MEASURE APPLICATIONS PARTNERSHIP

Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2016

FINAL REPORT

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QUALITY FORUM

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CONTENTS

EXECUTIVE SUMMARY

Together, Medicaid and the Children's Health Insurance Program (CHIP) cover more than 45 million children, including half of all low-income children in the United States.[1,2] Medicaid plays a key role in child and maternal health, financing healthcare services for approximately 48 percent of all births 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) requires the identification of a core set of healthcare quality measures for voluntary reporting by state Medicaid and CHIP programs. The 2016 Child Core Set contains **26 measures** representing the diverse health needs of the Medicaid and CHIP enrollee population, spanning many clinical topic areas, such as oral health, behavioral health, and maternal and perinatal care. The measures are relevant to children from birth to age 18, as well as pregnant women. The Centers for Medicare & Medicaid Services (CMS) is required to update the Child Core Set annually to ensure that the best available measures are being used.

The National Quality Forum (NQF) convenes the Measure Applications Partnership (MAP), a public-private collaboration of healthcare stakeholders, to provide input to the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for use in public reporting and performance-based payment programs. In this report, MAP provides its third set of annual recommendations to HHS for improving the Child Core Set of measures for Medicaid and CHIP, with a focus on addressing high-priority measurement gaps. MAP also provides recommendations to HHS on measures in the Adult Core Set of measures, as well as measures to assess the quality of healthcare for low-income Americans eligible for both Medicaid and Medicare.

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

- MAP recommends removal of NQF #1391 Frequency of Ongoing Prenatal Care, citing the measure as an ineffective tool for either accountability or quality improvement as it more likely reflects challenges women face when trying to obtain prenatal care (such as taking time off work and transportation) rather than the capacity of healthcare providers, health plans, or state Medicaid programs to provide access to prenatal care. MAP noted that another measure, NQF #1517 Prenatal & Postpartum Care (PPC) currently in both the Adult and Child Core Sets, is a better tool to assess access to prenatal care.
- MAP also recommends removal of a measure assessing child and adolescent access to primary care practitioners, because performance on the measure, which is not NQF-endorsed, was very high overall and presents a limited opportunity for improvement. MAP notes that there are other, more meaningful measures of access to care in the Core Set, such as measures that draw from patient experience surveys that include questions about access to care.

MAP supports the addition of five measures to the Child Core Set. These five measures were considered to be a good fit for the core set and were selected out of a total of 13 measures discussed by the Child Medicaid Task Force. The use of these measures would strengthen the core set by promoting measurement of various high-priority quality issues, including maternity care, behavioral health, and sickle cell disease. The gradual addition of measures to the core set has allowed states to build measure reporting infrastructure as evidenced by the increase in the number of states voluntarily reporting on measures. Voluntary reporting of measures for both Medicaid and CHIP has increased from 38 states in federal fiscal year (FFY) 2012 to 41 states in FFY 2013 and 44 states in FFY 2014.[4] Acknowledging the need for additional federal and state resources for each new measure, MAP rank-ordered the measures for phased addition to the current core set.

EXHIBIT ES1. MEASURES RECOMMENDED BY MAP FOR PHASED ADDITION TO THE CHILD CORE SET

Rank	Measure name and NQF number, if applicable
1	**NQF #2797**: Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia
	NQF #0480: PC-05 Exclusive Breast Milk Feeding (Conditional Support*)
	NQF #2830: PC-05 Exclusive Breast Milk Feeding (e-measure) (Conditional Support*)
2	**NQF #2801**: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
3	**NQF #2902**: Contraceptive Care – Postpartum (Conditional Support*)

* MAP has conditionally supported measures that are pending endorsement by NQF, undergoing a change by the measure steward, or have not received CMS confirmation of feasibility.

MAP recognizes that many important priorities for quality measurement and improvement do not yet have metrics available to address them. MAP identified measure gaps in the areas of care integration, adolescent transition to adult-focused healthcare, care coordination with community services, trauma care, exposure to adverse experiences, substance abuse, and health insurance coverage. These gaps, in addition to those identified in previous reports, will serve as a starting point for future discussions and will guide annual revisions to further strengthen the Child Core Set.

MAP discussed challenges faced by states in implementing the Core Set and, at the same time, recognized the need for adding measures in gap areas. The MAP Medicaid Adult Task Force and Medicaid Child Task Force members and invited state representatives together explored shared issues affecting the assessment of quality in Medicaid as well as successful, state-level adoption and use of Medicaid Core Set measures. Themes discussed included the characteristics and purpose of measures in the core sets, data availability and accessibility issues, the opportunities of innovation, the impact of collaborative learning, and state participation. Embedded in these discussions were issues and opportunities related to data collection challenges, balancing different types of measurement, and overall quality improvement goals.

MAP advocates for measuring "what matters most" and addressing issues related to alignment, care coordination, and community linkage. The discussion about alignment was extended this year to include policy aspects and implications of alignment, care coordination, and linkage with community supports and services. These concepts were discussed within the larger framework of healthcare and with respect to the recommendations and implications of the Institute of Medicine's *Vital Signs Core Metrics for Health and Health Care Progress* report.[5] The Task Forces also addressed alignment from a practical perspective by recommending that NQF measure #1799: Medication Management for People with Asthma—already in the Child Core Set—be considered for addition to the Adult Core Set as well.

MAP encouraged CMS to continue to engage and support states in efforts to adopt and report on measures. This recommendation recognizes the considerable innovation underway to implement measures at the state level. Ultimately, any core set adoption and reporting activities need to balance the cost of implementation versus benefits gained at the local, state, and national levels to improve care for Medicaid enrollees. Resources must be devoted to allow for and foster continuous quality improvement at all levels. Finally, successful innovation, implementation, and reporting of both core sets will require adequate and consistent financial investments that mirror actual resource needs.

MAP received numerous public comments on the draft recommendations for the Child Core Set. Comments were in support of or against the measure selection changes recommended by MAP. Commenters also reflected the need for more patient-centric measures in the core sets in order to effectively change healthcare quality. In addition, comments addressed many of the policy and strategic issues noted in the report, including alignment of measures across programs, need for a parsimonious approach to recommending and selecting measures for core sets, data collection challenges related to infrastructure and interoperability of health information systems, as well as the voluntary nature of the core sets.

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 healthcare quality measures for children enrolled in Medicaid and CHIP (referred to as the 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 selected 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 healthcare quality measures for adults enrolled in Medicaid (referred to as the Adult Core Set).

This is MAP's third set of recommendations on the Child Core Set; it follows a review performed in 2015. It evaluates the measures in CMS's 2015 Child Core Set, but used data from the Federal Fiscal Year (FFY) 2014 reporting cycle. MAP recommends changes that would be effective for the 2017 Child Core Set.

BACKGROUND ON MEDICAID AND THE CHILD CORE SET

Currently covering more than 43 million children, Medicaid is the largest health insurance program in the United States and the primary health insurance program for low-income individuals.[6,7] 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.[8]

Medicaid and CHIP Benefits for Children and Pregnant Women

Together, Medicaid and CHIP cover more than one in every three children, and half of all low-income children in the United States.[9,10] Medicaid plays a key role in child and maternal health across the states. In 2010, Medicaid financed healthcare services for approximately 48 percent of all births.[11] 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).[12] For 2016, the FPL is $24,300 for a family of four.[13] As of April 2016, 48 states and the District of Columbia covered children in families with incomes at or above 200 percent FPL, with 18 states extending eligibility to greater than 300% FPL.[14]

States establish and administer their own Medicaid programs but are required to offer certain mandatory benefits, in addition to choosing to provide other optional benefits. All children enrolled in Medicaid are entitled to the comprehensive set of healthcare services known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). This benefit provides comprehensive and preventive healthcare services for children under age 21 who are enrolled in Medicaid. The preventive focus of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early, before they become more complex and their treatment more costly.[15] Although pharmacy coverage is an optional benefit under federal Medicaid law, all states currently provide coverage for outpatient prescription drugs to all eligible individuals and to most other enrollees within their Medicaid programs.[16]

CHIP also ensures a comprehensive set of benefits for children, but states have flexibility to design the benefit package depending on how the CHIP program operates. Each state can design its CHIP program in one of three ways: as an expansion of the Medicaid program, as a separate Child Health Insurance Program, or as a combination of the two approaches. If it is a Medicaid Expansion CHIP program, it will provide the standard Medicaid benefit package, including EPSDT. Separate CHIP programs can provide either benchmark coverage or benchmark-equivalent coverage where benefits are tailored to meet the needs of specific Medicaid populations.[17]

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. Medicaid covers approximately two-thirds of all children with complex health needs, accounting for approximately 6 percent of the total number of children with Medicaid and nearly 40 percent of Medicaid spending on children.[18]

Approximately 100,000 Americans have sickle cell disease (SCD), and it disproportionately affects African-American and Hispanic-American children with SCD diagnoses occurring for one out of every 365 black or African-American births and 1 out of every 16,300 Hispanic-American births.[19] Without intervention, 11 percent of children with sickle cell anemia will have a stroke by age 20, and the risk of stroke is most significant between ages 2 and 5.[20] A child with SCD has a stroke risk that is 333 times greater than that of a healthy child without SCD or heart disease.[21] In children with "abnormal" transcranial Doppler (TCD) studies, the risk is more than 3,000 times greater. To date, transcranial Doppler (TCD) is the only method available to identify those who are at high risk for developing a stroke.[22]

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. Consequences associated with these types of pregnancies include inadequate or delayed prenatal care, premature birth, and low birthweight, among others.[23] Medicaid covers more than half of hospital stays related to short gestation, low birth weight, or inadequate fetal growth.[24] Breastfeeding carries many health benefits for mothers and babies, as well as potential economic and environmental benefits for communities. Among the known health benefits are balanced nutritional intake, some protection against common childhood infections, and better survival during the first year of life, including a lower risk of Sudden Infant Death Syndrome.[25] Similarly, increased access to high-quality care between pregnancies can reduce the risk of pregnancy-related complications, including maternal and infant mortality.[26]

Similar to SCD, asthma imposes significant burden on patients, families, and society, and it is also one of the most common chronic diseases. Asthma prevalence increased from 7.3 percent in 2001 to 8.4 percent in 2010.[27] In 2010, an estimated 25.7 million people had asthma: 18.7 million adults aged 18 and over, and 7 million children aged 0-17 years.[28] Children aged 0-17 years had higher asthma prevalence (9.5 percent) than adults aged 18 and over (7.7 percent) for the period 2008-2010.[29] During its 2015 review, MAP received comments that alternative asthma medication management measures, NQF #1800 Asthma Medication Ratio (AMR) and NQF #0548 Suboptimal Asthma Control (SAC) and Absence of Controller Therapy (ACT), may be superior to NQF #1799 Medication Management for People with Asthma. Because MAP did not have the opportunity to conduct a detailed review of the suggested measures prior to issuing the 2015 recommendations, MAP decided to examine all of the asthma measures during this year's annual review of the Child and Adult Core Sets. MAP reviewed and discussed each measure and concluded that NQF #1800 did not have a significant advantage over NQF #1799, so MAP did not support having two measures in this area given that measurement gaps persist in other important topic areas.

Children with behavioral health issues also deserve special attention in measurement due to their vulnerability, complex health needs, and the impact they have on Medicaid spending. MAP explored the issue of access to appropriate behavioral health services and the rising use of psychotropic medications for publicly insured children.[30] Behavioral health experts are especially concerned about the recent increase in prescribing of antipsychotic drugs, in part because of their serious side effects, including rapid weight gain and the increased risk for the development of diabetes.[31] Studies have shown that on average, 6.2 percent of noninstitutionalized children in Medicaid took psychotropic medications during a calendar year, and 21 percent of those children took an antipsychotic medication.[32] It was separately estimated that antipsychotic use among children eligible for Medicaid and foster care 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 period.[33]

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.[34] The measures contained within the core set are relevant to children ages 0-18 as well as pregnant women. The Adult Core Set did not yet exist when the initial Child Core Set was published.

CMS's 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.[35,36]

CMS has launched several initiatives in collaboration with states to increase reporting and use of specific measures in the core sets (i.e., Adult Core Set and Child Core Set) for improvement, including:

- **Oral Health Initiative**. Tooth decay, or dental caries, is one of the most common chronic diseases of children. The disease is almost entirely preventable through a combination of good oral health habits at home, a healthy diet, and early and regular use of preventive dental services. The primary objective for the Oral Health Initiative is to increase by 10 percentage points the proportion of children receiving a preventive dental service (PDENT). This measure (PDENT) assesses the percentage of children ages 1 to 20 that received preventive dental services. For FFY 2014, a median of 48 percent of children ages 1 to 20 had a preventable dental service (n = 50 states + District of Columbia). For FFY 2018, the national goal is 52 percent; however, each state has its own baseline and goal.

