NATIONAL QUALITY FORUM

Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2017

DRAFT REPORT FOR PUBLIC COMMENT

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Contents

Executive Summary

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals, serving 74.5 million individuals.[1] Medicaid covers some of the most high-need populations in the country. Since October 2013, Medicaid has experienced marked growth in adult enrollment, largely due to Medicaid expansion, which was defined in the Patient Protection and Affordable Care Act (ACA).[2] Medicaid beneficiaries with complex care needs and high costs account for roughly 54 percent of total Medicaid expenditures, despite comprising just five percent of Medicaid beneficiaries. Therefore, understanding the needs of the adult Medicaid population is imperative for improving health and the quality of care for this population.

Legislation mandated the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. The Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF), guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs. Annually, the Measure Applications Partnership (MAP) informs changes to the Adult Core Set of measures. Guided by MAP's Measure Selection Criteria and feedback from several years of state implementation, this report includes MAP's latest round of annual recommendations to HHS for strengthening and revising measures in the Adult Core Set. The report also identifies high-priority measure gaps for future consideration.

MAP supports all but two of the current measures for continued use in the Adult Core Set and proposes four measures for phased addition to the Adult Core Set.

- MAP recommends the removal of NQF #0476 PC-03 Antenatal Steroids, noting reporting challenges related to data collection. MAP noted that this measure is also being reported to the Joint Commission, where performance on the measure is high overall and presents limited opportunity for improvement. Therefore, MAP recommends removal of this measure from the Adult Core Set to reduce duplication and burden at the state level as well as increase bandwidth for reporting other measures.
- MAP also recommends removal of NQF #1517 Postpartum Care Rate, which is no longer NQF-endorsed. The Medicaid Adult Task Force members stressed the importance of measures focused on content of medical visits that directly address outcomes; whereas, this measure is focused on counting visits. MAP recommends removal of this measure, while strongly encouraging the addition of a meaningful and actionable replacement measure.

MAP recommends that CMS consider up to four measures for phased addition to the Adult Core Set (Exhibit ES1). MAP is aware that additional federal and state resources are required for each new measure added. Therefore, MAP ranked the recommended measures based on their order of relative importance.

EXHIBIT ES1. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE ADULT CORE SET

Rank	Measure Name and NQF Number, if applicable (* indicates conditional support)
1	NQF #1800 Asthma Medication Ratio
2	NQF # 2967 CAHPS @ Home and Community-Based Services Experience Measures*
	Concurrent Use of Opioids and Benzodiazepines*
3	NQF #2903 Contraceptive Care: Most & Moderately Effective Methods

MAP recognizes that many priority areas for quality measurement and improvement lack availability of fully developed metrics. MAP documented these gaps in current measures to communicate future measurement needs to the developer community. The list of 12 gap areas is meant to be a starting point for future discussions as well as guide annual revisions to the Adult Core Set.

MAP also discussed strategic issues that highlighted ways of improving quality and Core Set reporting at the state level. These discussions focused on the evolution in quality measurement and included the following topical areas: optimizing data connections; improving integration across programs and data systems; aligning measurement and data requirements; as well as incorporating methodological paradigm shifts through stratification of data and acknowledging the impact of social complexities on care delivery and outcomes.

As the Medicaid Adult Core Set evolves, success in improving quality is dependent on voluntary reporting which encompasses issues of data availability, collection and reporting burden. However, this dependency is equally reliant on methodological issues such as risk adjustment and measure stratification. Therefore, education, communication and collaboration across care systems will be necessary to foster as well as bring to fruition a successful evolution of Medicaid care quality.

Introduction and Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF). MAP was created to provide input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs. MAP also oversees the work of providing guidance and recommendations to enhance and update the Medicaid Adult and Child Core Sets of measures. Information and background on MAP is provided in Appendix A.

The MAP Medicaid Adult Task Force advises the MAP Coordinating Committee regarding measure recommendations for HHS. The purpose of the Task Force is to help HHS strengthen and revise the measures in the core set of healthcare quality measures for adults enrolled in Medicaid (Adult Core Set) as well as to identify high-priority measure gap areas. The Task Force considers provider and state level burden of reporting along with the potential for alignment across state and federal quality reporting

programs. The Task Force consists of current MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise (Appendix B).

MAP recommendations for the current Core Sets are based on Map's Measure Selection Criteria (MSC) (Appendix C), a defined decision algorithm (Appendix D) and most recent available measure implementation data from states. The Centers for Medicare & Medicaid Services (CMS) provided several materials to inform MAP's review, including: summaries of the number of states reporting each measure, detailed analysis of state performance on 12 publically reported measures, summary of reasons why states did not report measures, and the number and type of technical assistance requests submitted for each measure.

This report summarizes states' feedback on collecting and reporting measures as presented to MAP during the Task Force's deliberations. It also includes measure-specific recommendations to fill high-priority gap areas (Appendix H). In addition, MAP identified several strategic issues and opportunities for increasing state reporting relevant to both the Adult and Child Core Sets.

This report is MAP's fifth set of annual recommendations on the Adult Core Set. This review evaluated measures in CMS's 2017 Adult Core Set using data from the Federal Fiscal Year (FFY) 2015 reporting cycle. MAP-recommended changes, if instituted, would take effect for the 2018 Adult Core Set. The annual review process allows for a better understanding of Medicaid's evolution as a program, the measures in use, and how states are modifying the program based on state specific needs. HHS considers MAP's discussions and recommendations, including the state perspectives, as guidance to inform the statutorily required annual updates to the Adult Core Set.

Background on Medicaid and the Adult Core Set

Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals. Medicaid is financed through a federal-state partnership, in which each state designs and operates its own program while following federal guidelines. Medicaid serves 74.6 million individuals, nearly half of whom are adults.[2] Since October 2013, Medicaid has experienced marked growth in adult enrollment, largely due to Medicaid expansion, which was defined in the Patient Protection and Affordable Care Act (ACA).[2] States that expanded Medicaid have seen an average 9.2 percentage point reduction in the number of uninsured adults since 2014 compared to a 7.9 percentage point decrease among non-expansion states. These newly insured individuals experience greater financial stability through access to affordable care; additionally, increased access to primary care and prescription medications helps manage increased rates of chronic conditions diagnoses for these individuals as well.[3]

Medicaid covers a broad range of services to meet the diverse needs of its enrollees; therefore, performance measurement is critical for quantifying and addressing the program's state of health. States have the flexibility to determine the amount, duration, and scope of services within broad federal standards.[4] States are required to cover certain "mandatory" services through the Medicaid program, e.g., hospital care, laboratory services, and physician/nurse midwife/certified nurse practitioner services.[5] Many states also cover additional services that federal law designates as optional for adults

based on the unique needs of their enrollees. These optional services include prescription drugs, dental care, and hospice services. Notably, Medicaid also covers a broad spectrum of long-term care benefits not provided by Medicare or private payers.[4] As a result, Medicaid is the most significant source of financing for nursing home and community-based long-term care.

Medicaid Adult Population

Medicaid provides coverage to low-income adults, children, elderly persons, pregnant women, and people with disabilities.[6] In short, Medicaid covers some of the most high-need populations in the country. Although ACA expanded coverage to millions of low-income adults who were previously ineligible for Medicaid, critical gaps in care remain. Physician participation is generally lower in Medicaid when compared to commercial insurance options or Medicare. Additionally, psychiatrist and dentist participation is low, despite the elevated prevalence of behavioral health conditions among the Medicaid population and high demand for dental services.[7]

According to data collected in a recent survey of high need patients, approximately one in five older U.S. adults (ages 50-64) is covered by Medicaid. Within this age cohort, nearly half of the most high-need individuals – those with multiple major chronic conditions, limited ability to perform daily activities of living, and/or disabilities – rely on Medicaid.[8] Additionally, Medicaid beneficiaries with complex care needs and high costs account for roughly 54 percent of total Medicaid expenditures, despite comprising just five percent of Medicaid beneficiaries. Furthermore, one percent of Medicaid beneficiaries accounts for 25 percent of total Medicaid expenditures.[9]

Medicaid Adult Core Set

Legislation called for the creation of a core set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs, assist states in collecting and reporting on the measures, and facilitate use of the measures for quality improvement.[10] HHS published the initial Adult Core Set of measures in January 2012 in partnership with a subcommittee to the Agency for Healthcare Research and Quality's (AHRQ) National Advisory Council.[11] It has been updated annually since that time, with recent iterations reflecting input from MAP.

