NATIONAL QUALITY FORUM

# Measure Applications Partnership: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2015

*DRAFT REPORT FOR PUBLIC COMMENT*

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## Executive Summary

Together, Medicaid and the Children's Health Insurance Program (CHIP) cover more than 45 million children, which is more than 1 in every 3, and half of all low-income children in the United States.[1,2] Medicaid plays a key role in child and maternal health, financing about 40 percent of all births, on average, across the country.[3] Improving the health and healthcare of children enrolled in Medicaid and CHIP is an important opportunity and a priority for our nation.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP. The 2015 Child Core Set contains 24 measures representing the diverse health needs of the Medicaid and CHIP enrollee population, spanning many clinical topic areas. The measures are relevant to children ages 0-18 as well as pregnant women in order to encompass both prenatal and postpartum quality of care issues. CHIPRA also requires CMS to update the initial core set annually to ensure the best available measures are being used. Changes to the Child Core Set of measures are informed by the Measure Applications Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF). MAP provides input to HHS on the use of performance measures to assess and improve the quality of care. Guided by MAP's Measure Selection Criteria and feedback from several years of state implementation, MAP is providing its latest round of annual recommendations to HHS for strengthening and revising measures in the Child Core Set and identifying high-priority measure gaps.

Not finding significant implementation difficulties, MAP supported all of the FFY 2015 Child Core Set measures for continued use. In addition, MAP recommends that CMS consider up to six measures for phased addition. MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all measures supported by MAP is highly unlikely. Therefore, MAP rank ordered the measures it supports.

### *EXHIBIT ES1: MEASURES RECOMMENDED BY MAP FOR PHASED ADDITION TO THE CHILD CORE SET*

| Rank | Measure Name and NQF Number, if applicable |
|---|---|
| 1/2 (tie) | NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care<br>Use of Multiple Concurrent Antipsychotics in Children and Adolescents (not NQF endorsed) |
| 3 | Effective Postpartum Contraception Access (not NQF endorsed) |
| 4 | Use of Contraceptive Methods by Women Aged 15-20 Years (not NQF endorsed) |
| 5/6 (tie) | NQF #1360: Audiological Evaluation No Later Than 3 Months of Age<br>NQF #2393: Pediatric All-Condition Readmission Measure |

MAP recognizes many important priorities for quality measurement and improvement do not yet have metrics available to address them. MAP documented these gaps in the Core Set as a starting point for future discussions. They will guide annual revisions to further strengthen the Child Core Set.

## Introduction and Purpose

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

The MAP Medicaid Child Task Force advises the MAP Coordinating Committee on recommendations to HHS for strengthening and revising measures in the Core Set of Health Care Quality Measures for Children Enrolled in Medicaid and CHIP (Child Core Set), with a focus on addressing high-priority measure gaps. The task force consists of MAP members from the MAP Coordinating Committee and MAP workgroups with relevant interests and expertise (Appendix B).

Guided by the MAP Measure Selection Criteria (MSC) (Appendix C), MAP considered states' experiences as they continue to voluntarily implement the measures in the Child Core Set. To inform MAP's review, the Centers for Medicare & Medicaid Services (CMS) provided summaries of the number of states reporting each measure, deviations from the published measure specifications, the number and type of technical assistance requests states submitted, and actions taken in response to questions and challenges. This report summarizes select states' feedback on collecting and reporting measures as it was presented to MAP during the Task Force's deliberations. It also includes measure-specific recommendations to fill high-priority gaps (Appendix D). In addition, MAP identified several strategic issues related to the programmatic context for the Child Core Set and its relationship to the Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set).

This is MAP's second set of recommendations on the Child Core Set; it follows an Expedited Review performed in 2014. It evaluates the measures in CMS' Child Core Set being used in FFY 2015 and recommends changes that would be effective for FFY 2016 reporting. The annual process has allowed for a deeper understanding of the Medicaid landscape, the measures in use, and how states engage with the program. HHS uses MAP's findings, including the state perspectives, to inform the statutorily required annual update of the Child Core Set.

## Background on Medicaid and the Child Core Set

Currently covering more than 45 million children, Medicaid is the largest health insurance program in the U.S. and the primary health insurance program for low-income individuals.[4,5] CHIP provides coverage to children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. Both Medicaid and CHIP are financed through federal-state partnerships; each state designs and operates its own programs within federal guidelines.[6]

### Medicaid and CHIP Benefits for Children and Pregnant Women

Together, Medicaid and CHIP cover more than 45 million children, which is more than 1 in every 3, and half of all low-income children in the United States.[7,8] Medicaid plays a key role in child and maternal

health, financing about 40 percent of all births, on average, across the states.[9] The federal government sets minimum guidelines for Medicaid eligibility, but states can choose to expand coverage beyond the minimum threshold. Most states have elected to provide Medicaid to children with family incomes above the minimum of 100 percent of the Federal Poverty Level (FPL).[10] The FPL is determined by family size: it is $24,250 for a family of four in 2015.[11] As of April 2015, 28 states (including the District of Columbia) covered children in families with incomes at or above 250 percent FPL.[12] Additional background on Medicaid and CHIP structure and benefits for children and pregnant women was presented to MAP and is accessible in the report from the 2014 review.[13]

## Health Issues for Children in Medicaid and CHIP

Understanding the health-related needs of children in Medicaid and CHIP contributes to the selection of appropriate measures across the continuum of child health. While most children are healthy and the focus of their care is on strong development and prevention of disease, it is important to consider with equal attention the group of children with complex health needs. Approximately two-thirds of all children with complex health needs are covered by Medicaid, accounting for about 6 percent of the total number of children with Medicaid. However, this 6 percent of enrollees incur nearly 40 percent of costs.[14]

Poor birth outcomes have a disproportionately strong impact in the Medicaid population, and MAP discussed in detail the downstream negative effects of births resulting from unintended and/or closely spaced pregnancies. Risks associated with these types of pregnancies include inadequate or delayed prenatal care, premature birth, and low birthweight, among others.[15] More than half of hospital stays related to short gestation, low birth weight, or inadequate fetal growth are covered by Medicaid.[16]

The risk of pregnancy-related complications, including maternal and infant mortality, can be reduced by increasing access to high-quality care before and between pregnancies, also known as preconception and interconception care.[17] Many stakeholders, including state Medicaid agencies, are working to improve the availability and uptake of effective contraceptive methods, including long-acting reversible contraceptives (LARCs).[18] MAP's focus on this issue mirrors that of the public health field. For example, the Healthy People 2020 campaign aims to reduce unintended pregnancy in the United States by 10%, from 49% of pregnancies to 44% of pregnancies.[19]

