NATIONAL QUALITY FORUM

Strengthening the Core Set of Healthcare Quality Measures for Adults Enrolled in Medicaid, 2018

DRAFT REPORT FOR PUBLIC COMMENT

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Contents

Executive Summary

Medicaid is the largest health insurance program in the United States, serving 76 million Americans in FY 2016.[1] As the primary health insurance program for the nation's low-income population,[2] Medicaid covers many vulnerable individuals with a high need for medical, healthcare, and support services. Since October 2013, Medicaid has experienced marked growth in adult enrollment, largely due to Medicaid expansion defined in the Affordable Care Act (ACA).[3] Medicaid beneficiaries with complex care needs account for roughly 54 percent of total Medicaid expenditures, despite comprising just 5 percent of all Medicaid beneficiaries. In addition, Medicaid beneficiaries needing long-term services and supports more than doubled from FY 2012 to FY 2015, accounting for 20 percent of the total federal and state Medicaid spending.[4] Understanding the diverse needs of the adult Medicaid population is imperative for improving health and the quality of care for this population.

Section 1139B of the Social Security Act (amended by Section 2701 of the ACA) mandates the Core Set for the assessment of care quality 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 Workgroup, MAP recommends measures that would enhance the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (the Adult Core Set). Guided by MAP's Measure Selection Criteria, a defined decision algorithm, 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 quality measures are needed and/or appropriate measures are lacking.

In 2018, MAP supports all but two of the current Adult Core Set measures for continued use and recommends eight measures for phased addition to the Adult Core Set.

- MAP recommends the removal of NQF #0476 *PC-03 Antenatal Steroids*. Multiple state representatives noted reporting challenges related to data collection for this measure. In addition, the Workgroup members reiterated that this hospital-level measure is currently reported to The Joint Commission and this duplicative reporting only adds to measurement burden for resource constrained Medicaid programs. For the same reasons noted in 2017, MAP recommended removal of this measure from the Adult Core Set to reduce duplication and burden of reporting at the state level while increasing bandwidth for reporting other measures.
- MAP recommends the removal of NQF #2082 *HIV Viral Load Suppression* from the Adult Core Set. Multiple state representatives noted reporting challenges associated with NQF #2082 *HIV Viral Load Suppression*, including the measure's data source (i.e., electronic health records and paper medical records) and strict confidentiality laws associated with HIV and AIDS related clinical data.

MAP recommends that CMS consider up to eight 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 and Measure Title
1	NQF #2967 CAHPS® Home and Community Based Services (HCBS) Measures
2	NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer
3	NQF #0712e Depression Utilization of the PHQ-9 Tool
	NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*
4	NQF #0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
5	NQF #3175 Continuity of Pharmacotherapy for Opioid Use Disorder
6	NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	NQF #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

*Conditionally supported measure

MAP recognizes that many priority areas for quality measurement and improvement lack fully developed metrics and documents these gap areas as future measurement needs for the measure developer community. In addition to the identified gaps, the Workgroup noted the need for population based cross-cutting measures to address the range of priority areas and needs among different states and their Medicaid populations.

Additionally, MAP's strategic discussions included recommendations for improving Adult Core Set reporting at the state level. These discussions focused on maximizing data utility and lowering data burden. Both of these strategies focused on social determinants of health (SDOH), and how SDOH allow for the parsing of data based on unique population and/or subpopulation needs. Moreover, addressing SDOH allows Medicaid agencies, providers, and payers to consider nonclinical community-level factors that adversely affect health outcomes. These entities, however, often lack funding for SDOH-specific mitigation strategies.

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. The work of the Medicaid Adult Workgroup is under the purview of MAP. As such, the Medicaid Adult Workgroup advises the MAP Coordinating Committee on changes and updates to the Adult Core Set. The MAP Coordinating Committee serves as the final ratifying body that oversees the recommendations for HHS. During the 2017-2018 review, the Medicaid Adult Workgroup evaluated measures in CMS' 2018 Adult Core Set using state performance data from the federal fiscal year (FFY) 2016 reporting cycle to inform their deliberations. MAP-recommended changes, if instituted, would take effect for the 2019 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 Workgroup 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 Workgroup consists of organizational representatives, subject matter experts, and federal government liaisons with relevant interests and expertise (Appendix B).

MAP's recommendations for the current Core Set are based on MAP's Measure Selection Criteria (MSC) (Appendix C), a defined decision algorithm (Appendix D), and the most recent available measure reporting data from states. The Centers for Medicare & Medicaid Services (CMS) provided several materials to inform the Workgroup's review and recommendations, including summaries of the FFY 2016 measures reported by states and detailed analyses of state performance on 16 publicly reported measures.

This report summarizes the Workgroup's measure-specific recommendations to fill high-priority gap areas (Appendix I) and highlights states' feedback on collecting and reporting measures as presented to the Workgroup during the May 9-10, 2018 in-person meeting deliberations. In addition, the report outlines the strategic issues and opportunities for increasing state reporting identified by the Workgroup.

This report captures the Medicaid Adult Committee's sixth 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 and states' shifting priorities over time based on measures in use. HHS considers the Workgroup'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. In the 51 states reporting February 2018 data, 73,966,190 individuals were enrolled in the Medicaid and Children's Health Insurance Program (CHIP); specifically, 67,562,271 individuals were enrolled in Medicaid, and 6,403,919 individuals were enrolled in CHIP.[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 performance across states in a standardized manner. 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. Additionally, Medicaid also covers a broad spectrum of long-term care benefits not provided by Medicare or private payers[8] and has become the most significant source of financing for nursing home and community-based long-term care.

Medicaid Adult Core Set

In January 2012, the Center for Medicaid and CHIP Services (CMCS) released the initial Adult Core Set of healthcare quality measures to assess the quality of care for adults enrolled in Medicaid. From 2013, NQF's MAP has provided input to strengthen the Core Set and help promote measure alignment and parsimony. HHS established the Adult Core Set to standardize the measurement of healthcare quality across state Medicaid programs.[9] Section 1139B of the Social Security Act (amended by Section 2701 of the ACA) notes that the Adult Core Set shall be updated annually beginning in January 2014.[10] State Medicaid agencies voluntarily collect, report, and use Core Set measures to drive quality improvements.

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, making it difficult to glean an overall picture of quality nationwide. Annually, statute requires CMS to 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.

MAP's 2017 review and input helped inform CMCS's 2018 Adult Core Set update. Following MAP's recommendation, CMCS added three measures: *Concurrent Use of Opioids and Benzodiazepines,* NQF #1800 *Asthma Medication Ratio,* and NQF #2903 *Contraceptive Care—Most & Moderately Effective Methods*. These additions expand the measurement of quality of care for three populations—adults with substance use disorders, chronic health conditions, and reproductive age women, respectively. No measures were retired from the 2018 Core Set.

The 2018 Adult Core Set contains 33 measures relevant to adults ages 18 and older and can be found in Appendix E.

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. The data are presented in publications such chart packs and Performance on the Adult Core Set Measures.[11]

State Experience Collecting and Reporting the Adult Core Set

Presentations from invited states' Medicaid program representatives precede all 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 with collecting, reporting, and using either the Adult or the Child Core Set. Additionally, they highlight successful state-specific programs and care models. The Medicaid Adult and Child Core Set update process is based on real world experiential information solicited from the field, prior to finalizing recommendations for changes to the Core Sets. Ultimately, the goal is to use this experiential data to provide well-informed and targeted recommendations to inform the Core Set updates.

For the Adult Core Set, state Medicaid representatives from Pennsylvania and Minnesota presented an overview of their state Medicaid programs. Additionally, the representatives provided information related to Core Set use (i.e., value-based purchasing, quality improvement models, managed care contracting, behavioral health, social determinants of health, etc.), issues related to reporting and potential strategies for improving Core Set measure reporting rates.

Pennsylvania

The Pennsylvania Medicaid representative, David Kelley, MD, Chief Medical Officer, presented the state's experience with the Adult Core Set. The Pennsylvania Medicaid program covers 2.8 million individuals, including 1.1 million children and 60,000 deliveries. Since Pennsylvania expanded its Medicaid program in 2015, the state has enrolled 700,000 newly eligible individuals.

Pennsylvania is a mandatory managed care state with behavioral health carve-outs, and reports on 21 Adult Core Set measures. For the past decade, Pennsylvania has actively engaged in pay-for-performance and value-based purchasing programs. More recently, the state developed a program that focuses on behavioral health measures while incentivizing physical and behavioral health plans to engage in collaborative care. This program, referred to as the Integrated Care Program, requires managed care plans to engage in three processes. First, managed care plans are required to identify and stratify patients with serious, persistent mental illness based on cost and/or need. Second, physical health and behavioral health plans are required to co-design a member care plan for Medicaid beneficiaries with complex care needs, high costs, or high psychosocial needs. Finally, managed care organizations (MCOs) are required to notify their counterpart plans if high-need patients experience an inpatient stay, 90 percent of the time. For instance, a physical health plan must inform the patient's behavioral health plan if they experience an inpatient stay. If an MCO fails to meet any of these three requirements, the MCO is ineligible to receive the incentive.