The Adult Core Set is often used to provide a snapshot of quality within Medicaid. It is not comprehensive, but prior to its creation and implementation, performance measurement varied greatly by state, and it was not possible to glean an overall picture of quality. Statute requires CMS to release annual reports on behalf of the Secretary on the reporting of state-specific adult Medicaid quality information. CMS also issues reports to Congress on this subject every three years.

In January 2012, HHS published a final rule in the *Federal Register* to announce the initial core set of healthcare quality measures for Medicaid-eligible adults; annual updates including a 2017 version followed. For the 2017 update, CMS issued changes that were informed by MAP's 2016 review and input. Following MAP's recommendation, CMS added three measures: NQF #2607 *Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control* (>9.0%), NQF #2605 *Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug*

Dependence, and #2902 *Contraceptive Care – Postpartum Women*. These additions expand the measurement of quality of care for three populations – individuals managing diabetes, individuals with mental health conditions or substance use disorders, and women who have just delivered, respectively.

Additionally, CMS added the electronic clinical quality measure (eMeasure) format of NQF #0469 *PC-01 Elective Delivery*, paper measure, which is included in the Adult Core Set. CMS also retired NQF #0648 *Timely Transmission of Transition Record* (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care). CMCS retired this measure based on recommendations from the states. The 2017 version of the Adult Core Set contains a total of 30 measures. The characteristics of the 2017 Core Set can be found in Appendix E. Measures in the Core Set are relevant to adults ages 18 and older.

CMS' goals for the Adult Core Set are to increase the number of: 1) States reporting the Core Set measures; 2) Measures reported by each state; and 3) States using the Core Set measures to drive quality improvement. CMS uses the annual data submissions to capture a snapshot of quality across Medicaid and CHIP. These are presented in publications such chart packs and Performance on the Adult Core Set Measures.[12]

State Experience Collecting and Reporting the Adult Core Set

All MAP Medicaid Core Set measure related discussions and deliberations regarding addition and removal of measures are preceded by presentations from invited state Medicaid program representatives. These representatives provide an overview of their state Medicaid program as well as an overview of their experience with collecting, reporting and using either the Adult or the Child Core Set. This process aims to solicit information from the field, prior to recommending any changes for either Core Set. Ultimately, the goal is to use experiential data in an effort to provide well-informed and targeted recommendations.

For the Adult Core set, state Medicaid representatives from Colorado and Ohio were invited to provide the Task Force with an overview of their state Medicaid demographics along with information related to Core Set use, issues related to reporting and potential strategies for improving Core Set measure reporting rates.

Colorado

The Colorado Medicaid representative, Judy Zerzan, MD, MPH, Chief Medical Officer, presented the state's experience with the Adult Core Set. Overall, the program covers 1.3 million individuals - out of which forty-eight percent are adults. Most of the adult Medicaid beneficiaries live in urban areas (80%) and the remaining in rural areas. Many of these adult enrollees (75%) represent the working poor and are employed in service industries such as food, childcare and retail. Colorado is a Medicaid expansion state where expansion adults make up over thirty percent of the enrollees and have a high prevalence of both mental health and addiction needs. For this segment of the Medicaid population, behavioral health drives a significant portion of their physical health conditions and needs.

Colorado is a managed fee for service state where most of the programmatic cost is incurred for hospital services, specifically $2.8 billion, closely followed by community-based services and nursing facilities. Overall, the Colorado Medicaid program is set up as an Accountable Care Collaborative that provides care management through patient centered medical homes. The aim is to increase efficiency and lower cost through care coordination across behavioral health, specialty care, hospital services and community services. The Accountable Care Collaborative is made up of seven regional organizations that are directly responsible for the health of their Medicaid population and are paid a per member per month fee for managing them. Primary care providers in the state are also paid a per member per month fee for managing their Medicaid patients. The state uses this per member per month fee model to successfully control cost while improving quality. The presenter emphasized that the success of the program stems from allowing providers to create change and has resulted in a net savings of $60 million a year.

Colorado Medicaid reports on a third of the Adult Medicaid Core Set measures. It should be noted that measures not reported by the state include the four of the measures with the lowest reporting rates across all states. Due to the social and medical complexities of their beneficiaries which leads to data collection issues, they have chosen not to report on all of the core set measures. Other reasons provided for not reporting these measures focused mostly on implementation challenges including: behavioral health carve outs, age and/or risk adjustment issues with proprietary measures and licensing agreements, state firewall issues, use of hospital measures in medical homes, as well as non-administrative measures requiring chart/medical record reviews.

Subsequently, the Colorado representative provided recommendations on ways to address some of these implementation challenges including, focusing on alignment of the Core Set with other payment programs such as Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), State Innovation Models (SIM) and other similar programs. Currently, it is difficult for local practices and providers to report on multiple measures for a myriad of accountability and public reporting programs. Furthermore, when these entities are able to report on data, they have difficulties with age breakouts for the measures, especially where the Core Set measure age breakouts differ from Healthcare Effectiveness Data and Information Set (HEDIS) guidelines and specifications. Additionally, the presenter highlighted the need for meaningful measures that address social determinants, prevention, shared decision making and functional outcomes.

In an effort to address some of the measurement and social issues related to patient care quality, Colorado is focusing on a value-based payment model specifically for primary care. The goal of this program/initiative is to provide sustainable and appropriate funding for primary care that rewards high value, high quality care. In this model, practices are allowed to choose measures on which they will report and be held accountable. Based on their performance on these chosen measures, practices can earn up to four percent incentive pay and/or bear risk and lose up to four percent of pay. Mainly, payment additions or loses are based on not only performance, but also improvement in overall care quality. Additionally, Colorado Medicaid is providing comparative report cards for all of the Federally Qualified Health Centers, primary care providers, and hospitals serving Medicaid beneficiaries. The goal of doing so is to use competition as a lever for improving overall care by comparing providers and entities to their peers and competitors.

In conclusion, the representative emphasized that any quality improvement efforts should be focused on the uniqueness of the Medicaid population based on regional and geographical differences. For

example, Colorado Medicaid serves fewer than thirty thousand diabetics; whereas, West Virginia Medicaid has a very high burden of diabetics. Smoking is, however, an important public health issue for Colorado. Therefore, given the heterogeneity of the Medicaid population, the presenter recommended that states base their quality improvement initiatives around population needs specific to each state.

Ohio

The Ohio Medicaid presentation by Mary Applegate, MD, FAAP, FACP, Medical Director, Ohio Department of Medicaid, focused on the Adult and Child Core Set from a systems perspective with particular attention to maternity care. Ohio is the seventh largest Medicaid state covering over three million individuals. Over 90 percent of their enrollees are in managed care and efforts are underway to enroll the entire Medicaid population in managed care as well. Ohio Medicaid's aim is to provide systems of care through patient choice and patient engagement in an evidence-based care management environment. As a Medicaid expansion state, the program covers over 700,000 individuals through private managed care plans. Overall coverage is split fairly equally between individuals 19-64 years of age (52 percent of total Medicaid) and individuals 19 and younger (43 percent of total Medicaid) years of age.

Ohio reports on three fourths of the measures in the Adult and Child Core Sets. Funding from the Medicaid Adult Quality grant enabled voluntary reporting on the Core Set measures by providing funds for coding the measures for electronic data collection and submission.[13] Decision to report is mainly driven by the following consideration, "measures that make patients better." Given the state's focus on improving the quality of maternity care, the state reports on the following Child Core Set measures focused on maternity care: *Live Births Weighing Less than 2,500 Grams*, *Well-Child Visits in the First 15 Months of Life*, *Frequency of Ongoing Prenatal Care (>= 81% of expected visits)*, *Timeliness of Prenatal Care*, and *Postpartum Care Rate*.

The representative noted that decisions to report measures are based on challenges such as fragmented care system, administrative reporting burden along with provider workload issues. Furthermore, measurement decisions are based on the impact of measures at the practice level as well as connection to improved patient outcomes. However, the decision to not measure or report can also result from an effort to avoid duplication, especially when other mechanisms of improvement are underway, such as episodes of care based quality efforts and public health driven mechanisms. The primary focus of Ohio Medicaid is to implement and report all measure sets that facilitate and tie into population health management, while assisting with cost containment through better care and budget management. Therefore, all reported measures must be evidence-based and meaningful at the practice level.