Children with behavioral health issues also deserve special attention in measurement due to their complex health needs and the impact they have on Medicaid utilization and spending. MAP explored the issue of access to appropriate behavioral health services and the rising prescription of psychotropic medications for publicly insured children.[20] Behavioral health experts are especially concerned about the recent increase in prescribing of antipsychotic drugs, in part because of their very serious side effects including rapid weight gain and the increased risk for the development of diabetes.[21] Studies have shown that on average, 6.2 percent of non-institutionalized children with Medicaid took psychotropic medications during a calendar year, and 21 percent of those children took an antipsychotic medication.[22] It was separately estimated that antipsychotic use increased from 8.9 percent in 2002 to 11.8 percent in 2007 and that state-specific rates of prescribing increased in 45 states over the same time period.[23]

## Background and Use of the Child Core Set

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for the identification of a core set of healthcare quality measures for children enrolled in Medicaid and CHIP. CMS and the Agency for Healthcare Research and Quality (AHRQ) jointly charged a group of experts with creating this core set of measures in 2009.[24] The measures contained within the core set are relevant to children ages 0-18 as well as pregnant women in order to encompass both prenatal and postpartum quality of care issues. Additionally, the Adult Core Set did not yet exist when the initial Child Core Set was published.

CMS' three-part goal for the Child Core Set is to increase the number of states reporting Core Set measures, increase the number of measures reported by each state, and increase the number of states using Core Set measures to drive quality improvement. States voluntarily submit data to CMS once annually. CMS then uses the Child Core Set data to obtain a snapshot of quality across Medicaid and CHIP and to inform policy and program decisions. Data from the core set are also presented in several publications each year, including the annual child health quality report and other analyses such as chart packs.[25,26]

## Characteristics of the Current Child Core Set

CHIPRA also required CMS to update the initial core set annually beginning in January 2013. For the 2015 update, CMS issued changes that were informed by MAP's 2014 review and input. Following MAP's recommendation, CMS removed the measure Percentage of Eligibles That Received Dental Treatment Services and replaced it with the NQF-endorsed measure #2508 Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk. CMS also followed MAP's recommendation to add #1365 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment to augment the emphasis on behavioral health issues. Additionally, CMS has decided to pilot test the pediatric version of the Hospital Consumer Assessment of Healthcare Providers and Systems survey (Child HCAHPS) to determine how to aggregate the data for state-level reporting before full inclusion into the Core Set. Not including Child HCAHPS, the 2015 version of the Child Core Set contains a total of 24 measures (Appendix D).[27]

The 2015 Child Core measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 1).

*EXHIBIT 1: MEASURES IN THE CHILD CORE SET BY NATIONAL QUALITY STRATEGY PRIORITY*

| National Quality Strategy Priority | Number of Measures in the 2015 Child Core Set (n = 24) |
|---|---|
| Patient Safety | 1 |
| Person- and Family-Centered Experience of Care | 1 |
| Effective Communication and Care Coordination | 3 |
| Prevention and Treatment of Chronic Disease | 0 |
| Healthy Living and Well-Being | 17 |
| Affordability | 2 |

Viewed as an array of measure types, the set contains no structural measures, 21 process measures, 3 outcome measures, and 1 experience of care measure. Additionally, the Child Core Set is well-aligned with other quality and reporting initiatives: nine of the measures are used in one or more federal programs, including the Medicaid Adult Core Set and the Health Insurance Marketplace Quality Rating System Measure Set.[28] Representing the diverse health needs of the Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 2).

*EXHIBIT 2: MEASURES IN THE CHILD CORE SET BY CLINICAL AREA*

| Clinical Areas | Number of Measures (n = 24) |
|---|---|
| Access to Care | 1 |
| Behavioral Health | 3 |
| Care of Acute and Chronic Conditions (e.g., Asthma, Obesity) | 3 |
| Experience of Care | 1 |
| Maternal and Perinatal Care | 6 |
| Oral Health | 2 |
| Preventive Care | 8 |

## State Experience Collecting and Reporting the Core Set

MAP gathered feedback on the implementation of the Child Core Set from states that participated in reporting and the 2014 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP.[29] Representatives from Medicaid agencies in Louisiana and Minnesota shared their implementation experiences, measure-specific challenges, and quality improvement successes related to reporting the Child Core Set. Additionally, they provided feedback on strategic issues and measure gap areas to guide MAP's decisionmaking. These perspectives are a sample and not necessarily representative of all state Medicaid programs, but they were informative to MAP's measure-specific and strategic recommendations for the Child Core Set in support of CMS' three-part goal.

### Louisiana

In the state of Louisiana more than one million residents receive health care coverage through Medicaid, most of whom are children younger than 19.[30] Since June 2012 almost all children and pregnant women with Medicaid have been enrolled in a managed care benefit plan. On the whole, Louisiana's residents have below-average income and the state consistently finds itself at or near the bottom of health rankings.[31]

During the first year of participation in the Children's Health Quality Measures reporting program, Louisiana submitted six measures in the Child Core Set to CMS. With the belief that measurement processes can evolve and improve over time, state staff worked diligently to increase the number of measures reported each year. To do so, Louisiana built new capacities by partnering with public health agencies and other partners in the state. The agency also made significant strides in linking vital records and immunization registry information to their Medicaid data to enable the reporting of more measures. Louisiana was able to report an additional ten additional measures in 2014.

Representatives from Louisiana identified several measure-specific challenges to reporting the Child Core Set. The chart review process is expensive and time-consuming; the state has worked through multiple strategies to determine the most efficient ways of obtaining necessary medical records to support measurement. Measures based on administrative data are less burdensome. Additionally, the process of building trust in the provider network is slow but necessary; clinicians need tools and understandable data to drive improvement at the individual practice level.

Representatives from Louisiana also recommended to CMS and MAP that the core set include measures that address premature birth, as it influences a lifetime of health outcomes and is itself very costly. Specifically, the panelists urged more widespread access to progesterone for women at risk of a premature delivery. Representatives also suggested MAP consider measures of Attention Deficit Hyperactivity Disorder (ADHD), noting the geographic variation and potential overuse they have observed in their state.

## Minnesota

The state of Minnesota provides Medicaid-funded health care to more than 700,000 low-income Minnesotans each month. Three-fourths of the enrollees are children and families, pregnant women, and adults without children.[32] Both the state's CHIP and Medicaid programs use a managed care delivery system.