Pennsylvania's Integrated Care Program demonstrates how states can leverage Core Set measures to develop an incentive program that promotes care coordination at the plan level. The number of individuals who initiated and engaged in treatment rose during the performance period; however, the number of individuals who adhered to treatment decreased. Dr. Kelley attributed these mixed results to the rise in beneficiaries as a result of Medicaid expansion. While the number of beneficiaries who initiated and engaged in treatment increased, it was not in proportion to the significant increase in the number of eligible Medicaid beneficiaries. As the program evolves, the goal is to include both behavioral and physical health providers, which would facilitate care coordination across different care settings.

Dr. Kelley also highlighted Pennsylvania's work related to opioid use disorder (OUD). In the last year, Pennsylvania required managed care plans to develop prior authorization requirements based on Centers for Disease Control and Prevention (CDC) guidelines. Additionally, Pennsylvania worked in partnership with the University of Pittsburgh to conduct predictive modeling to pinpoint beneficiaries at high risk of an overdose event. Subsequently, the state shared this model with all the plans and required them to perform interventions accordingly. The state has also conducted data analyses on opioid measures to identify patients and providers who require focused outreach to either effectively tailor treatment or modify prescribing habits, respectively. Data have shown that patients with OUD frequent

the inpatient emergency department at higher rates than their counterparts without OUD. However, OUD beneficiaries also used behavioral health services at higher rates, and the majority had an established relationship with a primary care provider.

Dr. Kelley highlighted several key measurement priorities that the Workgroup should consider when suggesting edits and revisions to the Core Set. First, the Core Set stability is critical in keeping MCOs focused on priority measures. Additionally, population-based measures with national benchmarks serve as useful tools to gauge performance across states, regardless of NQF endorsement status. Finally, Pennsylvania views reporting burden, such as chart audits, as one of the principal reasons for excluding a Core Set measure from its portfolio.

Minnesota

The Minnesota Medicaid representative, Jeff Schiff, MD, MBA, Medical Director from the Minnesota Department of Human Services presented to the combined Medicaid Adult and Child Workgroups. He focused on Minnesota's experiences using social determinants of health as well as two initiatives on care integration. The presentation focused on healthcare's accountability paradox where the onus of measuring, tracking, and improvement falls both within and outside the healthcare system. The integrated care presentation focused on ways to analyze and harness the information present in data already collected, focusing mainly on SDOH factors, and applying the findings in the development of integrated care models and initiatives.

Minnesota (MN) Medicaid covers on average 1.1 million low-income individuals on a monthly basis of which 65 percent are families with children, 17 percent are seniors and people with disabilities, and 18 percent are adults without children. In treating these individuals, the state focuses on addressing the social determinants of health and seeks ways to address them within the healthcare system. In doing so, the state has identified two categories of SDOH, modifiable and non-modifiable, which are listed below.

Modifiable Social Determinants

- Family functioning:
  - Mental illness
  - Substance use disorder
  - Child protection involvement
  - Child abuse
  - Adverse childhood experiences (ACEs)

- Family economics:
  - Homelessness
  - Food insecurity
  - Lack of transportation
  - Deep poverty

Non-modifiable Social Determinants

- Culture
- Gender
- Gay, Lesbian, Bi-sexual, Transgender, Questioning (GLBTQ) status

To develop the SDOH list presented above, Minnesota looked at social determinants with the goal of identifying those that affect identifiable health outcomes. This effort resulted in very interesting findings. In Minnesota, only 10 to 20 percent of health outcomes are directly correlated to actual healthcare services. Consequently, most of the health outcomes noted in the Minnesota study resulted from environmental and SDOH factors that affect health and well-being. The study showed that in MN the prevalence of social determinants affecting health outcomes for children correlated with deep poverty, parental substance abuse disorder, homelessness, prior parental incarceration and child protective services (CPS) involvement. For example, study data showed that children who have a risk of homelessness also have a significantly higher risk and rate of asthma compared to the baseline population of all children on medical assistance.[12]

Ultimately, these SDOH factors increase the prevalence of health risks for the Medicaid population which in turn affects the cost of Medicaid programs. Additionally, a lack of public health support systems exacerbates the prevalence of health risks due to a lack of focus on prevention and community supports. Dr. Schiff noted a pronounced disconnect between the clinical Medicaid care delivery system and the public health system at large. He noted that this disconnect results in a lack of community based programs, educational resources, and outreach efforts, which leads to adverse events such as unplanned pregnancies and premature births. Therefore, any effort to address SDOH needs to address the importance of coordination and connections between both clinical care and public health systems.

The discussion of the disconnect between clinical care under Medicaid and the larger public health system highlighted that a lack of surveillance and primary and secondary prevention along with tertiary care results in SDOH factors outside of the purview of clinical care, which can only be addressed by community organizations and resources. Consequently, a lack of these services leads to poor health outcomes, which is both indicative of SDOH and community factors along with failures of the delivery system and increases both population vulnerability and social risk. Addressing SDOH has become an important priority for the health system from a cost and health equity perspective. As a result, healthcare entities are increasingly working with areas such as availability of food and access to community based health education, which are outside the defined clinical care system.

In Minnesota, this is being done through two initiatives focused on integrating care using SDOH factors: Integrated Health Partnership and Integrated Care for High Risk Pregnancies. The definition of integration used in the initiatives includes screening and referral, population-based interventions, and community/culturally based initiatives along with traditional healthcare services.

Integrated Health Partnership (IHP) is Minnesota's Medicaid Accountable Care Organization (ACO) and is responsible for a core set of health care services, which are paid for using a population-based payment model. This model includes shared risk arrangements with providers based on robust quality metrics

and data. The ultimate goal of this program is to understand patient populations and craft effective strategies to address the needs of these beneficiaries. Health improvement happens by focusing on provider requirements, direct and indirect payment-based incentives, along with facilitation and support of care delivery in addressing population needs. For example, the most successful initiative is the food insecurity screening and referral program, where referrals to community resources lead to holistic care of these individuals.

Integrated Care for High Risk Pregnancies (ICHRP) is another SDOH based initiative that focuses on disparities in birth outcomes for African American and American Indian populations. This initiative uses a population focused model which includes identifying high-risk pregnancies, providing necessary medical treatment, as well as considering community and cultural factors. Therefore, key services provided include a wide variety of medical and nonmedical services such as prenatal care, social services, family court, and substance use to name a few. The goal of ICHRP is to not only consider SDOH, but to also mitigate psychosocial risk such as housing, domestic abuse, and financial instability in developing and providing culturally sensitive pre-, post-, and peri-natal care.

Both initiatives mentioned above address the accountability of providers and are affected by the national opioid crisis/epidemic affecting the Medicaid population.[13] To counter the crisis, Minnesota opioid use reduction efforts focus on prescriber behavior, prescribing rate variation, and tiered measurement. The Medicaid program focuses on multilevel measures that capture the rate of new chronic use for patients along with clinic or health system and provider level prescriptions with the goal to reduce new chronic users. The program follows statewide opioid guidelines with thresholds meant to monitor and change prescription behavior; it thereby focuses on an adaptive culture change targeting both providers and their prescribing patterns.

Based on MN Medicaid's experience with these initiatives, Dr. Schiff highlighted the need for states to collect SDOH related information and use it along with provider focused accountability models to improve the health outcomes for their Medicaid populations. He also noted that these initiatives and models need to take into account both clinical and community based efforts to address the impact of SDOH on health outcomes. Given the lack of a robust public health infrastructure, Dr. Schiff cautioned states about the gap in services between public/population health and clinical services provided by Medicaid. Therefore, data parsing using SDOH factors needs to be supplemented with wrap-around support services in the community such as programs focused on housing and food insecurity.

MAP Review of the Adult Core Set

MAP evaluated the measures in the Adult Core Set to provide recommendations to strengthen the Core Set while facilitating CMS' 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 2018 Adult Core Set. The MSC are not absolute rules; rather, they 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.[14] Using the decision algorithm, MAP reviewed measures in the gap areas identified during previous annual reviews. NQF staff compiled measures in the following 13 gap areas:

- behavioral health;
- substance use;
- patient-reported outcomes;
- assessing and addressing of social determinants of health;
- care coordination;
- long-term supports and services;
- maternal and perinatal;
- asthma;
- promotion of wellness;
- workforce and access to care;
- new or chronic opiate use;
- polypharmacy; and
- patient engagement and activation.

MAP discussed measures recommended by individual Workgroup 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 prefers NQF-endorsed measures.

MAP generally favors ready-to-implement measures that promote parsimony and alignment, while addressing high-impact health conditions for adults enrolled in Medicaid. Therefore, 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. However, NQF-endorsed measures are not always available to address gap areas deemed relevant for the Adult Core Set. Therefore, Workgroup members helped identify measures in development and/or undergoing endorsement for discussion and consideration. For example, the group examined a hepatitis C measure that has not been submitted for endorsement, but is very relevant for the Medicaid population. Monitoring NQF-endorsed measures and other measures in the development pipeline is imperative for facilitating successful future annual reviews of the Adult Core Set.