For improving Medicaid Core Set measure reporting rates, the representative encouraged alignment of measures across programs, as well as increasing the use of administrative data based measures with the goal of making data collection simple. Moreover, there is a desire for data collection needs to be episode of care-focused and relevant for all stakeholders including providers, managed care plans and health systems. The representative encouraged the promotion and adoption of episodes of care measurement, where measures and even composites are built around a series of related services such as prenatal and postpartum care. This approach allows for longitudinal management of patient health at the population-level. Ohio Medicaid aims for every Medicaid patient to be assigned to a primary care

clinician who will be responsible for tracking and managing their care. This is essential to their approach for quality improvement as poor performance is often related to lack of follow-up.

The representative provided an example of a current public health initiative focused around the infant mortality crisis in Ohio. Given Ohio's move towards attributing patients to providers, it was noted that lack of follow-up is a known predictor of infant mortality. Socioeconomic factors such as lack of transportation also lead to missed appointments. Therefore, as a mitigation strategy, various postpartum visit settings are being considered for care delivery using a population perspective. Moreover, for the purposes of improving population health, postpartum care for this initiative addresses interpregnancy intervals as well as disparities in infant mortality. Quality improvement for this issue requires an understanding of community level disparities, consistent patient education, and community level services focused on patient engagement; all of which highlights the current disconnect between measurement and the impact of social risk factors on the outcomes of measurement.

Based on programmatic experience, the representative recommended and emphasized the need for community and patient engagement through outreach and education. The representative also highlighted the need for a systems view of care quality that encompasses all parties involved, including the patient and their community, the provider, the health plan, as well as the state. Therefore, any quality-focused initiative requires collaboration, communication and trust among all relevant parties.

MAP Review of the Adult Core Set

MAP evaluated the measures in the Adult Core Set to provide recommendations to revise and strengthen the measures while facilitating CMS's goals for the program. MAP's review of measures was guided by the Measure Selection Criteria (MSC) (Appendix C), a defined decision algorithm (Appendix D) and feedback from the most recent year of state implementation. The MSC are not absolute rules; rather, they are meant to provide general guidance on measure selection decisions to ensure the inclusion of high-quality measures that address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Using the decision algorithm, Task Force members reviewed measures in the gap areas identified during previous years' review. NQF staff compiled measures in the following 11 gap areas:

- mental health;
- substance use;
- patient-reported outcomes;
- care coordination;
- long-term supports and services;
- maternal and perinatal;
- asthma;
- promotion of wellness;
- workforce and access to care;
- polypharmacy; and
- patient engagement and activation.

MAP discussed measures recommended by individual Task Force members largely based on their specification, the MSC, and the feasibility of implementing them for statewide quality improvement. MAP recommended measures they judged to be a good fit. In addition to the measures compiled by

staff, all Task Force members had the opportunity to recommend other available measures for consideration as well.

MAP generally favored ready-to-implement measures that promote parsimony and alignment, while addressing high-impact health conditions for adults enrolled in Medicaid. NQF-endorsed measures are favored because: they have undergone a multi-stakeholder evaluation to ensure the measure's focus is evidence based, they are reliable and valid, and address aspects of care that are important and feasible. Following discussion of each measure, MAP voted to determine if there was sufficient support from Task Force members to recommend the measure for addition to the Core Set. Measures evaluated by MAP, but not supported for addition are listed in Appendix G.

NQF-endorsed measures are not always available to address gap areas deemed relevant for the Adult Core Set. Therefore, MAP did not restrict its review to endorsed measures only. Task Force members helped identify measures in development and/or undergoing endorsement for discussion and consideration. For example, MAP examined a substance use measure that has not yet been submitted for endorsement. Thereby, monitoring the development of new measures is imperative for facilitating the success of future annual reviews.

Additionally, CMS has underscored the importance of providing choice through multiple formats for data collection and reporting by states. Therefore, CMS will automatically include electronic measure specifications and formats, (i.e., e-specification also known as an eMeasure) for NQF-endorsed measures in the Core Set. CMS will add the e-specification, when available, not as a change but as an enhancement to the Core Set. For example, NQF measure #0418 has an eMeasure version, measure #3132. If endorsed, the eMeasure #3132 will be automatically included in the Adult Core Set.

Measure-Specific Recommendations

Measure Recommendation for Removal from the Adult Core Set

MAP noted that states' participation in reporting the Adult Core Set is strong, though there is much room for improvement in both the total number of states submitting measurement data and the number of states reporting each measure. Given the relative newness of the program, participation is expected to be lower than for the Child Core Set, but has increased each year. Not finding many significant implementation problems, MAP was comfortable supporting all but two of the current Core Set measures for continued use. Maintaining stability in the measure set will allow states to continue to gain experience in reporting the measures; thereby, potentially increasing the number of states submitting quality information to CMS and using the measures locally to drive quality improvement.

In general, MAP considers removing a measure when the following factors are observed:

- Consistently high levels of performance (e.g., >95 percent), indicating little opportunity for additional gains in quality
- Multiple years of very few states reporting a measure, indicating that it is not feasible or a priority topic for improvement
- Change in clinical evidence and/or guidelines have made the measure obsolete
- Measure does not yield actionable information for the state Medicaid program or its network of providers

- Superior measure on the same topic has become available and a substitution would be warranted

NQF #0476 PC-03 Antenatal Steroids

Multiple state representatives reported challenges when collecting data for NQF measure #0476 *PC 03 Antenatal Steroids*. In general, state representatives noted that measures collected via medical record review are resource intensive and can lead to gaps in data. In addition, it was noted that this hospital level measure is currently being reported to the Joint Commission. MAP encourages CMS to coordinate with other entities, such as the Joint Commission, and share data already being collected. Joint Commission reported that the performance rate for the measure was 97.2 percent in 2015, up from 91.8 in 2014, indicating little opportunity for additional gains in quality. Therefore, MAP recommends removal of this measure from the Adult Core Set to reduce duplication and burden at the state level as well as increase bandwidth for reporting other measures.

NQF #1517 Postpartum Care Rate

The Medicaid Adult Task members discussed measure aspects such as maintaining a measure focused on counting a visit, specifically the *Postpartum Care Rate* measure, versus supporting measures focused on content of medical visits that directly address outcomes. Since it is part of HEDIS, the Task Force members acknowledged the relative ease of reporting this measure. However, they also expressed their concern that this measure only counts visits between 21 and 56 days after delivery, which may disincentivize early visits necessary for appropriate breast feeding support, wound care, and other postpartum related issues. MAP recommends removal of this measure while strongly encouraging the addition of a meaningful and actionable replacement measure.

Additionally, during the 2016 maintenance review, the 2015-2016 Perinatal Standing Committee did not recommend this measure for continued endorsement because it did not pass the Evidence criterion. This measure lacks empirical evidence with regards to the association between outcomes and the visit schedule and/or number of visits. The developer, National Committee for Quality Assurance, subsequently withdrew the measure from consideration. Therefore, endorsement was removed from NQF #1517.

Measures for Phased Addition to the Adult Core Set

MAP recommends that CMS consider up to four measures for phased addition to the Adult Core Set (Exhibit 1, below, and Appendix F). These measures passed consensus threshold to gain MAP's support or conditional support for phased addition by receiving more than 60 percent approval by voting MAP Task Force members. Measures are supported conditionally for several reasons, including pending endorsement from NQF, pending CMS confirmation of feasibility…et cetera. MAP recommends that CMS add measures pending NQF endorsement once endorsement review is complete and the detailed technical specifications are made publicly available.

MAP is aware that additional federal and state resources are required for each new measure added. Therefore, immediate addition of all four recommended measures is unlikely. Given the burden of additional measurement requirements, MAP considered both parsimony and alignment when

recommending measures that address gap areas. Furthermore, MAP ranked the recommended measures based on their order of relative importance.

The 2017 Adult Core Set includes 30 measures, the largest number of measures to date. Given this size, there is a critical need to maintain stability of the number of measures since it increases the likelihood of states reporting the same measures. Also, a critical mass of reporting states is important and needed as there are resource implications at the federal level (e.g. resources only allow CMS to provide technical assistance for measures that at least 25 or more states report).

