Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2017

FINAL REPORT

AUGUST 31, 2017

NATIONAL QUALITY FORUM

CONTENTS

EXECUTIVE SUMMARY

Medicaid is the largest health insurance program in the United States, serving 74.6 million individuals. As the primary health insurance program for the nation's low-income population,[1] Medicaid covers many of those with a high need for medical and healthcare services. Since October 2013, Medicaid has experienced marked growth in adult enrollment, largely due to Medicaid expansion, which was defined in the Affordable Care Act (ACA).[2] Medicaid beneficiaries with complex care needs account for roughly 54 percent of total Medicaid expenditures, despite comprising just 5 percent of all Medicaid beneficiaries. 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 care for adults enrolled in Medicaid. The Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF), provides guidance to the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs. Each year, through its Medicaid Adult Task Force, MAP recommends improvements to the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (the Adult Core Set). Guided by MAP's Measure Selection Criteria and feedback from several years of state implementation, this report includes MAP's most recent recommendations to HHS for strengthening the Adult Core Set. The report also identifies for future consideration high-priority gaps where more or better quality measures are needed.

In 2017, 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*. MAP notes the reporting challenges related to data collection for this measure and that it is reported to The

Joint Commission, where performance on the measure is high overall and presents limited opportunity for improvement. MAP suggests that the Centers for Medicare & Medicaid Services (CMS) work toward streamlining reporting when data are reported to multiple sources to reduce burden. Removing this measure from the Adult Core Set will increase states' 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 emphasizes the importance of measures focused on the content of medical visits that directly affect 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	NQF Number (if applicable) and Measure Title
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 has conditionally supported measures that are pending endorsement by NQF, undergoing a change by the measure steward, or have not received CMS confirmation of feasibility.

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

MAP also discussed ways of improving quality and Child 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 between data systems and among organizations;

• improving integration across local, state, and federal health entities as well as coordination of programs and data systems;

• aligning measurement and data requirements; and

• incorporating methodological paradigm shifts through stratification of data and acknowledgment of the impact of social complexities on care delivery and outcomes.

As the Medicaid Adult Core Set evolves, success in improving quality depends on voluntary state reporting, which encompasses issues of data availability, collection, and reporting burden. Success also depends on methodological issues, such as risk adjustment for social factors and measure stratification. Therefore, education, communication, and collaboration across care systems treating adults covered by Medicaid will be necessary to advance the 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 U.S. 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. 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. Information and background on MAP is 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 the Adult Core Set of healthcare quality measures for adults enrolled in Medicaid 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 publicly reported measures, a 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. 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. The recommendations have been vetted through an opportunity for public comment (Appendix I). 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.[3] Since October 2013, Medicaid has experienced marked growth in adult enrollment, largely due to Medicaid expansion, which was defined in the Affordable Care Act (ACA).[4] 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 nonexpansion 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.[5]

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.[6] 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).[7] 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.[8] 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.[9] In short, Medicaid covers some of the most high-need populations in the country. Although the 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.[10]

According to data collected in a recent survey of high-need patients, Medicaid covers approximately, one in five older U.S. adults (ages 50-64). 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 services.[11] This study, therefore, highlights the need for continued funding for Medicaid to address the needs of older and chronically ill Medicaid beneficiaries. Additionally, Medicaid beneficiaries with complex care needs account for roughly 54 percent of total Medicaid expenditures, despite comprising just 5 percent of Medicaid beneficiaries. Furthermore, 1 percent of Medicaid beneficiaries account for 25 percent of total Medicaid expenditures.[12]

Medicaid Adult Core Set

Section 1139B of the Social Security Act (amended by the ACA) 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.[13] In January 2012, HHS published the initial Adult Core Set of measures in partnership with a subcommittee to the Agency for Healthcare Research and Quality's (AHRQ) National Advisory Council.[14] It has been updated annually since that time, with recent iterations reflecting input from MAP.

The Adult Core Set provides a snapshot of healthcare quality within Medicaid. It is not comprehensive, but it provides key indicators of healthcare access and quality for the beneficiaries served in Medicaid. Prior to the implementation of the Adult Core Set, performance measurement varied greatly by state, and it was not possible to glean an overall picture of quality nationwide. Statute requires CMS to annually provide updates on behalf of the Secretary of HHS 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 followed including a **2017 version**. MAP's 2016 review and input informed CMS's 2017 update. Following MAP's

recommendations, 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 NQF #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 was already 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). CMS retired this measure based on recommendations from the states. The 2017 version of the Adult Core Set contains 30 measures. The characteristics of the 2017 Core Set can be found in **Appendix E**. Measures in the Adult 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 as **chart packs** and **Performance on the Adult Core Set Measures**.[15]

STATE EXPERIENCE COLLECTING AND REPORTING THE ADULT CORE SET

Presentations from invited states' Medicaid program representatives precede all MAP Medicaid Core Set measure-related discussions and deliberations regarding the addition and removal of measures. These representatives provide an overview of their state Medicaid program as well as an overview of their experience collecting, reporting, and using either the Adult or the Child Core Set. This process solicits information from the field, prior to the MAP Task Force recommending any changes for either Core Set. Ultimately, the goal is to use experiential data 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 programs along with information related to Core Set use (i.e., value-based purchasing, quality improvement, managed care contracting, etc.), 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 Colorado Medicaid program covers 1.3 million individuals—out of which 48 percent are adults. Most of the adult Medicaid beneficiaries live in urban areas (80 percent) and the remaining ones, in rural areas. Many of these adult enrollees (75 percent) represent the working poor and are employed in service industries such as food service, childcare, and retail. Colorado is a Medicaid expansion state where expansion adults make up over 30 percent of the enrollees and have a high prevalence of both mental health and addiction issues. 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 costs incurred 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 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 Medicaid Adult Core Set measures. Dr. Zerzan noted that measures not reported by the state include the four that have 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 hybrid measures which involve both administrative and chart/medical record data and require additional resources to collect.

Dr. Zerzan provided recommendations on ways to address some implementation challenges that include focusing on alignment of the Core Set with other payment programs such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), State Innovation Models (SIM), and other similar programs. Currently, local practices and providers are asked to report on multiple measures for a myriad of accountability and public reporting programs, which is challenging. Furthermore, when these entities are able to report 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, Dr. Zerzan 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 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 can choose the measures that they will report and be held accountable for. Based on their performance on these chosen measures, practices can earn up to 4 percent incentive pay and/or bear risk and lose up to 4 percent of pay. Mainly, payment additions or losses 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 (FQHC), primary care providers (PCPs), and hospitals serving Medicaid beneficiaries. The goal of doing this is to use competition as a lever for improving

overall care by comparing providers and entities to their peers and competitors.

In conclusion, Dr. Zerzan emphasized that quality improvement efforts focus on the uniqueness of the Medicaid population based on regional and geographical differences. For example, Colorado Medicaid serves fewer than 30,000 diabetics; whereas, West Virginia Medicaid has a very high number of beneficiaries with diabetes. Smoking is, however, an important public health issue for Colorado. Given the heterogeneity of the Medicaid population, Dr. Zerzan recommended that states base their quality improvement initiatives on population needs specific to each state.

Ohio

Mary Applegate, MD, FAAP, FACP, Medical Director, Ohio Department of Medicaid, presented to the combined Adult and Child Task Forces and focused on the Adult and Child Core Sets from a systems perspective with particular attention to maternity care. Ohio is the seventh largest Medicaid state covering over 3 million individuals. Eighty-nine percent of their enrollees are in managed care, and efforts are underway to enroll the entire Medicaid population in managed care. Ohio Medicaid aims to provide systems of care through patient choice and patient engagement in an evidence-based care management environment. As a Medicaid expansion state, the Ohio 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 years of age and younger (43 percent of total Medicaid).

Ohio reports on three-fourths of the measures in both the Adult and Child Core Sets. Funding from the Adult Medicaid Quality (AMQ) grant enabled voluntary reporting on the Adult Core Set measures by providing funds for coding the measures for electronic data collection and submission.[16] "Measures that make patients better" mainly drive the decision to report. Given the

state's focus on improving the quality of maternity care, the state reports on the following Child and Adult 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 percent of expected visits), Timeliness of Prenatal Care,* and *Postpartum Care Rate*.

