National Committee for Quality Assurance (NCQA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to address measure gaps related to comorbid conditions among the behavioral health population. Research shows that low rates of ambulatory care contribute to poor performance on quality measures. Currently in its third year, the project is

developing measures that assess screening and follow up care for adults with serious mental illnesses such as schizophrenia, bipolar disorder, major depression, alcohol and other drug dependence. MAP members discussed the lack of services available to the behavioral health population and will continue to monitor these measure development efforts for their potential to address measure gaps.

Though not a priority for immediate use, MAP recommends that future reviews of the Adult Core Set consider potential complements to the current measure on antipsychotic adherence: NQF#1927 Cardiovascular Screening for People with Schizophrenia or Bipolar Disorders Who Are Prescribed Antipsychotic Medications and NQF#1932 Diabetes Screening for People with Schizophrenia or Mood Disorders Who Are Using Antipsychotic Medications.

Access to Primary Care

Finally, MAP emphasized the importance of measure development in access to preventive health services and wellness. Poor access and lack of care coordination contribute to overuse of emergency department and hospital services. In general, the Adult Core Set lacks measures of social determinants of health and access to primary care that contribute strongly to individual health outcomes. MAP specifically recommends measure development in the areas of person-centered care that can track longitudinal progress toward a health or quality of life goal.

Strategic Issues

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

Building State Capacity

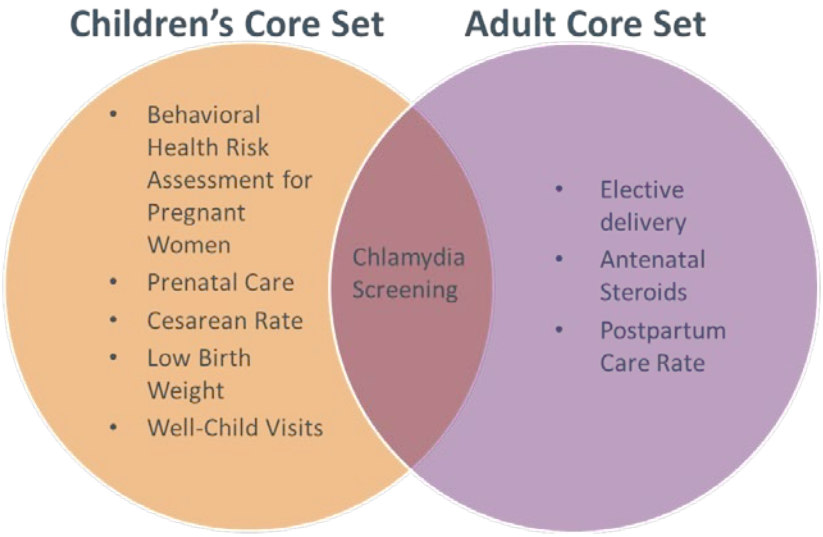
Since the start of the program just two years ago, many of the states participating in reporting the Adult Core Set have greatly increased their capacity and ability to use measures to advance quality improvement. State representatives enthusiastically discussed the vital importance of Medicaid in supporting low-income Americans in accessing basic health services, at the same time acknowledging that all Medicaid programs are under-resourced. State representatives described the benefit of CMS' grant program in providing funding that allowed the Medicaid agencies to form data-sharing partnerships with the public health system and other key stakeholders. Developing linkages to vital records systems, for example, assisted with the calculation of some measures and will benefit other population health monitoring efforts. In addition, state staff are growing more practiced in and expanding their uses of analytics to understand the health of their enrolled populations. MAP members shared the view that while investment in measurement requires sustained funding, a lack of action in addressing quality is costly and detrimental to population health in the long term.