- **Maternal and Infant Health Initiative.** Postpartum visits provide an opportunity to assess women's physical recovery from pregnancy and childbirth, and to address chronic health conditions, mental health status, and family planning. They also provide an opportunity for counseling on nutrition and breastfeeding and other preventive health issues. CMS's Maternal and Infant Health Initiative aims to increase by 10 percentage points the rate of postpartum visits among women in Medicaid and CHIP in at least 20 states over a 3-year period. Additionally, the Center for Medicaid and CHIP Services (CMCS) is collaborating with states to improve the rate and content of postpartum visits, and increase the use of effective methods of contraception in Medicaid and CHIP. For FFY 2014, a median of 58 percent of women delivering a live birth had a postpartum care visit on or between 21 and 56 days after delivery (n = 34 states).

Characteristics of the Current Child Core Set

CHIPRA also required CMS to update the initial core set annually beginning in January 2013. For the 2016 update, CMS issued changes that were informed by MAP's 2015 review and input. Following MAP's recommendation, CMS added two measures: NQF #1360 Audiological Evaluation No Later Than 3 Months of Age and the non-NQF endorsed measure, Use of Multiple Concurrent Antipsychotics in Children and Adolescents. These additions expand the measurement of quality of care for children prescribed psychotropic drugs and children at risk of hearing problems. Additionally, CMS has decided to continue 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 2016 version of the Child Core Set contains a total of 26 measures (Appendix D).[37]

The set contains no structural measures, 22 process measures, three outcome measures, and one experience-of-care measure (Exhibit 1). 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 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 Adult Core Set and the Health Insurance Marketplace Quality Rating System Measure Set.[38]

The 2016 Child Core Set measures are concentrated in the National Quality Strategy priority area of Healthy Living and Well-Being (Exhibit 2). Measures are not exclusive to each alignment category and can span across more than one alignment category.

Representing the diverse health needs of the Medicaid and CHIP population, the Child Core Set measures span many clinical topic areas (Exhibit 3).

EXHIBIT 1. CHARACTERISTICS OF MEASURES IN THE 2016 CHILD CORE SET

Medicaid Child Core Set Characteristics		# of Measures (n=26)
NQF Endorsement Status	Endorsed	19
	Not endorsed	7
Measure Type	Structure	0
	Process	22
	Outcome	3
	Person and family experience of care	1
Data Collection Method	Administrative claims	20
	Electronic clinical data	16
	eMeasure available	6
	Survey Data	2
Alignment	In use in one or more federal programs	9
	In the Adult Core Set	3*

* Frequency of Ongoing Prenatal Care has one rate in the Child Core Set and one rate in the Adult Core Set.

EXHIBIT 2. MEASURES IN THE CHILD CORE SET BY NATIONAL QUALITY STRATEGY PRIORITY

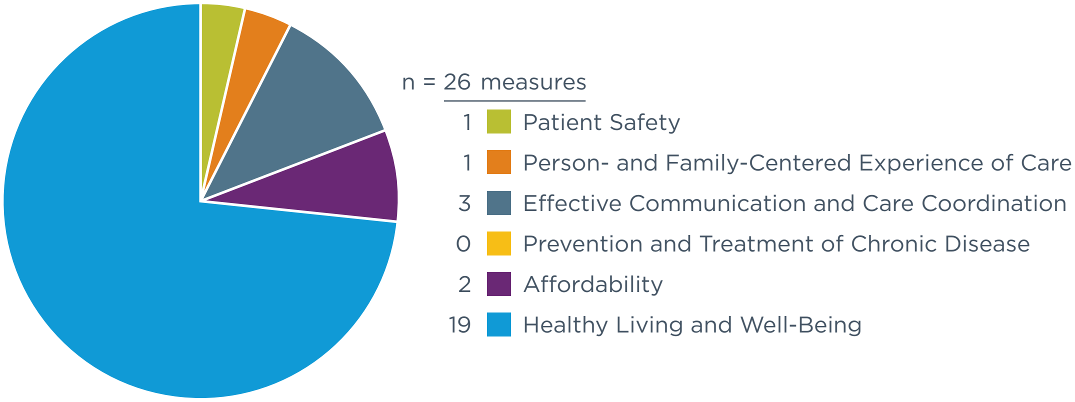

EXHIBIT 3. MEASURES IN THE CHILD CORE SET BY CLINICAL AREA

STATE EXPERIENCE COLLECTING AND REPORTING THE CHILD CORE SET

MAP gathered feedback on the implementation of the Child Core Set from states that participated in reporting and the **2015 Annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP**.[39] Representatives from Medicaid agencies in Minnesota and Oregon shared their implementation experiences, measure-specific challenges, and quality improvement successes related to reporting the Child Core Set. These perspectives are a sample and not necessarily representative of all state Medicaid programs, but they informed MAP's measure-specific and strategic recommendations for the Child Core Set in support of CMS's three-part goal of increasing the number of states reporting core set measures, increasing the number of measures reported by each state, and increasing the number of states using core set measures to drive quality improvement.

Minnesota

Medicaid is Minnesota's largest healthcare program and serves children and families, pregnant women, adults without children, seniors, and people who are blind or have a disability. 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 (i.e., state, managed care organizations, and Accountable Care Organizations), potential for quality improvement at the provider and/or community level, population comparison, known health disparities, and measure development policy. Likewise, the state representative observed that improving quality on a limited number of measures at a time is all the state can realistically expect to do, though the state does expect to report additional measures. Staff from Minnesota suggested ways to increase the reporting of the Child Core Set measures, including:

- Investing the time and resources to find the right state representative responsible for reporting.
- Proactive technical assistance (e.g., provide education on measure technical specifications earlier in the collecting and reporting cycle).
- Respecting the state reporting effort and commitment necessary to report (e.g., data entry requires a lot of time and is very complex).
- Providing timely and precise measurement technical specifications (e.g., provide current year technical specifications earlier since they are taken into account when deciding whether or not to report a measure).
- Motivating greater reporting by providing a return on the reporting investment.

Staff from Minnesota emphasized the burden of measurement reporting for both the state and the provider community due to the proliferation of measures and advised MAP and CMS to support meaningful measures that are aligned and can be used at multiple levels to drive quality improvement efforts. A set should strive to be parsimonious. Given the need for meaningful measurement, measuring "what matters most" should include purchasing and delivering healthcare services that meet the Medicaid population's healthcare needs and are valued by enrollees.

Oregon

Oregon's presentation focused on policy and on how the value and effect of measurement differ based on perspective. As a recipient of a Children's Health Insurance Program Reauthorization Act (CHIPRA)[40] grant for a three-state demonstration project that required inter- and intra-state implementation of the entire Child Core Set, Oregon's experiences are applicable across the Adult and Child Core Sets.

All measures in the Child Core Set were reported by Oregon and the other two states (West Virginia and Alaska) in the demonstration project. For the MAP deliberations, Oregon's representative highlighted analysis and results for the Weight Assessment and Counseling measure, which captures the percentage of children who have evidence of BMI percentile documentation in their medical record, noting that results lack face validity. The Oregon representative noted that states need to assess measure results critically based on the intent of the measure, because measure calculations can sometimes be inaccurate where measure results do not reflect disparities at the population level. The presenter noted that the magnitude of inaccuracies in measure calculations are multiplied when measure results are aggregated and used to implement population based public health initiatives. The presenter emphasized that analysis of data as well as interpretation of results requires consideration of factors such as diversity, disparity, and health equity. Stratification of data is helpful in analyzing and in identifying differences due to disability and disparities. Therefore, Oregon stratifies all measures in use at the state level. However, analyzing trends based on administrative and hybrid data is challenging because stratification results in very small sample sizes.

The Oregon representative further stated and the Task Force members agreed that when measures are produced and implemented, the measurement results impact policy and programs, even though they may not be capturing the true population characteristics of interest. The Weight Assessment and Counseling measure, presented by Oregon, was used to exemplify this point. In light of a perceived disconnect between measure intent and measurement result, the presenter emphasized the need for feedback loops that allow for continuous quality improvement as well as political will and support at the state level to succeed in addressing population health needs while reporting on individual measures.

The presenter noted that the flexibility to modify measures in the core set is necessary for quality improvement and successful reporting. For example, implementation of CMS core set measures requires modification of specifications from the technical specifications provided, especially since measures are not developed for multiple systems of care or for multiple levels of aggregation.

Oregon's representative recommended that Medicaid population characteristics such as housing, behavioral issues, and co-morbid health issues be considered when using data collected through measurement, especially since the most vulnerable cohorts may be missing due to population instability and transiency. For example, when looking at measures related to behaviors such as smoking, and alcohol and drug use, data segmenting by age is not always helpful, since any of these behaviors can start within a wide age range and co-relate to other behavioral and or medical conditions.

The presenter emphasized that all measurement should be "actionable," such that providers can use the data and provide follow-up services, and that compelling and meaningful outcomes are sometimes best presented through patient feedback and participation.

The presenter noted that the implications as well as the perceived applicability of data vary by perspective. Patients or the local, state, or federal governments will have different points of view. Perception is the basis of judging value versus effort, especially since a lack of value leads to the perception of burden. For successful implementation of the core set and measures in general, the value of a measure should be assessed from multiple perspectives in order to understand how the value/effort balance shifts and how to design and implement measures so as to increase the perception of value and decrease the perception of burden. To this point, MAP agreed that the need to report on measures should not lose sight of the intent of measurement, mainly improving the quality of healthcare and health improvement.

These issues and others are further explored in the Strategic Issues and Policy Themes sections.

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's 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, respond 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 2015 review as a baseline, NQF staff compiled and presented measures in the following topic areas: asthma, mental and behavioral health, care coordination, dental care, injuries and trauma, maternal/perinatal care, overuse, sickle cell disease, and patient-reported outcomes. This was the first year where measures discussed included Task Force member submissions. Consequently, MAP discussed in detail measures that staff and individual Task Force members judged to be a good fit for the core set. This judgment was largely based on the measure specifications, the MSC, and the feasibility of implementation for statewide quality improvement. All MAP Task Force members also had the opportunity to propose other available measures for discussion and consideration.

MAP examined NQF-endorsed measures and other measures in the development pipeline. MAP generally favored measures that can be implemented at the state level, promote parsimony and alignment, and address prevalent and/or high-impact health conditions for pediatric Medicaid and CHIP enrollees. MAP also favored NQF-endorsed measures because they have already met rigorous standards for importance, evidence, scientific acceptability of measure properties, and other criteria via a separate consensus-based process. Input from state representatives reflects concerns about the challenges of trying to implement measures that have not been fully specified or tested. 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. The measures that MAP examined but did not ultimately support for use in the program at this time are listed in **Appendix E**.

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.[41] A small number of PQMP measures have completed endorsement review, and developers will likely submit many more for endorsement review in the coming year. Monitoring the development of new measures will remain essential for future annual reviews.

Measure-Specific Recommendations

MAP supported all but two of the measures in the current Child Core Set for continued use in the program. In general, MAP considers removing a measure when the following factors are observed:

- Consistently high levels of performance (e.g., >95 percent) indicate little opportunity for additional gains in quality.
- Multiple years of very few states reporting a measure indicate that it is not feasible or a priority topic for improvement.
- Changes in clinical evidence and/or guidelines have made the measure obsolete.

- The measure does not yield actionable information for the state Medicaid program or its network of providers.
- A 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 individual measures that they are able to submit to CMS each year. MAP's measure-specific recommendations are described below, with details on the individual measures provided in Appendix D.

Measures for Removal from the Child Core Set

MAP recommended removal of NQF #1391 Frequency of Ongoing Prenatal Care. MAP stated that the measure is an ineffective tool for quality improvement because the measure does not assess the capacity of a plan to provide prenatal care. Rather, the measure more likely reflects challenges women face in obtaining prenatal care such as taking time off work, transportation, and childcare. Therefore, the information collected is less actionable by state Medicaid programs. Most importantly, insufficient evidence supports the relationship between visit frequency and improved outcomes for mothers and babies. NQF #1517 Prenatal & Postpartum Care (PPC) is currently in both the Adult and Child Core Sets. MAP favored NQF #1517 over NQF #1391, because NQF #1517 focuses on the timing of the prenatal and postpartum care, rather than frequency, and early visits are tied to levels of access to prenatal and postpartum care. Since MAP's review of measure #1391, the current Perinatal Standing Committee decided to not recommend the measure for endorsement, and the measure steward/developer (National Committee for Quality Assurance) withdrew the measure after public commenting. Therefore, endorsement for this measure will be removed.