EXHIBIT 1. MEASURES RECOMMENDED FOR PHASED ADDITION TO THE ADULT CORE SET

Rank	Measure Name and NQF Number, if applicable (* indicates conditional support)
1	NQF #1800 Asthma Medication Ratio
2	NQF # 2967 CAHPS @ Home and Community-Based Services Experience Measures*
	Concurrent Use of Opioids and Benzodiazepines*
3	NQF #2903 Contraceptive Care: Most & Moderately Effective Methods

The addition of recommended measures would strengthen the Core Set by promoting measurement of a variety of high-priority quality issues, including reproductive health, chronic disease management for people with asthma, and the prevention of substance abuse. Further explanation and rationale regarding MAP's support for these measures follow, in order of ranking.

NQF #1800 Asthma Medication Ratio

This measure assesses the percentage of patients 5–64 years of age identified as having persistent asthma and a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. During the 2016 review, MAP examined this measure at the request of public commenters who preferred NQF #1800 to MAP's recommended *Medication Management for People with Asthma* (NQF #1799) during the 2014, 2015 and 2016 reviews. Additionally, NQF #1799 lost endorsement during the 2015-2016 endorsement review. Although MAP did not support the inclusion of measure #1800 in 2016, they voted to support the measure this year. MAP also supported this measure for inclusion in the Child Core Set. Inclusion of the measure in both Sets would support alignment and facilitate seamless care transition across the two Core Sets.

*NQF # 2967 CAHPS @ Home and Community-Based Services Experience Measures**

MAP conditionally supported the inclusion of this measure, noting the great need for home and community-based metrics. *CAHPS Home and Community-Based Services Experience measures* are based on a disability survey and is focused on collecting feedback from adult Medicaid beneficiaries receiving home and community based services (HCBS). The measures address the quality of the long-term services and supports they receive in the community, as well as services delivered under the auspices of a state

Medicaid HCBS program. If added to the Core Set, this will be the only measure that addresses long-term care services provided in the community setting. MAP conditionally supported this measure, due to questions and uncertainty regarding the implementation feasibility at the state level.

*Concurrent Use of Opioids and Benzodiazepines**

MAP recommended the inclusion of this measure since it addresses two gap areas simultaneously: early opioid use and polypharmacy. The measure is conditionally supported pending NQF endorsement. This measure examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines. In the United States, deaths from co-prescribed opioids and benzodiazepines increased 14 percent per year from 2006 to 2011.[14] According to the *Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain – United States, 2016*, clinicians should avoid prescribing opioid pain medications and benzodiazepines whenever possible.[15] This is a claims based measure which increases the feasibility of reporting for states. Taskforce members unanimously agreed on the utility of this measure in providing clear guidelines regarding concurrent prescribing practices.

NQF #2903 Contraceptive Care: Most & Moderately Effective Methods

This measure captures the rate of contraception use among women who could experience unintended pregnancies. It assesses women who are provided a most (sterilization, intrauterine device, implant) or moderately (pill, patch, ring, injectable, diaphragm) effective method of contraception. MAP initially recommended this measure conditionally pending NQF endorsement, during its 2015 review. The measure was endorsed in 2016. After detailed discussions regarding the potential for providers to coerce patients, the group concluded that the end user should implement the measure with the understanding that the target performance rate should be well below 100%. MAP agreed to support this measure, mainly because it addresses the important gap issue of access to contraception. NQF #2903 is a complement to NQF #2902 *Contraceptive Care – Postpartum*, which was recently added to the 2017 Adult Core Set. This measure is also supported for inclusion in the Child Core Set.

Measure Concept Reviewed for Future Consideration

The Personal Outcomes Measures was presented for future consideration and addition to the Adult Core Set. Developed by the Council on Quality and Leadership (CQL), the Personal Outcome Measures survey is designed to determine the quality of life of people with disabilities in 21 areas. The survey also assesses if necessary supports are in place to assist individuals in achieving their desired outcomes. Discussion focused on the importance of capturing quality of life for Medicaid beneficiaries with disabilities. Currently, this survey does not include validated measures. MAP agreed that actionable measures addressing quality of life would be useful, and encouraged future development of such measures.

Remaining High Priority Gaps

Many important priorities for quality measurement and improvement lack the availability of fully developed metrics. Therefore, MAP discussed and documented these gaps in measurement. This list below is meant to communicate measure development focus areas for the developer community. The

gaps list provides a starting point for future discussions as well as guide annual revisions to further strengthen the Adult Core Set.

Gap areas for 2017 were identified from state feedback, review of 2015 reporting, and data on prevalent conditions affecting the adult Medicaid population. The Medicaid Adult Task Force began their discussion of gaps by considering NQF's prioritization criteria for the future of measurement (Exhibit 2, below, and Appendix H). The prioritization of gap areas is not meant to diminish the importance of the universe of gaps, including those topic areas not triaged as most important. Rather, ranking provides CMS with information on the relative importance of each gap area, and is meant to inform the addition and removal of measures from the Core Set.

EXHIBIT 2. PRIORITIZATION CRITERIA

Criterion	Description
Outcome-focused	Preference for outcome measures and measures with strong links to improved outcomes and costs
Improvable and actionable	Preference for actionable measures with demonstrated need for improvement and evidence-based strategies for doing so
Meaningful to patients and caregivers	Preference for person-centered measures with meaningful and understandable results for patients and caregivers
Support systemic and integrated view of care	Preference for measures that reflect care that spans settings, providers, and time to ensure that care is improving within and across systems of care

Among the 12 gap areas identified, MAP considered the following as the five key gap areas. These are listed in order of importance. An asterisk (*) denotes newly identified gap areas. Sub-bullets are illustrative examples of the gap area.

Adult Core Set Measure Gaps

1. Behavioral health (integration coordination with primary and acute care settings and outcomes)
2. Assessing and addressing social determinants of health*
3. Maternal/Reproductive health
    - Inter-conception care; poor birth outcomes
    - Access to OB care in the rural community
    - Postpartum complications
4. Long-term supports and services

5. New chronic opiate use (45 days)

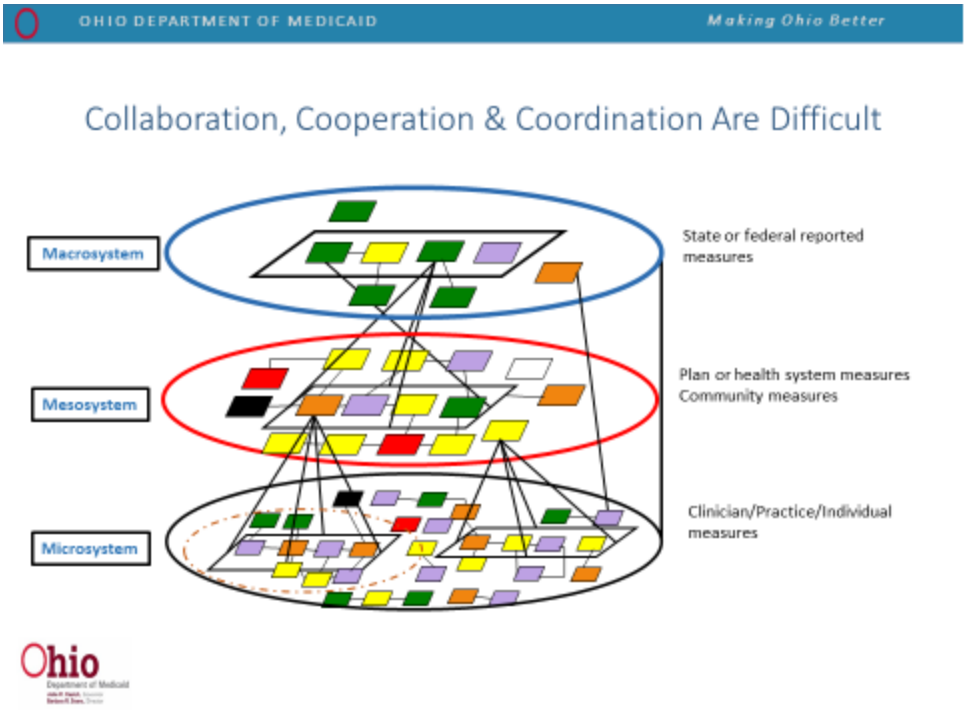
Strategic Considerations for State-level Quality Improvement

The Adult & Child Medicaid Task Forces conducted joint deliberations regarding issues that affect measure reporting rates along with strategies for increasing overall Core Set reporting rates. These discussions focused on the evolution in quality measurement and included the following topical areas: optimizing data connections; improving integration across programs and data systems; aligning measurement and data requirements; as well as incorporating methodological paradigm shifts through stratification of data and acknowledging the impact of social complexities on care delivery and outcomes.