Dr. Applegate noted that additional factors in the decision to report measures include challenges such as the fragmented care system, administrative reporting burden, and provider workload issues. Measurement decisions are based on the impact of measures at the practice level as well as connection to improved patient outcomes. However, the decision not to measure or report can also result from an effort to avoid duplication, especially when other mechanisms of improvement are underway, such as quality efforts based on episodes of care and public health driven mechanisms. The primary focus of Ohio Medicaid is to implement and report 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, Dr. Applegate 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 collected to focus on episodes of care. Such data capture all of the processes of care for a given condition, and are relevant for all stakeholders including providers, managed care plans, and health systems. Dr. Applegate 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 his or her care. This type of data collection is therefore essential to their approach for quality improvement, as poor performance is often related to lack of follow-up.

Dr. Applegate provided an example of a current public health initiative focused on the infant mortality crisis in Ohio. Ohio is moving towards attributing patients to providers in an effort to address issues with patient follow-up care usage. Certain populations in Ohio do not receive the necessary postpartum follow-up care, which is a known predictor of infant mortality. Social risk factors such as lack of transportation contribute to missed appointments among others. 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. Therefore, a lack of connection between measurement and community-level social risk factors results in measures that do not appropriately capture all factors affecting patient outcomes.

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

MAP REVIEW OF THE ADULT CORE SET

The MAP Task Force (also referred to as MAP) evaluated the measures in the Adult Core Set to provide recommendations to strengthen the Core Set while facilitating CMS's goals for the program. 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, MAP reviewed measures in the current Adult Core Set. 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.[17] Using the decision algorithm, MAP reviewed measures in the gap areas identified during previous years' reviews. NQF staff compiled measures in the following 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 measure specifications, the MSC, and the feasibility of implementing them for statewide quality improvement. MAP recommended measures they judged to be a good fit.

MAP generally favors ready-to-implement measures that promote parsimony and alignment, while addressing high-impact health conditions for adults enrolled in Medicaid. NQF-endorsed measures are preferred because they have undergone a multistakeholder evaluation to ensure that their focus is evidence-based, they are reliable and valid, and they address aspects of care that are important and feasible to measure. Following discussion of each measure, MAP voted to determine if there was sufficient support from MAP 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. MAP received public comments on the draft recommendations as part of a transparent and open process. Most comments supported the measurement changes MAP recommended.

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. MAP 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. Monitoring the development of new measures is imperative for facilitating the success of future annual reviews of the Adult Core Set.

Additionally, CMS has emphasized the importance of including measures in the Core Sets that provide states with multiple options/formats for data collection and reporting (i.e., electronically specified measures, administrative measures, and hybrid measures). Therefore, CMS will include electronic measure specifications and formats, (i.e., e-specification also known as an eMeasure) for 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 #3148 (formerly #0418) has an eMeasure version, measure #3132. Since this measure was recently endorsed in July 2017, it will be included in the annual update to the Core Set.

Measure-Specific Recommendations

Measures 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 it has increased each year. Not finding many significant implementation problems, MAP was comfortable supporting all but two of the current Adult Core Set measures for continued use. Maintaining stability in the measure set will allow states to continue to gain experience in reporting the measures.

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 for reporting or is not 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 #0476 *PC 03 Antenatal Steroids*. In general, state representatives noted that measures collected via medical record review are resource intensive, which can lead to gaps in data. In addition, the Task Force 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 collected. The 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 Force 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 the 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 be a disincentive to early visits necessary for appropriate breast-feeding support, wound care, and other postpartum 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

about 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 the 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. MAP conditionally supports measures for several reasons, including pending endorsement from NQF, pending CMS confirmation of feasibility, etc. MAP recommends that CMS add measures pending NQF endorsement once endorsement review is complete and the detailed technical specifications are 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. 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. Additionally, for a measure to be publicly reported, data must be provided to CMS by at least 25 states and meet internal standards for quality.

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

Rank	NQF Number (if applicable) and Measure Title
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

* indicates conditional support

The addition of recommended measures would strengthen the Core Set on a variety of high-priority healthcare quality areas, including reproductive health, chronic disease management for people with asthma, and substance abuse. Public commenters supported all measures recommended for phased addition to the Core Set. 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 to 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, it 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 need for home and community-based metrics during their in-person meeting discussions. *CAHPS Home and Community-Based Services Experience Measures* are survey measures 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 that beneficiaries 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 a community setting. MAP conditionally supported this measure, due to uncertainty regarding the implementation feasibility at the state level.

Concurrent Use of Opioids and Benzodiazepines*

MAP recommended the inclusion of this measure in the Adult Core Set as it addresses two gap areas simultaneously: early opioid use and polypharmacy. The measure is developed by Pharmacy Quality Alliance (PQA) and is conditionally supported pending NQF endorsement. This measure examines the percentage of individuals 18 years of age and older with concurrent use of prescriptions for opioids and benzodiazepines. In the United States, deaths from co-prescribed opioids and benzodiazepines increased 14 percent per year from 2006 to 2011.[18] 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.[19] This is a claims-based measure, which reduces the reporting burden for states. Task Force members unanimously agreed on the utility of this measure in providing clear guidelines regarding concurrent prescribing practices. Many public commenters supported the inclusion of this

measure, but emphasized the importance of NQF endorsement and encouraged the developer to submit the measure for endorsement.

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 effective (sterilization, intrauterine device, implant) or moderately effective (pill, patch, ring, injectable, diaphragm) 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 MAP's concerns related to setting performance targets for this measure, as well as the potential for coercion, the group concluded that the end user should implement the measure with the understanding that the target performance rate should be well below 100 percent. 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 added to the 2017 Adult Core Set. MAP also supported NQF #2903 for inclusion in the Child Core Set. Many public commenters supported the inclusion of this measure, noting that this measure will improve access to care.

Measure Concept Reviewed for Future Consideration

The Personal Outcome Measures survey was presented for future consideration for 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 different 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 fully developed metrics. MAP discussed and documented these gaps in measurement. The Adult Core Set Measure Gaps list is meant to communicate measure development focus areas for the developer community. The list of measure gaps is a starting point for future discussions as well as a guide to annual revisions to the Adult Core Set.

State feedback, review of 2015 reporting, and data on prevalent conditions affecting the adult Medicaid population influenced the 2017 gap areas. The Medicaid Adult Task Force began its discussion of gaps by considering NQF's prioritization criteria for the future of measurement (Exhibit 2 and Appendix H). The prioritization of gap areas is not meant to diminish the importance of other 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.

Among the 12 gap areas identified, MAP considered the following as the five key gap areas. An asterisk (*) denotes newly identified gap areas.

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

Adult Core Set Measure Gaps

1. Behavioral health (integration and 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 obstetric care in the rural community

   – Postpartum complications

4. Long-term supports and services

5. New chronic opiate use

Public commenters supported MAP's assessment of high-priority measure gaps for the Adult Medicaid population, supporting the prioritization of measure gap areas. A few commenters encouraged measure development in a few additional areas, including person driven outcome measures, social vulnerability measures, and measures related to function and performance.

STRATEGIC CONSIDERATIONS FOR STATE-LEVEL QUALITY IMPROVEMENT

The Adult and Child Medicaid MAP 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; and incorporating methodological paradigm shifts through stratification of data and acknowledging the impact of social complexities on care delivery and outcomes.

Comments from health plans, specialty providers, consumer advocates, and other stakeholders were supportive of these strategic issues. They highlighted and further elaborated on topics such as data challenges related to measurement alignment and integration as well as development of a vital set of measures along with measures for social vulnerability. Public commenters also addressed the need for aligning measures across the healthcare spectrum using a multilevel perspective. The MAP Coordinating Committee also discussed and enthusiastically supported the issue of alignment, specifically with regards to fragmentation of care due to a lack of alignment of measures among and within the varying systems of care. Lastly, commenters acknowledged and emphasized the need for measures that address quality of care and outcomes versus measures that focus on counts and processes.