Alignment of Measures across Adult and Children's Core Sets

When making recommendations about measures for the Adult Core Set, MAP recognized the importance of coordinating the selected measures with those contained in the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Children's Core Set). Though the two measurement programs are separate, both CMS and States regard them as working together to provide

an overall picture of quality within Medicaid. This is especially apparent when considering the quality of the continuum of the prenatal, maternity, and postnatal care of mothers and infants. As shown in Exhibit 5, several measures are in the Children's Core Set because they are more closely tied with the health outcomes of the child, while one is common to both sets and three others are unique to the Adult Core Set. It is necessary to view the two programs together to see the full spectrum of measures that promote better birth outcomes.

Exhibit 5: Overlapping Maternal and Child Health Measures in the Medicaid Quality Programs



Other quality issues are important to all age groups and are also common to both measure sets. A measure of follow-up after hospitalization for mental illness is currently included in the Children's and Adult Core Sets. MAP has also recommended a measure of medication management for people with asthma be added to the Adult Core Set. This measure is currently in the Children's Core Set. The alignment achieved by including the same chlamydia, asthma, and follow-up after hospitalization measures in both programs, rather than similar but different measures, is vitally important in controlling reporting burden on states and directing quality improvement efforts efficiently.

Impact of Payment Models

Input from states brought to light two issues related to potential impact of payment models on measurement. First, bundled payment, the reimbursement of health care providers on the basis of expected costs for clinically-defined episodes of care rather than fee-for-service (FFS), can limit the availability of data. Specifically, bundled payments for maternity care can include postpartum visits and states expressed concern that results on the Postpartum Care Rate Measure would be underreported if based solely on claims. While a hybrid measure specification is available to address this issue, chart review is resource-intensive and not preferred by participating states. Second, it is standard practice to audit measures derived from managed care data but this is not routinely performed in FFS systems. This inconsistency might lead to poorer accuracy of measures based on FFS claims unless they are reviewed by an organization external to the state Medicaid agency. While no immediate solutions were found, these factors directly relate to the feasibility of implementing measures and merit continued

consideration. The variation in state payment models and implications for data collection could affect the comparability of measure results across states.

Incorporating Beneficiaries' Perspectives on Quality

MAP found the Adult Core Set to be strong on many fronts, including its parsimonious size, its alignment with other programs, and its responsiveness to chronic conditions that are common in the Medicaid population. However, members were not confident that the measures would reflect the issues that matter most to Medicaid enrollees. A first step to ensuring that the measure set is responsive would be to gather evidence on the quality measures that most resonate with the population of adults with Medicaid to guide future decision-making. Specifically, MAP would benefit from more detailed information on the services that are most important to Medicaid enrollees to help prioritize improvement efforts.

The measure set currently gauges beneficiary experience of care through a CAHPS survey, but the scope of CAHPS items was felt to be limited. Implementation of CAHPS is uneven across states, with sixteen states reporting this measure to CMS in FFY 2013. While CMS plans to perform a nationwide CAHPS survey of adult Medicaid enrollees that will mitigate data collection burden on states somewhat, the measure set could be further strengthened with regard to incorporating beneficiaries' perspectives on quality.[25] For example, MAP also urges the future inclusion of performance measures based on patient-reported outcomes, to the extent those measures are available for state-level programs.

Balancing Rigor and Voluntary Participation

States vary in their infrastructure, political climates, and other factors that influence their participation in quality reporting. With the voluntary nature of the reporting program in mind, state representatives expressed different opinions on how challenging the measures within the Adult Core Set should be. At one end of the spectrum, some stakeholders believe that the role of a core measure set is to provide a modest baseline set of measures that are highly feasible for all to report. At the opposite end, others believe that the measure set should demand more significant and sophisticated analysis to understand and change health outcomes. Fortunately, states are not required to submit all of the measures in the Adult Core Set to CMS; they can select those that most closely meet their needs and capabilities. While MAP felt the current set to be balanced in its level of rigor, it is not well-understood how the measures themselves might have affected the decision of some states not to participate in reporting. Further outreach to representatives of non-participating states could be conducted to inform subsequent reviews.