MAP also recommended removal of the measure, Child and Adolescents' Access to Primary Care Practitioners. MAP noted that performance on this non-NQF endorsed measure was very high overall with little opportunity for improvement. Additionally, there are other, more meaningful measures of access including the delivery of preventive services for children/adolescents ages 0-18 and patient experience surveys which include questions regarding access to care. Overall, given the need for parsimony and a collective desire to add more measures to the set to fill gap areas, it is appropriate to remove lower value measures to make way for higher value ones.

Public commenters generally agreed with MAP's recommendation to remove from the core set NQF #1319 and the non-NQF endorsed measure, Child and Adolescents' Access to Primary Care Practitioners.

Measures for Phased Addition to the Child Core Set

MAP recommended that CMS consider up to five 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 full or conditional support. MAP conditionally supported measures that are not currently NQF-endorsed; MAP recommended that CMS add these measures to the programs once they are fully vetted through the NQF endorsement process and the detailed technical specifications are made publicly available.

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, behavioral health, and sickle cell disease. 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	**NQF #2797**: Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia	Support
	NQF #0480: PC-05 Exclusive Breast Milk Feeding	Conditional Support, undergoing NQF maintenance review and pending decision on continued endorsement
	NQF # 2830: PC-05 Exclusive Breast Milk Feeding (e-measure)	Conditional Support, pending successful NQF maintenance review and continued endorsement
2	**NQF #2801**: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Support
3	**NQF #2902**: Contraceptive Care – Postpartum	Conditional Support, pending successful NQF maintenance review and continued endorsement

MAP conducted a lengthy discussion of possible 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. 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 that would strengthen the presence of perinatal care issues in the Child Core Set. MAP also recommended measures in other subject areas that are important for improving quality for children with Medicaid and CHIP.

NQF #0480: PC-05 Exclusive Breast Milk Feeding

MAP previously recommended this measure during the 2014 review. This year, MAP's prioritization placed the measure at the top of the list, tying with NQF #2797: Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia. Measure #0480 assesses the number of newborns exclusively fed breast milk during the newborn's entire hospitalization, excluding newborns admitted to the neonatal intensive care unit. Breastfeeding carries many health benefits for mothers and babies, as well as potential economic and environmental benefits for communities. Among the known health benefits are balanced nutritional intake, some protection against common childhood infections, and better survival during the first year of life, including a lower risk of Sudden Infant Death Syndrome.[42] Similarly, breast milk feeding is associated with a variety of positive downstream health outcomes for both mothers and babies, including reducing the risk for certain allergic diseases, asthma, obesity, and type 2 diabetes.[43] Poor results on this measure would indicate missed opportunities to provide guidance to women about the benefits of breastfeeding for both mothers and babies.

NQF #2830: PC-05 Exclusive Breast Milk Feeding (e-measure) (Not NQF-endorsed)

This is the eMeasure version of NQF #0480 PC-05 Exclusive Breast Milk Feeding. The information on benefits is the same as for NQF #0480. CMS has the option to include one or both measures depending on the readiness of states to report eMeasures. One commenter suggested that the inclusion of NQF #2830 would not necessarily increase reporting burden for states since it is the eMeasure version of NQF #0480.

NQF #2902: Contraceptive Care – Postpartum (Not NQF-endorsed)

This measure assesses the use of postpartum contraception for women who have had a live birth. Members noted the importance of family planning and birth spacing as pregnancy within a year of giving birth is associated with an increased risk of poor birth outcomes. MAP members commented that one important aspect of the measure is that it focuses on discussions of postpartum contraception during the hospital stay immediately following birth as well as during the postpartum visit period, (i.e., between birth and 60 days following birth). The Committee felt that the inclusion of the hospital stay within the measure specification was important because it identified another point along the continuum of care where mothers could be provided information about postpartum contraception. This is particularly relevant for the mothers who do not have a postpartum visit. While several commenters supported the inclusion of this measure because it addresses an important measurement gap in contraception access and counseling, many highlighted the need for more detailed specifications.

NQF #2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Stakeholders have become increasingly concerned about rising rates of psychotropic medication use in the pediatric population and the risks associated with these classes of drugs. Psychotropic medications are an integral part of current evidence-based treatment for mental illness in children and adolescents, but studies have found high levels of potentially inappropriate psychotropic drug use by Medicaid enrollees. This places these children and adolescents at increased risk for adverse lifetime health events and death.[44] After reviewing several measures that evaluate different aspects of this problem, MAP fully supported NQF #2801 to address inappropriate use of antipsychotics in children and adolescents. Measure #2801 focuses on children and adolescents 1-17 years of age with a new prescription for an antipsychotic medication without a Food and Drug Administration (FDA) indication for antipsychotics (schizophrenia, bipolar disorder, psychotic disorder, autism, tic disorders), but who had psychosocial care either before or immediately after the prescription. The developer stated that in many cases antipsychotics are prescribed for ADHD or disruptive behaviors for which antipsychotics are not indicated, and in these cases, psychosocial therapy should be recommended as the first treatment option. MAP intends this measure to promote the use of nonpharmacologic, evidence-informed approaches to the treatment of mental and behavioral health problems of these children. Because the measure uses administrative data and has been tested at the state level, MAP members agreed that feasibility of reporting would be relatively high.

NQF #2797: Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia

The Committee supported the Q-METRIC (supported with CHIPRA funding to PQMP) – a University of Michigan process measure assessing the percentage of children ages 2 through 15 years old with sickle cell anemia (Hemoglobin SS) who received at least one transcranial Doppler (TCD) screening within a year. NQF #2797 fills a gap area—care for children with sickle cell disease—identified by MAP last year. Without intervention, 11 percent of children with sickle cell anemia will have a stroke by the age of 20, and the risk of stoke is most significant between ages 2 and 5.[45] This measure aligns with National Institutes of Health (NIH) National Heart, Lung, and Blood Institute (NIHLB) guidelines for annual transcranial Doppler (TCD) screening of children with sickle cell anemia. TCD ultrasonography is the only method available to identify those children with sickle cell disease who are at high risk for developing a stroke. This measure addresses disparities in care for a population that is high need based on potential for adverse events. MAP agreed that this measure is important to identify those who are at high risk for developing a stroke.

Remaining High Priority Gaps

Many important priorities for quality measurement and improvement do not yet have fully developed 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. MAP first identified gap areas during its 2014 review and further addressed the gap areas during its 2016 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
  - Care integration to assess efficacy and outcomes from integrated behavioral health in primary care Medical Homes, as well as collaborative care between primary and subspecialty care providers for patients with chronic conditions*
  - Adolescent Preparation for Transition to Adult-Focused Healthcare*
  - Care coordination for conditions requiring community linkages*
- Screening for abuse and neglect
- Injuries and Trauma
  - Trauma specifically, since trauma in adolescents is one of the leading causes of death*
- Mental health
  - Access to outpatient and ambulatory mental health services
  - Emergency Department use for behavioral health
  - Behavioral health functional outcomes that stem from trauma-informed care
- Exposure to Adverse Childhood Experiences (ACEs)*
- Overuse/medically unnecessary care
  - Appropriate use of CT scans
  - Measures that assess appropriate use, misuse, and overuse*
- Durable medical equipment (DME)
- Cost measures
  - Targeting people with chronic needs
  - Families' out-of-pocket spending
- Sickle cell disease
- Substance abuse*
- Patient-reported outcome measures
- Dental care access for children with disabilities—could stratify current measures
- Duration of children's health insurance coverage over a 12-month period*

Public comments supported MAP's assessment of high-priority measure gaps for Medicaid and CHIP enrollees. Commenters suggested the addition of several measure gaps, including access to inpatient psychiatric care, access to specialty mental health care, measures assessing care within school systems, value-based performance measures, and care coordination measures.

STRATEGIC ISSUES

As healthcare payments move from volume to value, the quantification and assessment of value becomes an integral part of that process. One of the most prevalent ways to assess value of care quality, even if indirectly, is through the use of quality metrics and performance measurement. The Medicaid Adult Task Force and the Medicaid Child Task Force members and state panelists held joint deliberations to explore shared issues of strategic importance that affect the assessment of value in Medicaid. The themes discussed included the characteristics and purpose of measures in the core sets, data, innovation, and state participation. Embedded in these discussions were issues and opportunities related to data collection challenges, balancing different types of measurement, and overall quality improvement.

Comments from health plans, specialty providers, consumer advocates, and other stakeholders were supportive of these strategic issues. They highlighted and further elaborated on topics such as data challenges related to data collection and reporting infrastructure, and interoperability of electronic health records. Commenters also addressed the issue of burden relative to the type of measure, i.e., a measure based on a hybrid of medical records and administrative data versus a measure based on claims data. Commenters also reflected on how relative stability in the measures included in the core set limits burden that would otherwise result from more frequent changes in the composition of the core set.

Measure Characteristics

The joint discussions started with an analysis of the characteristics and purpose of measures available for reporting as well as the opportunities for quality improvement provided by their individual attributes. Determination of measure characteristics, as in how a measure is described and implemented, is based on the use and purpose of the measure. The members of both Task Forces further suggested that measures could be categorized as analytic, improvement, and/or accountability measures. These are not mutually exclusive categories.

- Analytic measures are descriptive and are characterized by a lack of clear benchmarks backed by empirical data. Therefore, the measures are used to explore variations and address questions related to the results that may be affected by artifacts of data collection.[46]
- Improvement measures are intended primarily for quality improvement. These measures are used to improve care quality through monitoring and data analysis. MAP noted that these measures hold the most promise as tools for quality improvement within Medicaid.[47]
- Accountability measures are used to hold providers and organizations accountable for care quality. With these measures, payment is linked to reporting and performance benchmarks. The purpose of these measures is to promote transparency through mandated reporting of measure results. As such, there is a higher standard applied with regard to scientific acceptability.

Mandatory Versus Voluntary Reporting

In discussing these measure characteristics, Task Force members explored the implications and benefits of the voluntary nature of reporting in the Medicaid program. A majority of the discussants agreed that voluntary reporting allows for innovation as well as provides flexibility needed to address quality at the state level, and public comments echoed this sentiment. Flexibility is especially important since the core sets are relatively new, and states are at various stages of developing the infrastructure needed for measure adoption and reporting. However, a minority of members argued that requiring reporting of core sets through a mandate can be an impetus for states to prioritize resources for data reporting and quality improvement infrastructure development. Some Task Force members noted that mandates can also impede quality improvement by changing the focus from improving quality to fulfilling the reporting requirement.

One of the public comments for the Child Core Set suggested that the measure set should be further separated into two smaller sets of measures where one would be implemented as a “foundational” set with mandatory reporting requirements and the other would be a “supplemental” set from which states would be able to choose measures that address their individual priorities.

Data Collection Burden

This discussion around reporting introduced issues related to resource availability and data collection burden for hybrid and medical record measures. Measures requiring abstraction of medical record data—either alone or in conjunction with use of administrative data—are the most burdensome. The high level of effort or cost can thus drive the decision not to report on the measures. States attribute their decision not to report on certain measures—or attribute low reporting rates—to the requirement that medical records or a hybrid of medical records and administrative data be reviewed.[48] In furthering this discussion, the Task Force members and the state panelists acknowledged both the burden as well as the value of outcome and hybrid measures, especially in comparison to claims based process measures. As a way forward, the group emphasized the need for balancing of measure types in the core sets. This need for balance was reaffirmed in public comments. The group agreed that the relative nascence of the core sets, along with the amount of resources needed to build infrastructure, makes a strong case for allowing the Medicaid Adult and Child Core Sets to mature over the next few years. Factors that will facilitate this maturation include data considerations, innovation, and support for states.

Data Specificity

The Task Force discussed the ease of collecting claims-based data versus conducting medical record reviews or collecting hybrid measure data (i.e., data from both administrative claims and medical records). Administrative data generally lack clinical granularity and other features of care delivery not related to the core function of billing and financial accountability. This has important implications for whether clinicians accept quality improvement efforts and find them useful. The group noted that bundling of services, for example, can limit the specificity of conclusions, where payment is provided for a service bundle and therefore individual codes may not be submitted for those services. Task Force members agreed that requiring physicians to provide individual codes for the bundled services would require additional effort, and thereby diminish the value of bundling from the provider’s perspective. In this regard, the movement toward “value based payments” and “global payments” may run counter to a desire for greater specificity in coding procedures, services, and interventions in order to enhance the utility of billing data.