Alignment

Task Force members and state Medicaid panelists emphasized the continued importance of addressing alignment from a multilevel perspective comprising macro-, meso-, and micro-systems of care (Exhibit 3). 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 paradigm shift replaces fragmented data collection and measurement with an integrated system, where a holistic view of quality is promoted and achieved in part through a sense of shared responsibility for each patient and population group. This matrixed paradigm of measurement allows for population health management through coordination of measurement across the healthcare spectrum. Successful integration across systems depends on data integration and coordination of efforts with a population health focus. With this shift in perspective, the goal of measurement is not only to support improvement in individual-level care and health outcomes, but also improvement in the health of the population. MAP Task Force members encouraged continued efforts at aligning measure sets and quality efforts across healthcare.

EXHIBIT 3. SYSTEMS VIEW OF MEASUREMENT[a]
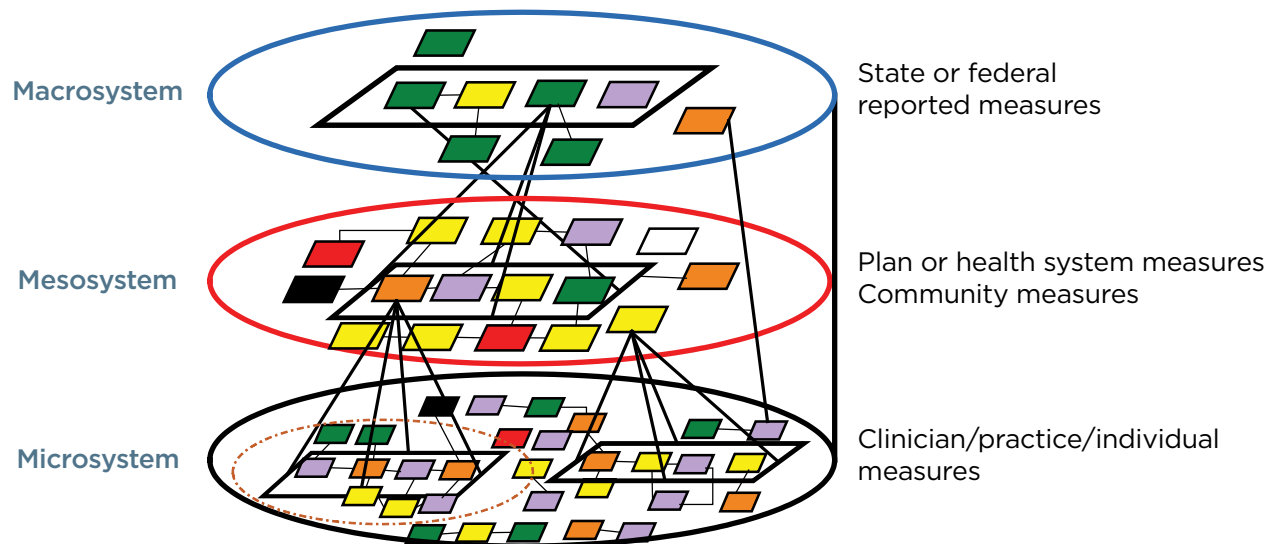
a   Applegate, M. Ohio Department of Medicaid. MAP Medicaid Joint Adult and Child In-Person Meeting. May 24, 2017. Washington, DC.

Data: Integration and Connection

Both the Adult and Child MAP 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 transmission of care information. 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 agencies.

Both the Ohio and Colorado state representatives and the MAP Task Force members expressed frustration with data lag times and a lack of use of a universal coding language. 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 fragmentation and duplication of services, which is further perpetuated through state-specific behavioral health carve-outs.

MAP Task Force members recommended focusing efforts on working around systems integration issues at the federal level. For example, they recommended that CMS and The 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 about 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; this knowledge then can be used to address population-level health issues and outcomes.

Task Force members noted that stratification can also help overcome the divide between behavioral health and general medical health, by allowing for the analysis of a medical care measure based on the presence or absence of behavioral health comorbidity (e.g., segmenting individuals with severe mental illness and other especially vulnerable populations). Furthermore, the MAP Task Force recommended that states use stratification to address state-specific quality improvement needs in a transparent manner. Stratification methodologies should be readily accessible and wherever possible consistent across states. 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 with best practices based on previously successful implementation.

Social Risk Factors and Impact on Health

As risk adjustment for social risk factors evolves, stakeholders are becoming aware of the inextricable roles of social risk and medical complexity with regards to care and health quality outcomes at both the individual and population level. Unfortunately, this inextricability is intensified within the Medicaid population, due to persistent social risk factor related vulnerabilities. Dr. Applegate from Ohio Medicaid 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 and reduce both preterm births and infant mortality as well.

The Task Forces also discussed the concept of health equity. Equity encompasses the

communities' relationships with healthcare delivery systems, trust between providers, patients, and community, along with open communication among all stakeholders. The group emphasized that any community-level care quality considerations should acknowledge health equity as well. Given the complexity of social risk factors and health equity, the MAP Task Force members recognized the need to assess and address the impact of these factors on health outcomes and therefore 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 ensure high-quality healthcare is being provided, drive delivery system reform efforts, and meet the needs of a growing beneficiary population. The Adult MAP Task Force provided measure recommendations for the 2018 Adult Core Set to support states' 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 MAP Task Force recommended the removal of two measures included in the 2017 Adult Core Set: NQF #0476 *PC-03 Antenatal Steroids* and NQF #1517 *Postpartum Care Rate*. The Task Force also recommended the addition of four measures which address critical gap areas in the Medicaid adult population: 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 depends on voluntary reporting which encompasses issues of data availability, collection, and reporting burden. Success also depends on methodological issues such as risk adjustment for social risk factors and measure stratification. Ultimately, education, communication, and collaboration across care systems will be necessary to advance the evolution of Medicaid care quality.

Current changes in billing and reimbursement structures will provide opportunities to leverage emerging strategies such as risk adjustment for social risk factors 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 targeting outcomes, and timely and actionable measurement is replacing the traditional focus on counting and checking boxes.

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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 U.S. 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 multistakeholder groups to provide input on the selection of quality measures" for various uses.[a]

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 decision making.

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 decision making, 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

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a   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.

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 MAP, in addition to helping to 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 Exhibit 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.

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.

EXHIBIT A1. MAP STRUCTURE
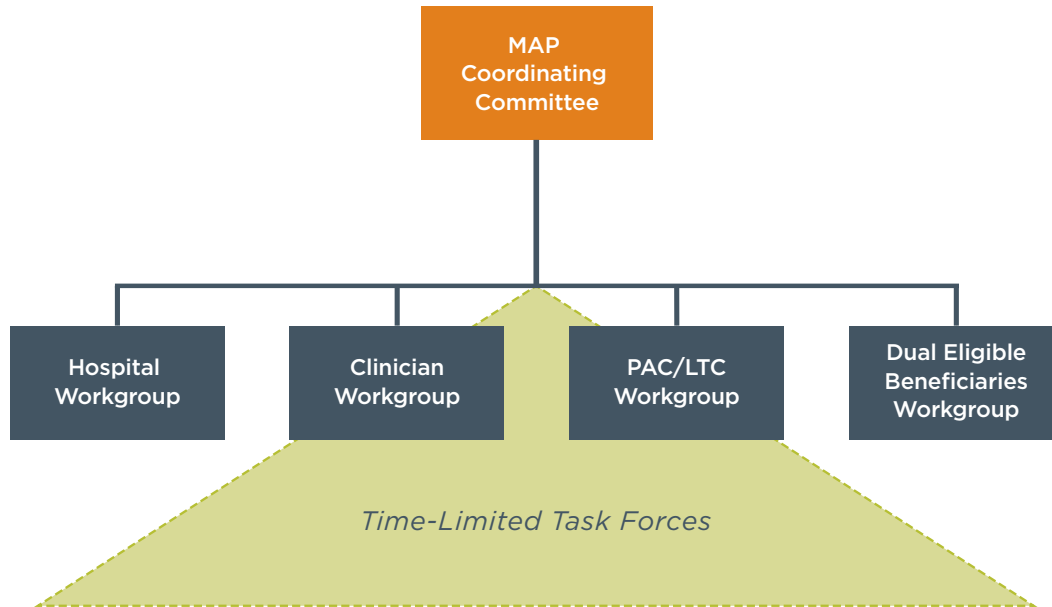
Timeline and Deliverables

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 goals 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.