During the past three consecutive years of participation, Minnesota submitted five measures in the Child Core Set to CMS. To select and report these measures, state officials considered accountability, potential for quality improvement, population comparison, known health disparities, and development policy. Likewise, the state representative observed that making a concerted effort to improve quality on 3-4 measures at a time is all the state can realistically prioritize; though they could report additional measures.

Staff from Minnesota emphasized the need for vertical integration of measures and advised MAP and CMS to support measures that are meaningful to providers. The state and its delivery system partners have had success in reducing early elective delivery rates, in part because this quality improvement opportunity was perceived as actionable. Minnesota also identified opiate exposure for neonates, behavioral health functional outcomes stemming from trauma-informed care, and care coordination/case management to address social determinants as measure gaps in the Child Core Set.

## MAP Review of the Child Core Set

MAP reviewed the measures in the Child Core Set to provide recommendations to strengthen the measure set in support of CMS' goals for the program. Guided by MAP's Measure Selection Criteria (MSC) (Appendix C) and feedback from several years of state implementation, MAP carefully evaluated current measures. The MSC are not absolute rules, rather, they provide general guidance for selecting measures that would contribute to a balanced measure set. The MSC dictate that the measure set should address the National Quality Strategy's three aims, be responsive to specific program goals, and include an appropriate mix of measure types, among other factors.

MAP also used the MSC to review currently available measures and identify those with the best potential to fill gaps in the current set. Using measure gap areas identified in the 2014 review as a starting place, NQF staff compiled and presented measures in the following topic areas: cost as represented by hospital readmissions, care coordination, measures in the inpatient care setting, maternal/perinatal care, and behavioral health. MAP specifically discussed a small number of measures staff judged to be a good fit for the Core Set largely based on their specifications, and the MSC, and the feasibility of implementing them for statewide quality improvement. All MAP Task Force members also had the opportunity to raise other available measures for discussion and consideration.

MAP examined NQF-endorsed measures and other measures in the development pipeline. MAP generally favored measures that are able to be implemented at the state level, promote parsimony and alignment, and address prevalent and/or high-impact health conditions for children enrolled in Medicaid and CHIP. NQF endorsed measures were also favored because they have been successfully evaluated through a separate consensus-based process for importance, evidence, scientific acceptability of measure properties, and other rigorous criteria. Following discussion of each measure, MAP voted to determine if there was sufficient support from Task Force members to consider it for addition to the Core Set.

NQF has not yet endorsed measures in all relevant topic areas. For example, MAP reviewed measures newly developed under the auspices of the AHRQ-CMS Pediatric Quality Measures Program (PQMP). This grant program was established under CHIPRA to increase the portfolio of evidence-based, consensus-driven pediatric quality measures available to the field.[33] A small number of PQMP measures have completed endorsement review and it is likely that many more will be submitted and reviewed for endorsement in the coming year. Monitoring the development of new measures will continue to be relevant for future annual reviews.

### Measure-Specific Recommendations

#### *Current Measures*

Not finding any significant implementation problems with the current measure set, MAP supported all of the FFY 2015 Child Core Set for continued use. No measures were recommended for removal. In general, MAP considers removing a measure when the following factors are observed:

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

Maintaining stability in the measure set will allow states to continue to gain experience reporting the measures, potentially increasing the number of states using the measures to drive quality improvement locally. MAP encourages continued focus on data fidelity and strategies to improve the completeness of data reported by states on an annual basis.

### *Measures for Phased Addition to the Child Core Set*

MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set (Exhibit 3, below, and Appendix D). These measures passed the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support. Measures that are not currently NQF endorsed are supported conditionally; MAP recommends that CMS add them to the programs once endorsement review is complete. The use of the recommended measures would strengthen the measure set by promoting measurement of a variety of high-priority quality issues, including maternity care and behavioral health. MAP is aware that additional federal and state resources are required for each new measure; immediate addition of all measures supported by MAP is highly unlikely. Therefore, MAP rank ordered the measures it supports.

*EXHIBIT 3: MEASURES RECOMMENDED FOR PHASED ADDITION TO THE CHILD CORE SET*

| Ranking | Measure Number and Title | MAP Recommendation |
|---|---|---|
| 1/2 (tie) | #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care | Support |
| | *Not NQF endorsed:* Use of multiple concurrent antipsychotics in children and adolescents | Conditional Support, pending successful NQF endorsement |
| 3 | *Not NQF endorsed:* Effective Postpartum Contraception Access | Conditional Support, pending successful NQF endorsement |
| 4 | *Not NQF endorsed:* Use of Contraceptive Methods by Women Aged 15-20 Years | Conditional Support, pending successful NQF endorsement |

| Ranking | Measure Number and Title | MAP Recommendation |
|---|---|---|
| 5/6 (tie) | #1360: Audiological Evaluation no later than 3 months of age (EHDI-3)<br><br>#2393: Pediatric All-Condition Readmission Measure | Support<br><br>Support |

MAP conducted a lengthy discussion of the maternal and perinatal care measures because of the central importance of reproductive health for female Medicaid enrollees and their children. Measures in this topic area are currently included in both the Child Core Set and Adult Core Set of measures. The group reviewed a large volume of available measures to determine which measures would be the most effective additions to state-level reporting, emphasizing three with a tie to improving birth outcomes. MAP also recommended measures in other subject areas that are important for improving quality for children with Medicaid and CHIP. Discussion of those measures follows the maternal/perinatal measures.

### NQF #0477: Under 1500g Infant Not Delivered at Appropriate Level of Care

This measure was previously recommended during MAP's 2014 review. This year MAP's prioritization placed the measure at the top of the list, tying with the measure of multiple concurrent antipsychotic medications. Measure 0477 captures the frequency at which low birth weight babies are delivered at hospitals that are not ideally equipped to care for them. Availability of a Level 3 neonatal intensive care unit is associated with better outcomes for low birthweight infants.[34] The measure indicates missed opportunities to provide guidance for women with high-risk pregnancies and coordinate care regionally across facilities.

### Not NQF Endorsed: Effective Postpartum Contraception Access

This measure assesses the utilization of postpartum contraception for women who have had a live birth. Members noted the importance of family planning, specifically that pregnancy within a year of giving birth is associated with an increased risk of placental abruption, preterm birth, and other negative effects. MAP members commented that one important aspect of the measure is that it can be stratified by the time period during which the consumer was prescribed contraception, including during the hospital stay immediately following birth. Seeking alignment across programs, MAP also conditionally supported this measure for addition to the Adult Core Set.