Data Availability/Accessibility

Task Force members agreed that any consideration of data needs to address the expansion of coverage and the recent growth of the Medicaid population. It is well accepted that longitudinal data allow for analyzing changes in quality over time. However, a lack of data on newly insured Medicaid enrollees—who are entering the Medicaid system through coverage expansions—affects baseline determinations of overall care as well as health quality, which in turn affect the ability to capture changes in health or care for these individuals. Another data-related consideration is the lack of seamless sharing of behavioral and physical health information. This barrier can result from local, state, and federal regulatory requirements, where resource intensive processes of obtaining inter-organizational data sharing agreements hinder data integration and sharing. The Task Force noted that organizations are often reluctant to share data across different settings of care. However, this issue of inaccessibility is multifaceted and includes technology limitations, mainly interoperability, and data mining considerations along with regulation-based barriers.

Ownership of data leads to fragmented data repositories. The need for data sharing agreements adds another layer of burden to an already strained healthcare system. The Task Force noted that in our medically focused system, data sharing is structured and includes firewalls based on varied clinical parameters, thereby creating artificial barriers to access. Task Force members discussed the implications of not sharing data, and noted that a path forward has to allow for bi-directional flow of information between different organizations, providers, and care settings such as medical and behavioral care.

The Task Force noted that future success will require adequate information technology infrastructure to capture specific data and make that data available. However, in some cases when data are unavailable, flexibility is needed to substitute measures and capture necessary care-related information. The Task Force acknowledged that data issues will always exist, along with resource allocation issues. As a result, evolution of the use of the core set, along with participation in data collection, will rely heavily on innovation both at the federal and state levels. MAP encouraged the Medicaid Adult and Child Core Set programs to continue to foster this innovation through grants and other supports.

The Task Force members also acknowledged the potential value of emerging health technology as a means of capturing data and reporting on measures using the data through vehicles such as health exchanges, as well as registries. Although registries are primarily a clinical tool to facilitate ongoing care management, they can also serve as a data repository related to outcomes of care. Many states use data sources such as registries to productively link Medicaid data to population health data using birth and death records.

Innovation

The success of the Medicaid program depends on the ability to innovate at the state level. Task Force members noted that innovation can be as minor as repurposing current patient experience surveys as mobile applications or as major as improving data infrastructure and interoperability of information technology. However, it will always be difficult to assess the impact of innovation in the short term. The Task Force members, as well as the state panelists, agreed that innovation is happening in measurement; however, the information regarding innovation is not readily available beyond those achieving the innovation. This may create inefficiencies through duplication of efforts at various levels and across states.

The meeting discussions highlighted that the voluntary nature of the Medicaid core sets allows for innovation, especially when measures need to be adapted for local considerations or used in novel ways for understanding variation or for improvement. To maximize the value of this voluntary effort, resources are needed to ensure effective communication, shared learning, and collaboration among states for improving technology, data systems, and measure applications. As the core sets evolve along with the Medicaid program, opportunities for learning and innovation are central to fostering state participation in data collection and submission.

State Participation

The ultimate goal of addressing data issues as well as innovation is to increase voluntary state participation in core set reporting. To this point, both Task Forces as well as the state panelists noted that reporting is affected by other factors such as measure alignment, cost of data abstraction, and infrastructure, along with the intent of reporting. Task Force members acknowledged that the CHIPRA and Adult Medicaid Quality grants have helped states build infrastructure; however, the grants are finite, and the need for infrastructure development and maintenance is ongoing. This issue of infrastructure for reporting can also be addressed through alignment of initiatives. The Task Force noted that aligning various quality improvement initiatives and measurement requirements across public and private sectors allows for economies of scale at the state level, where the same infrastructure and data can be used to fulfill multiple reporting requirements. Currently, states are circumspect in choosing measures to report based on the relative burden required to do so. Therefore, alignment of initiatives and measurement will alleviate the need to choose among competing initiatives and thereby increase overall reporting rates across states and providers.

Alignment in itself does not alleviate the need for building infrastructure and capacity. However, it does allow for focused improvements, where the cost of capacity-building can be dispersed through many different funding streams. Task Force members noted that data collection and reporting at the state level currently vary between fee-for-service (FFS) and managed care in Medicaid. The type of delivery system affects measurement as much as the goals of measurement. For example, managed care is less likely to report on measures with high provider performance, since its focus is to manage cost and improve performance; whereas, states have more control in collecting data from FFS plans. Plans are also more likely to report on HEDIS measures compared to measures in the core sets. The Task Force noted that higher levels of measure reporting by all states will require reporting mandates. Additionally, states will need to be empowered innovate in measurement based on state-specific needs and resources so as to maximize the use of the core sets.[49]

Task Force members as well as state panelists encouraged CMS to engage and support states in efforts to adopt and report on measures. This recommendation includes consideration for innovation happening at the state level as well as allowing for flexibility at the point of implementation. Ultimately, any core set adoption and reporting activities need to balance the cost of implementation against benefits gained at the local health system, state, and federal levels.

OVERARCHING POLICY THEMES

Background

The rapid growth and adoption of quality measurement has created a proliferation of measures. This proliferation has increased the burden on providers and hindered benchmarking efforts due to a lack of alignment and harmonization within areas of measure focus. Given the expansion of the number of measures as well as increased requirements for reporting, measure developers, policymakers, and quality improvement organizations are slowly changing their focus to create parsimony, alignment, and harmonization among the existing measures.[50]

As part of this effort, the Task Forces discussed the **Vital Signs Core Metrics for Health and Health Care Progress report** from the National Academies of Sciences, Engineering, and Medicine (formerly the Institute of Medicine). The report describes the Vital Signs core metrics as a parsimonious set of measures for health and healthcare that can contribute to reducing the burden of measurement and improving health outcomes nationwide.[51] The report advocates for measuring "what matters most" and aims at addressing some of the performance measurement gap areas addressed by both the Medicaid Adult and Child Task Forces, such as chronic condition measures in the ambulatory setting for prevalent conditions such as diabetes. MAP considered the overall intent of the report and discussed issues around alignment, care coordination, and community linkage.

Public comments amplified MAP's discussions in these areas by highlighting the importance of alignment across core sets and reporting requirements while balancing the need for parsimony and measure set stability, with the need to evolve and stay current through addition of new measures.

Alignment

Previous iterations of the core set reports have looked at macro-level alignment of measures between the Adult and Child Core Sets. The intent of measure alignment is to decrease burden and stretch available resources to the maximum and use the same data collection and reporting infrastructure for multiple measures. The focus of alignment across measures has mostly been in the area of perinatal and maternity care, as this is a frequently measured topic across the core sets.

Task Force members acknowledged that alignment is a broader concept and expanded their focus from a concentration on specific measures to a fuller discussion encompassing the types of alignment as well as conceptualizing alignment at the point of implementation. The group discussed how alignment can be defined as the same measure, the same measure concept, or the same measure across multiple different programs, populations, or ages.

The MAP Coordinating Committee's 2015/2016 definition of alignment as the use of the same or a related measure unless there is a compelling reason for multiple similar or narrowly focused measures was revisited as a starting point for discussion.[52] The Task Forces and state panelists expanded MAP's definition with the understanding that alignment can be viewed as mandated alignment of measures (of specific measures or of measure concepts) or alignment of measurement methodology. Alignment of measure concepts allows for flexibility and variation as long as the conceptual basis for measurement is held constant. In contrast, alignment of specific measures is more restrictive and requires the same measure to be implemented across the board. The value of the conceptual alignment is in the flexibility it allows for balancing the goal of measurement with the effort required for implementation. [53]

The Task Force noted that alignment should also consider data implications such as time intervals and alignment across different age groups, (i.e., infancy, childhood, adolescence, adulthood). Another data issue to consider in alignment is the level of comparability. If the extent of variation between measures is not known, then two measures addressing the same concept can be capturing disparate data. For example, measuring assessed versus actual measured ranges of HbA1c provides different information, and these are two different measures capturing different but related data. The appearance of comparability does not always equate to actual comparability.

Ideally, alignment would address all levels and components of the Medicaid system within a state as well as across states, including health plans and managed care organizations. However, this system level alignment requires resources for which states need to make a political as well as policy case. Task Force members noted that performance measures and performance measurement are complex, and explaining this complexity to policymakers requires a clear clinical and policy rationale. The eventual success of the core sets will depend on building political will and financial sustainability by focusing on clearly demonstrable results of measurement that affect health, healthcare, and value.

Care Coordination

Given the importance of integrating behavioral health and primary care as well as coordinating care for Medicaid beneficiaries more generally, Task Force members and state presenters noted that no formal or standard definition of care coordination currently exists at the federal level. The absence of a clear definition along with a lack of financial and structural integration for most healthcare environments creates ongoing challenges in the development of viable care coordination measures. This absence of and need for a formal definition for care coordination was highlighted in public comments as well.

Given the potential benefits of care coordination, Task Force members recommended that one way to promote successful care coordination across all states is to allow physicians and other appropriately trained professionals to code for it and bill for care coordination as a separate service. The Task Force recognized that this would require the development of new codes as well as allocation of resources to compensate for care coordination services. The Task Force noted that complex care management codes are currently being reimbursed by the Medicare program, and suggested that CMS should clarify if state Medicaid programs can get a federal match for those codes.

The Task Force members also noted that care coordination is a concept that may look different based on patient needs and the lens of analysis. For example, a chronically ill adult may need care coordination in the form of support with coordinating clinical care; whereas, a child with disabilities may need a lot more coordination including management of connection to supports and services for clinical and behavioral health, including rehabilitation and social services.[54] Accordingly, Task Force members suggested that future discussions regarding care coordination should evolve to address available models and frameworks,[55] and acknowledged that successful adoption of care coordination at the state level will require resource allocation and availability of services.

Public comments reflected the different types of care coordination mentioned above and highlighted the need for care coordination throughout the care continuum, especially as children with special needs transition into adulthood.

Community Linkage

In discussing care coordination and the Vital Signs report, the Task Force members also addressed the importance of coordination across medical, behavioral, and community supports and services through integration and community linkages. Task Force members noted that homelessness is a major issue for many Medicaid recipients, especially for those seeking care in the behavioral health setting. Ideally, providers should conduct an assessment of housing stability and link enrollees with appropriate community services. However, Task Force members acknowledged that most community supports and services organizations are financially challenged nonprofit organizations and may not have adequate resources to provide support for large populations in need. This issue is magnified when considering the increase in the number of Medicaid enrollees. The Task Force members expressed concern that these individuals may present with needs for care coordination and linkage with community supports and services that far exceed the capacity of the social service and support system. Moreover, even if these organizations are providing services, capturing the long-term outcomes of these services is difficult.

CONCLUSION

With more than a third of the nation's children receiving healthcare through Medicaid and CHIP, it is crucial for the program to deliver high-quality healthcare to its enrollees. 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 voluntary reporting program. MAP members found information offered by state representatives about their implementation experiences to be highly valuable input into the approach and selection of meaningful quality measures for children.

MAP recommended that CMS remove two measures (i.e., NQF #1391 Frequency of Ongoing Prenatal Care and Child and Adolescents' Access to Primary Care Practitioners [not NQF-endorsed]) from the Child Core Set because there are other more actionable measures addressing the same quality concept. MAP supported continued use of the remaining measures in the current Child Core Set, ensuring stability in the measure set which will allow states to continue to gain experience reporting the measures. This stability and experience may enable states to increase the number of measures they are able to submit to CMS on an annual basis. To address critical measure gap areas identified during the review, MAP recommended that CMS consider up to five measures for phased addition to the Child Core Set. MAP also refined and expanded its list of gap areas for future development, consideration, and action.

As in previous years, MAP looked to state perspectives on the use of measures to inform its decisionmaking process. State representatives reinforced MAP's approach of recommending a parsimonious set of measures and thinking creatively about more efficient methods for data collection and analysis. As this voluntary reporting program continues to gain ground and more measures are reported by each state, the program measure set is expected to adapt to changing needs and priorities.

MAP also emphasized the importance of considering the overlap and alignment of the measures across the Child and Adult Core Sets, especially for high-impact conditions like reproductive and behavioral health. Alignment of asthma measures was promoted in the current cycle of review with the addition of an asthma measure that, if added to the Adult Core set, would span both core sets. Aligned measures are expected to 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 inform quality improvement initiatives.

The discussion of alignment was extended this year to include policy aspects and implications of alignment, care coordination, and linking with community supports and services. The goal is to address both Adult and Child Core Set evolution within the changing policy structure of the Medicaid program and the evolution of thinking regarding "measures that matter."