Ultimate Uses of Measurement Information

The intention of measuring quality and performance in the health system is to provide data that informs and motivates improvement. One of the most straightforward uses of a quality measure is for a single entity to track its own data over time, monitor the trend, and initiate actions that would improve the results. This type of internally-focused quality improvement effort is usually an appropriate starting place. Quality measures can also be used to compare an entity's performance to a benchmark level or to its peers to illuminate differences. Understanding one's own performance relative to others can be critical for understanding success. However, making comparisons across states must be done carefully to avoid reaching inaccurate conclusions. Populations of Medicaid enrollees vary tremendously by state

and it would not be fair to expect measured performance to be the same across the country. Causes of variation include, but are not limited to, urban/rural mix, financial and categorical eligibility policy, distribution of chronic diseases, age, gender, and other factors. The stakes would be further raised if the comparative performance information was made public or tied to a financial incentive.

While CMS is required to issue annual reports to the HHS Secretary about states' use of the Adult Core Set, they do not plan to publish any results or state-identifiable information in the next summary. Given that this was the first year of program implementation and some technical specifications were refined mid-year, there is not enough confidence in the accuracy of the data to make it available. As this improves over time, measure results could be publicly reported as they are for the slightly older Children's Core Set.[26] Further statistical support for risk adjustment or other methods would be needed to enable cross-state comparisons or national benchmarking. Some states have already expressed a strong desire to rate their own performance against others.

Conclusion

MAP's recommendations to HHS on the Medicaid Adult Core Set are intended to strengthen the program measure set and assist in meeting the three-part goal to increase state participation in reporting and quality improvement. In summary, MAP suggests the continued use of most measures in the set to provide stability and the opportunity to gain additional experience and data. In the case of three measures, continued use is conditional upon further exploration or NQF endorsement of the measures. MAP also recommends that one measure be removed from the set because it no longer conforms to current clinical guidelines. Finally, MAP noted three measures for phased addition to the program measure set over time, beginning with a measure of poor hemoglobin A1c control among people with diabetes.

States' perspectives on the use of measures during their first year of implementation contributed greatly to MAP's discussion and decisionmaking process. State representatives enthusiastically described the value of participating in the quality measurement program and how they have used information to inform direct quality improvement efforts. MAP encourages further state efforts to report additional measures and capitalize upon the infrastructure and partnerships being developed. MAP endeavored to maintain a measure set that is feasible for states' continued engagement and reflective of the diversity found in state Medicaid programs, including variability in enrolled populations, capacity for data analysis, and quality issues of interest.

In the long term, MAP recommends that CMS continue to support states' efforts to gather, report, and analyze data that informs quality improvement activities. Uses of quality data are expected to gradually mature from an internal focus on accuracy and year-over-year improvement to a more sophisticated approach involving benchmarking and public reporting. At the same time, CMS and MAP remain conscious of the voluntary nature of participation in submitting data on the Adult Core Set; rigor must be tempered with a realistic understanding of abilities and potential trade-offs. The program measure set will continue to evolve in response to changing federal, state, and stakeholder needs and should be considered a long-term strategic process.

Appendix A: MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment, and other programs. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[27]

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

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

MAP's objectives are to:

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

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to

help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

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

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

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

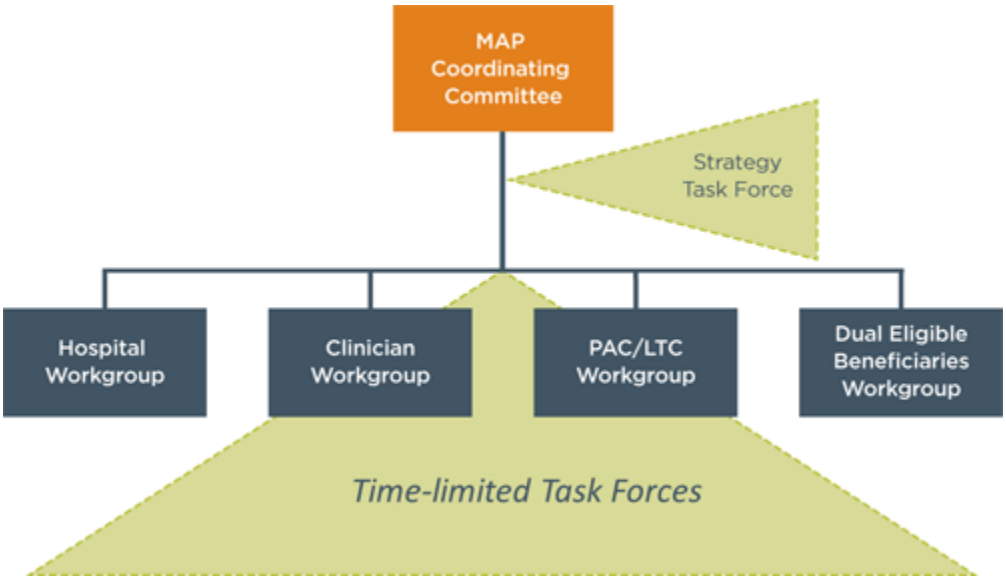
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Structure

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

Figure A1. MAP Structure



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

Timeline and Deliverables

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

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

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

Developed **Coordination Strategies** intended to elucidate opportunities for public and private stakeholders to accelerate improvement and synchronize measurement initiatives.

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

Roster for the MAP Medicaid Task Force

CHAIR (VOTING)
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Academy of Family Physicians	Alvia Siddiqi, MD, FAAFP
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
March of Dimes	Cynthia Pellegrini
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Consumer Voice for Quality Long-Term Care	Lisa Tripp, JD
National Rural Health Association	Brock Slabach, MPH, FACHE

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Disparities	Marshall Chin, MD, MPH, FACP
Medicaid ACO	Ruth Perry, MD
Mental Health	Ann Marie Sullivan, MD
State Medicaid	Marc Leib, MD, JD

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

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

Roster for the MAP Coordinating Committee

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

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
AARP	Joyce Dubow, MUP

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerry Shea
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 (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Shari Davidson
National Partnership for Women and Families	Alison Shippy
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Researchers and Manufacturers of America (PhRMA)	Christopher Dezii, RN, MBA,CPHQ

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)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
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)	Kevin Larsen, MD, FACP

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

NQF Staff

Megan Duevel Anderson	Project Manager
Elizabeth Carey	Project Manager
Laura Ibragimova	Project Analyst
Sarah Lash	Senior Director
Allison Ludwig	Senior Project Manager
Yetunde Ogungbemi	Project Analyst

Appendix C: MAP Measure Selection Criteria

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

Criteria

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

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

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 decisionmaking, 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)

Appendix D: Medicaid Adult Core Set and MAP Recommendations

In January 2012, HHS published a final notice in the *Federal Register* to announce the initial core set of health care quality measures for Medicaid-Eligible adults; a 2014 version followed. The table below lists the measures included in the Core Set along with their current NQF endorsement number and status. States voluntarily collect the Medicaid Adult Core Set measures using the 2014 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System.

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: NCQA	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. a. Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	18 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report
0006 Endorsed CAHPS Health Plan Survey - Adult questionnaire Measure Steward: NCQA	30-question core survey of adult health plan members that assesses the quality of care and services they receive.	16 states reported FFY 2013 (11 states reported using CAHPS 5.0H; 4 states reported using CAHPS 4.0H; 1 state used an agency-designed CAHPS-like survey) Alignment: Medicare Shared Savings Program, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Moderate levels of states reporting observed due to high costs to implementation Addresses NQS and CMS Quality Strategy priority area of Person- and Family-Centered Experience of Care