### Not NQF Endorsed: Use of Contraceptive Methods by Women Aged 15-20 Years

This measures the rate of contraceptive use among young women who could experience unintended pregnancy. It complements a related measure of a different age group (21-44) that MAP conditionally supported for the Adult Core Set. The measure captures use of both moderately (e.g., injectables) and highly (e.g., LARC) effective forms of contraception. After detailed discussion of potential ethical implications and strong agreement that the target rate for this measure would be well below 100%, MAP conditionally supported the measure and recommended that it be reviewed by NQF for endorsement.

### Not NQF Endorsed: Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Stakeholders have become increasingly concerned about rising rates of psychoactive medication use in the pediatric population and the risks associated with those classes of drugs. While psychotropic medications are an integral part of current evidence-based treatment for mental illness, studies have found high levels of potentially inappropriate psychotropic drug use by Medicaid enrollees that places these individuals at increased risk for adverse health events and death, particularly for children.[35] After reviewing several measures that evaluate different aspects of this problem, MAP conditionally supported NCINQ's measure of the rate at which children and adolescents are prescribed multiple antipsychotic medications. MAP intended this measure to enhance the presence of mental and behavioral health in the program. Because the measure uses administrative data, has been tested at the state level, and is included in the HEDIS program, MAP members agreed that feasibility of reporting would be relatively high.

### NQF #1360: Audiological Evaluation No Later Than 3 Months of Age (EHDI-3)

MAP supported the addition of NQF measure #1360 to increase prompt follow-up care for infants who do not pass an initial hearing screening performed in a hospital. After learning that 2012 performance data on this measure is only 69%, an opportunity to improve quality became obvious. MAP agrees this measure is an important indicator of access. In terms of alignment, the measure is also a part of the electronic health record incentive program.

### NQF #2393: Pediatric All-Condition Readmission Measure

With support from the PQMP, the Center of Excellence for Pediatric Quality Measurement developed a case-mix-adjusted rate of hospital readmissions occurring within 30 days. MAP supported this measure to enhance measurement of potentially avoidable costs to Medicaid. MAP members also felt the addition of this measure to the Child Core Set could improve discharge planning, coordination across settings, and integration with community services and supports. This measure is harmonized with #1768 Plan All-Cause Readmission Rate, which is included in the Adult Core Set. The pediatric version includes all conditions and covers patients discharged from general acute care hospitals, including children's hospitals.

## Recommendations to Address High Priority Gaps

Many important priorities for quality measurement and improvement do not yet have metrics available to address them. MAP discusses and documents these gaps in current measures to communicate its vision for the future of measurement to the developer community. Additionally, the list of measure gaps will be a starting point for future discussions and will guide annual revisions to further strengthen the Child Core Set. The Core Set includes measures related to some of the topics below, but MAP did not perceive them as comprehensive. Other gap areas were first identified during MAP's 2014 review. An asterisk (*) denotes newly identified gap areas.

### *Child Core Set Measure Gaps*

- Care coordination
    - Home- and community-based care

    - Social services coordination
    - Cross-sector measures that would foster joint accountability with the education and criminal justice systems*
- Screening for abuse and neglect
- Injuries and trauma
- Mental health
    - Access to outpatient and ambulatory mental health services
    - ED use for behavioral health
    - Behavioral health functional outcomes that stem from trauma-informed care*
- Overuse/medically unnecessary care
    - Appropriate use of CT scans
- Durable medical equipment (DME)
- Cost measures
    - Targeting people with chronic needs
    - Families' out-of-pocket spending
- Sickle-cell disease*
- Patient-reported outcome measures*
- Dental care access for children with disabilities – could stratify current measures*

## Strategic Issues

For its 2015 review of the Child and Adult Core Sets, MAP conducted joint deliberations of the Medicaid Adult Task Force and the Medicaid Child Task Force to better explore shared issues of strategic importance. These included alignment of measures across programs, the approach to selecting measures that will maximize health outcomes, and enabling quality improvement activities within states.

### Alignment

The Child Core Set and Adult Core Set reporting programs were authorized by separate pieces of legislation, at separate times, but CMS and states generally regard them as working together to provide a picture of quality across Medicaid. The two sets differ in the measures they include because of the distinctly different health and medical needs of the pediatric and adult populations, but as we increasingly adopt a lifespan view of wellness, it becomes especially clear that the two measurement efforts should be synchronized to the extent possible.

Alignment of measures has macro-level considerations. Across the health system, but especially in the context of resource-constrained state Medicaid programs, investments in quality measurement and improvement have a finite budget. Often this forces trade-offs between competing priorities. When measures in the Adult and Child Core Sets are also used in other programs relevant to Medicaid, efficiencies are gained by reducing the number of measures that need to be collected. State panelists emphasized the importance of alignment with HEDIS, health insurance exchanges, Medicaid health homes, and Meaningful Use incentive programs, in particular. Another essential aspect of alignment is

the use of the same measurement specifications in each of the programs, unless there are compelling reasons why they should be different. When measures are edited by one program and not others, it has the effect of reducing comparability and potentially adding burden and complexity to data collection and reporting.

MAP's discussion also acknowledged that if alignment is over-emphasized, it could lead to a few measures having an outsized effect on provider behavior. For example, if a small number of measures become part of multiple influential programs, it could have the effect of sharpening focus on them to the detriment of other opportunities. When measures are used across multiple programs simultaneously, it is especially important that they warrant the compounded incentives. Measures best suited for widespread use should be able to influence desirable health outcomes, as opposed to minute process steps.

The choice of measures for the Child and Adult Core Sets has specific consequences for CMS and for states. The CMS technical specifications manual for state-level reporting is released once annually. Following its release, states need time to program systems and plan for data collection. MAP members heard that this can involve negotiation with one or more contractors and potentially greater expense. For these and other reasons, states prefer to use measures that can satisfy multiple reporting requirements. Program experience to date demonstrates that it takes at least two years, and often longer, for a measure to experience significant uptake across states. CMS refrains from publishing performance data publicly until they have at least 25 states reporting on a given measure. As a result, the full utility of the measure is not realized until this threshold of participation is met.

## Reproductive Health

One of Medicaid's core functions is to ensure that pregnant women and young children have access to health services that are vital for a healthy birth and lifelong wellness. Female reproductive health care continues from puberty to menopause, and the health outcomes of a woman and her child or children are highly intertwined. As a result, MAP considered measurement of reproductive health across the lifespan and its implications for both the Child and Adult Core Sets.