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)

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)

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)

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 Health Care 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

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)

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

Helen Burstin, MD, MPH
Chief Scientific Officer

Elisa Munthali, MPH
Acting Senior Vice President, Quality Measurement

Debjani Mukherjee, MPH
Senior Director

Shaconna Gorham, MS, PMP
Senior Project Manager

Miranda Kuwahara, MPH
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 of 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 decision making, 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, NQF staff provided a preliminary analysis of all measures under consideration using the MAP Medicaid Preliminary Analysis Algorithm derived from the Measure Selection Criteria.
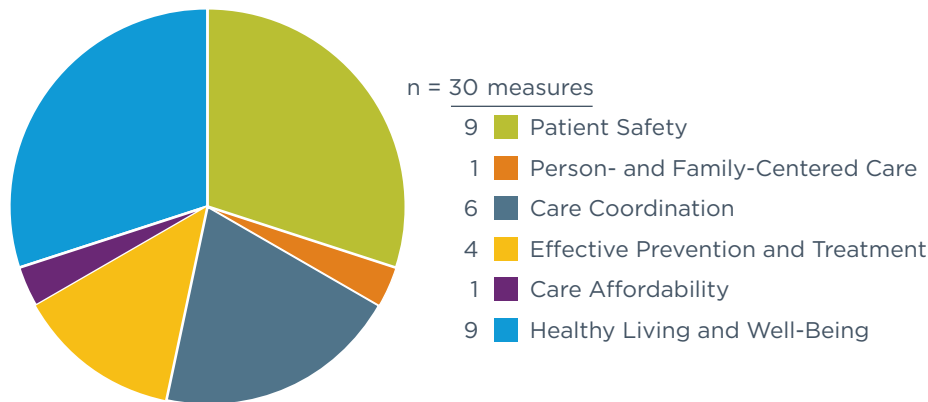
Assessment	Definition	Outcome
1. The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or • The measure is responsive to specific program goals and statutory or regulatory requirements; or • The measure 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 is an outcome measure.	• For process and structural measures: The measure has a strong scientific evidence-base to demonstrate that when implemented, it 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

Assessment	Definition	Outcome
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 superior 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; or • 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 measure 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 the 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 issues that outweigh the benefits of the measure have been identified.	• Feedback from end users has not identified any unreasonable implementation issues that outweigh the benefits of the measure; or • 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.	**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

APPENDIX E:
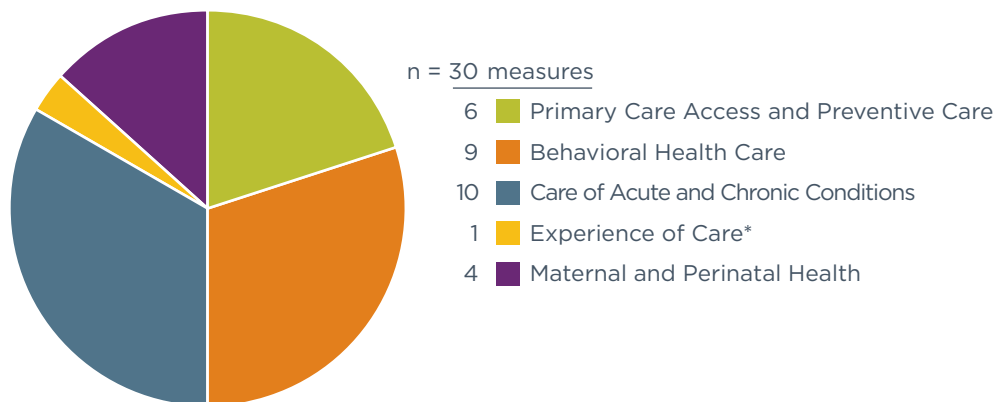## Characteristics of the Current Adult Core Set

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

n = 30 measures

9		Patient Safety
1		Person- and Family-Centered Care
6		Care Coordination
4		Effective Prevention and Treatment
1		Care Affordability
9		Healthy Living and Well-Being

With respect to measure types, the set contains no structural measures, 22 process measures, seven outcome measures, and one 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: 18 of the measures are used in one or more federal programs, including the Child Core Set and the Merit-Based Incentive Payment System (MIPS).[a] 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

n = 30 measures

6		Primary Care Access and Preventive Care
9		Behavioral Health Care
10		Care of Acute and Chronic Conditions
1		Experience of Care*
4		Maternal and Perinatal Health

a   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.

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

There are 30 measures in the 2017 Adult Core Set. MAP recommended four measures 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. The 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 Adult Core Set.

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

Measure #, NQF Status, Title, and Steward	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 (IET)** *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 **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid) [Adult Version]** *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
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

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
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 (CCS)** *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
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 Older** *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 5.0 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

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
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
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 (COPD) or Asthma in Older Adults Admission Rate (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 **Congestive Heart Failure 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
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

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
3148 (formerly 0418) Endorsed **Preventive Care and Screening: 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 Status, Title, and Steward	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 (FUH)** *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
NQF #1517 **(Not NQF-Endorsed)** **Prenatal & Postpartum Care [postpartum care rate only]** *Measure Steward: NCQA*	The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	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 Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
1768 Endorsed **Plan All-Cause Readmissions (PCR)** *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** *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	Added to the Core Set in 2016 **Alignment**: N/A	Support for continued use in the program

Measure #, NQF Status, Title, and Steward	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 (MPM)** *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 Status, Title, and Steward	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: NCQA*	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
2607 Endorsed **Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** *Measure Steward: NCQA*	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 Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2015 and Alignment	MAP Recommendation and Rationale
2902 Endorsed **Contraceptive Care – Postpartum** Measure Steward: U.S. 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 effective (i.e., injectables, oral pills, patch, ring, or diaphragm) 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: Pharmacy Quality Alliance (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	Added to the Core Set in 2016 **Alignment**: N/A	Support for continued use in the program
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 (NCQA)*	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 (CMS)*	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.) 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.	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.

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
	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.

Measure & NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
2903 Endorsed **Contraceptive Care – Most & Moderately Effective Methods** *Measure Steward: U.S. Office of Population Affairs*	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 method of contraception. 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.	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 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 measure is flawed or unimportant. This measure and others could be reconsidered during a future review of the Adult Core Set.

NQF #	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.*

Behavioral Health and Integration with Primary Care

Assessing and Addressing of Social Determinants of Health

Maternal/Reproductive Health

- Inter-conception care to address risk factors

- Poor birth outcomes (e.g., premature birth)

- Postpartum complications

- Support with breastfeeding after hospitalization

Long-Term Supports and Services

- Home and community-based services

New or Chronic Opiate Use (45 days)

Efficiency

- Inappropriate emergency department utilization

Beneficiary-Reported Outcomes

- Health-related quality of life

Access to Primary, Specialty, and Behavioral Healthcare

- Access to care by a behavioral health professional

Polypharmacy

Workforce/Access

Treatment Outcomes for Behavioral Health Conditions and Substance Use Disorders

Care Coordination

APPENDIX I:
Public Comments

General Comments

American Psychiatric Association
Samantha Shugarman

The American Psychiatric Association (APA) is an organization of over 37,000 psychiatrist members working together to ensure humane care and effective treatment for all persons with mental illness, including substance use disorders. As the "voice and conscience of modern psychiatry," the APA's "vision is a society that has available, accessible quality psychiatric diagnosis and treatment." As such, we are pleased with majority of the recommendations reported in the MAP-convened Medicaid Task Force's draft reports of the "Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid CHIP, 2017" and for the "Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid CHIP, 2017."