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0018 Endorsed Controlling High Blood Pressure Measure Steward: NCQA	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/ 90) during the measurement year.	15 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Addresses NQS and CMS Quality Strategy priority area Prevention and Treatment of Chronic Conditions
0027 Endorsed Medical Assistance With Smoking and Tobacco Use Cessation Measure Steward: NCQA	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.	15 states reported FFY 2013 Alignment: PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0031 Submitted for Endorsement: In Public and Member Commenting Breast Cancer Screening Measure Steward: NCQA	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	26 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program pending NQF endorsement Measure has been submitted with updated specifications to meet clinical guidelines, has been recommended for endorsement by the Steering Committee
0032 Endorsed Cervical Cancer Screening Measure Steward: NCQA	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	28 states reported FFY 2013 Reason states did not report: measure was not identified as a key priority; other Alignment: Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program
0033 Endorsed Chlamydia screening in women [ages 21-24 only] Measure Steward: NCQA	The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	25 stated reported FFY 2013 Alignment: Meaningful Use Stage 2- Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0039 Endorsed Flu shots for Adults Ages 18 and Over Measure Steward: NCQA	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	12 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report
0057 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.	29 states reported FFY 2013 Alignment: PQRS, HEDIS, Marketplace Quality Rating System	Support for continued use in the program MAP recommended the addition of # 0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) as a complement to address this high-impact condition in the Medicaid Adult population
0063 Endorsed Comprehensive Diabetes Care: LDL-C Screening Measure Steward: NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an LDL-C test during the measurement year.	29 states reported FFY 2013 Alignment: PQRS, HEDIS	Conditional support for continued use in the program Measure should be removed from the program if retired by NCQA and replaced by a measure that is consistent with clinical guidelines

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0105 Endorsed Antidepressant Medication Management (AMM) Measure Steward: NCQA	The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	24 states reported FFY 2013 Alignment: Meaningful Use Stage 2 - Eligible Professionals, PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program
0272 Endorsed Diabetes Short-Term Complications Admissions Rate (PQI 1) Measure Steward: AHRQ	The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	23 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Disparities-sensitive measure for which there is a gap in care Addresses an important clinical condition for the Medicaid Adult population
0275 Endorsed Chronic obstructive pulmonary disease (PQI 5) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	23 states reported FFY 2013 Alignment: Medicare Shared Savings Program	Support for continued use in the program
0277 Endorsed Heart Failure Admission Rate (PQI 8) Measure Steward: AHRQ	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population.	23 states reported FFY 2013 Alignment: Medicare Shared Savings Program	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0283 Endorsed Asthma in Younger Adults Admission Rate (PQI 15) Measure Steward: AHRQ	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	23 states reported FFY 2013 Alignment: N/A	Support for continued use in the program MAP recommended the addition of #1799 Medication Management for People with Asthma as a complement to address this high-impact condition in the Medicaid Adult population
0418 Endorsed Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan Measure Steward: CMS	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	5 states reported FFY 2013 [4 states reported Adult Core Set specifications; 1 state reported PCMH measure (includes screening for 24 mo. but not follow-up plan)] Alignment: MU Stage 2 - Eligible Professionals, Medicare Shared Savings Program, PQRS	Support for continued use in the program Addresses an important measurement gap in mental and behavioral health treatment and outcomes Measure requires medical record review, as a result it is burdensome for states to report
0469 Endorsed PC-01 Elective Delivery Measure Steward: The Joint Commission	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	13 states reported FFY 2013 Alignment: Hospital Inpatient Quality Reporting, Meaningful Use Stage 2-Hospitals, CAHs	Support for continued use in the program MAP recommends the steward consider including the impact of psychosocial determinants (e.g., substance abuse, mental illness) in the measure Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0476 Endorsed PC-03 Antenatal Steroids Measure Steward: The Joint Commission	This measure assesses patients at risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns. 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-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	5 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report
0576 Endorsed Follow-Up After Hospitalization for Mental Illness Measure Steward: NCQA	This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1. The percentage of members who received follow-up within 30 days of discharge Rate 2. The percentage of members who received follow-up within 7 days of discharge.	27 states reported FFY 2013 Alignment: PQRS, HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program MAP encouraged use of a longer follow-up period (e.g., 3-6 months) Addresses NQS and CMS Quality Strategy priority area of Healthy Living and Well-Being Measure requires data linkage, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
0648 Endorsed Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/ Self Care or Any Other Site of Care) Measure Steward: AMA-PCPI	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	4 states reported FFY 2013 Alignment: N/A	Support for continued use in the program Addresses NQS and CMS Quality Strategy priority area of Effective Communication and Care Coordination Measure requires medical record review and/or data linkage, as a result it is burdensome for states to report MAP recommends measures be implemented as endorsed and adding the paired measure: 0647 Transition Record with Specified Elements Received by Discharged Patients
1517 Endorsed Prenatal & Postpartum Care [postpartum care rate only] Measure Steward: NCQA	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	28 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Support for continued use in the program Measure requires medical record review, as a result it is burdensome for states to report Measure requires data linkage, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
1768 Endorsed Plan All-Cause Readmissions Measure Steward: NCQA	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories: 1. Count of Index Hospital Stays (IHS) (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission 4. Observed Readmission (Numerator/ Denominator) 5. Total Variance Note: For commercial, only members 18–64 years of age are collected and reported; for Medicare, only members 18 and older are collected, and only members 65 and older are reported.	18 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program MAP recommends the development and application of a risk-adjustment model for the Medicaid population
1879 Endorsed Adherence to Antipsychotic Medications for Individuals with Schizophrenia Measure Steward: CMS	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).	18 states reported FFY 2013 Alignment: HEDIS	Support for continued use in the program Addresses the needs of vulnerable population at greater risk of readmissions and non-adherence to medications Measure requires medical record review, as a result it is burdensome for states to report MAP recommends the steward consider refining this measure to simplify the data collection methodology