Following discussion of each measure and public comment, voting occurred to determine if there was sufficient support from Workgroup members to recommend the measure for addition to the Core Set. Measures evaluated by the Workgroup, but not supported for addition, are listed in Appendix G.

Additionally, CMS includes measures in both 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 #0418 has an eMeasure version, measure #0418e.

Measure-Specific Recommendations

Measures for Removal from the Adult Core Set

The Workgroup noted that states' participation in reporting the Adult Core Set is strong and has steadily increased each year, though there is always room for improvement in both the total number of states submitting measurement data and the number of states reporting each measure. Forty-one states voluntarily reported at least one Adult Core Set measure for FFY 2016, with 31 states reporting at least 14 of the 30 FFY 2016 Adult Core Set measures. Two states reported Adult Core Set measures for the first time for FFY 2016.[15] Maintaining stability in the measure set allows states to continue to gain experience in reporting these measures.

In general, MAP considers recommending the removal of 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

Not finding many significant implementation problems, MAP was comfortable supporting all but two of the current Adult Core Set measures for continued use. These measures were among the measures least reported by states in 2014, 2015, and 2016. Measures most burdensome for states to report tend to be measures that are not administrative or claims based. Both measures recommended for removal are specified as electronic health records/data and paper medical records.

NQF #0476 PC-03 Antenatal Steroids (The Joint Commission)

Initially, NQF #0476 *PC 03 Antenatal Steroids* was recommended for removal in 2017. Multiple state representatives noted reporting challenges related to data collection for this measure. In general, state representatives noted that the feasibility of collecting and reporting hospital-based measures is extremely difficult (e.g., measures collected via medical record review are resource intensive). In addition, the Workgroup members reiterated that this hospital-level measure is currently being reported to The Joint Commission. Therefore, collecting data on this measure leads to burden due to redundancies in data collection. MAP is aware that CMS continues to consider ways to coordinate with other entities, such as The Joint Commission, to share data already collected. For the same reasons noted in 2017, MAP recommended removal of this measure from the Adult Core Set to reduce duplication and burden of reporting at the state level while increasing bandwidth for reporting other measures.

NQF #2082: HIV Viral Load Suppression (HRSA)

Multiple state representatives noted reporting challenges associated with NQF #2082 *HIV Viral Load Suppression*, including the measure's data source (i.e., electronic health records and paper medical records) and strict confidentiality laws associated with accessing HIV and AIDS related clinical data. A Workgroup member suggested that this measure might be better suited as a provider level measure to adequately address adherence to care. Thus, this may not be the best measure for a state reported measurement set. MAP recommends removal of this measure from the Adult Core Set.

Measures for Phased Addition to the Adult Core Set

MAP recommends that CMS consider up to eight measures for phased addition to the Adult Core Set (Exhibit 1, below, and Appendix F). The Workgroup had a robust conversation regarding measures that address behavioral health conditions and substance use disorders during this review. Six of the eight measures recommended address these conditions and disorders. All recommended measures passed the consensus threshold to gain support or conditional support for phased addition by receiving more than 60 percent approval by voting Workgroup 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 also aware that additional federal and state resources are required for each new measure added. Therefore, immediate addition of all eight 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 2018 Adult Core Set includes 33 measures, the largest number of measures to date. Given this size, there is a critical need to maintain stability of the number of measures, which will increase the likelihood of states reporting the same measures consistently. 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 #2967 CAHPS® Home and Community Based Services (HCBS) Measures
2	NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer
3	NQF #0712e Depression Utilization of the PHQ-9 Tool
	NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*
4	NQF #0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
5	NQF #3175 Continuity of Pharmacotherapy for Opioid Use Disorder
6	NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
	NQF #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

* indicates conditional support

The addition of recommended measures would strengthen the Core Set on a variety of high-priority healthcare quality areas, including patient-reported outcomes, long-term services and supports, and

behavioral health and substance use. Further explanation and rationale regarding MAP's support for these measures follow, in order of ranking.

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

MAP supported the inclusion of this measure, noting the need for home and community-based metrics. *CAHPS Home and Community-Based Services Experience* measures are survey based 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 initially supported this measure conditionally in 2017, pending confirmation from CMS on the feasibility of implementation at the state level. CMS confirmed that while they are unable to collect performance data from states, states are able to report whether they are using the measure. To date, 16 states have reported using either the entire HCBS survey or the 19 measures included in NQF #2967.

NQF #2950 Use of Opioids from Multiple Providers in Persons Without Cancer

This measure examines the proportion of individuals without cancer receiving prescriptions for opioids from four or more prescribers and four or more pharmacies. This is a claims-based measure, which reduces the reporting burden for states. In 2015, MAP initially recommended this measure and two related measures (NQF #2940 and #2951) conditionally pending NQF endorsement. Subsequently, all three measures were endorsed in 2017. CMS added NQF #2940 to the 2016 Core Set, but did not accept the recommendation for NQF #2950 and NQF #2951. MAP reaffirms its 2015 rationale and puts forth the same rationale to recommend the measure for inclusion in the 2019 Adult Core Set. This measure is timely and imperative for the Medicaid population because it addresses the opioid epidemic along with opioid related morbidity and mortality. MAP agreed this measure could potentially address the issue of "doctor shopping" happening across state lines.

NQF #0712e Depression Utilization of the PHQ-9 Tool

This measure captures the number of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have had at least one PHQ-9 or PHQ-9M tool administered during a four month measurement period. The PHQ-9 tool is validated for use to assess the level of depression severity (for initial treatment decisions) and as an outcome tool (to determine treatment response).[16,17] This process measure is paired with four outcome measures that were not recommended for addition to the Core Set (NQF #0710, #0711, #1884 and #1885). This measure's data source is specified as electronic health records and paper medical records. A state Medicaid representative on the Workgroup expressed concern that reporting this measure will not be feasible for many states, since many states are unable to collect electronic health records and have moved away from resource-intensive paper chart audits. Ultimately, MAP supported the inclusion of this measure because it supports measurement-based care that systematically assesses patients for depression over time based on their response to treatment.

NQF #0028 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*

Tobacco use and smoking rates among Medicaid beneficiaries are significantly higher than the general population.[18] NQF #0028 assesses the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation intervention, if identified as a tobacco user. MAP conditionally supported the inclusion of this measure in the Adult Core Set, pending the removal of NQF #0027 *Medical Assistance with Smoking and Tobacco Use Cessation*, which is currently in the Core Set. MAP agreed that NQF #0028 (and NQF #0028e) is a superior measure as the measure provides a variety of collection methods, including claims, registry, and electronic health records. In addition, this measure includes screening and whether or not there is a cessation intervention, whereas measure #0027 only addresses whether cessation assistance was offered.

NQF #0104e Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

This measure assesses the percentage of patients with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. Workgroup members noted that since this measure is only e-specified, it would pose significant reporting burden due to an inability to collect data for many states, if added to the Core Set, which may prevent its use. In addition, they noted that this measure lacks a detailed description of what counts as a suicide risk assessment and suggested that the developer clarify as well as modify the measure by including detailed specifications of acceptable risk assessment tools. Ultimately, MAP recommended this measure for inclusion in the Adult Core Set, noting that the importance of the topic of suicide and need for this measure outweigh the identified limitations mentioned above.

NQF #3175 Continuity of Pharmacotherapy for Opioid Use Disorder

This measure assesses the percentage of adults 18-64 years of age on pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment. MAP recommended the inclusion of this measure in the Adult Core Set, because it addresses continuity of treatment retention and care. The numerator of the measure includes patients who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days. The Workgroup noted that better patient outcomes are often associated with longer retention periods (i.e. ≥180 days).

NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

This measure assesses the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months and who received brief counseling if identified as an unhealthy alcohol user. The Workgroup discussed several barriers associated with this measure, including reporting burden (i.e., states' inability to collect registry data) and broad screening tool specifications (i.e., current specification include a systematic screening method rather than a validated screening tool). However, the decision to support this measure for inclusion was based on the importance of measuring alcohol screening and counseling rates, especially for vulnerable populations. In 2016, MAP also recommended this measure for addition noting that it fosters the principles of care coordination through screening and follow-up counseling.

NQF #0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

NQF #0541 assesses the percentage of patients 18 years of age and older who met the proportion of days covered (PDC) threshold of 80 percent during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, and Statins. The inclusion of this measure would support alignment of other quality programs (e.g., Medicare Part D Star Ratings, Health Insurance Marketplace Quality Rating Systems, etc.) with the Medicaid Adult Core Set. MAP recommended this measure for addition during its 2016 review and again during this current review. The Workgroup again agreed that this measure is important because successful treatment of chronic conditions requires consistent medication management and patient adherence to taking prescribed medications.

Measure Concept Reviewed for Future Consideration

The Personal Outcome Measures survey, National Core Indicators (NCI) survey, and National Core Indicators – Aging and Disabilities (NCI-AD) Adult Consumer Survey were presented for future consideration for addition to the Adult Core Set.

- Personal Outcome Measures: 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 assesses if necessary supports are in place to assist individuals in achieving their desired outcomes.
- National Core Indicators: Developed in partnership with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI), the NCI survey's primary goal is to gather data on the performance of public intellectual/developmental disabilities (I/DD) service systems.
- National Core Indicators – Aging and Disabilities: The National Association of States United for Aging and Disabilities (NASUAD), HSRI, and NASDDDS developed the NCI-AD to obtain data on publicly funded programs for older adults and individuals with physical disabilities.