Alignment:

Task Force members and state Medicaid panelists emphasized the continued importance of addressing alignment from a multi-level perspective comprising of macro-, meso-, and micro- systems of care. The ultimate goal is to connect clinician/practice level measures (microsystem) with plan/health system and community level measures (mesosystem), which then roll up to state or federal level measures (macrosystem). This matrixed paradigm of measurement allows for population health management through coordination of measurement across the health care spectrum. However, successful integration across systems is dependent on data integration and coordination of efforts with a population health focus; whereby, measurement at the patient level is not only an indicator of the individual's health, but also a single point marker for a population's health as well. This paradigm shift replaces fragmented data collection and measurement with an integrated system, where a holistic view of quality is promoted and achieved through shared responsibilities for each patient. Therefore, Task Force members encouraged continued efforts at aligning measure sets and quality efforts across health care.

EXHIBIT 3: SYSTEMS VIEW OF MEASUREMENT[1]



Data: Integration and Connection

Both the Adult and Child Task Forces agreed that data challenges represent the most consistent and pervasive barrier to measure reporting. Specifically, this discussion focused on the lack of data system integration. In this environment, care delivery has to be coordinated and optimized using disconnected and fragmented medical, laboratory and claims data systems. For example, laboratory data systems are not connected to claims databases; therefore, access to laboratory results requires extra release form authorizations from patients, which increases paperwork burden and creates barriers to seamless care information transmission. Furthermore, Task Force members noted that this issue is also a system-level hindrance with respect to data sharing among public health registries, accreditation bodies, and state/federal level agencies.

Both the Ohio and Colorado state representatives and Task Force members expressed frustration with data lag times and a lack of universal coding language usage. For example, public health data often has a lag time of at least two years, and does not use Logical Observations Identifiers, Names, Codes (LOINC®)- a common language (set of identifiers, names, and codes) for identifying health measurements, observations, and documents. However, CMS data systems are based on LOINC codes. Additionally, a lack of medical and behavioral health integration causes care duplication, which is further perpetuated through state-specific behavioral health carve-outs.

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[1] Applegate, M. Ohio Department of Medicaid. MAP Medicaid Joint Adult and Child In-Person Meeting. May 24, 2017. Washington, D.C.

Task Force members recommended focusing efforts on working around systems integration issues at the federal level. For example, they recommended that CMS and Joint Commission should share data related to antenatal steroid use. This will not only reduce data collection and reporting burden for the state Medicaid agencies, but also increase Medicaid programmatic efficiency at the federal level by re-purposing data already collected.

Data: Stratification

The discussion regarding leveraging existing data and increasing efficiency also addressed methodological tools such as data stratification. In general, stratification allows for the parsing and dissection of data based on certain parameters and helps identify care quality trends and patterns. For example, stratifying public health measures based on geographical location can highlight disparities, which then can be used to address population level health issues and outcomes.

Task Force members noted that stratification can also help overcome the behavioral health/general medical health divide, by allowing for the parsing of a medical care measure based on the presence/absence of behavioral health comorbidity (e.g., segmenting individuals with Severe Mental Illness) and other especially vulnerable populations. Furthermore, the Task Force recommended that states should use stratification to address state-specific quality improvement needs in a transparent manner. Stratification methodologies used should be readily accessible. This sharing of stratification methodologies can also serve as a repository of methodological information as well as provide a learning network where states assist each other in determining what is best for them based on what has already been successfully done.

Social Determinants of Health

As risk adjustment for social determinants of health and risk factors evolve, stakeholders are becoming aware of the inextricable role of social risk and medical complexity with regards to care and health quality outcomes at both the individual and population level. Unfortunately, this relationship is compounded and magnified within the Medicaid population, due to persistent socioeconomic and sociodemographic risk factor (SES and SDS) related vulnerabilities. The presenter from Ohio emphasized this by highlighting infant mortality within the state; while underscoring the need for community education and patient empowerment, since higher education levels lead to fewer early pregnancies. Furthermore, this reduces both preterm births and infant mortality as well.

The concept of health equity was also discussed by the group. Equity encompasses community relations with health care delivery systems, trust between providers, patients and community, along with open communication among all stakeholders. The group emphasized that any community level care quality consideration should acknowledge health equity as well. Given the complexity of SDS and health equity, the Task Force members recognized the need to assess and address social determinants of health, and, thereby, emphasized the need for developing social vulnerability measures.

Conclusion:

Medicaid is the largest health insurance provider in the U.S. As such, states require accurate performance measurement data to drive delivery system reform efforts and meet the needs of a growing beneficiary population. The Adult Task Force provided measure recommendations for the 2018 Adult Core Set to support state's quality improvement efforts, increase the number of states voluntarily reporting on Core Set measures, and increase the number of Core Set measures reported by each state. MAP's recommendations were informed by state Medicaid representatives' experiences implementing, reporting, and leveraging the Adult Core Set measures.

The Task Force recommended the removal of two measures included in the 2017 Adult Core Set (i.e., NQF #0476 *PC-03 Antenatal Steroids and Postpartum Care Rate* [NQF #1517]). The Task Force also recommended the addition of four measures which address critical gap areas in the Medicaid adult population (i.e., NQF #1800 *Asthma Medication Ratio*, NQF #2967 *CAHPS @ Home and Community-Based Services Experience Measures*, *Concurrent Use of Opioids and Benzodiazepines* [not NQF-endorsed], and NQF #2903 *Contraceptive Care: Most & Moderately Effective Methods*). MAP's recommendations for measure removal and addition reflect Task Force members' prioritization of parsimony and states' evolving priorities (e.g., opioid addiction). MAP supported the continued use of all remaining measures included in the Core Set.

As the Medicaid Adult Core Set evolves, success in improving quality is dependent on voluntary reporting which encompasses issues of data availability, collection and reporting burden. However, this dependency is equally reliant on methodological issues such as risk adjustment for SDS and measure stratification. Ultimately, education, communication and collaboration across care systems will be necessary to foster as well as bring to fruition a successful evolution of Medicaid care quality.

Current changes in billing and reimbursement structures will provide opportunities to leverage emerging strategies such as SDS risk adjustment while transitioning care to a population based system. Quality measurement has been undergoing these changes gradually, and is moving to a "measuring what matters" system. The focus is changing from counting processes to focusing on outcomes, where timely and actionable measurement replaces the traditional focus of provider's counting and checking boxes.

Next steps:

The report will be out for public comments from July 7 - August 6, 2017.

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Appendix A: MAP Background

Purpose

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

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

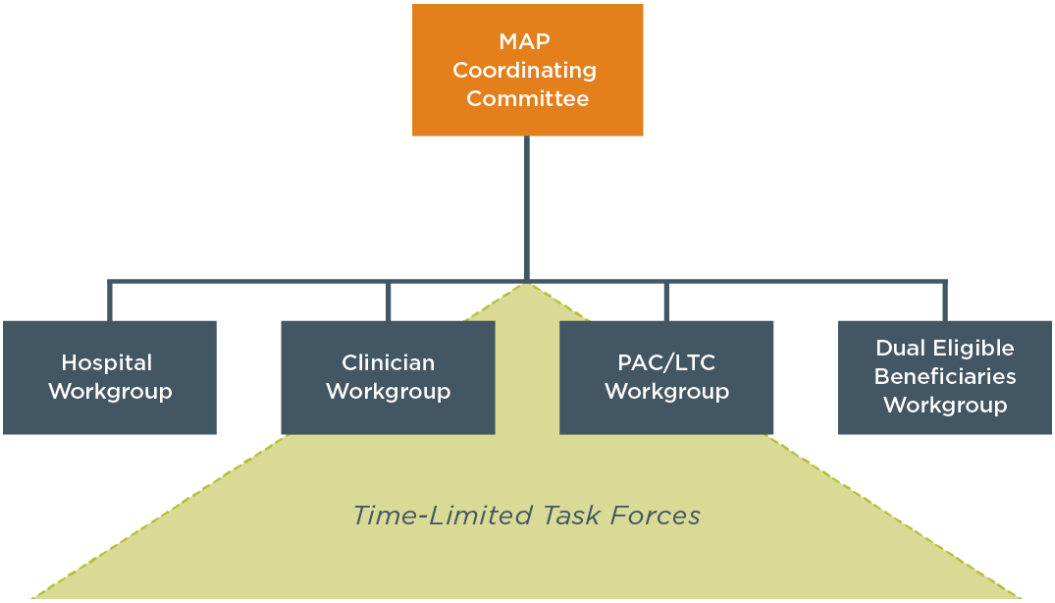
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for 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 whether 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 provides final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with specific topics 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 2015 Pre-Rulemaking Deliberations). Additionally, MAP engages in strategic activities throughout the year to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

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

1 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 August 2015.