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
2082 Endorsed HIV Viral Load Suppression Measure Steward: HRSA	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.	Alignment: N/A	Support for continued use in the program. Measure addresses a high risk population and high priority gap area. MAP recommends careful consideration of the potential modifications required on the measure. As currently specified, the identification of the measure denominator and code sets pose feasibility challenges. An alternative HIV/AIDS measure may need to be considered in the future.
2371 Submitted for Endorsement: In Public and Member Commenting Annual Monitoring for Patients on Persistent Medications Measure Steward: NCQA	The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the four rates separately and as a total rate : Rates for each: Members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB), Digoxin, diuretics, or anticonvulsants Total rate (the sum of the four numerators divided by the sum of the four denominators)	22 states reported FFY 2013 Alignment: HEDIS, Health Insurance Marketplace Quality Rating System	Conditional support for continued use in the program pending NQF endorsement Measure requires data linkage which does not currently exist and has some coding challenges, as a result it is burdensome for states to report

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting and Alignment	Recommendations and Rationale
Not Endorsed Adult Body Mass Index Assessment Measure Steward: NCQA	The percentage of Medicaid Enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	16 states reported FFY 2013 Alignment: Health Insurance Marketplace Quality Rating System	Support for continued use in the program MAP encourages the steward to submit this measure for NQF endorsement MAP recommends measure be maintained for stability of the set because of moderate levels of state implementation Measure requires medical record review, as a result it is burdensome for states to report MAP recommends improving the feasibility of data collection

Appendix E: Measures Associated with the Top 10 Conditions for Readmissions among Adults in Medicaid

A recent analysis by the Healthcare Cost and Utilization Project (HCUP) found that non-elderly Adult Medicaid beneficiaries experienced a total all-cause, 30 day readmissions rate of 14.6 per 100 admissions, adding up to approximately 700,000 readmissions in 2011. These readmissions cost approximately $7.6 billion and "the 10 conditions with the most all-cause, 30-day readmissions accounted for 34.1% of all Medicaid readmissions." These 10 conditions and how they relate to current or potential measures are outlined below.