Workgroup discussions focused on the importance of capturing data for Medicaid beneficiaries with disabilities, specifically, community integration, beneficiary experience, and quality of life data. The surveys address priority gap areas for intellectually, developmentally, and physically disabled populations, such as beneficiary reported outcomes and long-term services and supports. The three survey instruments have been validated but do 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

State Medicaid agency medical director feedback, review of 2016 reporting, and data on prevalent conditions affecting the adult Medicaid population influenced the 2018 gap areas. The prioritization of specific gap areas is not meant to diminish the importance of all existing gaps in measurement. Rather, ranking along with broad discussions of these areas provides CMS with information on the collective importance of the gaps list, and is meant to inform the addition and removal of measures from the Core Set.

The Workgroup considered the previously ranked five key gap areas to guide their discussions. Following the review of the 2017 key priority gaps presented in Appendix I, the Workgroup members expressed the need to highlight a subset of the existing priority areas with some additions and clarifications:

- Interpregnancy
- Planning and transition to well woman care
    - Minimize low value care
- Disparities and equity focused measures in conjunction with social determinants of health
- Beneficiary reported outcomes
    - Perception of care
- Behavioral health
    - Integration of substance use disorders with mental health

The Workgroup noted that many measurement priorities for quality improvement lack fully developed metrics. Therefore, the list above is meant to communicate measure development needs and areas of focus for the measure developer community. This list of measure gaps is a starting point for future discussions as well as a guide for annual revisions to the Adult Core Set.

Additionally, Workgroup members noted that measurement in general is siloed; hence, gaps, needs, and priorities become siloed based on measure availability along with individual state Medicaid needs. However, all members of the Workgroup unanimously agreed that maternal health and postpartum measures remain an important gap for all Medicaid agencies. Medicaid state representatives emphasized that even though an exhaustive list of gaps exist, each state is very different, and this variation in Medicaid populations leads to differing gaps and priorities. For example, cancer—specifically colorectal cancer—is a priority area for California Medicaid, whereas violence, accidents, and substance abuse are priority areas for Colorado Medicaid.

Given the variance in Medicaid needs among states, the Workgroup discussed the utility of population based cross-cutting measures addressing a set of core metrics. This approach to measurement reduces data collection and reporting burden while promoting consistency in reporting and allowing for a holistic view of patient care. Focusing on patient-reported outcomes allows for meaningful care delivery that is patient-centric and patient-appropriate. This approach will also allow states to gather data across primary, secondary, and tertiary care settings including behavioral health related information instead of collecting siloed data based on subpopulations and specific conditions only. The group recommended that development of this core set of patient-centric measures should focus on the "appropriateness" of measures across settings. For example, measures should be culturally appropriate versus merely culturally competent such that the measures will take into account all beneficiaries including those with disabilities and multiple complex chronic conditions.

The Workgroup unanimously agreed that a core set of measures with robust, comprehensive data on medical, behavioral, and SDOH factors can help state Medicaid programs address their resource constraints and data needs.

Strategic Considerations for State-Level Reporting

The Adult and Child Medicaid Workgroups conducted joint deliberations regarding issues that affect measure-reporting rates along with strategies for increasing overall Core Set reporting. The discussion mainly focused on the impact of social determinants of health on care outcomes and patient experiences.

Both Adult and Childhood Workgroups identified SDOH as a way to address care quality while simultaneously minimizing disparities and increasing equity. For example, screening for and addressing food insecurity not only improves overall nutrition and health, but also health equity issues like food deserts. Additionally, considering SDOH allows measurement to focus on outcomes that are important to both populations and subpopulations of interest within Medicaid. For example, a measure may focus on maternal health and the subpopulation would be mothers with known substance use disorders. The group noted that this type of analysis—in which parsing data related to SDOH factors results in increased granularity—allows for streamlining of state-level quality improvement efforts as a way to potentially fill gaps in measurement and care.

Workgroup members suggested that state Medicaid agencies use SDOH factors to customize programs according to their unique state needs. Additionally, state Medicaid directors on the Workgroup panels encouraged states to undertake the assessment of SDOH factors in relation to disparities. For example, they recommended that people with multiple complex chronic conditions be considered a disparity-based subpopulation requiring additional services not necessary for the larger Medicaid population.

The Workgroup also discussed methodological considerations related to SDOH analysis. State Medicaid directors recommended over-sampling of the Medicaid population of interest to allow for various subanalyses based on different SDOH factors. They also suggested that states initially parse the data at the state/systems level prior to undertaking further, more granular analyses. Subsequently, states should work with their Medicaid plans and providers and modify quality improvement strategies through shared accountability. To do this successfully, states need to track important SDOH factors. However, a lack of SDOH related data as well as inadequate tracking of SDOH factors leads to a dearth of information, which ultimately hinders consideration of SDOH for quality improvement efforts. The ultimate goal is to address quality from a broad state-level perspective as well as address nuances and care needs of each subpopulation within the larger Medicaid cohort.

Finally, the Workgroup revisited and reaffirmed past recommendations regarding cross-cutting measures that interface between medical and behavioral health, while acknowledging the fact that some measurement needs are community-based and outside the purview of healthcare. The group emphasized the need for parsimony in creating a core set of cross-cutting metrics with a focus on maximizing collection of SDOH related data points. The group also reiterated and reemphasized the need to use SDOH with patient-reported outcomes.

Workgroup members discussed their new and previous recommendations with an expanded patient-centric focus that addresses nonclinical factors such as SDOH and the impact of these factors on overall care outcomes.

Conclusion

In order to meet the care needs of the nation's most medically vulnerable individuals, states require high-value performance measures to support their delivery system reform efforts and improve patient outcomes. The Adult Medicaid Workgroup provided measure recommendations for the 2019 Adult Core Set to increase the number of states voluntarily reporting on Core Set measures and increase the number of Core Set measures reported by each state. The Workgroup's recommendations were informed by state Medicaid representatives' experiences implementing and reporting on the Adult Core Set measures.

The Adult Workgroup recommended the removal of two measures included in the 2018 Adult Core Set: NQF #0476 *PC-03 Antenatal Steroids* and NQF #2082 *HIV Viral Load Suppression*. The Workgroup also recommended the addition of eight measures which address critical gap areas in the Medicaid adult population: NQF #2967 *CAHPS Home and Community-Based Services Measures*, NQF #2950 *Use of Opioids from Multiple Providers in Persons Without Cancer,* NQF #0712e *Depression Utilization of the PHQ-9 Tool,* NQF #0028 *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention,* NQF #0104e *Adult Major Depressive Disorder (MDD): Suicide Risk Assessment,* NQF #3175 *Continuity of Pharmacotherapy for Opioid Use Disorder,* NQF #2152 *Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling,* and NQF #0541 *Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category.*

MAP's recommendations for measure removal and addition reflect Workgroup members' prioritization of patient-centered outcomes and states' evolving needs. The Workgroup supported the continued use of all remaining measures included in the Core Set.

With the evolution of the Medicaid program, success in improving quality depends on maximizing data utility and harnessing the potential of addressing SDOH. This new perspective enhances previous recommendations put forth by the group. Considering SDOH increases the usefulness of data and addresses data granularity issues when looking at populations and subpopulations within Medicaid. In a patient-centered healthcare environment, collecting data on and analyzing the effect of SDOH factors on outcomes will allow Medicaid to address measurement from a holistic view that includes both clinical and nonclinical factors spanning healthcare to public health to communities and homes. This expanded perspective allows for the analysis of factors—the majority of which are outside the purview of healthcare—that significantly impact the overall health of the Medicaid population. Assessing SDOH factors will also enable the analysis of nonclinical factors such as community and patient related characteristics that shape the outcome of care more than the clinical attributes of Medicaid providers, services, and supports.

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Appendix A: MAP Background

Description

The Patient Protection and Affordable Care Act (ACA) of 2010 requires that the U.S. Department of Health and Human Services (HHS) implement an annual, federal pre-rulemaking process to provide private-sector input to the quality and efficiency measures being considered for select federal public-reporting and performance-based payment programs. Since 2011, the National Quality Forum (NQF) has convened the Measure Applications Partnership (MAP) as a multistakeholder entity to provide recommendations on measures under consideration for use in federal programs by HHS. Under statute, HHS is required to publish a list of measures under consideration for rulemaking by December 1 of each year, and MAP then provides input to HHS on those measures by February 1 of the following year.

To accomplish this, NQF uses a three-step process to elicit multistakeholder input on measures under consideration:

1. **Develop a program measure set framework.** Using CMS' critical program objectives and NQF's Measure Selection Criteria, NQF staff organize each program's finalized measure set. These frameworks will be used to better understand the current measures in the program and how well any new measures might fit into the program by allowing Workgroup members to quickly identify gaps and other areas of needs.
2. **Evaluate measures under consideration for what they would add to the program measure sets.** MAP uses the Measure Selection Criteria and a defined decision algorithm to determine whether the measures under consideration will enhance the program measure sets. Staff perform a preliminary analysis based on the algorithm, and MAP workgroups discuss their recommendations for each measure under consideration during December in-person meetings.
3. **Identify and prioritize gaps for programs and settings.** MAP continues to identify gaps in measures within each program and provide measure ideas to spur development. MAP also considers the gaps across settings, prioritizing by importance and feasibility of addressing the gap when possible.