The measure of chlamydia screening appears in both core sets, with different age groups reported in each one. The placement of other measures in the maternal and perinatal health area reflects the historical artifact that the creation of the Child Core Set preceded the Adult Core Set. As a general but imperfect rule of thumb, measures relating more to the mother's health appear in the Adult Core Set and those that relate more to the infant's health are in the Child Core Set. MAP conducted extensive discussion to ensure that the division of measures in this manner was not artificially limiting quality measurement. Age ranges captured in both core sets should include all relevant populations impacted by the care being measured. For example, MAP advised that adult core set measures need to include all pregnancies, even if the Medicaid enrollee is a teenager outside of the age range that would otherwise be considered part of adult measurement.

Reproductive health is already the most frequently measured topic across the Child and Adult Core Sets, and MAP's 2015 recommendations would further expand it. Measures of contraceptive access and use

gained strong, albeit conditional, support from MAP because of the robust and growing evidence that well-timed, intentional pregnancies are associated with better health outcomes for both the mother and the infant. Additionally, there is significant opportunity for improvement and cost effectiveness in this area. For example, eleven states have made specific policy changes to encourage placement of long-acting reversible contraception immediately postpartum, with the potential for others to follow.

## Increasing State-Level Capacity for Quality Improvement

### *Peer-to-Peer Learning and Collaboration*

State panelists' presentations of lessons learned from participation in reporting yielded strategic information that is potentially relevant to others. For example, "data not available" was the most frequently reported reason for not reporting the majority of measures. States cited budget constraints, lack of staff capacity, data sources that are not easily accessible, or information is required for the measure that is not routinely collected. However, states that have made investments in building information infrastructure have overcome this barrier by creating a variety of data linkages. Leadership and political will are necessary precursors, as are savvy partnerships with the public health sector, academia, providers, and others in the delivery system. MAP encourages CMS to enhance states' abilities to communicate with each other through the technical assistance available in the reporting program.

### *Strategies to Understand and Address Disparities*

MAP discussed the nature of health disparities within the Medicaid-enrolled population and observed several types: across states, across enrollee sub-populations including racial/ethnic groups and people with disabilities, and across diagnosis groups such as individuals with mental illness. Medicaid enrollees, by virtue of their low income, are already a group that experiences inequities in health and healthcare, and the other factors only compound the situation.

Stratification of measures by such factors of interest is one strategy that can be used to better understand and address disparities. For example, MAP members suggested that states and CMS more deeply examine the performance of the oral health measures in the Child Core Set by stratifying results for children with special healthcare needs. High-quality, appropriate dental care for children with disabilities and/or behavioral health challenges is a well-documented area needing improvement. Different strata could be created for other measures, as appropriate. Once made transparent, any disparities discovered are better able to be understood and addressed with targeted action.

### *Appropriate Performance Benchmarks*

States requested support from CMS and other partners in the measurement enterprise to better understand and set performance benchmarks for their measures. This is especially relevant for states implementing pay-for-performance models with contracted health plans. Benchmarks that are too high or too low fail to motivate quality improvement action. Incentives need to be designed to be achievable but enough of a stretch to produce meaningful change. Furthermore, MAP members suggested that setting a reasonable benchmark in place of highly complex denominator exclusions—especially those

that require medical record review to derive—would be a less burdensome way to implement a variety of measures.

MAP discussed that setting appropriate performance expectations is especially important for measures where 100% compliance is either unrealistic or potentially harmful. This is the case for the conditionally supported measures of contraceptive use, though it applies to other topics as well. The framing of how the measures should be interpreted is both important and sensitive to many stakeholder groups. It must be abundantly clear that by measuring rates of contraceptive use, the program would not be setting a universal expectation that all women should use contraceptives. Many women, in collaboration with their healthcare providers, choose to forego contraception for a variety of reasons. It is imperative that this choice be honored. However, far too many women who are interested in avoiding or delaying pregnancy lack access to effective family planning education and resources. To use a less politically charged example, measurement of emergency department utilization would be expected to operate in much the same way. The expectation of the measure is not to reach zero percent; rather, it is to ensure that consumers are able to have routine health needs met in less costly and less acute environments before conditions are exacerbated to the point that urgent treatment is required.

## Conclusion

With more than a third of the nation's children receiving healthcare through Medicaid and CHIP, it is crucial for the program to be delivering high-quality health care. MAP's recommendations to HHS are intended to strengthen the program measure set and support CMS's goals for states' participation in the Child Core Set reporting program. MAP members found the information offered by state representatives about their implementation experiences to be highly valuable in grounding the deliberations.

To maintain stability in the measure set, MAP supports all measures in the current Child Core Set for continued use, encouraging continued focus on state-driven quality improvement projects and data accuracy and completeness. To address critical measure gap areas identified during the review, MAP recommends that CMS consider up to six measures for phased addition to the Child Core Set. MAP also refined and expanded its list of gap areas for future action.

MAP also emphasized the importance of considering the relationship of the measures across the Child and Adult Core Sets, especially regarding high-impact conditions like perinatal care and behavioral health. Aligned measures will result in less burdensome data collection, and ultimately better rates of state reporting. MAP will continue to collaborate with CMS as infrastructure is enhanced to support states' efforts to gather, report, and analyze data that informs quality improvement initiatives.

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# Appendix A: MAP Background

## Purpose

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

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

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

MAP's objectives are to:

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

## Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning

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

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

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

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

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

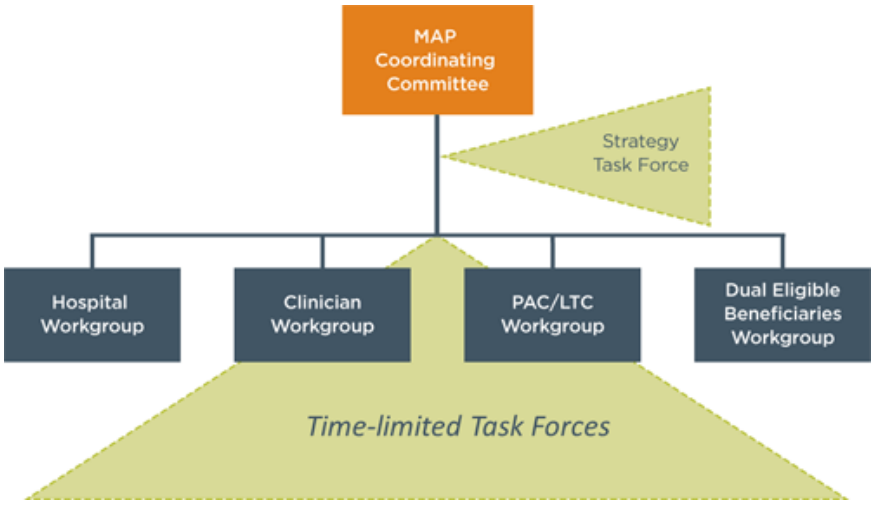
**Impact and Evaluation.** Performance measures are important tools to monitor and encourage progress on closing performance gaps. Determining the intermediate and long-term impact of performance measures will elucidate whether measures are having their intended impact and are driving improvement, transparency,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

## Structure

MAP operates through a two-tiered structure (see Exhibit A1). The MAP Coordinating Committee provides direction to the MAP workgroups and task forces and provides final input to HHS. MAP workgroups advise the Coordinating Committee on measures needed for specific care settings, care providers, and patient populations. Time-limited task forces charged with developing "families of measures"—related measures that cross settings and populations—and a multiyear strategic plan

provide further information to the MAP Coordinating Committee and workgroups. Each multistakeholder group includes representatives from public- and private-sector organizations particularly affected by the work and individuals with content expertise.