Top 10 Conditions for Readmission[28]	Current Measures in the Medicaid Adult Core Set	Potential Additions
Septicemia (except in labor)	None	N/A
Congestive Heart Failure (nonhypertensive)	#0277 Heart Failure Admission Rate (PQI 8)	#0358 Congestive Heart Failure (CHF) Mortality Rate (IQI 16)
Diabetes Mellitus with complications	#0272 Diabetes Short-Term Complications Admission Rate (PQI 1) #0063 Comprehensive Diabetes Care: LDL-C Screening #0057 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	#0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) #0575 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Chronic Obstructive Pulmonary Disorder and Bronchiectasis	#0275 Chronic obstructive pulmonary disease (PQI 5)	#2020 Adult Current Smoking Prevalence
Other complications related to pregnancy	#1517 Prenatal & Postpartum Care	
Early or threatened labor	#0469 PC-01 Elective Delivery #0476 PC-03 Antenatal Steroids	
Schizophrenia and other psychotic disorders	Adherence to Antipsychotics for individuals with schizophrenia #0576 Follow-Up After Hospitalization for Mental Illness	#1927 Cardiovascular Screening For People With Schizophrenia Or Bipolar Disorders Who Are Prescribed Antipsychotic Medications #1932 Diabetes Screening For People With Schizophrenia Or Mood Disorders Who Are Using Antipsychotic Medications

Top 10 Conditions for Readmission[28]	Current Measures in the Medicaid Adult Core Set	Potential Additions
Mood disorders	#0576 Follow-Up After Hospitalization for Mental Illness #0105 Antidepressant medication management #0576 Follow-Up After Hospitalization for Mental Illness	#1880 Adherence to Mood Stabilizers for Individuals with Bipolar Disorder #0580 Bipolar animatic agent
Alcohol related disorders	#0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment #0576 Follow-Up After Hospitalization for Mental Illness	
Substance related disorders	#0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment #0576 Follow-Up After Hospitalization for Mental Illness	

Endnotes

[1] Department of Health and Human Services (HHS). 2013 CMS Statistics. Baltimore, MD: Centers for Medicare and Medicaid Services (CMS), 2013. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf. Last accessed June 2014.

[2] Kaiser Family Foundation, "Medicaid Moving Forward," Oakland, CA: KFF, June 17, 2014. Available at http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/. Last accessed June 2014.

[3] Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Downloads/2014-Federal-Poverty-level-charts.pdf. Last accessed June 2014.

[4] Kaiser Family Foundation, "Medicaid Moving Forward," Oakland, CA: KFF, June 17, 2014. Available at http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/. Last accessed June 2014.

[5] Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, 2014," Oakland, CA: KFF, June 10, 2014. Available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Last accessed June 2014.

[6] Kaiser Family Foundation, "Medicaid Enrollment: An Overview of the CMS April 2014 Update," Oakland, CA: KFF, April 2014. Available at http://kff.org/medicaid/fact-sheet/medicaid-enrollment-an-overview-of-the-cms-april-2014-update/. Last accessed June 2014.

[7] Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence," Oakland, CA: KFF, April 2, 2013. Available at http://kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/. Last accessed June 2014.

[8] Kaiser Family Foundation, "Visualizing Health Policy: Understanding the Effect of Medicaid Expansion Decisions in the South," Oakland, CA: KFF, June 25, 2014. Available at http://kff.org/infographic/visualizing-health-policy-understanding-the-effect-of-medicaid-expansion-decisions-in-the-south/. Last accessed June 2014.

[9] Kaiser Family Foundation, "What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence," Oakland, CA: KFF, April 2013. Available at http://kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/. Last accessed June 2014.

[10] Kaiser Family Foundation, "Low-Income Adults Under Age 65 – Many are Poor, Sick, and Uninsured," Oakland, CA: KFF, June 2009. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7914.pdf. Last accessed June 2014.

[11] Healthcare Cost and Utilization Project (HCUP). *Statistical Brief #172: Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011*. Rockville, MD: Agency for Healthcare Quality and Research (AHRQ); 2014. Available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.jsp. Last accessed June 2014.

[12] Centers for Medicare and Medicaid Services (CMS), Adult Health Care Quality Measures, Winter/Spring 2014. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Adult-Health-Care-Quality-Measures.html. Last accessed June 2014.