Approach

The pre-rulemaking process allows input from stakeholders affected by or interested in the use of quality measures. This process encompasses several steps:

- Conduct an all-MAP orientation call to educate stakeholders on the role of MAP and the pre-rulemaking process;
- Convene the MAP Coordinating Committee for a strategic planning meeting in the fall to provide input on the pre-rulemaking process and issues for the setting-specific workgroups to consider;
- Convene the setting-specific workgroups for an orientation on the federal programs and conduct the feedback loop process;
- Post the list of measures under consideration on or before December 1 of each year;

- Conduct a public comment period on the measures under consideration to solicit input on them prior to the workgroups' deliberations;
- Convene the setting-specific workgroups via in-person meetings to provide initial recommendations;
- Conduct a second public comment period to obtain input on the draft recommendations;
- Convene the MAP Coordinating Committee to review public comments, review and finalize MAP recommendations, and consider strategic issues that may arise during the pre-rulemaking cycle; and
- Solicit and review nominations for the annual MAP membership nominations process.

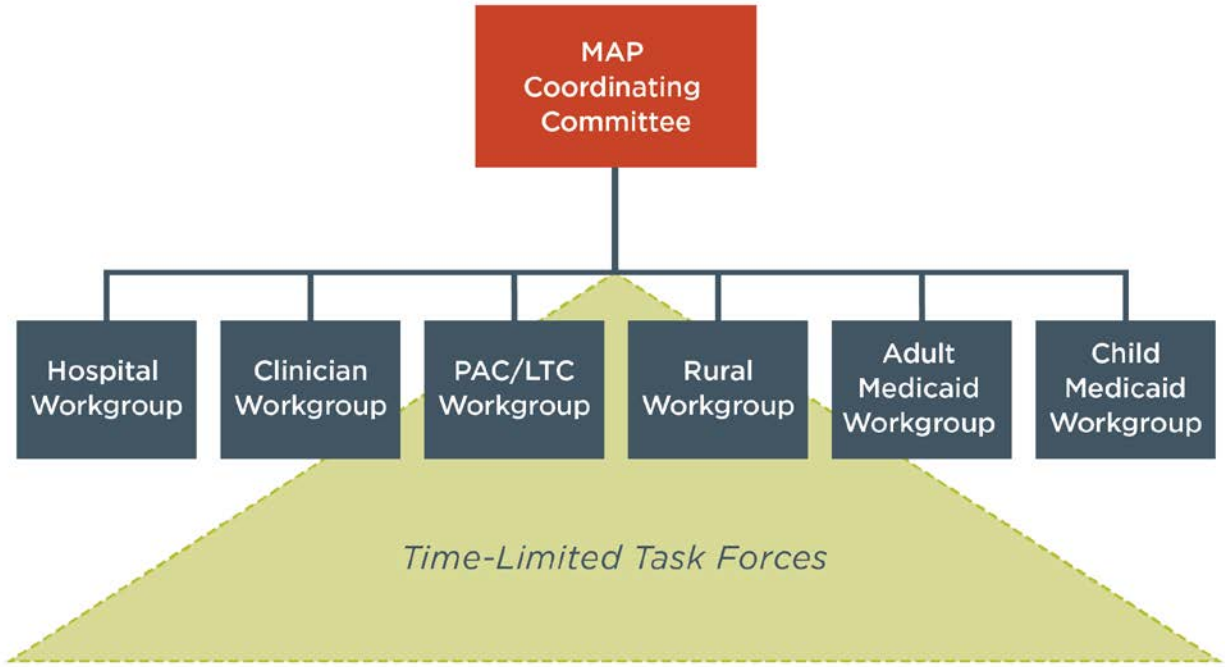
NQF solicits input on measures under consideration through a series of webinars and in-person meetings. In convening MAP, NQF brings together stakeholder groups in a unique collaboration that balances the interests of consumers, businesses and purchasers, health plans, clinicians and providers, communities and states, and suppliers. MAP's Coordinating Committee and six workgroups consist of over 150 healthcare leaders and experts representing nearly 90 organizations, subject matter experts, and seven federal agencies (as ex officio members). The co-chairs of the Medicaid workgroups participate in the setting-specific workgroups as nonvoting liaisons to share the Medicaid perspectives during discussions regarding Medicaid-relevant measures.

Input is also provided 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. Specifically, the Medicaid Adult Workgroup advises the MAP Coordinating Committee on recommendations to HHS for strengthening the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (the Adult Core Set).

Structure

MAP operates through a two-tiered structure (see Exhibit A1). The MAP Coordinating Committee provides direction to the MAP workgroups, including the Medicaid Adult and Child Workgroups, 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.

Exhibit A1. MAP Structure



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

Beginning in 2017, NQF held a formal nominations process to seat the Medicaid committees as workgroups to ensure a broader representation of Medicaid expertise. Representatives are either organizational representatives or individuals with specific subject matter expertise. Prior to this, Medicaid committees were task forces and members were drawn from the MAP Coordinating Committee and other pre-rulemaking workgroups.

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 (see MAP 2017-2018 Pre-Rulemaking Deliberations). Additionally, MAP engages in strategic activities throughout the year to inform MAP's pre-rulemaking input. Please note that the Medicaid Workgroup's deliberation happens off-cycle, (i.e., from January through August), from the rest of MAP's work.

Appendix B: Rosters for the NQF Medicaid Adult Workgroup and MAP Coordinating Committee

NQF Medicaid Adult Workgroup

CHAIRS (VOTING)
Harold Pincus, MD
Marissa Schlaifer, RPh, MS

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVE
American Association on Health and Disability	Clarke Ross, DPA
American Association of Retired Persons (AARP)	Lynda Flowers, JD, RN, MSN
American College of Obstetricians and Gynecologists (ACOG)	Michelle H. Moniz, MD, MSc
American Association of Nurse Practitioners (AANP)	Sue Kendig, JD, WHNP-BC, FAAPN
American Occupational Therapy Association	Joy Hammel, PhD
Association for Community Affiliated Plans (ACAP)	Deborah Kilstein, RN, MBA, JD
Human Services Research Institute	David Hughes, PhD
Intermountain Health	Jesse Spencer, MD
National Association of Medicaid Directors (NAMD)	Rachel La Croix, PhD
Ohio Department of Medicaid	Mary Applegate, MD

INDIVIDUAL SUBJECT MATTER EXPERTS (VOTING)	ORGANIZATION
Kim Elliott, PhD, CPHQ	Health Services Advisory Group
Diana Jolles, PhD, CNM, FACNM	Frontier Nursing University and El Rio Community Health Center
SreyRam Kuy, MD, MHS, FACS	Department of Veterans Affairs
Julia Logan, MD	California Department of Health Care
Lisa Patton, PhD	IBM Watson Health
Janice Tufte	Patient Representative
Judy Zerzan, MD	Colorado Department of Health Care Policy and Financing

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)	REPRESENTATIVE
Health Resources and Services Administration (HRSA)	Maura Maloney and Sue Lin, PhD, MS
Substance Abuse and Mental Health Services Administration (SAMHSA)	Laura Jacobus-Kantor, PhD
Centers for Medicare & Medicaid Services (CMS)	Marsha Smith, MD, MPH, FAAP

Measure Applications Partnership Coordinating Committee

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

ORGANIZATIONAL MEMBERS (VOTING)	REPRESENTATIVES
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AFL-CIO	Shaun O'Brien, JD
America's Health Insurance Plans	Rajesh Davda, MD
American Board of Medical Specialties	R. Barrett Noone, MD, FACS
American Academy of Family Physicians	Amy Mullins, MD FAAFP
American College of Physicians	Amir Qaseem, MD, PhD, MHA
American College of Surgeons	Bruce Hall, MD PhD, MBA, FACS
American HealthCare Association	David Gifford, MD, MPH
American Hospital Association	Maureen Kahn, MSN
American Medical Association	Carl Sirio, MD
American Nurses Association	Mary Beth Bresch White
AMGA	Samuel Lin, MD, PhD, MBA, MPA, MS
Consumers Union	John Bott, MSSW, MBA
Health Care Service Corporation	Derek Robinson, MD, MBA, FACEP, CHCQM
The Joint Commission	David Baker, MD, MPH, FACP
The Leapfrog Group	Leah Binder, MA, MGA
Medicare Rights Center	Joe Baker
National Alliance for Caregiving	Gail Hunt *Substitute: Grace Whiting, JD*
National Association of Medicaid Directors	Rachel LaCroix, PhD, PMP
National Business Group on Health	Steve Wojcik, MA
National Committee for Quality Assurance	Mary Barton, MD
National Partnership for Women and Families	Erin Mackay, MPH
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

EXPERTISE	INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)
Child Health	Richard Antonelli, MD, MS

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

NQF Project Staff

STAFF MEMBER	TITLE
Elisa Munthali, MPH	Senior Vice President, Quality Measurement
Debjani Mukherjee, MPH	Senior Director
Shaconna Gorham, MS, PMP	Senior Project Manager
Miranda Kuwahara, MPH	Project Manager

Appendix C: MAP Measure Selection Criteria

The Measure Selection Criteria (MSC) are intended to assist the Workgroup 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 provide general guidance on measure selection decisions and complement program-specific statutory and regulatory requirements. Central focus should be on the selection of high-quality measures that optimally address the National Quality Strategy's three aims, fill critical measurement gaps, and increase alignment. Although competing priorities often need to be weighed against one another, the MSC can be used as a reference when evaluating the relative strengths and weaknesses of a program measure set, and how the addition of an individual measure would contribute to the set.