*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 meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

## Timeline and Deliverables

MAP convenes each winter to fulfill its statutory requirement of providing input to HHS on measures under consideration for use in federal programs. MAP workgroups and the Coordinating Committee meet in December and January to provide program-specific recommendations to HHS by February 1 (see MAP 2015 Pre-Rulemaking Deliberations). Additionally, MAP engages in strategic activities throughout the year to inform MAP's pre-rulemaking input. To date MAP has issued a series of reports that:

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

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

### MAP Medicaid Child Task Force

| CHAIRS (VOTING) |
|---|
| Foster Gesten, MD |

| ORGANIZATIONAL MEMBERS (VOTING) | REPRESENTATIVE |
|---|---|
| Aetna | Sandra White, MD, MBA |
| American Academy of Family Physicians | Alvia Siddiqi, MD, FAAFP |
| American Academy of Pediatrics | Terry Adirim, MD, MPH, FAAP |
| American Nurses Association | Susan Lacey, RN, PhD, FAAN |
| American's Essential Hospitals | Denise Cunill, MD, FAAP |
| Blue Cross and Blue Shield Association | Carole Flamm, MD, MPH |
| Children's Hospital Association | Andrea Benin, MD |
| Kaiser Permanente | Jeff Convissar, MD |
| March of Dimes | Cynthia Pellegrini |
| National Partnership for Women and Families | Carol Sakala, PhD, MSPH |

| INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING) |
|---|
| Luther Clark, MD |
| Anne Cohen, MPH |
| Marc Leib, MD, JD |

| FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO) | REPRESENTATIVE |
|---|---|
| Agency for Healthcare Research and Quality | Denise Dougherty, PhD |
| Health Resources and Services Administration | Ashley Hirai, PhD |
| Office of the National Coordinator for Health IT | Kevin Larsen, MD, FACP |

### NQF Project Staff

| STAFF MEMBERS | TITLE |
|---|---|
| Sarah Lash | Senior Director |
| Shaconna Gorham | Senior Project Manager |
| Nadine Allen | Project Manager |
| Severa Chavez | Project Analyst |

## MAP Coordinating Committee

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

| ORGANIZATIONAL MEMBERS (VOTING) | REPRESENTATIVES |
|---|---|
| AARP | Joyce Dubow, MUP |
| Academy of Managed Care Pharmacy | Marissa Schlaifer, RPh, MS |
| AdvaMed | Steven Brotman, MD, JD |
| AFL-CIO | Shaun O'Brien |
| American Board of Medical Specialties | Lois Margaret Nora, MD, JD, MBA |
| American College of Physicians | Amir Qaseem, MD, PhD, MHA |
| American College of Surgeons | Frank Opelka, MD, FACS |
| American Hospital Association | Rhonda Anderson, RN, DNSc, FAAN |
| American Medical Association | Carl Sirio, MD |
| American Medical Group Association | Sam Lin, MD, PhD, MBA |
| American Nurses Association | Marla Weston, PhD, RN |
| America's Health Insurance Plans | Aparna Higgins, MA |
| Catalyst for Payment Reform | Shaudi Bazzaz, MPP, MPH |
| Consumers Union | Lisa McGiffert |
| Federation of American Hospitals | Chip Kahn |
| Healthcare Financial Management Association | Richard Gundling, FHFMA, CMA |
| The Joint Commission | Mark R. Chassin, MD, FACP, MPP, MPH |
| LeadingAge (formerly AAHSA) | Cheryl Phillips, MD, AGSF |
| Maine Health Management Coalition | Elizabeth Mitchell |
| National Alliance for Caregiving | Gail Hunt |
| National Association of Medicaid Directors | Foster Gesten, MD, FACP |
| National Business Group on Health | Steve Wojcik |
| National Committee for Quality Assurance | Margaret E. O'Kane, MHS |
| National Partnership for Women and Families | Alison Shippy |
| Pacific Business Group on Health | William Kramer, MBA |
| Pharmaceutical Research and Manufacturers of America (PhRMA) | Christopher Dezii, RN, MBA,CPHQ |

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

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

## Appendix C: MAP Measure Selection Criteria

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

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

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

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

**Sub-criterion 1.2** Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs

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

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

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

**Sub-criterion 2.1** Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment

**Sub-criterion 2.2** Healthy people/healthy communities, demonstrated by prevention and well-being

**Sub-criterion 2.3** Affordable care

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

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

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

**Sub-criterion 3.2** Measure sets for public reporting programs should be meaningful for consumers and purchasers

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

**Sub-criterion 3.4** Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program

**Sub-criterion 3.5** Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

**Sub-criterion 4.1** In general, preference should be given to measure types that address specific program needs

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

**Sub-criterion 4.3** Payment program measure sets should include outcome measures linked to cost measures to capture value

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

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

**Sub-criterion 5.1** Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination

**Sub-criterion 5.2** Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives

**Sub-criterion 5.3** Measure set enables assessment of the person's care and services across providers, settings, and time

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

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

**Sub-criterion 6.1** Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)

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

### *7. Program measure set promotes parsimony and alignment*

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

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

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

## Appendix D: Current Child Core Set and MAP Recommendations for Addition

In February 2011, HHS published the initial core set of quality measures for children enrolled in Medicaid and CHIP. The authorizing legislation also requires HHS to publish annual changes to the Child Core Set beginning in January 2013. Exhibit D1 below lists the measures included in the 2015 version of the Child Core Set along with their current NQF endorsement number and status, including rates of state participation in 2013 reporting. Not finding any significant implementation problems, MAP recommended all measures currently in the Child Core Set continue to be used. In FFY 2015, states will be voluntarily collecting the Child Core Set measures using the 2015 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 D2 lists the measures supported by MAP for potential addition to the Child Core Set.