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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, affordable care, and healthy people/healthy communities. Accordingly, MAP informs the selection of performance measures to achieve the goal of **improvement, transparency, and value for all**.

MAP's objectives are to:

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

Coordination with Other Quality Efforts

MAP activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency and healthcare decisionmaking, aligning payment with value, rewarding providers and professionals for using health information technology to improve patient care, and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare. Foundational to the success of all of these efforts is a robust quality enterprise that includes:

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

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

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

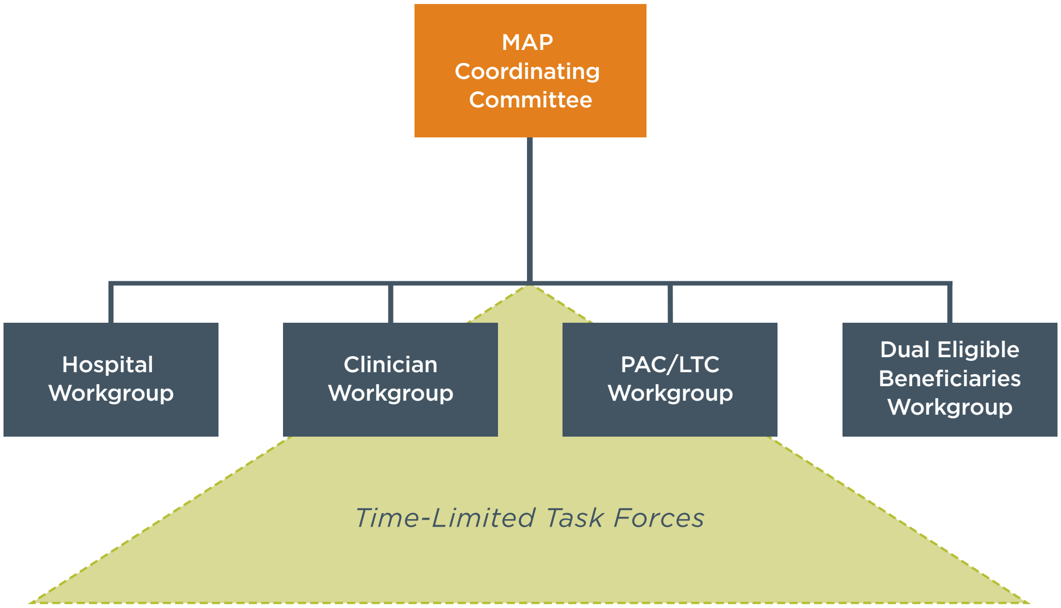
Measure selection and measure use. Measures are selected for use in a variety of performance measurement initiatives conducted by federal, state, and local agencies; regional collaboratives; and private-sector entities. MAP's role within the quality enterprise is to consider and recommend measures for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

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

Structure

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

FIGURE A1. MAP STRUCTURE



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

Timeline and Deliverables

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

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

ENDNOTES

1 Patient Protection and Affordable Care Act (ACA), PL 111-148 Sec. 3014.2010: p.260. Available at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. Last accessed August 2015.

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

MAP Medicaid Child Task Force

CHAIRS (VOTING)

Foster Gesten, MD

ORGANIZATIONAL MEMBERS (VOTING)

American Academy of Pediatrics
Terry Adirim, MD, MPH, FAAP

American Nurses Association
Susan Lacey, RN, PhD, FAAN

American's Essential Hospitals
Kathryn Beattie, MD

Association for Community Affiliated Plans
Margaret (Meg) Murray, MPA

Blue Cross and Blue Shield Association
Reed Melton

Children's Hospital Association
Andrea Benin, MD

Kaiser Permanente
Robert (Bo) Riewerts, MD

March of Dimes
Cynthia Pellegrini

National Partnership for Women and Families
Carol Sakala, PhD, MSPH

Patient-Centered Primary Care Collaborative

Fatema Salam, MPH

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

Richard Antonelli, MD

Luther Clark, MD

ORGANIZATIONAL MEMBER (NON-VOTING)

National Association of Medicaid Directors

Deidre Gifford, MD, MPH

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

Agency for Healthcare Research and Quality
Kamila Mistry, PhD, MPH

Centers for Medicare & Medicaid Services
Laura de Nobel

Health Resources and Services Administration
Gopal Singh, PhD

Office of the National Coordinator for Health IT

David Hunt, MD

MAP Coordinating Committee

CO-CHAIRS (VOTING)

Elizabeth McGlynn, PhD, MPP

Harold Pincus, MD

ORGANIZATIONAL MEMBERS (VOTING)

AARP
Lynda Flowers, JD, MSN, RN

Academy of Managed Care Pharmacy
Marissa Schlaifer, RPh, MS

AdvaMed
Steven Brotman, MD, JD

AFL-CIO
Shaun O'Brien

America's Health Insurance Plans
Aparna Higgins, MA

American Board of Medical Specialties
R. Barrett Noone, MD, FAcS

American College of Physicians
Amir Qaseem, MD, PhD, MHA

American College of Surgeons
Frank Opelka, MD, FACS

American HealthCare Association
David Gifford, MD, MPH

American Hospital Association
Rhonda Anderson, RN, DNSc, FAAN

American Medical Association
Carl Sirio, MD

American Medical Group Association
Sam Lin, MD, PhD, MBA

American Nurses Association
Marla Weston, PhD, RN

Blue Cross and Blue Shield Association
Trent T. Haywood, MD, JD

Consumers Union
Lisa McGiffert

Federation of American Hospitals
Chip N. Kahn, III, MPH

Healthcare Financial Management Association
Richard Gundling, FHFMA, CMA

The Joint Commission
Mark R. Chassin, MD, FACP, MPP, MPH

The Leapfrog Group
Melissa Danforth

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
Mary Barton, MD, MPP

National Partnership for Women and Families
Carol Sakala, PhD, MSPH

Network for Regional Healthcare Improvement
Elizabeth Mitchell

Pacific Business Group on Health
William E. Kramer, MBA

Pharmaceutical Research and Manufacturers of America (PhRMA)
Christopher M. Dezii, RN, MBA,CPHQ

INDIVIDUAL SUBJECT MATTER EXPERT MEMBERS (VOTING)

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Population Health
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Disparities
Marshall Chin, MD, MPH, FACP

FEDERAL GOVERNMENT MEMBERS (NON-VOTING, EX OFFICIO)

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Centers for Disease Control and Prevention (CDC)
Chesley Richards, MD, MH, FACP

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

Office of the National Coordinator for HIT (ONC)
Kevin Larsen, MD, FACP

NQF Project Staff

Debjani Mukherjee
Senior Director

Shaconna Gorham
Senior Project Manager

Nadine Allen
Project Manager

Severa Chavez
Project Analyst

APPENDIX C:
MAP Measure Selection Criteria

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

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

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

Subcriterion 1.1	Measures that are not NQF-endorsed should be submitted for endorsement if selected to meet a specific program need
Subcriterion 1.2	Measures that have had endorsement removed or have been submitted for endorsement and were not endorsed should be removed from programs
Subcriterion 1.3	Measures that are in reserve status (i.e., topped out) should be considered for removal from programs

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

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

Subcriterion 2.1	Better care, demonstrated by patient- and family-centeredness, care coordination, safety, and effective treatment
Subcriterion 2.2	Healthy people/healthy communities, demonstrated by prevention and well-being
Subcriterion 2.3	Affordable care

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

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

Subcriterion 3.1	Program measure set includes measures that are applicable to and appropriately tested for the program's intended care setting(s), level(s) of analysis, and population(s)
Subcriterion 3.2	Measure sets for public reporting programs should be meaningful for consumers and purchasers
Subcriterion 3.3	Measure sets for payment incentive programs should contain measures for which there is broad experience demonstrating usability and usefulness (Note: For some Medicare payment programs, statute requires that measures must first be implemented in a public reporting program for a designated period)
Subcriterion 3.4	Avoid selection of measures that are likely to create significant adverse consequences when used in a specific program
Subcriterion 3.5	Emphasize inclusion of endorsed measures that have eMeasure specifications available

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

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

Subcriterion 4.1	In general, preference should be given to measure types that address specific program needs
Subcriterion 4.2	Public reporting program measure sets should emphasize outcomes that matter to patients, including patient- and caregiver-reported outcomes
Subcriterion 4.3	Payment program measure sets should include outcome measures linked to cost measures to capture value

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

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

Subcriterion 5.1	Measure set addresses patient/family/caregiver experience, including aspects of communication and care coordination
Subcriterion 5.2	Measure set addresses shared decisionmaking, such as for care and service planning and establishing advance directives
Subcriterion 5.3	Measure set enables assessment of the person's care and services across providers, settings, and time

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

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

Subcriterion 6.1	Program measure set includes measures that directly assess healthcare disparities (e.g., interpreter services)
Subcriterion 6.2	Program measure set includes measures that are sensitive to disparities measurement (e.g., beta-blocker treatment after a heart attack), and that facilitate stratification of results to better understand differences among vulnerable populations

7. Program measure set promotes parsimony and alignment

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

Subcriterion 7.1	Program measure set demonstrates efficiency (i.e., minimum number of measures and the least burdensome measures that achieve program goals)
Subcriterion 7.2	Program measure set places strong emphasis on measures that can be used across multiple programs or applications (e.g., Physician Quality Reporting System, Meaningful Use for Eligible Professionals)

APPENDIX D:
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 2016 version of the Child Core Set along with their current NQF endorsement number and status, including rates of state participation in 2014 reporting. 2015 reporting data were unavailable during the 2016 review. In FFY 2016, states will be voluntarily collecting the Child Core Set measures using the 2016 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 2014 REPORTING