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

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

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

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

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

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

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

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

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

Subcriterion 2.3 Affordable care

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcriterion 5.2 Measure set addresses shared 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 [PQRS], Meaningful Use for Eligible Professionals, Physician Compare)

Appendix D: MAP Medicaid Preliminary Analysis Algorithm

For the 2017-2018 cycle, to support the Workgroup's review of potential measures, NQF staff provided a preliminary analysis of all measures under consideration using the NQF Medicaid Preliminary Analysis Algorithm derived from the Measure Selection Criteria.

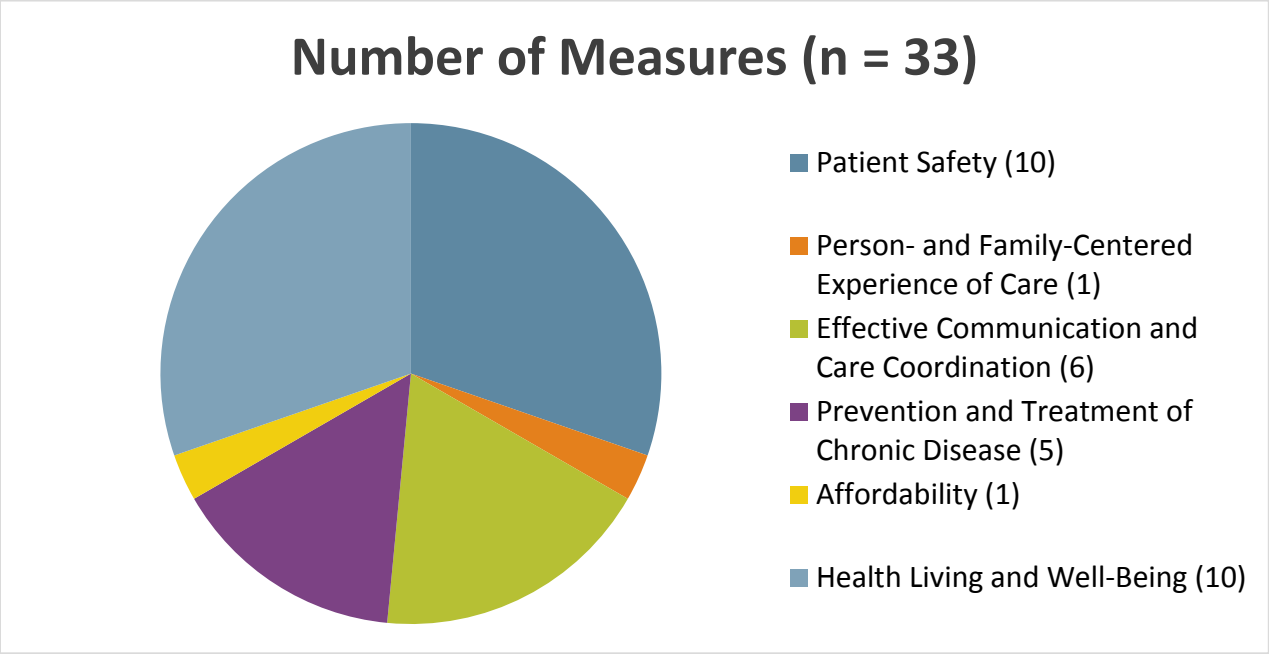
Assessment	Definition
1. The measure addresses a critical quality objective not adequately addressed by the measures in the program set.	• The measure addresses the broad aims and one or more of the six National Quality Strategy priorities; or • The measure is responsive to specific program goals and 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
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.
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.
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.

Assessment	Definition
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 constraints on the state. • Medicaid agencies at the state level can implement the measure without tweaking it and or changing the level of analysis.
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.
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.

Appendix E: Characteristics of the Current Adult Core Set

The 2018 Adult Core Set measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being and Patient Safety (Exhibit E1). Measures are not exclusive to each alignment category and can span across more than one alignment category.

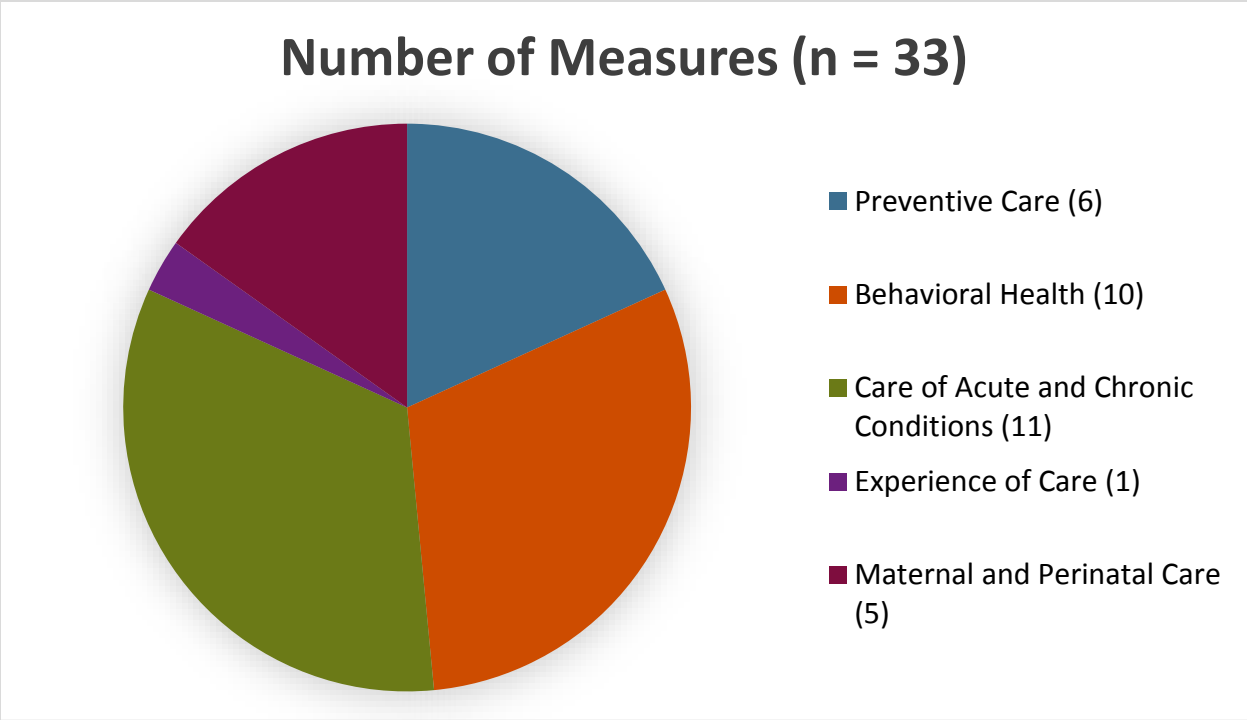
Exhibit E1. Measures in the Adult Core Set by National Quality Strategy Priority



With respect to measure types, the set contains no structural measures, 22 process measures, 10 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: 13 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).

[a] Centers for Medicare & Medicaid Services. CMS Measures Inventory. 2018. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/CMS-Measures-Inventory.html. Last accessed June 2018.

Exhibit E2. Measures in the Adult Core Set by Clinical Area



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

There are 33 measures in the 2018 Adult Core Set. The Workgroup recommended two measures for removal from the 2019 Adult Core Set and eight measures for phased addition. Exhibit F1 below lists the measures included in the 2018 version of the Adult Core Set along with their current NQF endorsement number and status, including rates of state participation in FFY 2016 reporting. The 2017 reporting data were unavailable during the 2018 review. In FFY 2018, states will voluntarily collect the Adult Core Set measures using the 2018 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 the Workgroup for potential addition to the Adult Core Set.