Reinforced in these draft reports, Medicaid enrollees (e.g., child and adult) maintain a high prevelence of "behavioral health" (i.e., mental illnesses and substance use disorders)conditions. Notably beneficiaries aged 2-17, maintain anywhere from 13 to 20 percent experience a mental disorder, annually. Alarmingly, suicide is recognized as the second leading cause of death among these beneficiaries. Therefore, it is justifiable that the prevalence of psychotropic medication prescriptions, for publicly insured children is increasing. However, due to barriers to care, discrepancies in the provision of evidence-based care and prescribing practices, it is important to examine state level quality measurement data for this patient population.

APA agrees that it is more valuable to measure the "aspects of care" administered, compared to the "frequency of care." However, until the provision of evidence-based standards of care consistently occurs, and psychiatric outcomes are broadly identified, it is necessary to track care administration frequency. By elucidating variation in treatment frequency, Medicaid and CHIP programs can better determine how and where to utilize their resources

(e.g., regional disparities; or education for care givers, patients, and/or providers, etc.).

The APA applauds the MAP for continued acknowledgement that gaps in behavioral health care persist for adults and children. Considering this assertion, we support the Task Force's suggestion to phase in two new behavioral health measures, out of the five-total recommended into the Child Core Set, and one new behavioral health measure into the Adult Core Set.

Anthem, Inc.
Amy Ingham

General Comments: Anthem appreciates the work that MAP and CMS have undertaken to produce its 2017 report. We believe that the success of quality measurement and improvement is best achieved through ensuring a stable, concise set of targeted and meaningful measures from which states may choose. Generally, we strongly encourage that MAP's decision-making continue to be grounded in the implementation experience of state agencies and health plans. Furthermore, we believe that a parsimonious approach to the addition of new measures assists in increasing collections of those measures already included in the set. Lastly, we recommend that MAP consider further prioritizing measures in the future so that there is more emphasis on fewer, more targeted measure sets. One recommendation is that MAP consider development of a set of the "vital few" measures that can be used to help CMS and states prioritize the most valuable measures from which to select.

The SCAN Foundation
Megan Burke

The MAP report for Adult Medicaid promotes broad use of patient-reported outcome measures (PROMs), while acknowledging a need for the

development of PROMS by including it as a measure gap category. The National Committee for Quality Assurance (NCQA), in partnership with The SCAN Foundation and the John A. Hartford Foundation, is currently working to develop person-driven outcome measures1 that focus on coordination and delivery of LTSS. This body of work tests two promising methods for documenting person-driven outcomes in a standardized format, and could form a basis for building person-driven quality metrics in the future. We recommend reviewing NCQA's work, with consideration of person-driven outcome measures when available.

1. NCQA, Person-Driven Outcomes - http://www.ncqa.org/hedis-quality-measurement/research/measuring-what-matters-most

Adventist Health System
Michael Griffin

Adult Core Set

AHS supports the general recommendations included in the Adult Core Set report, which are aligned with reducing the co-morbidities that cause suffering amongst patients. Additionally, we would like to see a measure, in addition to NQF #2800 Metabolic Screening for Children and Adolescents Newly on Antipsychotics, which determines the frequency of psychosis diagnoses within vulnerable populations and the potential bias that can occur from the provider.

Measure-Specific Comments

Academy of Managed Care Pharmacy

Tricia Wilkins

AMCP is the nation's leading professional association dedicated to increasing patient access to affordable medicines, improving health outcomes and ensuring the wise use of health care dollars. Through evidence- and value-based strategies and practices, the Academy's 8,000 pharmacists, physicians, nurses and other practitioners manage medication therapies for the 270 million Americans served by health plans, pharmacy benefit management firms, emerging care models and government.

Re: Concurrent Use of Opioids and Benzodiazepines

AMCP recommends that this measure should initially be considered a display measure prior to consideration as part of the Star Ratings.

American Association on Health and Disability

E. Clarke Ross

The American Association on Health and Disability and the Lakeshore Foundation appreciate and support the draft report on Medicaid adult measures. Specifically:

1. Of the 4 additions proposed to the adult core measure set, we applaud and fully support the addition of the CAHPS HCBS Experience Survey. See: pages 5, 14-15, and 48-50.

2. We appreciate the Measure Gap Areas & Prioritization & Prioritization Criterion: See pages 11, 15-17, and 53; and the Social Determinants of Health discussion: See page 19.

The American Association on Health and Disability and Lakeshore Foundation respectfully submit two additional comments (in addition to our previous submission):

3. CQL Personal Outcome Measures: (for future consideration) (page 15): Thank you for arranging this presentation and including in the draft report. The paragraph states that the Personal Outcome Measures tool has not been validated. CQL did actually just perform a revalidation this year. The citation is: Friedman, C. (2017). The Personal Outcome Measures® 2017: Measuring outcomes now and into the future. Towson, MD: The Council on

Quality and Leadership.

CQL also has a manuscript with the validation findings under review. Friedman, C. (2017). The Personal Outcome Measures®. Manuscript under review.

4. National Core Indicators: The NQF committee on HCBS, workgroup on persons dually eligible for Medicare and Medicaid, and committee on Medicaid innovation have each discussed the potential use of the National Core Indicators. While not discussed at the May NQF Medicaid adult measures meeting, we believe that both POM and NCI should be referred, together, whenever one is mentioned. They are consistent and mutually reinforcing approaches, each with over 2 decades of experience (recognizing their purpose and application vary).

American College of Obstetricians and Gynecologists

Sean Currigan

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), a professional organization representing more than 58,000 physicians and partners in women's health, we continue to support the three nationally endorsed measures in contraceptive health care (most and mod, LARC access, and postpartum contraception). We encourage CMS and state Medicaid agencies to work on improving access to effective contraception and family planning.

American Occupational Therapy Association

Jeremy Furniss

Adult Report

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

The American Occupational Therapy Association (AOTA) supports the inclusion of NQF #2967 in the Adult Core Measure Set. Measuring the quality of home and community based services is critical to identify practice gaps and improve quality. HCBS can prevent institutionalization and facilitate a meaningful life in the community while promoting participation in meaningful activities. Measuring the

patient experience related to these services is clearly important and can provide providers and payers with valuable information to ensure quality services.

American Pharmacists Association

Thomas Menighan

The American Pharmacists Association (APhA) appreciates the opportunity to provide support for the Measures Application Partnership's (MAP) inclusion of the Pharmacy Quality Alliance's (PQA) "Concurrent Use of Opioids and Benzodiazepines" measure for the Medicaid Adult Core Set. APhA, founded in 1852 as the American Pharmaceutical Association, represents 64,000 pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in improving medication use and advancing patient care. APhA members provide care in all practice settings, including community pharmacies, hospitals, long-term care facilities, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and the uniformed services.

The MAP recommended the inclusion of the "Concurrent Use of Opioids and Benzodiazepines" measure since it addresses two gap areas simultaneously: early opioid use and polypharmacy. The measure is claims based which increases the feasibility of state reporting and unanimously agreed to by the Task Force because of its utility in providing clear guidelines regarding concurrent prescribing practices. Recently, the Centers for Medicare and Medicaid Services (CMS) expressed concern with the concurrent use of opioids and benzodiazepines because the combination can exacerbate respiratory depression, the primary factor in fatal opioid overdose.[1] In fact, the risk of opioid-related morbidity and mortality is increased in all patients, even those who do not show signs of aberrant drug behavior.[2] In a 2015 study, investigators found that 49% of a study population who died from a drug overdose while taking opioid analgesics were concurrently prescribed benzodiazepines. [3] Furthermore, the Centers for Disease Control and Prevention (CDC) advises clinicians to avoid prescribing opioids and benzodiazepines concurrently whenever possible.[4] As you likely know, CMS is currently monitoring concurrent use of opioids and benzodiazepines among Medicare Part D enrollees and inclusion of the measure in the Medicaid Adult Core Set would be instrumental in the future oversight or performance measurement of beneficiaries enrolled in these plans.

Thank you for the opportunity to provide comments in support of NQF's inclusion of the PQA measure "Concurrent Use of Opioids and Benzodiazepines." in the Medicaid Adult Core Set. APhA is committed to working collaboratively with other stakeholders to reduce substance use disorders and improve the safe use of opioids.