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

Measure Applications Partnership Medicaid Adult Task Force

CHAIR (VOTING)
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
National Rural Health Association	Diane Calmus, JD
Centene Corporation	Mary Kay Jones, MPH, BSN, RN, CPHQ
American Association of Nurse Practitioners	Sue Kendig, JD, WHNP-BC, FAANP
Association for Community Affiliated Health Plans	Deborah Kilstein, RN, MBA, JD
National Association of Medicaid Directors	Rachel La Croix, PhD, PMP
American Academy of Family Physicians	Roanne Osborne-Gaskin, MD, MBA, FAAFP
Consortium for Citizens with Disabilities	Clarke Ross, DPA
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Health Resources and Services Administration (HRSA)	Suma Nair, MS, RD
Substance Abuse and Mental Health Services Administration (SAMHSA)	Lisa Patton, PhD
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD

Measure Applications Partnership Coordinating Committee

CO-CHAIRS (VOTING)
Charles Kahn, III, MPH
Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Shaun O'Brien, JD
America's Health Insurance Plans	Aparna Higgins, MA
American Academy of Family Physicians	Amy Mullins, MD FAAFP
American Board of Medical Specialties	R. Barrett Noone, MD, FACS
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Bruce Hall, MD PhD, MBA, FACS
American HealthCare Association	David Gifford, MD, MPH
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Samuel Lin, MD, PhD, MBA, MPA, MS
American Nurses Association	Mary Beth Bresch White
Consumers Union	John Bott, MSSW, MBA
Healthcare Financial Management Association	Richard Gundling, FHFMA, CMA
The Joint Commission	David Baker, MD, MPH, FACP
The Leapfrog Group	Leah Binder, mA, MGA
Maine Health Management Coalition	Brandon Hotham, MPH
National Alliance for Caregiving	Gail Hunt
National Association of Medicaid Directors	Foster Gesten, MD, FACP
National Business Group on Health	Steve Wojcik, MA
National Committee for Quality Assurance	Mary Barton, MD
National Partnership for Women and Families	Carol Sakala, PhD, MSPH
Network for Regional Healthcare Improvement	Chris Queram, MS
Pacific Business Group on Health	William Kramer, MBA
Pharmaceutical Research and Manufacturers of America (PhRMA)	Jennifer Bryant, MBA
Providence Health and Services	Ari Robicsek, MD

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS
State Policy	Doris Lotz, MD, MPH

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVES
Agency for Healthcare Research and Quality (AHRQ)	Nancy J. Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MH, FACP
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD, MSc
Office of the National Coordinator for HIT (ONC)	David Hunt, MD, FACS

NQF Project Staff

STAFF MEMBER	TITLE
Debjani Mukherjee	Senior Director
Shaconna Gorham	Senior Project Manager
Miranda Kuwahara	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 relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

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

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

Subcriterion 1.1 Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need

Subcriterion 1.2 Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

Subcriterion 1.3 Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

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

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

Subcriterion 2.1 Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

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

Subcriterion 2.3 Affordable care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Program measure set promotes parsimony and alignment

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

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

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

Appendix D: MAP Medicaid Preliminary Analysis Algorithm

For the 2016-2017 cycle, to support the Task Force's review of potential measures, staff provided a preliminary analysis of all measures under consideration using the MAP Medicaid Preliminary Analysis Algorithm derived from the Measure Selection Criteria.

Assessment	Definition	Outcome
1) The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or • The measure is responsive to specific program goals and statutory or regulatory requirements; or • The measure is can distinguish differences in quality, is meaningful to patients and providers, and/or addresses a high-impact area or health condition. • Focus on high impact areas and health conditions along with gap areas for Medicaid adult and child populations	Yes: Review can continue. Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support
2) The measure is evidence-based and is either strongly linked to outcomes or an outcome measure.	• For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented can lead to the desired outcome(s). • For outcome measures: The measure has a scientific evidence-base and a rationale for how the outcome is influenced by healthcare processes or structures.	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization.

		No: Measure will receive a Do Not Support
3) The measure addresses a quality challenge.	• The measure addresses a topic with a performance gap or addresses a serious reportable event (i.e. a safety event that should never happen); or • The measure addresses unwarranted or significant variation in care that is evidence of a quality challenge.	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support
4) The measure contributes to efficient use of measurement resources and/or supports alignment of measurement across programs.	• The measure is either not duplicative of an existing measure or measure under consideration in the program or is a superior measure to an existing measure in the program; or • The measure captures a broad population; or • The measure contributes to alignment between measures in a particular program set (e.g. the measure could be used across programs or is included in. a MAP "family of measures") or • The value to patients/consumers outweighs any burden of implementation. • Alignment across various non-Medicaid quality related Core Sets is facilitated, such as CMS Quality Collaborative Core Set-Adult Set.	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support

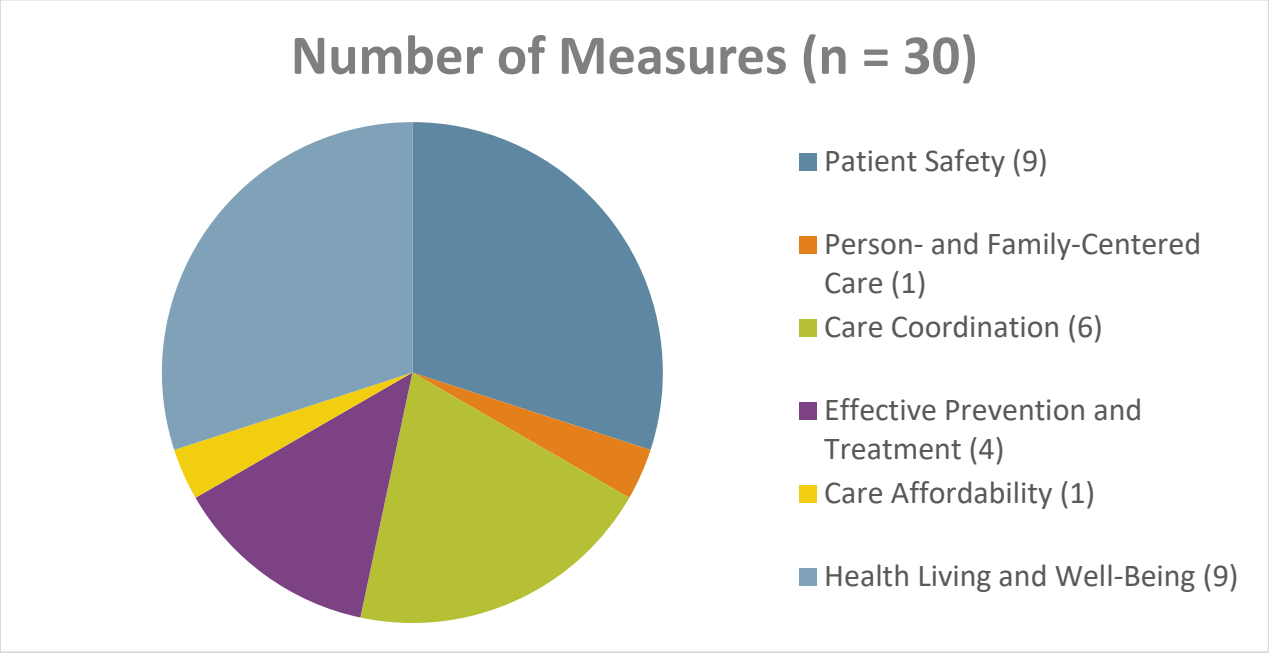
5) The measure can be feasibly reported.	• The measure can be operationalized (e.g. the measure is fully specified, specifications use data found in structured data fields, and data are captured before, during, or after the course of care.) • The can be feasibly implemented at the state Medicaid level. • Data for the measure can be collected easily. • The measure does not pose undue resource constrains on the state. • Medicaid agencies at the state level can implement measure without tweaking it and or changing the level of analysis.	Yes: Review can continue Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support
6) The measure is reliable and valid for the level of analysis, program, and/or setting(s) for which it is being considered	• The measure is NQF-endorsed; or • The measure is fully developed and full specifications are provided; and • Measure testing has demonstrated reliability and validity for the level of analysis, program, and/or setting(s) for which it is being considered.	Yes: Support measure. Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support
7) If a measure is in current use, no unreasonable implementation	• Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or	Yes: Support measure.

issues that outweigh the benefits of the measure have been identified.	• Feedback from implementers or end users has not identified any negative unintended consequences (e.g., premature discharges, overuse or inappropriate use of care or treatment, limiting access to care); and • Feedback is supported by empirical evidence.	Conditional Support: Task Force will provide a rationale for the decision to conditionally support or make suggestions on how to improve the measure for a future support categorization. No: Measure will receive a Do Not Support

Appendix E: Characteristics of the Current Adult Core Set

The 2017 Adult Core Set measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being and Patient Safety (Exhibit E1). Measures are not exclusive to each alignment category and can span across more than one alignment category.