Exhibit F1. 2018 Adult Core Set of Measures with FFY 2016 Reporting Data

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2016 and Alignment	MAP Recommendation or Removal Rationale
0004 Endorsed **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment** Measure Steward: National Committee for Quality Assurance (NCQA)	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of patients 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 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), Merit-Based Incentive Payment System (MIPS) Program (Finalized), and Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)	Support for continued use in the program
The Adult Core Set includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006) Not NQF-Endorsed **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid)** Measure Steward: NCQA	This measure provides information on beneficiaries' experiences with their health care and gives a general indication of how well the health care meets the beneficiaries' expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates. Four global rating questions reflect overall satisfaction: • Rating of All Health Care • Rating of Health Plan • Rating of Personal Doctor • Rating of Specialist Seen Most Often Five composite scores summarize responses in key areas: • Customer Service • Getting Care Quickly • Getting Needed Care • How Well Doctors Communicate • Shared Decision Making Item-specific question summary rates are reported for the rating questions and each composite question, the "written materials/Internet provided needed information" question, and the "forms were easy to fill out" question. Question summary rates are also reported individually for two items summarizing the following concepts: • Health Promotion and Education • Coordination of Care	27 states reported FFY 2016 Alignment: N/A	Support for continued use in the program
0018 Endorsed **Controlling High Blood Pressure** Measure Steward: NCQA	The percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled during the measurement year based on the following criteria: • Patients 18-59 years of age whose blood pressure was <140/90 mm Hg. • Patients 60-85 years of age with a diagnosis of diabetes whose blood pressure was <140/90 mm Hg. • Patients 60-85 years of age without a diagnosis of diabetes whose blood pressure was <150/90 mm Hg.	26 states reported FFY 2016 Alignment: Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), and QHP QRS (Implemented)	Support for continued use in the program
0027 Endorsed **Medical Assistance With Smoking and Tobacco Use Cessation** Measure Steward: NCQA	The three components of this measure assess 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 patients 18 years of age and older who are 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 patients 18 years of age and older who are 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 patients 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.	18 states reported FFY 2016 Alignment: QHP QRS (Implemented)	Support for continued use in the program

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2016 and Alignment	MAP Recommendation or Removal Rationale
0032 **Endorsed** **Cervical Cancer Screening** Measure Steward: NCQA	Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	39 states reported FFY 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), and QHP QRS (Implemented)	Support for continued use in the program
0033 **Endorsed** **Chlamydia Screening in Women [ages 21-24]** Measure Steward: NCQA	Percentage of women ages 21 to 24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	37 stated reported FFY 2016 Alignment: 2018 Child Core Set, Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), and QHP QRS (Implemented)	Support for continued use in the program
0039 **Endorsed** **Flu Vaccinations for Adults Ages 18 to 64** Measure Steward: NCQA	Percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H Adult Survey was completed.	18 states reported FFY 2016 Alignment: QHP QRS (Implemented)	Support for continued use in the program
0057 **Endorsed** **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing** Measure Steward: NCQA	The percentage of patients 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 2016 Alignment: QHP QRS (Implemented)	Support for continued use in the program
0059 **Endorsed** **Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)** Measure Steward: NCQA	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is >9.0% during the measurement year.	24 states reported FY 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Implemented), MIPS (Finalized)	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 who were treated antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	33 states reported FFY 2016 Alignment: Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), MIPS (Finalized), QHP QRS (Implemented)	Support for continued use in the program
0272 **Endorsed** **PQI 01: Diabetes Short-Term Complications Admissions Rate** Measure Steward: Agency for Healthcare Research and Quality (AHRQ)	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.	25 states reported FFY 2016 Alignment: N/A	Support for continued use in the program
0275 **Endorsed** **PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate** Measure Steward: AHRQ	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 1,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	23 states reported FFY 2016 Alignment: N/A	Support for continued use in the program
0277 **Endorsed** **PQI 08: Congestive Heart Failure Rate** Measure Steward: AHRQ	Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions.	25 states reported FFY 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 2016 and Alignment	MAP Recommendation or Removal Rationale
0283 **Endorsed** **PQI 15: Asthma in Younger Adults Admission Rate** Measure Steward: AHRQ	Admissions for a principal diagnosis of asthma per 1,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions.	23 states reported FFY 2016 Alignment: N/A	Support for continued use in the program
0418 : 0418e **Endorsed** **Preventive Care and Screening: Screening for Depression and Follow-Up Plan** Measure Steward: Centers for Medicare & Medicaid Services (CMS)	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	7 states reported FFY 2016 Alignment: 2018 Child Core Set, Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Implemented), MIPS (Finalized)	Support for continued use in the program
0469 : 0469e **Endorsed** **PC-01: Elective Delivery** Measure Steward: The Joint Commission	This measure assesses patients with elective vaginal deliveries or elective cesarean births 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 Birth, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)	11 states reported FFY 2016 Alignment: Hospital Inpatient Quality Reporting (Implemented), Hospital Value-Based Purchasing (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals (Implemented)	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 <34 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 Birth, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	4 states reported FFY 2016 Alignment: N/A	The Workgroup recommends the removal of this measure from the Core Set. The Workgroup recommended removal to reduce duplication and burden at the state level as well as increase bandwidth for reporting other measures.
0576 **Endorsed** **Follow-Up After Hospitalization for Mental Illness: Age 21 and Older** Measure Steward: NCQA	Percentage of discharges for beneficiaries age 21 and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	36 states reported FFY 2016 Alignment: 2018 Child Core Set, Hospital Compare (Implemented), Inpatient Psychiatric Facility Quality Reporting (Implemented), Medicare Physician Quality Reporting System (Implemented), MIPS (Finalized), Physician Feedback/Quality Resource Use Report (Implemented), Physician Value-Based Payment Modifier (Implemented), QHP QRS (Implemented)	Support for continued use in the program
Not NQF-Endorsed (NQF #1517 is no longer endorsed) **Prenatal & Postpartum Care [postpartum care rate only]** Measure Steward: NCQA	Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.	37 states reported FFY 2016 Alignment: 2018 Child Core Set, QHP QRS (Implemented)	Support for continued use in the program

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2016 and Alignment	MAP Recommendation or Removal Rationale
1768 **Endorsed** **Plan All-Cause Readmissions** Measure Steward: NCQA	For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned 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* (denominator) 2. Count of 30-Day Readmissions (numerator) 3. Average Adjusted Probability of Readmission *An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).	22 states reported FFY 2016 Alignment: Hospital Inpatient Quality Reporting (No Status), QHP QRS (Implemented)	Support for continued use in the program
1800 **Endorsed** **Asthma Medication Ratio: Ages 19-64** Measure Steward: National Committee for Quality Assurance	The percentage of beneficiaries ages 19 to 64 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.	Added to the Core Set in 2018 Alignment: N/A	Support for continued use in the program
Not NQF-Endorsed **The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure (NQF #1879)** **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)** Measure Steward: National Committee for Quality Assurance	Percentage of beneficiaries ages 19 to 64 with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period during the measurement year.	30 states reported FFY 2016 Alignment: Medicare Physician Quality Reporting System (Implemented), MIPS (Finalized), Physician Feedback/Quality Resource Use Report (Implemented), Physician Value-Based Payment Modifier (Implemented)	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.	25 states reported FFY 2016 Alignment: N/A	Support for continued use in the program
2082 **Endorsed** **HIV Viral Load Suppression** Measure Steward: Health Resources and Services Administration - HIV/AIDS Bureau	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.	4 states reported FFY 2016 Alignment: Medicare Physician Quality Reporting System (Implemented), MIPS (Finalized), Physician Feedback/Quality Resource Use Report (Implemented), Physician Value-Based Payment Modifier (Implemented)	The Workgroup recommends the removal of this measure from the Core Set. The Workgroup recommended removal due to reporting challenges (e.g., data source and strict confidentiality laws associated with HIV and AIDS related clinical data).
2371 **Endorsed** **Annual Monitoring for Patients on Persistent Medications** Measure Steward: NCQA	This measure assesses the percentage of patients 18 years of age and older who received a 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 the following three rates and a total rate: • Rate 1: Annual Monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB): At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. • Rate 2: Annual monitoring for patients on diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. • Total rate (the sum of the two numerators divided by the sum of the two denominators)	32 states reported FFY 2016 Alignment: N/A	Support for continued use in the program
2372 **Endorsed** **Breast Cancer Screening** Measure Steward: NCQA	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer	35 states reported FFY 2016 Alignment: Medicare Shared Savings Program (Implemented), MIPS (Finalized), QHP QRS (Implemented)	Support for continued use in the program

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2016 and Alignment	MAP Recommendation or Removal Rationale
2605 **Endorsed** **Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or 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.	Added to the Core Set in 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.	Added to the Core Set in 2017 Alignment: N/A	Support for continued use in the program
2902 **Endorsed** **Contraceptive Care – Postpartum Women Ages 21-44** Measure Steward: U.S. Office of Population Affairs	Among women ages 21 to 44 who had a live birth, the percentage that: 1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery. 2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period. These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 60 days of delivery is used to monitor the provision of contraception throughout the postpartum period. (A 60-day period is used because the American Congress of Obstetricians and Gynecologists [ACOG] recommends a postpartum visit at 6 weeks, and two additional weeks are allowed for women whose postpartum care visit is delayed.)	Added to the Core Set in 2017 Alignment: 2018 Child Core Set	Support for continued use in the program
2903 **Endorsed** **Contraceptive Care – Most and Moderately Effective Methods: Ages 21-44** Measure Steward: U.S. Office of Population Affairs	Among women ages 21 to 44 at risk of unintended pregnancy, the percentage that: 1. Were provided a most effective or moderately effective method of contraception. 2. Were provided a long-acting reversible method of contraception (LARC). The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods. A state should exercise caution in using this measure for payment purposes, because performance on this measure is a function of a woman's preferences. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state, and see where there is room for improvement. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods.	Added to the Core Set in 2018 Alignment: 2018 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.	14 states reported in FFY 2016 Alignment: N/A	Support for continued use in the program
Not NQF-endorsed **Adult Body Mass Index Assessment** Measure Steward: NCQA	Percentage of beneficiaries 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.	33 states reported FFY 2016 Alignment: QHP QRS (Implemented)	Support for continued use in the program

Measure #, NQF Status, Title, and Steward	Measure Description	Number of States Reporting to CMS FFY 2016 and Alignment	MAP Recommendation or Removal Rationale
Not NQF-endorsed **Concurrent Use of Opioids and Benzodiazepines (COB)** Measure Steward: Pharmacy Quality Alliance (PQA)	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.	Added to the Core Set in 2018 Alignment: N/A	Support for continued use in the program

Exhibit F2. Measures Supported by the Adult Workgroup for Phased Addition to the Adult Core Set

Measures in the table are listed in the order in which the Workgroup prioritized them for inclusion. Workgroup members equally prioritized NQF #0712e *Depression Utilization of the PHQ-9 Tool* and NQF #0028 *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention* as well as NQF #2152 *Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling* and NQF #0541 *Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category*.