American Psychiatric Association

Samantha Shugarman

Adult comments below, Child comments included in Strategic Comment Section.

Reinforced in this draft report, Medicaid beneficiaries maintain an "elevated prevalence of behavioral health conditions," but are hampered by low psychiatrist Medicaid participation. The APA applauds the MAP for continuing to acknowledge that gaps in behavioral health care, comprising of the treatment of mental illness and substance use disorders, persist. Considering this assertion, we respectfully disagree with the decision to rank the measure addressing Concurrent Use of Opioids and Benzodiazepines second, with the CAHPS survey. Though limited details of the Opioid/Benzodiazepine measure are available, considering that the draft report highlights this measure as reportable via claims data, this will increase reporting feasibility for states. This measure will help those examining the Medicaid Core Set measure data to identify where variation in this care exists. We request the MAP-convened Medicaid Task Force upgrade the Opioid/Benzodiazepine measure to first on the additions ranking list.

We also have concerns about the recommendation of the CAHPS Home and Community-Based Services Experience measure. We question the ease with which this measure is implemented, as it seems there are problems with the survey questions. We request clarity on how interviewers and survey raters will determine whether a survey question is answered "incorrectly," as we fear bias in the interpretation of what is or is not considered "correct".

CVS/Caremark (Corporate HQ)

Alex Crawford

NQF is seeking comments on its recommendations to fill identified gaps in the Medicaid Adult and Child core sets of measures.

On behalf CVS Health, we appreciate NQF's consideration of measures to strengthen Medicaid quality for children and adults and are pleased to provide comments. PBMs, Pharmacies, and pharmacists play an integral role in health quality outcomes yet there are relatively few quality measures today that are pharmacy-related (e.g., Antidepressant Prescription Management). Prescription medications, medication therapy management and pharmacy counseling can drive meaningful results and should be considered in the Adult and Child core set of measures.

With regard to specific measures, CVS Health supports "NQF #1800 Asthma Medication Ratio," which 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. Conditions such as asthma are also highly prevalent in Medicaid populations, and it is a measure that that would help to fill a gap in the Adult core set of measures. We also support this measure for inclusion in the Child Core Set of measures and as a replacement to the measure "Medication Management for people with Asthma" - which has lost NQF endorsement. Inclusion of the measure in both Sets would support CMS' efforts for alignment when appropriate for the populations served and facilitates a more seamless care and measurement transition across the two Core Sets.

CVS Health also supports the Measure Application Partnership's (MAP) recommendation to include the "Concurrent Use of Opioids and Benzodiazepines" measure for inclusion in the Medicaid Adult Core Measure Set. The measure was developed by the Pharmacy Quality Alliance (PQA) and examines the percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines. MAP recommended the inclusion of this measure since it addresses two gap areas simultaneously: early opioid use and polypharmacy and noted that in the United States, deaths from

co-prescribed opioids and benzodiazepines increased 14 percent per year from 2006 to 2011. CVS Health recognizes that CMS is currently monitoring concurrent use of opioids and benzodiazepines among Medicare Part D enrollees, and inclusion of the measure in the Adult Core Set is important for the future oversight and care for Medicaid beneficiaries.

Thank you for the opportunity to provide comments in support of NQF's inclusion of NCQA's measure "Asthma Medication Ratio" and the inclusion of PQA's measure "Concurrent Use of Opioids and Benzodiazepines."

Healthfirst, Inc.

Fareesa Silva

Healthfirst is a managed care organization in New York City, which serves over 900,000 Medicaid beneficiaries.

We support the inclusion of the Concurrent Use of Opioids and Benzodiazepines measure to the Medicaid Adult Core Set. We support the inclusion of this measure as it addresses two important public health issues: opioid use and polypharmacy. Identifying this targeted population will allow health plan's to better address and monitor provider prescribing patterns and prevent unnecessary ER and hospitalization visits. Additionally, we request that NQF share Medicaid benchmarks for this measure so that plans can assess how they perform on this measure both regionally as well as nationally and work against these benchmarks to improve performance and health outcomes for members.

Humana Inc.

Clay Rhodes

Humana supports the addition of the Pharmacy Quality Alliance measure "Concurrent Use of Opioids and Benzodiazepines" to address opioid utilization and polypharmacy. We believe this measure focuses on an area of high importance currently and addresses a national problem. Concurrent utilization of opioids and benzodiazepines pose a significant concern due to the increased risk of severe respiratory depression, coma, overdose, and death. The importance of this measure is supported by the August 2016 FDA release requiring boxed warning

and patient-focused Medication Guides on these products regarding the significant risks of concurrent use. As the FDA indicated, data demonstrates an increase in concurrent prescribing of these agents (41% between 2002 and 2014) and that overdose fatalities from taking both medications nearly tripled between 2004 and 2011.

We agree that utilization of this measure along with combined education and efforts, such as the FDA's, will help to achieve the goal of careful and thorough evaluation of use on a patient-by-patient basis of benefits and risks of these agents. Humana believes it is critical to implement this measure in the Medicaid population to address this growing problem in a high-need population.

National Partnership for Women & Families
Debra Ness

The 2017 MAP Medicaid Adult and Child draft reports recommend adding NQF #2903 Contraceptive Care – Most and Moderately Effective Methods to the Adult and Child Core Sets. The National Partnership for Women & Families strongly supports this recommendation. It is highly appropriate to include a newly available measure of this foundational preventive service that is relevant to nearly the entire population of reproductive age women and girls in both of the Core Sets. This would help increase the proportion of adolescents and women who are provided with an informed choice of more effective methods of contraception, reduce unintended pregnancies, and provide an important tool for identifying gaps and disparities to remedy. The NQF Perinatal and Reproductive Health Standing Committee strongly supported this measure in its 2016 consensus development process cycle. This would be an important complement to #2902 Contraceptive Care – Postpartum, which has just been added to the Medicaid core sets. These are aligned in employing informed choice among most and moderately effective methods. In 2016, NQF endorsed three first-ever contraceptive care measures, and #2903 provides an important opportunity to improve the care and outcomes of the Medicaid population. Because of the singular importance of autonomy and informed choice in reproductive decision making, and the history of reproductive coercion of low-income women,

we urge the adoption of this measure in strict compliance with its design, in order to guard against misuse or coercion.

The 2017 MAP Medicaid Adult Task Force report recommends the removal of NQF #0473 PC-03 Antenatal Steroids from the Adult Core Set, with the rationale that this measure is topped out. The National Partnership for Women & Families urges CMS to delay consideration of this recommendation until the performance of smaller hospitals on this measure is available. The conclusion that this measure is topped out is based on data limited to hospitals with 1,100 or more births per year, which began collecting and reporting this measure in 2014, as mandated by The Joint Commission. The Joint Commission subsequently mandated that hospitals with 300-1,099 birth annually also begin to collect and report this measure, beginning in 2016. The Joint Commission is currently analyzing the 2016 data, and will report these in their next annual report. It is conceivable that larger tertiary care centers perform better than community hospitals on this measure, and it would be premature to remove it from the Core Set without considering the performance of hospitals that began to collect and report this measure in 2016, which will soon be available.

The 2017 MAP Medicaid Child draft report recommends removing Prenatal and Postpartum Care – Timeliness of Prenatal Care from the Child Core Set. And the 2017 MAP Medicaid Adult draft report recommends removing Prenatal and Postpartum Care – Postpartum Care Rate from the Adult Core Set. Together, these are two component of a legacy HEDIS measure that lost endorsement during the 2016 consensus development process cycle of the NQF Perinatal and Reproductive Health Standing Committee. The National Partnership for Women & Families strongly supports removal of these sub-measures from the Medicaid Core Sets.

The measurement enterprise has evolved in important respects. The developer identified expert consensus, typically understood to be the lowest level of evidence, as support for this measure. This does not meet current standards of the National Quality Forum, which recommends the much higher bar of evidence at the level of a systematic review.