[13] Department of Health and Human Services (HHS), Medicaid Program: Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, Federal Register, 2012;77(2):286-291. Available at https://www.federalregister.gov/articles/2012/01/04/2011-33756/medicaid-program-initial-core-set-of-health-care-quality-measures-for-medicaid-eligible-adults. Last accessed June 2014.

[14] Department of Health and Human Services (HHS). Health Report to Congress: HHS Secretary's Efforts to Improve the Quality of Health Care for Adults Enrolled in Medicaid, 2014. Baltimore, MD: HHS. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_2014_Adult.pdf

[15] Centers for Medicare & Medicaid Services (CMS). 2014 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. Baltimore, MD: CMS. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/ChildCoreMeasures.pdf. Last accessed June 2014.

[16] CMS. Health Insurance Marketplace: Final 2015 Quality Rating System Beta Test Measure Set. Baltimore, MD: CMS. Available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html. Last accessed June 2014.

[17]National Quality Forum (NQF). MAP Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults. Washington, DC: NQF. Available at http://www.qualityforum.org/Publications/2013/10/MAP_Expedited_Review_of_the_Initial_Core_Set_of_Measures_for_Medicaid-Eligible_Adults.aspx Last accessed June 2014.

[18] CMCS Informational Bulletin: 2014 Updates to the Child and Adult Core Health Care Quality Measurement Sets http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf

[19] Kaiser Commission on Medicaid and the Uninsured. Medicaid Enrollment: December 2013 Data Snapshot. June 2014. Available at http://kaiserfamilyfoundation.files.wordpress.com/2014/06/8050-08-medicaid-enrollment-snapshot_december-2013.pdf. Last accessed June 2014.

[20] Kaiser Commission on Medicaid and the Uninsured. Medicaid Enrollment: December 2013 Data Snapshot. June 2014. Available at http://kaiserfamilyfoundation.files.wordpress.com/2014/06/8050-08-medicaid-enrollment-snapshot_december-2013.pdf. Last accessed June 2014.

[21] The Henry J Family Foundation. How will the Uninsured in New Hampshire Fare Under the Affordable Care Act?. March 2014. Available at http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-new-hampshire/. Last accessed June 2014.

[22] Kaiser Commission on Medicaid and the Uninsured. Medicaid Enrollment: December 2013 Data Snapshot. June 2014. Available at http://kaiserfamilyfoundation.files.wordpress.com/2014/06/8050-08-medicaid-enrollment-snapshot_december-2013.pdf. Last accessed June 2014.

[23] Virginia Department of Medical Assistance Services (DMAS). *2014 Managed Care Annual Report: Measurably Better Care, Quality, and Value Through Partnerships*. Richmond, VA: DMAS; 2014. Available at http://www.dmas.virginia.gov/Content_atchs/mc/AnnualReport2014Final.pdf. Last accessed June 2014.

[24]National Quality Forum (NQF). MAP Expedited Review of the Initial Core Set of Measures for Medicaid-Eligible Adults. Washington, DC: NQF. Available at http://www.qualityforum.org/Publications/2013/10/MAP_Expedited_Review_of_the_Initial_Core_Set_of_Measures_for_Medicaid-Eligible_Adults.aspx Last accessed June 2014.

[25] Department of Health and Human Services (HHS). *Center for Medicaid & CHIP Services Informational Bulletin: Nationwide CAHPS Survey of Adult Medicaid Enrollees*. Baltimore, MD: DHHS; 2014. Available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CAHPS-Survey-of-Adult-Medicaid-Enrollees.pdf. Last accessed June 2014.

[26] Department of Health and Human Services (HHS). *2013 Annual Report on the Quality of Care for Children in Medicaid and CHIP*. Washington, DC: DHHS; 2011. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2013-Ann-Sec-Rept.pdf. Last accessed June 2014.

[27] Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014.2010: p.260. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed June 2014.

[28] Healthcare Cost and Utilization Project (HCUP). *Statistical Brief #172: Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011*. Rockville, MD: Agency for Healthcare Quality and Research (AHRQ); 2014. Available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.jsp. Last accessed June 2014.