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
0024 Endorsed Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC) *Measure Steward: National Committee for Quality Assurance (NCQA)*	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: • Body mass index (BMI) percentile documentation • Counseling for nutrition • Counseling for physical activity	33 states reported FFY 2014 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)	Support for continued use in the program
0033 Endorsed Chlamydia Screening in Women (CHL) *Measure Steward: NCQA*	The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	37 states reported FFY 2014 Alignment: HEDIS, Medicaid Adult Core Set, MU-EP, PQRS, Physician Value-Based Payment Modifier, HIX-QRS	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
0038 Endorsed Childhood Immunization Status (CIS) *Measure Steward: NCQA*	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.	39 states reported FFY 2014 Alignment: HEDIS, MU-EP, PQRS, HRSA program(s), Physician Value-Based Payment Modifier	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
0108 Endorsed Follow-Up Care for Children Prescribed ADHD Medication (ADD) *Measure Steward: NCQA*	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. • 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. • 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.	34 states reported FFY 2014 Alignment: HEDIS, MU-EP, PQRS, Physician Value-Based Payment Modifier	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
0139 Endorsed National Healthcare Safety Network (NHSN) Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure *Measure Steward: Centers for Disease Control and Prevention (CDC)*	Standardized Infection Ratio (SIR) of healthcare-associated, central line-associated bloodstream infections (CLABSI) will be calculated among patients in the following patient care locations: • Intensive Care Units (ICUs) • Specialty Care Areas (SCAs) - adult and pediatric: long term acute care, bone marrow transplant, acute dialysis, hematology/oncology, and solid organ transplant locations • 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 FFY 2013* 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 * FFY 2014 data not available for this measure.	Support for continued use in the program
0471 Endorsed PC-02 Cesarean Section *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).	16 states reported FFY 2014 Alignment: N/A	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
0576 Endorsed Follow-Up After Hospitalization for Mental Illness (FUH) *Measure Steward: NCQA*	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: • The percentage of discharges for which the patient received follow-up within 30 days of discharge • The percentage of discharges for which the patient received follow-up within 7 days of discharge.	34 states reported FFY 2014 Alignment: HEDIS, Medicaid Adult Core Set, Inpatient Psychiatric Hospital Quality Reporting, HIX-QRS	Support for continued use in the program
1360 Endorsed Audiological Evaluation No Later Than 3 Months of Age (AUD) *Measure Steward: Centers for Disease Control and Prevention*	This measure assesses the percentage of newborns who did not pass hearing screening and have an audiological evaluation no later than 3 months of age.	New measure added to 2016 Core Set	Support for continued use in the program
1365 Endorsed Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment *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 FFY 2013 (New for 2015) Alignment: MU-EP; Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier	Support for continued use in the program
1382 Endorsed Percentage of Low Birthweight Births *Measure Steward: CDC*	The percentage of births with birth weight <2,500 grams	29 states reported FFY 2014 Alignment: Health Resources and Services Administration/ Maternal and Child Health Bureau Title V Maternal and Child Health Program	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
1391 Endorsed Frequency of Ongoing Prenatal Care (FPC) *Measure Steward: NCQA*	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: • <21 percent of expected visits • 21 percent–40 percent of expected visits • 41 percent–60 percent of expected visits • 61 percent–80 percent of expected visits • > or =81 percent of expected visits	28 states reported FFY 2014 Alignment: HEDIS	MAP recommends the removal of this measure from the program. The measure is an ineffective tool for quality improvement because the measure does not assess the capacity of a plan to provide prenatal care. The information collected is less actionable by state Medicaid programs.
1392 Endorsed Well-Child Visits in the First 15 Months of Life (W15) *Measure Steward: NCQA*	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: • No well-child visits • One well-child visit • Two well-child visits • Three well-child visits • Four well-child visits • Five well-child visits • Six or more well-child visits	41 states reported FFY 2014 Alignment: HEDIS	Support for continued use in the program
1407 Endorsed Immunizations for Adolescents (IMA) *Measure Steward: NCQA*	The percentage of adolescents 13 years of age who had the recommended immunizations by their 13th birthday.	37 states reported FFY 2014 Alignment: HEDIS	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
1448 Endorsed Developmental Screening in the First Three Years of Life *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 FFY 2014 Alignment: N/A	Support for continued use in the program
1516 Endorsed Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) *Measure Steward: NCQA*	Percentage of patients 3-6 years of age who received one or more well-child visits with a PCP during the measurement year.	46 states reported FFY 2014 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
1517 Endorsed Prenatal & Postpartum Care (PPC)* Measure Steward: National Committee for Quality Assurance **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. • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	36 states reported FFY 2014 Alignment: HEDIS, Medicaid Adult Core Set, HIX-QRS	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
1799 Endorsed Medication Management for People with Asthma (MMA) *Measure Steward: NCQA*	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. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.	27 states reported FFY 2014 Alignment: HEDIS	Support for continued use in the program
1959 Endorsed Human Papillomavirus Vaccine for Female Adolescents (HPV) *Measure Steward: NCQA*	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	32 states reported FFY 2014 Alignment: HEDIS	Support for continued use in the program
2508 Endorsed Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk *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 FFY 2014 (New for 2015) Alignment: N/A	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
Not NQF-endorsed Maternity Care: Behavioral Health Risk Assessment *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	4 states reported FFY 2014 Alignment: N/A	Support for continued use in the program
Not NQF-endorsed Children and Adolescents' Access to Primary Care Practitioners *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.	43 states reported FFY 2014 Alignment: HEDIS	MAP recommends the removal of this measure from the program. The performance on this non-NQF endorsed measure was very high overall with little opportunity for improvement. Overall, given the need for parsimony and a collective desire to add more measures to the set to fill 'gap' areas, it is appropriate to remove lower value measures to make way for higher value ones.
Not NQF-endorsed Adolescent Well-Care Visits *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.	44 states reported FFY 2014 Alignment: HEDIS, HIX-QRS	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
Not NQF-endorsed Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0, Child Version *Measure Steward: NCQA*	This measure provides information on parents' experience with their child's healthcare 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.	39 states reported FFY 2014 Alignment: HEDIS, HIX-QRS	Support for continued use in the program
Not NQF-endorsed Percentage of Eligible Children Who Received Preventive Dental Services *Measure Steward: Centers for Medicare & Medicaid Services*	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.	51 states reported FFY 2014 Alignment: N/A	Support for continued use in the program
Not NQF-endorsed Ambulatory Care: Emergency Department Visits *Measure Steward: NCQA*	The rate of emergency department visits per 1,000 member months among children up to age 19.	37 states reported FFY 2014 Alignment: HEDIS	Support for continued use in the program

Measure Number and NQF Endorsement Status	Measure Description	Number of States Reporting to CMS FFY 2014 and Alignment	MAP Recommendations and Rationale
Not NQF-endorsed Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) *Measure Steward: NCQA*	The percentage of children and adolescents 1–17 years of age who were on two or more concurrent antipsychotic medications.	New measure added to 2016 Core Set	Support for continued use in the program

EXHIBIT D2. MEASURES SUPPORTED BY MAP FOR PHASED 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
2797 Endorsed Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia *Measure Steward: Q-METRIC – University of Michigan*	The percentage of children ages 2 through 15 years old with sickle cell anemia (Hemoglobin SS) who received at least one transcranial Doppler (TCD) screening within a year.	N/A	Support addition of this measure to the program. Enhances the Child Core Set and would be important to identify those who are at high risk for developing a stroke. This sickle cell measure also gets to disparities in care for a population that is high-need based on potential for adverse events.
0480 Endorsed PC-05 Exclusive Breast Milk Feeding *Measure Steward: The Joint Commission*	PC-05 assesses the number of newborns exclusively fed breast milk during the newborn´s entire hospitalization. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns).	Meaningful Use Stage 2 (EHR Incentive Program) - Hospitals, CAHs	Conditionally support addition of this measure to the program pending NQF decision on continued endorsement. Enhances perinatal measures and would reduce the risk for certain allergic diseases, asthma, obesity, and type 2 diabetes.
2830 Not NQF-endorsed PC-05 Exclusive Breast Milk Feeding (Conditionally Support) *Measure Steward: The Joint Commission*	PC-05 assesses the number of newborns exclusively fed breast milk during the newborn´s entire hospitalization. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns). PC-05, Exclusive Breast Milk Feeding, is one of two measures in this set that have been reengineered as eCQMs and are included in the EHR Incentive Program and Hospital Inpatient Quality Reporting Program.	Meaningful Use Stage 2 (EHR Incentive Program) - Hospitals, CAHs	Conditionally support addition of this measure to the program pending NQF endorsement. Enhances perinatal measures and would reduce the risk for certain allergic diseases, asthma, obesity, and type 2 diabetes.

Measure Number and NQF Endorsement Status	Measure Description	Alignment	MAP Recommendation and Rationale
2801 Endorsed Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics *Measure Steward: National Committee on Quality Assurance*	Percentage of children and adolescents 1–17 years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment.	N/A	Support addition of this measure to the program. Addresses the challenges in tracking and measuring behavioral health issues in children.
2902 Not NQF-endorsed Contraceptive Care – Postpartum (Conditionally Support) *Measure Steward: US Office of Population Affairs*	Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1. A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2. A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care.	N/A	Conditionally support addition of this measure to the program pending NQF endorsement. Enhances perinatal measures and would reduce the risk of pregnancy-related complications by increasing access to high-quality care before and between pregnancies.

APPENDIX E:
Additional Measures Considered

MAP considered several measures that did not pass the consensus threshold (>60 percent of voting members) to gain MAP's support or conditional support for use in the Child Core Set. MAP needed to limit the number of measures it supported for the sake of parsimony and practicality; lack of support for one of these measures does not indicate that the measure is flawed or unimportant. These and other measures could be reconsidered during a future review of the Child Core Set.

Measure Number and NQF Endorsement Status	Measure Title	Measure Steward
0716 Endorsed	Unexpected Complications in Term Newborns	California Maternal Quality Care Collaborative
1800 Endorsed	Asthma Medication Ratio	National Committee for Quality Assurance
2789 Endorsed	Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused Health Care	Center of Excellence for Pediatric Quality Measurement
2393 Endorsed	Pediatric All-Condition Readmission Measure	Center of Excellence for Pediatric Quality Measurement
2903 Not NQF-endorsed	Contraceptive Care – Most & Moderately Effective Methods	US Office of Population Affairs
Not NQF-endorsed	Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Disease	Q-METRIC
Not NQF-endorsed	Duration of first observed enrollment	The Children's Hospital of Philadelphia (CHOP)
Not NQF-endorsed	Informed coverage (IC)	The Children's Hospital of Philadelphia (CHOP)

APPENDIX F:
Public Comments

General Comments

American Academy of Family Physicians

Sandy Pogones

The AAFP supports endorsement of the Core Measure Sets established by the multi-payer Core Quality Measures Collaborative led by America's Health Insurance Plans (AHIP). We encourage the MAP Medicaid initiative to adopt the same measures for their adult core set. The Collaborative has participation from the Centers for Medicare and Medicaid Services (CMS), health plans, the National Quality Forum, primary care, specialty care, and the National Committee for Quality Assurance, in addition to consumers and employers. The Collaborative works to create consistency and alignment across measures being used by both public and private payers and promotes measures that are evidence-based and useful for quality improvement, decision-making, and value-based payment and purchasing. The core measure sets are designed to be meaningful to patients and consumers and to physicians, while maintaining parsimony and reducing the collection burden and cost. The Pediatric measure set is currently under consideration and we encourage Medicaid to adopt this same measure set for children as soon as it is finalized.

The AAFP opposes endorsement of measure sets that are not part of the Core Measures as established by the Collaborative. The simple fact that a measure has been collected in the past is not sufficient reason to continue collecting it in the future, and we must actively pursue a reduction in reporting burden, particularly for primary care.

American Academy of Pediatrics

Caitlin Van Sant

The American Academy of Pediatrics (AAP or Academy), a non-profit professional organization of 66,000 primary care pediatricians, pediatric medical specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, appreciates the opportunity to comment on the Measurement Applications Partnership (the MAP) document entitled "Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2016." AAP salutes the time and effort taken by the MAP to examine child health and its measurement and wrestle with the difficult challenges the current haphazard measurement regime presents.

The Academy would respectfully request the opportunity to offer three main suggestions regarding any final version of the document. Initially, AAP urges that measures should be chosen for the core set based on their impact on child health. Additionally, AAP would respectfully suggest that the focus on the Medicaid and CHIP populations is too limited as all children deserve quality care and Medicaid and CHIP finance the minority of care for children in the United States. Finally, AAP would urge that the MAP and CMS stress the need for further resources in this area so that better harmonization and more significant impact on child health can be achieved.

Many pediatricians seek guidance on how to select and implement quality improvement in their practice, where the vast majority of care is delivered to the US pediatric population. The profession of pediatrics does not lack in the number of quality measures available to implement with many being developed and published in the last few years. The challenge now is for a consensus to be forged around measurement domains and specific measures that are beneficial to children and families, are meaningful to the practice of pediatrics, and are clinically relevant at the practice level.

Thank you for your attention to the views of the American Academy of Pediatrics.

American Nurses Association

Maureen Dailey

The SC was productive and the decisions that were made were based on evidence, relevance, and compelling information provided by two state Medicaid directors and other stakeholders present. The SC continues to represent diverse perspectives, technical and practical expertise, resulting in thoughtful discussions.

American Occupational Therapy Association

Sharmila Sandhu

The American Occupational Therapy Association (AOTA) is disappointed to see that the Report does not reference any language or quality measures addressing schools systems as Medicaid providers. Schools are the front line entity in identifying childhood disabilities under the IDEA Child Find mandate. Also, with advances in screening capacity, (e.g., certifying shool staff in mental health first aid, expanded kindergarten health assessments, etc.) through multi-tiered systems of support (MTSS) schools are increasingly involved in identification of both physical and mental health needs. Finally, public schools exceed all other practice settings in the provision of therapy services to children (Perrin, 2002), so it would be logical to measure the quality of those services in terms of student outcomes. Thus, on the other end of the health care spectrum, quality measures of Medicaid-funded healthcare for children could easily be tracked by reviewing existing data sets in schools such as: attendance records; grades; graduation rates; discipline referrals, among other factors.

American Psychiatric Foundation

Samantha Shugarman

We agree that care integration, care coordination with community services, exposure to adverse experiences, substance abuse and health insurance coverage are significant gaps in quality measurement and appreciate NQF identifying these areas as high priority. However, the bullet points providing examples of care coordination (p16) does not specifically state access to specialty mental health care and it is not clear if “subspecialty care providers for patient with chronic conditions” include general or child and adolescent psychiatrists. Under mental health (p16), access to care is mentioned but does not include inpatient psychiatric care. In addition, “ED use for behavioral health” is vague and “behavioral health functional outcomes that stem for trauma-informed care” merits clarification.

Throughout the document, specialty mental health care is often referred to as “behavioral health care”, and psychiatric disorders are often called “behavioral health issues”. Nevertheless, the target disorders for some of the child mental health quality measures are Attention Deficit Hyperactivity Disorder (ADHD), a neurodevelopmental disorder, and Major Depressive Disorder (MDD), a chronic mental disorder whose target symptoms include changes in mood, sleep, appetite, weight gain or loss, poor concentration and suicidal ideation. These disorders are not limited to change in behavior. In addition, substance abuse is commonly viewed as simply aberrant behavior, but PTSD, MDD, Bipolar disorder are common comorbid conditions.