The measurement enterprise is also evolving to emphasize a parsimonious number of robust

measures that clearly advance high-value care. This measure merely identifies the fact of a visit at a particular time (which for the postpartum visit is problematic; see below). The fact of a visit provides no information about the care provided, the outcome of care, the woman's experience, resources used or other more meaningful indicators. The results are thus difficult to interpret. Instead, we need measures that encourage provision of known high-value elements of prenatal, intrapartum and postpartum care, as well as achievement of optimal maternal and newborn outcomes, experiences and resource use.

In a cost-constrained environment, this measure also raises concerns about appropriate use of resources. In addition to resources used to collect and report this measure, some health plans spend large sums to enhance their performance on this measure. As results are difficult to interpret, the National Partnership prefers that the various stakeholders invest resources in more meaningful measures.

The postpartum component is especially problematic for two reasons. First due to use of global billing codes, it is undercounted, so again, difficult to interpret. Second, the measure only counts if the visit is after 21 days postpartum, which is a disincentive in some settings for getting appropriate earlier care, for example, for breastfeeding support or for cesarean or perineal wound issues.

We hope that removal of this measure from the Medicaid Core Sets and other measure sets will expedite the process of putting in its place much-needed measures with a stronger, clearer relationship to high-value maternal-newborn care.

Pharmacy Quality Alliance
Bill Lademann

PQA (Pharmacy Quality Alliance) supports the MAP's conditional support of the PQA measure, Concurrent Use of Opioids and Benzodiazepines, for inclusion in the Medicaid Adult Core Set:

Overdoses from opioids continues to be a growing national crisis. Benzodiazepines use has been associated with over 30% of opioid overdose deaths and opioid use has been associated with over 77% of benzodiazepine overdose deaths. Concurrent use of these central nervous system (CNS) depressants increase the risk for severe respiratory depression,

which can be fatal. These adverse events can occur in patients who do not exhibit signs of drug abuse. Several studies suggest that concurrent use of opioids and benzodiazepines might put patients at greater risk for potentially fatal overdose. Although concurrent use of opioids and benzodiazepines has an unfavorable balance of benefit and harm for most individuals, co-prescribing of these medications is common. The Centers for Disease Control and Prevention (CDC) has advised clinicians to avoid prescribing opioids and benzodiazepines concurrently whenever possible. In addition, the Food and Drug Administration (FDA) rquires a boxed warning in product labeling detailing that concurrent use of opioids and benzodiazepines can be fatel if taken together. This measure simultaneously addresses the gap areas of opioid use and polypharmacy for the adult Medicaid population.

PhRMA
Kelsey Lang

PhRMA supports inclusion of the Pharmacy Quality Alliance (PQA) measure, Concurrent Use of Opioids and Benzodiazepines claims-based measure in the Medicaid Adult Core Measure Set. We support continued efforts to monitor concurrent use of opioids and benzodiazepines, particularly given the FDA's guidance that health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate.

Planned Parenthood Federation of America
Emily Stewart

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments in response to two draft reports for public comment regarding core sets of health care quality measures for adults and children enrolled in Medicaid. We appreciate this opportunity to provide feedback on the draft proposal to recommend inclusion of contraceptive care measure NQF#2903, which was endorsed by the NQF in 2016.

We support MAP's recommendation to add this measure to both sets. NQF#2903 measures the

provision of a most or moderately effective method of contraception to women at risk for unintended pregnancy. This is an important measure for assessing the quality of health care women are receiving and is appropriate for use in the Medicaid program. Medicaid plays a critical role for women and their families. The vast majority of women enrolled in Medicaid are of reproductive age (18-44) and Medicaid funds nearly half of U.S. births. Measuring and improving access to the full range of contraceptive methods will fill a significant gap in health care quality efforts in Medicaid and across the health care system.

Around half of U.S. pregnancies are unintended, often contributing to poor maternal and child outcomes. The 2015 Institute of Medicine/National Academy of Medicine (IOM) report, Vital Signs: Core Metrics for Health and Health Care Progress, identified unintended pregnancy as a "significant challenge for both individual and community health," and recommended that contraceptive care be included as a core quality measure in the health care system. Indeed each woman should have the opportunity to select the method of contraception that best meets her needs, including with respect to her medical history, age, and lifestyle. NQF#2903 is appropriately defined to include various effective methods so that women are not inadvertently pressured toward a specific contraceptive method.

Adding these measures to the core sets will improve access to the care women need, and promote quality improvement efforts in Medicaid that address the majority of the program's population. We thank MAP for its thoughtful consideration and recommendation for the Medicaid core measure sets.

Raising Women's Voices for the Health Care We Need

Sarah Christopherson

Raising Women's Voices for the Health Care We Need is a national initiative working to ensure that the health care needs of women and our families are addressed in federal and state health policies. We have a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, women with disabilities, and members of the LGBTQ community.

We support recommending to CMS that it add NQF #2903, measuring access to most or moderately-effective contraceptive methods, to the Medicaid core measure sets for 2018. The measure covers a range of contraceptive methods, promoting patient choice and guarding against coercion, and will improve maternal and infant outcomes and address disparities in women's access to quality care.

Access to the full range of contraceptive methods and counseling is essential preventive health care for women, and has lifelong benefits for women's economic security as well. Too often, a woman's interaction with her provider is a missed opportunity for her to access this essential preventive health care. CMS recognition could lead to more providers screening women for their pregnancy intentions, providing patient-centered contraceptive counseling, and providing the full range of contraceptive methods so that women may choose the method that best suits their individual needs and goals.

RxAnte

Tori Erxleben

RxAnte, Inc supports the inclusion of the PQA's Concurrent Use of Opioids and Benzodiazepines measure in the Medicaid Adult Core Measure Set. Inclusion of this measure will bring attention and oversight to the potentially harmful drug interaction between opioids and benzodiazepines that can negatively affect patient health outcomes and increase total cost of care. RxAnte encourages plan sponsors to find ways to implement this measure that do not impact access to patients that may be appropriately using these medications, but instead identify those misusing or abusing these medications to modify patient behavior. RxAnte has experience in identification of patients at risk for unsafe opioid use and have found benzodiazepine concomitant use to be an important factor to identify patients who may be at risk for unsafe opioid use. RxAnte believes the implementation of this measure is feasible and important to improving patient care.

Statewide Parent Advocacy Network

Diana Autin

For adult measures:

adults: -removing antenatal steroids duplicative as being measured by Joint Commission so agree

removing post-partum care rate since doesn't focus on content/outcomes-agree

• adding asthma meds.-agree

• HCBS strongly agree

• opiods strongly agree

• effective contraception to prevent unintended pregnancies-agree

The Council on Quality and Leadership

Mary Rizzolo

Thank you for the opportunity to provide comments on the draft report highlighting MAP's recommendations for strengthening the Adult Core Set.

On page 15 of the Healthcare Quality Measures for Adults report you note "currently, this survey [the Personal Outcome Measures®] does not include validated measures." However, we would like to clarify that the Personal Outcome Measures® has been re-validated a number of times in alignment with the advances made by people with disabilities, and the disability service system; the most recent validation was complete in 2017. As a result of findings from a Principal Components Analysis the newest Personal Outcome Measures® has twenty-one indicators organized into five factors: My Human Security; My Community; My Relationships; My Choices; and, My Goals. The 2017 construct validation manuscript is currently undergoing peer review at a prestigious disability journal; it is also published open access as a shorter report summary. Please see:

Friedman, C. (2017). The Personal Outcome Measures®. Manuscript under review.

Friedman, C. (2017). The Personal Outcome Measures® 2017: Measuring outcomes now and into the future. Towson, MD: The Council on Quality and Leadership.

The Personal Outcome Measures® is also a reliable tool; all interviewers are required to have at least 85% reliability before administering the Personal Outcome Measures®.

CQL has over 45 years of experience developing tools to measure and support provision of high-quality, person-centered services and supports. We thank you in advance for considering methods that include the perspectives of the people receiving supports, themselves, in your quality measurement efforts.