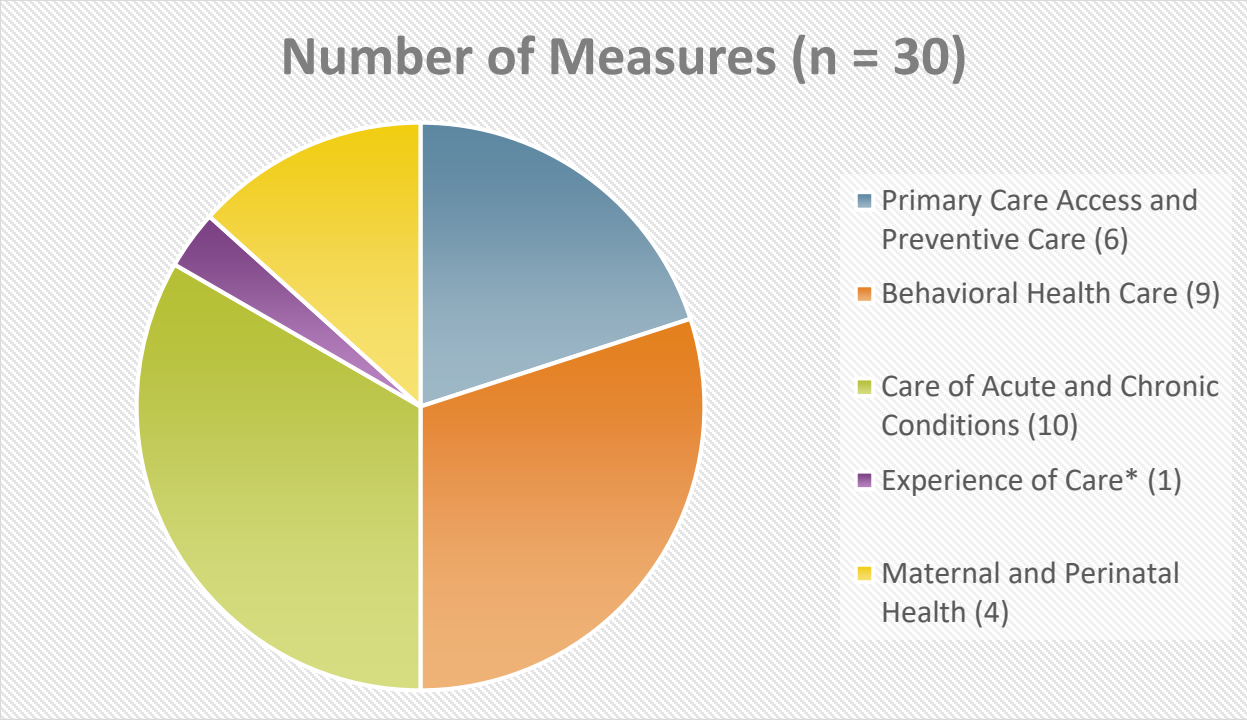
EXHIBIT E1. MEASURES IN THE ADULT CORE SET BY NATIONAL QUALITY STRATEGY PRIORITY



With respect to measure 'types', the set contains no structural measures, 22 process measures, 7 outcome measures, 1 intermediate clinical outcome, and 1 experience-of-care measure. Even though the Adult and Child Core Sets do not contain structural measures, they are part of the Medicaid program portfolio in which structural issues are addressed through programs such as home health and patient centered medical home, among others. Additionally, the Adult Core Set is well aligned with other quality and reporting initiatives: eighteen of the measures are used in one or more federal programs, including the Child Core Set and the Merit-Based Incentive Payment System (MIPS).[1] Representing the diverse health needs of the Medicaid population, the Adult Core Set measures span many clinical topic areas (Exhibit E2).

EXHIBIT E2. MEASURES IN THE ADULT CORE SET BY CLINICAL AREA

[1] Centers for Medicare & Medicaid Services. CMS Measures Inventory. 2017. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html. Last accessed June 2017.


Number of Measures (n = 30)
Primary Care Access and Preventive Care (6)
Behavioral Health Care (9)
Care of Acute and Chronic Conditions (10)
Experience of Care* (1)
Maternal and Perinatal Health (4)

Appendix F: Current Adult Core Set and MAP Recommendations for Addition

There are 30 measures in the 2017 Adult Core Set and four measures MAP recommended for phased addition to the 2018 Adult Core Set. Additionally, Task Force members recommended the removal of two measures. Exhibit F1 below lists the measures included in the 2017 version of the Adult Core Set along with their current NQF endorsement number and status, including rates of state participation in FFY 2015 reporting. 2016 reporting data were unavailable during the 2017 review. In FFY 2017, states will be voluntarily collecting the Adult Core Set measures using the 2017 Technical Specifications and Resource Manual. Each measure currently or formerly endorsed by NQF is linked to additional details within NQF's Quality Positioning System. Exhibit F2 lists the measures supported by MAP for potential addition to the Child Core Set.

EXHIBIT F1. 2017 ADULT CORE SET OF MEASURES WITH FFY 2015 REPORTING DATA

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
0004 Endorsed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure Steward: National Committee for Quality Assurance (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.	27 states reported FFY 2015 Alignment: HEDIS, Merit-Based Incentive Payment System (MIPS)	Support for continued use in the program
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.	25 states reported FFY 2015 Alignment: HEDIS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation 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.	22 states reported FFY 2015 Alignment: HEDIS, MIPS, Medicare Shared Savings Program (MSSP)	Support for continued use in the program
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.	19 states reported FFY 2015 Alignment: HEDIS	Support for continued use in the program
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.	36 states reported FFY 2015 Alignment: HEDIS, MIPS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
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.	35 stated reported FFY 2015 Alignment: HEDIS, Medicaid Child Core Set (ages 16-20); MIPS	Support for continued use in the program
0039 Endorsed Flu Vaccinations 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.	19 states reported FFY 2015 Alignment: HEDIS	Support for continued use in the program
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.	37 states reported FFY 2015 Alignment: HEDIS	Support for continued use in the program
0059 Endorsed Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Measure Steward: NCQA	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	20 states reported FY 2015 Alignment: MSSP, MIPS	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation 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).	29 states reported FFY 2015 Alignment: HEDIS, MIPS	Support for continued use in the program
0272 Endorsed Diabetes Short-Term Complications Admissions Rate (PQI 1) Measure Steward: Agency for Healthcare Research and Quality (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.	28 states reported FFY 2015 Alignment: N/A	Support for continued use in the program
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.	27 states reported FFY 2015 Alignment: MSSP	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.	28 states reported FFY 2015 Alignment: MSSP	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation 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.	27 states reported FFY 2015 Alignment: N/A	Support for continued use in the program
0418 Endorsed Screening for Clinical Depression and Follow-Up Plan Measure Steward: Centers for Medicare and Medicaid Services (CMS)	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	6 states reported FFY 2015 Alignment: MSSP, MIPS	Support for continued use in the program
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)	12 states reported FFY 2015 Alignment: Hospital Inpatient Quality Reporting Program (IQR), Hospital Value-Based Purchasing (HVBP)	Support for continued use in the program
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).	3 states reported FFY 2015 Alignment: N/A	MAP recommends the removal of this measure from the program. Rationale: The Task Force noted that the measure's data source (medical records) may be potentially burdensome for states to collect. In addition, the measure's historic performance metrics indicate little opportunity for gains in quality.