“Strategic Issues” section appears to be describing trade-offs (mandatory vs. voluntary reporting), barriers to implementation, and limitations of commonly used data sources. Remarkably, there is no discussion related to the challenges of accurately interpreting the data (i.e., missing data over time). This is a significant omission if CMS’s goal is to use these data “to inform policy and program decisions.” We also agree that alignment of measures does not fully address the need for building and maintaining the infrastructure to use data on the level of adherence to a quality measure and its predictors to inform quality improvement interventions.

On page 22, the example to support the importance of community linkage appears to be more appropriate for an adult population (i.e., homeless persons needing mental health care and on Medicaid)

Among the organizational members, representation from the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry is missing. The individual subject matter expert members are a pediatrician with experience developing a framework for care coordination and a cardiologist who works full time for Merck. (Global Director, Scientific Medical and Patient Perspective (SMPP) in the Office of the Chief Medical Officer). Although the MAP Coordinating Committee is co-led by Harold Pincus, MD a psychiatrist who is a national leader in mental health services research, it appears that neither a psychiatrist or child psychiatrist were on the MAP Medicaid Child Task Force.

Quality Measures Related to Child Mental Health Care

To the best of our knowledge, the clinical validity of the child mental health quality measures has not been established. This raises the question of whether any of these measures meet MAP measure selection criteria. Sub-criterion 4.2 states that “public reporting program measure sets should emphasize outcomes that matter to patients”. These selection criteria also prioritize measures that have the capacity to assess services across providers (5.3), yet there is little to no capacity for these measures to track adherence across the multiple care sectors that a child may receive mental health care (i.e., primary care, specialty mental health care, public school, foster care, juvenile justice).

Anthem, Inc.

Amy Ingham

Anthem appreciates the work that MAP has undertaken to produce its 2016 report. However, we are generally concerned with the number of measures that MAP has recommended be added and removed over the years to the Children’s core measure set. We believe that the success of quality measurement and improvement is best achieved through ensuring a stable, concise set of targeted and meaningful measures from which states may choose. Data set stability is important to states and Medicaid managed care organizations (MCOs) in the design of data collection and implementation approaches as well as helps ensure meaningful analysis of quality improvement projects. Furthermore, we believe that a parsimonious approach to the addition of new measures assists in increasing collections of those measures already included in the set.

It would be helpful for CMS to share the challenges and results of these measures from all states that have reported, since the states highlighted in NQF’s report seemed to have limited exposure to all measures. It is valuable to reporting entities to learn what measures among the measure sets have valid and consistent data year to year. This information could help with establishing reliable national benchmarks for non-HEDIS measures.

Anthem supports MAP’s focus on parsimony and alignment of measures and would also emphasize that alignment of measures for ease in collection by providers including hospitals, practitioners and health plans would result in improvements in the overall delivery of healthcare.

Boston Children’s Hospital/Harvard Medical School

Alyna Chien

The Center of Excellence for Pediatric Quality Measures at Boston Children’s Hospital appreciates that NQF’s MAP Medicaid Task Force report highlights the health care needs of children with disabilities. The NQF community may appreciate knowing that the Pediatric Quality Measures Program developed the Children with Disabilities Algorithm (CWDA), which would allow the stratifications and comparisons proposed in the report. This may in turn help states with their activities, fill measurement gaps, and query potential care coordination issues. The algorithm is described in Chien AT et al. Development of the Children With Disabilities Algorithm. Pediatrics 2015;136;e871.

We believe this paper may be particularly relevant to the following sections of the draft report: pg. 9 paragraph 2, pg. 10 paragraph 3, pg. 16 at the bottom, and pg. 22 paragraph 4.

Children's Hospital Association

Sally Turbyville

The Children's Hospital Association (CHA) appreciates the opportunity to comment on the 2016 NQF Child Medicaid Measurement Application Partnership (MAP) 2016 report, which makes recommendations to CMS on the Child Medicaid Core Set. CHA applauds the thorough review and careful deliberations of Child Medicaid MAP members. Further, CHA appreciates that NQF's MAP Medicaid Task Force report highlights the health care needs of children with disabilities. The NQF community may appreciate knowing that the Pediatric Quality Measures Program has looked at measures targeting children who have special needs and who have complex chronic and acute conditions.

CHA provides these comments with full acknowledgment of the volume of work for NQF staff and the MAP participants. We applaud their efforts and hard work. However, because the recommendations coming from this group are far reaching and because of the fast pace in which the measures must be reviewed, clear and consistent guidance is critical. CHA would like to express concerns regarding some of the confusion and changing guidance provided to the MAP work group during the meeting and asks that CMS and NQF work together to ensure more clear and consistent guidance be provided to the work group. In particular, in the following areas:

- MAP recommendation decision algorithms for NQF-endorsed compared to non-endorsed measures
- Re-prioritization of measures previously prioritized by the MAP with a lack of reintroduction of the importance and validity of these measures (memories are short)—e.g., the Pediatric 30-Day All-Condition Readmission Measure; and
- Purpose(s) of the Child Medicaid Core Set. At least one committee member asked if this core set is strictly a measure set of "quality" measures, or is it a set of measures for state, benchmarking that can include measures not necessarily indicative of the quality of care and outcomes for a state. This question seems to have been left unanswered.

While we expect committee members to have questions and seek guidance as part of a consensus-based approach, we ask NQF and the committee to revisit final recommendation votes that may have been impacted due to a lack of committee clarity.

Last, as we see the emergence of other core sets (e.g., CHM/AHIP core sets), CMS may want to consider if the MAP has a role in making recommendations about set alignment, in addition to considering measure alignment.

Again, thank you for the opportunity to comment, and the continued dedication.

National Association of Pediatric Nurse Practitioners

Laura Searcy

NAPNAP appreciates the efforts of the MAP to expand the pediatric core set, and to be more aware of the need for pediatric-specific measures. We urge you to ensure the consistent use of appropriate provider neutral language in all measure descriptions. The Task Force should be mindful of the existence of artificially created barriers to care that result from the inability of advanced practice registered nurses (APRNs) to certify the need for home health and therapy services. These place an even greater burden on children with special health care needs and the APRNs that care for them.

NAPNAP also strongly urges you to recommend policies that will ensure that each service provided to a patient is clearly and directly associated with the actual provider of the service, rather than masked by the billing procedures of a group practice. Problems related to fee-for-service practices such as incident-to billing obscure the identity of the rendering provider, undermining the ability to accurately assess quality performance and hindering providers from being individually accountable for the care they render.

We agree that broader adoption of quality measurement is increasing burdens on providers and complicating benchmarking efforts because of the lack of alignment within areas of measure focus. We concur with the National Academies of Sciences, Engineering, and Medicine regarding measuring “what matters most” and addressing performance measurement gaps, particularly for children. NAPNAP believes further support is needed to address the needs of children with special health care needs and those transitioning into adult medicine.

NAPNAP also supports developing clear federal definitions of care coordination for children, including management of supports and services for clinical and behavioral health, rehabilitation and social services, and providing the financial and structural integration to develop viable care coordination measures. We strongly agree that appropriately trained health care providers, specifically including APRNs, should be authorized to code for and bill for care coordination as a separate service. We also concur that the Centers for Medicare and Medicaid Services should clarify if state Medicaid programs can receive a federal match for those codes.

While breast milk feeding in extremely low birth weight and other Neonatal Intensive Care Unit (NICU) infants is extremely beneficial in reducing illness and complications, the value of breast milk for all infants merits additional recommendations. Promotion of healthy nutrition in early infancy, such as breastfeeding support and appropriate guidance on solid food introduction should be an integral part of all appropriate pediatric office visits. Nutrition counseling and growth monitoring in primary care settings should also be extended until the child transitions to adult medical care.

National Partnership for Women & Families

Debra Ness

With Medicaid expansion, the work of the Child and Adult Task Forces contributes to the care of over 80 million beneficiaries. The National Partnership for Women & Families commends the exemplary MAP process of multi-stakeholder collaboration that brings together members of the MAP Medicaid Child Task Force, members of the MAP Medicaid Adult Task Force (for areas of overlapping scope), state Medicaid program leaders, CMS staff, NQF staff and interested members of the public. This provides a strong basis for work to strengthen the child core measure set program and improve the quality of care provided to children and childbearing women covered by Medicaid, the nation’s largest insurer, and CHIP. The Child Task Force recommendations for both removing lower-value measures and adding new higher-value measures that fill important gaps will strengthen the measure set and enhance the ongoing development of this important, maturing program.

TX HHSC

Denbigh Shelton

Thank you for the opportunity to comment on the draft MAP report. Texas reports on the child core set annually and values the ability to look our quality performance in the national context and in comparison to other states. At the same time, core set reporting requires time and resources and so we have a stake in ensuring that the measures are as meaningful as possible and that reporting is practicable within our resource limitations.

Texas generally supports the measure selection criteria used by MAP and believes more emphasis could be placed on prevention. Texas would like to see consideration of measures that lead to value-based performance as well as measures that assess care coordination and look at social determinants of health. Other than the diabetes measures, the measure set is primarily process focused rather than outcome focused.

The community linkages, described as an outcome of the feedback from stakeholders, does not seem to have been incorporated in the measure set.

Additionally, it is not clear if the recommendations made by the Oregon team have been implemented; they provide a rigorous framework for measure development.

WellCare Health Plans, Inc.

Howard Shaps

In the sections entitled, “State Experience Collecting and Reporting the Child Core Set,” the State of Oregon recommended that “Medicaid population characteristics such as housing, behavioral issues and co-morbid health issues be considered when using data collected through measurement, especially since the most vulnerable cohorts may be missing due to population instability and transiency.” WellCare supports considering Medicaid sociodemographic characteristics such as housing, behavioral issues, and co-morbid health issues when using data collected through measurement because sociodemographic characteristics can play a significant role in data outcomes.

As a health plan dedicated solely to serving public program beneficiaries, WellCare has considerable experience serving populations that tend to be of lower socioeconomic status (SES). We believe that the current quality rating systems do not account for the health, education, and economic characteristics when evaluating the average beneficiary’s experience. Without accounting for such factors, performance results may lead to inaccurate and misleading findings that quality is worse in low-income areas, or that providers and plans serving these communities are providing services of lower quality.

Measure-Specific Recommendations

Academy of Managed Care Pharmacy

Susan Oh

The Academy of Managed Care Pharmacy (AMCP) appreciates this opportunity to offer comments on the draft report “Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2016.”

AMCP is a professional association of pharmacists and other practitioners who serve society by the application of sound medication management principles and strategies to improve health care for all. The Academy’s 8,000 members develop and provide a diversified range of clinical, educational, medication and business management services and strategies on behalf of more than 200 million Americans covered by a managed care pharmacy benefit.

AMCP supports the inclusion of NQF measure #2801Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics recommending psychosocial therapy as the first treatment option for care of ADHD or disruptive behavior. Antipsychotic medications do not have a Food and Drug Administration for these conditions, but are often inappropriately or unnecessarily prescribed.

American Academy of Pediatrics

Caitlin Van Sant

Initially, AAP urges that measures should be chosen for the core set based on their impact on child health. First, pediatricians want to measure what is important to child health, not only what is easy to collate and process. AAP is concerned that the measures that were both chosen to be removed and also to be phased in to the core set do not have large impacts on child health outcomes. To avoid this in the future, CMS and the MAP should clarify the goals the core set is trying to achieve for child health. Currently, there is a lack of balance in the domains that are prioritized versus represented in the core set, and while critical for child health, maternity care/perinatal measures are disproportionately represented. AAP would urge that the MAP focus on measures that will expose core issues about the health of children in a balanced and holistic way and more deeply explore what kinds of measures will help us know that care providers are meeting those goals.

American Nurses Association

Maureen Dailey

There are inherent Implications for the nursing profession as a whole, education, and the broad range of settings where nurses care for children and their families for all endorsed measures. Nurses at all levels of preparation, care for children with conditions represented in the endorsed measures. Nurses are also inextricably linked to the optimal care coordination, including transitional care, and family experience with care coordination and other PROMPM measures. Additionally, nurses have been at the forefront of many of the additional quality issues addressed by the SC.