The National Campaign to Prevent Teen and Unplanned Pregnancy

Andrea Kane

Measure 2902 Contraceptive Care - Postpartum Women Ages 15-20

Measure 2903 Contraceptive Care - Most & Moderately Effective Methods

The National Campaign to Prevent Teen and Unplanned Pregnancy applauds the careful work that went into developing these measures and is pleased that they are now NQF-endorsed. We believe they can be a valuable tool that contributes to ensuring that all women have access to the full range of contraceptive methods, including the most effective ones for them. This includes being offered contraception post-partum, as well as at other times that are appropriate for an individual woman.

The SCAN Foundation

Megan Burke

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

The SCAN Foundation supports the inclusion of the CAHPS Home and Community-Based Services (HCBS) Experience measures in the Adult Core Set, especially as the Centers for Medicare and Medicaid Services already extensively uses other CAHPS surveys. Inclusion of these measures begins to address the existing LTSS measure gap. This is especially important when measuring quality in integrated care programs.

Measurement Gaps

The SCAN Foundation is pleased to see long-term services and supports (LTSS) identified as a priority on the MAP's measurement gap list. People with complex care needs (chronic conditions and functional limitations) represent a large portion of Medicaid costs. It's important to measure the

quality of services provided across the spectrum of care, including LTSS, to ensure people are receiving quality services that meet their needs. Additionally, evaluation of integrated care models has elevated the need for standard LTSS quality measures. The lack of LTSS quality measures creates challenges in assessing and comparing the quality of the growing number and types of integrated care models and programs. As such, we recommend moving LTSS measurement up on the priority list.

The NQF criteria the MAP used to prioritize measurement gaps closely aligns with four Essential Attributes Attributes1 of a high-quality system of care, developed by a panel of national experts in 2016. The Essential Attributes center on person-centered care concepts that address what matters most to people with complex care needs. We recommend using the Essential Attributes framework to identify and develop quality measures that address the identified gaps.

1. What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs - http://www.thescanfoundation. org/what-matters-most-essential-attributes-high-quality-system-care-adults-complex-care-needs?platform=hootsuite

Adventist Health System

Michael Griffin

Adult Core Set

NQF-Endorsed Measures

#2605 AHS supports this measure. However, we believe that the measure should include discharge

from any setting, not just the ED. Many readmissions are due to psychiatric co-morbidities that go unaddressed while the patient's physical diagnosis was treated.

#1800 AHS supports the measure. We believe it is important that the measure collects information on not just the numbers of patients with asthma medications, but also determines the appropriateness of medication management based on the type of asthma.

#2967 AHS supports all six global measures, which help to reduce readmissions. We recommend that the Physical Safety Measure section include an additional question regarding patient falls. While the current Physical Safety Measure "hit or hurt by staff" is important, it is more of a reactive measure. A question on patient falls will get at preventative efforts; were the appropriate guardrails put in place to prevent falls?

Although we support NQF #2967, we are concerned that the cost associated with the increased administrative burden to capture these measures will fall to states. Given current funding limitations, and threats of cuts to Medicaid, additional costs such as these may be at the expense of reduced Medicaid services.

#2903 AHS supports this measure but believes that it should be revised. The denominator should be limited to women who do not want to become pregnant.

Not NQF-Endorsed Measures

Concurrent Use of Opioids and Benzodiazepines AHS conditionally supports the measure, pending NQF endorsement.

Strategic Comments

American Occupational Therapy Association

Jeremy Furniss

Adult Core Set Measure Gaps

AOTA agrees that the priority areas outlined by MAP are very important. We would also encourage the MAP and Coordinating Committee to consider measures related to function and performance when considering high priority gap areas. AOTA agrees with Dr. Zerzan from Colorado that functional outcome measures are very important to better understand if care delivery impacts a person's ability to care for him or herself and provide care to others. These are particularly important for persons who are living in the community and may be at risk for increased care or institutionalization. Measures of function (such as those being explored in the CMS Testing Experience and Function Tools project) are meaningful outcomes that can identify gaps in services and quality.

Anthem, Inc.

Amy Ingham

We thank MAP for seeking to ensure alignment with NCQA HEDIS measures.

Anthem agrees that reporting should be voluntary and not mandatory. While health plans have experience to report internally and externally (when states require it), the burden of collecting data is very high, especially for non-HEDIS measures where either medical record review or eRecord are expected. In several measures, such as elective deliveries, health plans may need to use much higher sample sizes than with HEDIS measures in order to achieve the right denominator (members in the right gestational age to fit the denominator definition). Now that more measures of this kind have been added, we support phasing in adoption to alleviate operational burdens.

Additionally, these measures also tend to have extra medical record burden just to find the right denominator. When looking at the Adult Core Set – Elective Delivery measure – we need to include many more individuals than necessary in the sample. This measure looks at members who delivered at 37 – 39 gestational weeks. However, this information is not

provided by claims data. To ensure our sample is appropriate, we need to oversample by 60 percent to ensure we have enough individuals included in the measure denominator.

Measures should include detailed technical specifications -

• If claims information should be used, then Dx/CPT codes should be provided,

• If medical record review should be used, then denominator/numerator components of medical record review should be defined,

• Specific definitions and clear guidelines should always be provided.

We recommend better alignment with the HEDIS and the Children's and Adult Core sets. Anthem agrees that the measures across the Child and Adult Core Sets are aligned. Alignment across these two sets will also ease the feasibility of data collection. Overall, Anthem supports MAP's focus on parsimony and alignment of measures and we emphasize that alignment of measures for ease in collection by providers and health plans would result in overall healthcare improvements.

We also recommend that measures track quality improvement and quality of care in the most efficient and accurate manners. Medical record review is unduly burdensome and vital statistics data is often not available or not timely. These barriers result in a lack of timely and complete data, which is necessary for effective interventions. For example, Elective Delivery in the Adult Core Set.

Adult Core Set

Asthma Medication Ratio: Anthem supports adding this measure given the alignment with the Adult core set and its relevance to patients.

CAHPS Home and Community-Based Services Experience Measures: Anthem agrees that Home and Community-Based Services measures are a long-standing gap in Medicaid, however, states have limited experience with such surveys. If added, Medicaid agencies should be responsible for fielding the CAHPS tool.

Concurrent Use of Opioids and Benzodiazepines: Anthem recommends that NQF provide more

information regarding the details of this measure. To fill gaps, Anthem recommends including a comprehensive, controlled substance measure along with sub-measures assessing opioid benzodiazepines use.

Contraceptive Care: Most & Moderately Effective Methods: Contraceptive care is critically important, but we recommend against setting specific targets regarding contraception utilization as this assumes there should be a certain level of uptake and it may lead to pressure placed on patients.

PC-03 Antenatal Steroids: Anthem supports removing this measure.

Postpartum Care Rate: Anthem does not support the removal of the Postpartum Care Rate measure. Anthem understands that the measures are flawed, but we recommend maintaining these measures until new improved measures are developed.

The SCAN Foundation

Megan Burke

Strategic considerations: measurement alignment

The MAP discussed the importance of aligning measures from a multi-level perspective (i.e., clinical, health system, and state/federal levels). A 2016 Bipartisan Policy Center (BPC) report1 recommends that the Centers for Medicare and Medicaid Services (CMS) align oversight functions for programs serving dual eligible individuals. Such consolidation of authority within CMS could begin to help in aligning measure sets and quality efforts.

1. Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid - https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/

Adventist Health System

Michael Griffin

In both the Adult and the Child Core Set reports, the MAP identifies certain areas of focus for quality measurement. These areas include: 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.

AHS supports the NQF's emphasis on these areas and believes they are essential for quality measurement and the move towards value-based care. Seeking the alignment of measures across the Adult and Child Core Sets, especially for high-impact conditions like reproductive and behavioral health, is necessary for the successful integration of care. Identifying measures that overlap and eliminating duplication can improve the delivery of care by reducing the data collection and reporting burden placed on providers.

Additionally, AHS supports the development of social vulnerability measures because of the complex role of social risk factors at both the individual and population level. The adoption of these measures will likely help improve patient outcomes for vulnerable populations.