### *EXHIBIT D1. CHILD CORE SET OF MEASURES FOR FFY 2015 REPORTING*

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| 0024 Endorsed<br><br>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)<br><br>Measure Steward: National Committee for Quality Assurance | Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year:<br><br>• Body mass index (BMI) percentile documentation<br>• Counseling for nutrition<br>• Counseling for physical activity | 25 states reported FY 2013<br><br>Alignment: HEDIS, Meaningful Use Stage 2 – Eligible Professionals (MU-EP), Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier, Health Insurance Exchange–Quality Rating System (HIX-QRS) |
| 0033 Endorsed<br><br>Chlamydia Screening in Women (CHL)<br><br>Measure Steward: National Committee for Quality Assurance | The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. | 37 states reported FY 2013<br><br>Alignment: HEDIS, Medicaid Adult Core Set, MU-EP, PQRS, Physician Value-Based Payment Modifier, HIX-QRS |

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| 0038 Endorsed<br><br>Childhood Immunization Status (CIS)<br><br>Measure Steward: National Committee for Quality Assurance | Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B(HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. | 34 states reported FY 2013<br><br>Alignment: HEDIS, MU-EP, PQRS, HRSA program(s), Physician Value-Based Payment Modifier |
| 0108 Endorsed<br><br>Follow-Up Care for Children Prescribed ADHD Medication (ADD)<br><br>Measure Steward: National Committee for Quality Assurance | The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.<br><br>• Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.<br>• Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended. | 31 states reported FY 2013<br><br>Alignment: HEDIS, MU-EP, PQRS, Physician Value-Based Payment Modifier |

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| 0139 Endorsed<br><br>National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure<br><br>Measure Steward: Centers for Disease Control and Prevention | Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations:<br><br>• Intensive Care Units (ICUs)<br>• Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations<br>• other inpatient locations. (Data from these locations are reported from acute care general hospitals (including specialty hospitals), freestanding long term acute care hospitals, rehabilitation hospitals, and behavioral health hospitals. This scope of coverage includes but is not limited to all Inpatient Rehabilitation Facilities (IRFs), both freestanding and located as a separate unit within an acute care general hospital. Only locations where patients reside overnight are included, i.e., inpatient locations. | 41 states reported FY 2013<br><br>Alignment: Hospital Acquired Condition Reduction Program, Hospital Compare, Hospital Inpatient Quality Reporting, Hospital Value-Based Purchasing, Long-term Care Hospital Quality Reporting, PPS-Exempt Cancer Hospital Quality Reporting |
| 0471 Endorsed<br><br>PC-02 Cesarean Section<br><br>Measure Steward: Joint Commission | This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding). | 17 states reported FY 2013<br><br>Alignment: N/A |
| 0576 Endorsed<br><br>Follow-Up After Hospitalization for Mental Illness (FUH)<br><br>Measure Steward: National Committee for Quality Assurance | The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:<br><br>• The percentage of discharges for which the patient received follow-up within 30 days of discharge<br><br>• The percentage of discharges for which the patient received follow-up within 7 days of discharge. | 28 states reported FY 2013<br><br>Alignment: HEDIS, Medicaid Adult Core Set, Inpatient Psychiatric Hospital Quality Reporting, HIX-QRS |

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| 1365 Endorsed<br><br>Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment<br><br>Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) | Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk | 0 states reported FY 2013 (New for 2015)<br><br>Alignment: MU-EP; Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier |
| 1382 Endorsed<br><br>Percentage of low birthweight births<br><br>Measure Steward: Centers for Disease Control and Prevention | The percentage of births with birth weight <2,500 grams | 21 states reported FY 2013<br><br>Alignment: N/A |
| 1391 Endorsed<br><br>Frequency of Ongoing Prenatal Care (FPC)<br><br>Measure Steward: National Committee for Quality Assurance | Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits:<br><br>•<21 percent of expected visits<br>•21 percent–40 percent of expected visits<br>•41 percent–60 percent of expected visits<br>•61 percent–80 percent of expected visits<br>•> or =81 percent of expected visits | 27 states reported FY 2013<br><br>Alignment: HEDIS |
| 1392 Endorsed<br><br>Well-Child Visits in the First 15 Months of Life (W15)<br><br>Measure Steward: National Committee for Quality Assurance | Percentage of patients who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. Seven rates are reported:<br><br>•No well-child visits<br>•One well-child visit<br>•Two well-child visits<br>•Three well-child visits<br>•Four well-child visits<br>•Five well-child visits<br>•Six or more well-child visits | 44 states reported FY 2013<br><br>Alignment: HEDIS |

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| 1407 Endorsed<br><br>Immunizations for Adolescents (IMA)<br><br>Measure Steward: National Committee for Quality Assurance | The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday. | 31 states reported FY 2013<br><br>Alignment: HEDIS |
| 1448 Endorsed<br><br>Developmental Screening in the First Three Years of Life<br><br>Measure Steward: Oregon Health & Science University | The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age. | 20 states reported FY 2013<br><br>Alignment: N/A |
| 1516 Endorsed<br><br>Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)<br><br>Measure Steward: National Committee for Quality Assurance | Percentage of patients 3–6 years of age who received one or more well-child visits with a PCP during the measurement year. | 47 states reported FY 2013<br><br>Alignment: HEDIS, HIX-QRS |
| 1517 Endorsed<br><br>Prenatal & Postpartum Care (PPC)*<br><br>Measure Steward: National Committee for Quality Assurance<br><br>*Child Core Set includes "Timeliness of Prenatal Care" rate only. "Postpartum Care" rate is evaluated in Medicaid Adult Core Set. | The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.<br><br>• Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.<br><br>• Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. | 27 states reported FY 2013<br><br>Alignment: HEDIS, Medicaid Adult Core Set, HIX-QRS |

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| 1799 Endorsed<br><br>Medication Management for People with Asthma (MMA)<br><br>Measure Steward: National Committee for Quality Assurance | The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.<br><br>1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.<br><br>2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period. | 23 states reported FY 2013<br><br>Alignment: HEDIS |
| 1959 Endorsed<br><br>Human Papillomavirus Vaccine for Female Adolescents (HPV)<br><br>Measure Steward: National Committee for Quality Assurance | Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. | 23 states reported FY 2013<br><br>Alignment: HEDIS |
| 2508 Endorsed<br><br>Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk<br><br>Measure Steward: American Dental Association on behalf of the Dental Quality Alliance | Percentage of enrolled children in the age category of 6-9 years at "elevated" risk (i.e., "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year. | 0 states reported FY 2013 (New for 2015)<br><br>Alignment: N/A |
| N/A Not Endorsed<br><br>Maternity Care: Behavioral Health Risk Assessment<br><br>Measure Steward: AMA-PCPI/NCQA/ACOG | Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening | 2 states reported FY 2013<br><br>Alignment: N/A |