Measure & NQF Endorsement Status	Measure Description	Alignment	Workgroup Recommendation and Rationale
2967 Endorsed **CAHPS® Home- and Community-Based Services Measures** Measure Steward: Centers for Medicare & 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 1. Global Ratings Measures 8. Global rating of personal assistance and behavioral health staff – top-box score on a 0-10 scale 9. Global rating of homemaker – top-box score on a 0-10 scale 10. Global rating of case manager – top-box score on a 0-10 scale Recommendations Measures 11. Would recommend personal assistance/behavioral health staff to family and friends – top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 12. Would recommend homemaker to family and friends – top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 13. Would recommend case manager to family and friends – top-box score on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 14. Unmet Needs Measures 15. Unmet need in dressing/bathing due to lack of help – top-box score on a Yes, No scale 16. Unmet need in meal preparation/eating due to lack of help – top-box score on a Yes, No scale 17. Unmet need in medication administration due to lack of help – top-box score on a Yes, No scale 18. Unmet need in toileting due to lack of help – top-box score on a Yes, No scale 19. Unmet need with household tasks due to lack of help – top-box score on a Yes, No scale 20. Physical Safety Measure 21. Hit or hurt by staff – top-box score on a Yes, No scale	N/A	Support for inclusion in the 2019 Adult Core Set The Workgroup supported the inclusion of this measure, noting the need for home and community-based metrics. If added to the Core Set, this will be the only measure that addresses long-term care services provided in a community setting.

Measure & NQF Endorsement Status	Measure Description	Alignment	Workgroup Recommendation and Rationale
2950 Endorsed **Use of Opioids from Multiple Providers in Persons Without Cancer** Measure Steward: Pharmacy Quality Alliance	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	N/A	Support for inclusion in the 2019 Adult Core Set The Workgroup recommended the inclusion of this measure in the Adult Core Set because it addresses the epidemic of opioid morbidity and mortality.
0712e Endorsed **Depression Utilization of the PHQ-9 Tool** Measure Steward: MN Community Measurement	The percentage of adolescent patients (12 to 17 years of age) and adult patients (18 years of age or older) with a diagnosis of major depression or dysthymia who have a completed PHQ-9 or PHQ-9M tool during the measurement period.	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status) and Merit-Based Incentive Payment System (MIPS) Program (Finalized)	Support for inclusion in the 2019 Adult Core Set The Workgroup supported the inclusion of this measure because it supports measurement-based care, systematically assessing patients for depression over time based on their response to treatment.
0028 Endorsed **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention** Measure Steward: PCPI Foundation	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	Medicare Shared Savings Program (Implemented), Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status), and Merit-Based Incentive Payment System (MIPS) Program (Finalized)	Conditional support for inclusion in the 2019 Adult Core Set The Workgroup conditionally supported the inclusion of this measure in the Adult Core Set, pending the removal of NQF #0027 *Medical Assistance with Smoking and Tobacco Use Cessation*, which is currently in the Core Set. The Workgroup agreed NQF #0028 (and NQF #0028e) is a superior measure as the measure provides a variety of collection methods, including claims, registry, and electronic health records. In addition, #0028 includes screening and whether or not there is a cessation intervention, whereas, measure #0027 does not.
0104e Endorsed **Adult Major Depressive Disorder (MDD): Suicide Risk Assessment** Measure Steward: PCPI	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (No Status) and Merit-Based Incentive Payment System (MIPS) Program (Finalized)	The Workgroup recommended this measure for inclusion, noting the importance to measure outweighed the burden to report.
3175 Endorsed **Continuity of Pharmacotherapy for Opioid Use Disorder** Measure Steward: University of Southern California	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment	N/A	The Workgroup recommended the inclusion of this measure in the Adult Core Set, emphasizing that it addresses retention and care.
2152 Endorsed **Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling** Measure Steward: PCPI Foundation	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	Medicare Physician Quality Reporting System (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized), Physician Feedback/Quality Resource Use Report (Finalized), Physician Value-Based Payment Modifier (Finalized)	The Workgroup supported this measure for inclusion in the Adult Core Set because of its importance to measure, despite the burden to report and broad definition of qualifying screening assessment.
0541 Endorsed **Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category** Measure Steward: Pharmacy Quality Alliance	The percentage of patients 18 years and older who met the proportion of days covered (PDC) threshold of 80% during the measurement year. A performance rate is calculated separately for the following medication categories: Renin Angiotensin System (RAS) Antagonists, Diabetes Medications, Statins. A higher score indicates better quality.	Medicare Part D Star Rating (Implemented)	The Workgroup agreed that this measure is important because successful treatment of chronic conditions requires consistent medication management and patient adherence to prescribed medications.

Appendix G: Additional Measures Considered

The Adult Workgroup discussed but did not ultimately recommend the addition of eleven measures to the 2019 Core Set. The Workgroup either voted on these measures and did not achieve the consensus threshold (>60 percent of voting members) to gain support or conditional support for use in the Adult Core Set or the measures did not receive two motions of support from Workgroup members to initiate a vote. The Workgroup needed to limit the number of measures it supported for the sake of parsimony and practicality; lack of support for these measures does not indicate that the measures are flawed or unimportant. These measures and others could be reconsidered during a future review of the Adult Core Set.

NQF Measure Number	Measure Title	Measure Steward
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	Agency for Healthcare Research and Quality
0055	Comprehensive Diabetes Care: Eye Exam (retinal) performed	National Committee for Quality Assurance
0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	National Committee for Quality Assurance
0097	Medication Reconciliation Post-Discharge	National Committee for Quality Assurance
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Centers for Medicare & Medicaid Services
0575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	National Committee for Quality Assurance
0710e	Depression Remission at Twelve Months	MN Community Measurement
0711	Depression Remission at Six Months	MN Community Measurement
0726	Patient Experience of Psychiatric Care as Measured by the Inpatient Consumer Survey (ICS)	National Assoc. of State Mental Health Program Directors Research Institute, Inc. (NRI)
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	National Committee for Quality Assurance
N/A	Treatment of Chronic Hepatitis C: Completion of Therapy	Pharmacy Quality Alliance

Appendix H: Withdrawn Measures

NQF solicited Adult Workgroup members' measure recommendations for addition and removal prior to the in-person meeting and requested that they serve as the lead discussants for their measures during deliberations. Four lead discussants withdrew six measures preliminarily recommended for addition and two measures preliminarily recommended for removal based on measure discussions, input from the states, or CMS' feedback on the Core Set's architecture.

NQF Measure Number	Measure Title	Measure Steward	Recommendation Type
0275	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI 05)	Agency for Healthcare Research and Quality	Removal
0277	Congestive Heart Failure Rate (PQI 08)	Agency for Healthcare Research and Quality	Removal
0326	Advance Care Plan	National Committee for Quality Assurance	Addition
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	National Committee for Quality Assurance	Addition
1934	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	National Committee for Quality Assurance	Addition
1888	Workforce Development Measure Derived from Workforce Development Domain of the C-CAT	American Medical Association	Addition
1892	Individual Engagement Measure Derived from the Individual Engagement Domain of the C-CAT	American Medical Association	Addition
2483	Gains in Patient Activation (PAM) Scores at 12 Months	Insignia Health	Addition

Appendix I: Key Gap Areas in the Adult Core Set

The Adult Workgroup identified several gap areas in the Adult Core Set of measures. Newly identified gap areas are denoted with an asterisk (*). All other gap areas presented below are recurring gap areas identified by the Task Forces in previous review years.

Behavioral Health and Integration with Primary Care

- Integration of substance use disorders with mental health*

Assessing and Addressing of Social Determinants of Health

- Disparities and equity focused measures in conjunction with 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
- Interpregnancy*

Planning And Transition To Well Woman Care*

- Minimize low value care

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
- Perception of care*

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