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
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.	31 states reported FFY 2015 Alignment: Medicaid Child Core Set, HEDIS, MIPS, Inpatient Psychiatric Facilities Quality Reporting (IPFQR)	Support for continued use in the program
Not NQF-Endorsed (formerly NQF #1517) 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.	35 states reported FFY 2015 Alignment: Medicaid Child Core Set, HEDIS	MAP recommends the conditional removal of this measure from the program. Rationale: Task Force members expressed concerns that this measure does not count visits over 21 days, which may disincentivize early visits appropriate for breast feeding support, wound care, and other issues that arise early on. Additionally, the Task Force recognized the measure's endorsement removal during the 2016 maintenance review.

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation 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.	24 states reported FFY 2015 Alignment: HEDIS	Support for continued use in the program
1879 Endorsed Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) Measure Steward: Centers for Medicare & Medicaid Services	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	25 states reported FFY 2015 Alignment: HEDIS, MIPS	Support for continued use in the program
1932 Endorsed Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) Measure Steward: NCQA	The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	0 states reported FY 2014 (Added in 2016) Alignment: N/A	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation 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.	3 states reported FFY 2015 Alignment: MIPS	Support for continued use in the program
2371 Endorsed 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)	32 states reported FFY 2015 Alignment: HEDIS	Support for continued use in the program
2372 Endorsed Breast Cancer Screening Measure Steward: NCQA	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	33 states reported FFY 2015 Alignment: HEDIS, MIPS, MSSP	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
2605 Endorsed Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence Measure Steward: National Committee for Quality Assurance	The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: - The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.	0 states reported in FFY 2015 (New for 2017) Alignment: N/A	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
2607 Endorsed Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) Measure Steward: National Committee for Quality Assurance	The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA.	0 states reported in FFY 2015 (New for 2017)	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
2902 Endorsed Contraceptive Care - Postpartum Measure Steward: US Office of Population Affairs	"Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care."	0 states reported in FFY 2015 (New for 2017) Alignment: Medicaid Child Core Set	Support for continued use in the program
2940 Endorsed Use of Opioids at High Dosage in Persons Without Cancer Measure Steward: PQA	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	0 states reported FY 2014 (Added in 2016) Alignment: N/A	Support for continued use in the program

Measure & NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
Not NQF-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.	29 states reported FFY 2015 Alignment: HEDIS	Support for continued use in the program

EXHIBIT F2. MEASURES SUPPORTED BY MAP FOR PHASED ADDITION TO THE ADULT CORE SET

Measures in the table are listed in the order in which MAP prioritized them for inclusion. Task Force members equally prioritized NQF #2967 CAHPS @ Home and Community-Based Services Experience Measures and Concurrent Use of Opioids and Benzodiazepines.

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
1800 Endorsed **Asthma Medication Ratio** Measure Steward: National Committee for Quality Assurance	The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.	N/A	Support addition of this measure to the program. Rationale: MAP recommended NQF #1800 for inclusion in both the Adult and Child Core Sets in an effort to promote alignment.
2967 Endorsed **CAHPS® Home- and Community-Based Services Measures** Measure Steward: Centers for Medicare and Medicaid Services	CAHPS Home- and Community-Based Services measures derive from a cross disability survey to elicit feedback from adult Medicaid beneficiaries receiving home and community based services (HCBS) about the quality of the long-term services and supports they receive in the community and delivered to them under the auspices of a state Medicaid HCBS program. The unit of analysis is the Medicaid HCBS program, and the accountable entity is the operating entity responsible for managing and overseeing a specific HCBS program within a given state. (For additional information on the accountable entity, see Measures Testing form item #1.5 below.)	N/A	Conditionally support addition of this measure to the program pending CMS' assessment to ensure NQF #2967 can be implemented feasibly at the state level. Rationale: MAP recommended this measure to address a measurement gap, services provided through long-term care programs.

	The measures consist of seven scale measures, 6 global rating and recommendation measures, and 6 individual measures: Scale Measures 1. Staff are reliable and helpful –top-box score composed of 6 survey items 2. Staff listen and communicate well –top-box score composed of 11 survey items 3. Case manager is helpful - top-box score composed of 3 survey items 4. Choosing the services that matter to you - top-box score composed of 2 survey items 5. Transportation to medical appointments - top-box score composed of 3 survey items 6. Personal safety and respect - top-box score composed of 3 survey items 7. Planning your time and activities top-box score composed of 6 survey items Global Ratings Measures 8. Global rating of personal assistance and behavioral health staff- top-box score on a 0-10 scale 9. Global rating of homemaker- top-box score on a 0-10 scale 10. Global rating of case manager- top-box score on a 0-10 scale Recommendations Measures 11. Would recommend personal assistance/behavioral health staff to family and friends – top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 12. Would recommend homemaker to family and friends — top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 13. Would recommend case manager to family and friends– top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes)		

	Unmet Needs Measures 14. Unmet need in dressing/bathing due to lack of help–top-box score on a Yes, No scale 15. Unmet need in meal preparation/eating due to lack of help– top-box score on a Yes, No scale 16. Unmet need in medication administration due to lack of help– top-box score on a Yes, No scale 17. Unmet need in toileting due to lack of help– top-box score on a Yes, No scale 18. Unmet need with household tasks due to lack of help– top-box score on a Yes, No scale Physical Safety Measure 19. Hit or hurt by staff – top-box score on a Yes, No scale		
Not NQF-endorsed **Concurrent Use of Opioids and Benzodiazepines** Measure Steward: Pharmacy Quality Alliance (PQA)	This measure examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines. The denominator includes individuals 18 years and older by the first day of the measurement year with 2 or more prescription claims for opioids filled on 2 or more separate days, for which the sum of the days supply is 15 or more days during the measurement period. Patients in hospice care and those with a cancer diagnosis are excluded. The numerator includes individuals from the denominator with 2 or more prescription claims for benzodiazepines filled on 2 or more separate days, and concurrent use of opioids and benzodiazepines for 30 or more cumulative days.	N/A	Conditionally support addition of this measure to the program pending NQF endorsement. Rationale: MAP recommended this measure to address two gap areas simultaneously, early opioid use and polypharmacy
2903 Endorsed **Contraceptive Care – Most & Moderately Effective Methods**	The percentage of women aged 15-44 years at risk of unintended pregnancy that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception.	N/A	Support addition of this measure to the program. Rationale: MAP recommended this measure to address the measurement gap, access to contraception. This

Measure Steward: US Office of Population Affairs	The proposed measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.		measure also complements NQF #2902 Contraceptive Care – Postpartum, which is included in the 2017 Adult Core Set and the 2017 Child Core Set.

Appendix G: Additional Measures Considered

MAP considered one measure that did not pass the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support for use in the Adult Core Set. MAP members considered NQF #0711: Depression Remission at Six Months but did not ultimately vote on the measure. MAP needed to limit the number of measures it supported for the sake of parsimony and practicality; lack of support for this measure does not indicate that the measures are flawed or unimportant. This measure and others could be reconsidered during a future review of the Adult Core Set.

NQF Measure Number	Measure Title	Measure Steward
0711	Depression Remission at Six Months	Minnesota Community Measurement

Appendix H: Key Gap Areas in the Adult Core Set

MAP identified several gap areas in the Adult Core Set of measures. The most prominent gap areas are listed below in order of prioritization. All gap areas presented in the table are recurring gap areas identified previously by the Task Force, with the exception of *Assessing and addressing of social determinants of health.*

Gap Area
Assessing and addressing of social determinants of health
Behavioral health and integration with primary care
Long-term supports and services • Home and community-based services
Maternal/Reproductive health • Inter-conception care to address risk factors • Poor birth outcomes (e.g., premature birth) • Postpartum complications • Support with breastfeeding after hospitalization
New or chronic opiate use (45 days)
Access to primary, specialty, and behavioral healthcare • Access to care by a behavioral health professional
Beneficiary-reported outcomes • Health-related quality of life
Efficiency • Inappropriate emergency department utilization
Care coordination
Polypharmacy
Treatment outcomes for behavioral health conditions and substance use disorders
Workforce/Access