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| N/A Not Endorsed<br><br>Children and Adolescents' Access to Primary Care Practitioners<br><br>Measure Steward: NCQA | The percentage of children 12 months –19 years of age who had a visit with a primary care practitioner. Four separate percentages are reported: Children 12 through 24 months and children 25 months through 6 years who had a visit with a primary care practitioner during the measurement year; Children 7 through 11 years and adolescents 12 through 19 years who had a visit with a primary care practitioner during the measurement year or the year prior to the measurement year. | 45 states reported FY 2013<br><br>Alignment: HEDIS |
| N/A Not Endorsed<br><br>Adolescent Well-Care Visits<br><br>Measure Steward: NCQA | The percentage of enrolled adolescents 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. | 43 states reported FY 2013<br><br>Alignment: HEDIS, HIX-QRS |
| N/A Not Endorsed<br><br>Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0, Child Version<br><br>Measure Steward: NCQA | This measure provides information on parents' experience with their child's health care for population of children with chronic conditions. Results include same ratings, composites, and individual question summary rates as reported for the CAHPS Health Plan Survey 4.0H, Child Version. Three CCC composites summarize satisfaction with basic components of care essential treatment, management and support of children with chronic conditions. 1. Access to Specialized Services; 2. Family Centered Care: Personal Doctor Who Knows Child; 3. Coordination of Care for CCC. Question summary rates also reported individually for summarizing the following two concepts: 1. Access to Prescription Medicines; 2. Family Centered Care: Getting Needed Information. Five composite scores summarize responses in key areas: 1. Customer Service; 2. Getting Care Quickly: 3. Getting Needed Care: 4. How Well Doctors Communicate; 5. Shared Decision Making. | 41 states reported FY 2013<br><br>Alignment: HEDIS, HIX-QRS |
| N/A Not Endorsed<br><br>Percentage of Eligible Children Who Received Preventive Dental Services<br><br>Measure Steward: CMS | The percentage of individuals ages one to twenty years old eligible for Medicaid or CHIP Medicaid Expansion programs (that is, individuals eligible to receive EPSDT services) who received preventive dental services. | 49 states reported FY 2013<br><br>Alignment: N/A |

| Measure Number and NQF Endorsement Status | Measure Description | Number of States Reporting to CMS FFY 2013 and Alignment |
|---|---|---|
| N/A Not Endorsed<br><br>Ambulatory Care: Emergency Department Visits<br><br>Measure Steward: NCQA | The rate of emergency department visits per 1,000 member months among children up to age 19. | 32 states reported FY 2013<br><br>Alignment: HEDIS |

### *EXHIBIT D2. MEASURES SUPPORTED BY MAP FOR ADDITION TO THE CHILD CORE SET*

Measures in the table are listed in the order in which MAP prioritized them for inclusion.

| Measure Number and NQF Endorsement Status | Measure Description | Alignment | MAP Recommendation and Rationale |
|---|---|---|---|
| 0477 Endorsed<br><br>Under 1500g infant Not Delivered at Appropriate Level of Care<br><br>Measure Steward: California Maternal Quality Care Collaborative | The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant. | N/A | Support addition of this measure to the program.<br><br>Enhances perinatal measures and would improve regional care coordination for high-risk pregnancies. |
| *Not NQF endorsed*<br><br>Use of multiple concurrent antipsychotics in children and adolescents<br><br>Measure Steward: AHRQ-CMS CHIPRA National Collaborative for Innovation in Quality Measurement (NCINQ) | The number per 1,000 livebirths of <1500g infants delivered at hospitals not appropriate for that size infant. | HEDIS | Conditionally support addition of this measure to the program pending successful NQF endorsement.<br><br>Addresses the challenges in tracking and measuring behavioral health issues in children. |

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| *Not NQF endorsed*<br><br>Effective Postpartum Contraception Access<br><br>Measure Steward: TBD | The percentage of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the utilization of postpartum contraception.<br><br>Part A: Highly effective postpartum contraception access. The percentage of women who received contraceptives such as implants, intrauterine devices or systems (IUD/IUS), or female sterilization within 99 days after birthing.<br><br>Part B: Moderately effective postpartum contraception access. The percentage of women who received contraceptives such as injectables, oral pills, patch, or ring within 99 days after birthing. | N/A | Conditionally support addition of this measure to the program pending successful NQF endorsement.<br><br>Enhances perinatal measures and would reduce the risk of pregnancy-related complications by increasing access to high-quality care before and between pregnancies. |
| *Not NQF endorsed*<br><br>Use of Contraceptive Methods by Women Aged 15-20 Years<br><br>Measure Steward: Centers for Disease Control and Prevention/Office of Population Affairs | The percentage of women aged 15-20 years who are at risk of unintended pregnancy and who:<br><br>1) Adopt or continue use of the most effective or moderately effective FDA-approved methods of contraception.<br><br>2) Adopt or continue use of a long-acting reversible method of contraception (LARC).<br><br>The first measure is an intermediate outcome measure, and it is desirable to have a high proportion of women at risk of unintended pregnancy using most or moderately effective contraceptive methods. The second measure is an access measure, and the focus is on making sure that some minimal proportion of women have access to LARC methods. | N/A | Conditionally support addition of this measure to the program pending successful NQF endorsement.<br><br>Enhances perinatal measures and would reduce unplanned pregnancies as well as the risk of pregnancy-related complications by increasing access to high-quality care before and between pregnancies. |

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| 1360 Endorsed<br>Audiological Evaluation no later than 3 months of age (EHDI-3)<br>Measure Steward: Centers for Disease Control and Prevention | This measure assesses the percentage of newborns who did not pass hearing screening and go on to have an audiological evaluation no later than 3 months of age. | N/A | Support addition of this measure to the program.<br>Ensures that children enrolled in Medicaid receive follow-up care for an important developmental risk factor. |
| 2393 Endorsed<br>Pediatric All-Condition Readmission Measure<br>Measure Steward: Center of Excellence for Pediatric Quality Measurement | This measure calculates case-mix-adjusted readmission rates, defined as the percentage of admissions followed by 1 or more readmissions within 30 days, for patients less than 18 years old. The measure covers patients discharged from general acute care hospitals, including children's hospitals. | N/A | Support addition of this measure to the program.<br>Addresses important opportunity for quality improvement and additional cost associated with hospital readmission. |