American Psychiatric Foundation

Samantha Shugarman

Child Core Set (FFY 2014 reporting)

1. Follow-up Care for Children Prescribed ADHD Medication (#0108, NQF-endorsed; NCQA)

This is one of earliest measures developed for child mental health. This is a HEDIS measure. The originally intended data source is the health care plan. Remarkably, there has been little improvement between 2006-2014 in adherence rates to either the initiation or continuation phase for this measure. (Initiation: 2006: Commercial HMO 33%, Medicaid HMO 31.8%. 2014: Commercial HMO 38.2%, Medicaid HMO 40.1%. Continuation: 2006: Commercial HMO 38.1%, Medicaid HMO 34%. 2014: Commercial HMO 46.5%, Medicaid HMO 47.5%).1 These findings raise the question of whether monitoring adherence to this indicator is effective in promoting improvement?

In addition, a limitation of this measure is the requirement for children to remain of stimulant medication for at least 210 days to be eligible to be in the sample for the continuation phase. A substantial proportion of children are likely omitted in the denominator for this second phase. Thus simply reporting adherence rate for the continuation phase using a smaller denominator could be misleading to the consumer.

Aside, in the NCQA report on rates of adherence, 1 the "bottom line" assumes the prescriber is a pediatrician, stating "It is important that children be monitored by a pediatrician with prescribing authority."

2. Follow-up After Hospitalization for Mental Illness (#0576, NQF-endorsed; NCQA)

Improvement in adherence rates over time has also been modest and variable. (7 days: 2001: Commercial HMO 51.3%, Medicaid HMO 33.2%. 2014: Commercial HMO 53%, Medicaid HMO 43.9%. 30 days: 2001 Commercial HMO 73.2%, Medicaid HMO 52.2%. 2014: Commercial HMO 71%, Medicaid HMO 63%).1

The specifications are clearly described.

The original data source is the health plan. The assumption is that the data source spans hospital discharge and encounter data for outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of a mental illness within one health plan. The responsibility is thus on the health plan to improve access to care for persons discharged. However, this assumption may not be completely fulfilled. A limitation is that this quality measure may be challenging to use if Medicaid data from different types of providers must be linked. For example, discharge from an inpatient psychiatric unit and then received care in a community mental health center that provides publicly funded care as part of a behavioral health carve-out through a contract with the county department of mental health. The medical performance exclusion also assumes that the clinician will document the reason a patient was unable to complete the follow-up, which is likely to be under-reported.

Measure recommended for phased addition to the Child Core Set 4. Use of First-line Psychosocial Care for Children and Adolescent on Antipsychotics (#2801, NQF-endorsed, NCQA) The overarching goal however of the measure is to address "inappropriate us of antipsychotics in children and adolescents" (p15). The assumption is that if an antipsychotic medication is not FDA approved for the indication, that the use of this medication is inappropriate. However, anti-psychotic medication may sometimes be clinically indicated for severe aggression or self-injurious behavior (i.e., head banging) to reduce risk of injury and use of physical restraints. Ensuring patient safety may be clinically appropriate, and this will not be captured with diagnosis or CPT Code. Other ACA organizations use anti-psychotic medication prescription in children and adolescents to trigger an administrative review of the direct record (i.e., North Carolina). Thus, how appropriateness of antipsychotic medication is operationally defined is simplistic at best, and at worse could have an unintended consequence of placing the child at greater risk for injury to self or others.

The data source is "administrative data" (p15). How do they determine FDA approved indication? Is this based solely on the diagnosis in the health plan data? Primary diagnosis only?

It has only been tested at the state level, with the assumption this is based on Medicaid pharmacy claims data. If so, these data do not include clinical rationale for use of the medication to inform the decision of whether use of the medication was clinically appropriate or not.

How is psychosocial care operationally defined?

The definition of suicide risk assessment is quite broad: "Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness." The operational definition (numerator) is also broad and states, "The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient." The minimum elements are: "1) Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that may influence the desire to attempt suicide; 2) current severity of suicidality; 3) most severe point of suicidality in episode and lifetime." How is judgment operationally defined to standardize training on how to abstract data and decide what counts as a "pass"? For example, does one pass if only specific high risk age, sex and at least one stressor are documented? How is the extent of religious belief or concern not to hurt family determined to be protective? Nevertheless we agree with the option that documentation of suicide risk can be met by use of a standardize tool, such as the Columbia-Suicidal Severity Rating Scale. In addition, there is some inconsistency with AMA's adult measure, NQF 0104 which specifies clearly the frequency of suicide risk assessment and assumes suicide risk assessment is done during the initial evaluation. The description is, "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." The instructions are: "This measure is to be reported a minimum of once during the reporting period for all patients with an active diagnosis of major depressive disorder (MDD) seen individually during the reporting period, including episodes of MDD that began prior to the reporting period." The components of suicide risk are also more clearly defined: "Suicide risk assessment must include questions about the following: 1) Suicidal ideation; 2)Patient's intent of initiating a suicide attempt; AND, if either is present, 3) Patient plans for a suicide attempt; 4) Whether the patient has means for completing suicide.

Anthem, Inc.

Amy Ingham

- Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia Level of Care: Anthem supports inclusion of this measure as Sickle Cell Disease is a measure gap. The measure would help address the gap in a way designed for use among MCOs and states, which would support a comprehensive approach to quality management. We request more detailed specification around this measure, as health plan experience with this measure has been limited thus far.
- PC-05 Exclusive Breast Milk Feeding: Anthem recognizes the valuable contributions of breast feeding to improving public health. However, we do not support the addition of this measure. It is endorsed for hospital usage which makes sense considering that state Medicaid agencies and MCOs would have very limited influence over a hospital's practice to encourage use of breast milk feeding. Furthermore, the data needed to calculate the measure is only collected within facilities. Health plans would only be able to obtain information if facilities were to be forced to include the information on all delivery claims, but otherwise, patient interviews and costly chart reviews would be necessary. Lastly, we are concerned with testimony that MAP has received regarding the higher risk of gaming of this measure.
- PC-05 Exclusive Breast Milk Feeding (e-measure): Anthem holds similar concerns with the addition of this measure as those described above.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: Anthem is not fully supportive of the addition of this measure as there is already a separate measure included in the core set which measures antipsychotic overuse. In an effort to maintain a concise set of measures, we suggest MAP refrain from recommending the inclusion of additional measures which may prove duplicative.
- Contraceptive Care – Postpartum: Anthem supports effective access to contraceptive care. However, we recommend that unless this particular measure is NQF endorsed for "state populations" and "health plan" levels of analysis, MAP refrain from recommending this as an additional measure.
- Frequency of Ongoing Prenatal Care Measure: Anthem supports the recommendation that this measure be removed. We wish to note that as more states move toward bundled payments for maternity care, MCOs lack the specificity of data needed to calculate this measure.
- Child and Adolescents' Access to Primary Care Practitioners: Anthem does not object to the removal of this measure.

Centers for Disease Control and Prevention

Suzanne Beavers

We support NQF Measure #1800 (Asthma Medication Ratio) because of its association with improved outcomes for patients with persistent asthma. Several studies have shown that both children and adults with persistent asthma with a ratio of controller medications to total asthma medications dispensed of at least 0.5 are less likely to have an asthma exacerbation and less likely to visit the emergency department or be hospitalized than persons who have a ratio of less than 0.5. 1-4 A ratio of 0.5 or greater for the asthma medication ratio has also been associated with improved asthma control. 4 In addition, the asthma medication ratio may better control for asthma severity than other measures evaluating asthma controller use that have not shown an association with improved outcomes. 1 By encouraging the use of regular controller medications for the management of asthma and discouraging excess prescription of short-acting Beta-agonists for asthma management, the asthma medication ratio also promotes guidelines-based care (2) and patient safety. It is the only current asthma measure that addresses the National Quality Strategy priority of safer care.

Because the asthma medication ratio encourages guidelines-based care and is the process measure most closely associated with better asthma control, decreased ED visits, and decreased hospitalizations due to asthma, we support its inclusion in the Medicaid Child Core Measure Set.

1) Yong PL, Werner RM. Process quality measures and asthma exacerbations in the Medicaid population. J Allergy Clin Immunol 2009;124:961-966.

2) Vernacchio L, Trudell EK, Muto JM. Correlation of care process measures with childhood asthma exacerbations. Pediatrics 2013;131:e136-3143.

3) Andrews AL, Simpson AN, Basco WT, Teufel RJ. Asthma medication ratio predicts emergency department visits and hospitalizations in children with asthma. Medicare and Mediciaid Research Review 2013;3:E1-E10.

4) Schatz M, Zeiger RS, Vollmer WM, Mosen D, Mendoza G et al. The controller-to-total asthma medication ratio is associated with patient-centered as well as utilization outcomes. Chest 2006;130:43-50.

The conclusions expressed here are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Idaho Medicaid

Matt Wimmer

Thank you for the opportunity to comment on the Draft Map Report for the Child Core Set.

Idaho Medicaid does agree with MAP's recommendation to remove NQF#1391 and the Child and Adolescent Access to Primary Care Practitioners. The administrative burden to collect/report on these measures is greater than the benefit.

Idaho Medicaid would also agree that measures (such as the asthma, HPV & chlamydia measures) which span both the child and adult populations have proven to be less of an administrative burden for our organization to report on and as a result, we've reported on all of these measures.

National Association of Pediatric Nurse Practitioners

Laura Searcy

After clarification regarding several of the measures, mostly related to making sure that the NICU population is not lumped in with otherwise normal healthy infants, NAPNAP supports the proposed changes and additions to the measures and offers the following specific comments:

Measure 1959: To be consistent with CDC guidelines for HPV vaccination, this measure should be broadened to include HPV vaccination for all adolescents, as male and female adolescents should receive the HPV vaccine series.

Measure 0033: The measure should assess chlamydia screening in both male and female patients. The patients currently included in the measure are sexually active 16-24 year olds, but the age should be broadened to include younger male and female adolescents, beginning at age 14, who are sexually active.

Measure 0024: The current measure, which refers to patient who had an outpatient visit with a primary physician or an OB/GYN should be revised with provider-neutral language to refer to "primary care clinician."

Measure 2801: NAPNAP is pleased to see the addition of this measure. Psychosocial interventions are first-line evidence-based interventions for many behavioral disorders (depression, anxiety) and important adjunctive treatments for others (ADHD). However, we are concerned about the denominator statement focused on children and adolescents who prescribed antipsychotic medication for which they do not have a primary indication recognized by the Food and Drug Administration. Many atypical antipsychotic medications have common, accepted, and some evidence-based off-label uses that may appear inappropriate because they are not for "primary" FDA indications. NAPNAP encourages the MAP to consider the use of off-label medications as appropriate therapy for the treatment of pediatric mental health conditions since these medications are limited through the FDA approval process for use in pediatrics.

Measure 0480 and measure 2830: NAPNAP supports the inclusion of these measure to encourage the adoption of and support the use of quality measures in the perinatal period to help mothers meet their goals for exclusive breastfeeding. We also support the re-engineering of PC-05 as an electronic clinical quality measure (eCQM) to enhance data collection.

Measure 2902: We believe contraceptive counseling in the early postpartum period should be tailored to support breastfeeding and that methods that may reduce maternal milk supply should be avoided until the mother's milk supply is well-established and breastfeeding is going well.

National Partnership for Women & Families

Debra Ness

The National Partnership for Women & Families strongly supports the Child Task Force recommendation to remove both #1391 Frequency of Ongoing Prenatal Care and Child and Adolescents' Access to Primary Care Practitioners (latter is not NQF-endorsed) from the Child Core Set. Measures of the fact of a visit do not provide meaningful information about the quality of care provided, patient-reported and other outcomes of care, patient experience of care, resource use, and other more direct indications of health care quality. Further, we note that the evidence base for #1391 is expert consensus, which does not meet NQF consensus development standards, and that the concurrent Perinatal and Reproductive Health Standing Committee is recommending against continued endorsement of this measure. We also note that the measure of primary care visits is topping out. Recommendations in both cases are respectful of use of states' limited Medicaid resources, considerable efforts for collection and reporting of core measures and use of these measures for quality improvement. In general, limiting the core set to measures with a clear, strong relationship to quality will enhance participant buy-in, wise use of resources and program success.

The National Partnership for Women & Families strongly supports the Child Task Force recommendation to add NQF #0480 PC-05 Exclusive Breast Milk Feeding and its companion emeasure format #2380 to the child core set. Both versions received strong support from the concurrent Perinatal and Reproductive Health Standing Committee and are completing the consensus development process (#0480 would be maintained, and #2380 would be newly endorsed). Further, this would contribute to the broader goal of measure alignment by adding to the combined MAP Medicaid Core Sets another measure within the Obstetrics and Gynecology set of the Core Quality Measures Collaborative.

In considering burden for states, we view #0480 and #2380 to be two collection options for the same measure and not two new independent measures, and we encourage a reframing in the report to reflect this. We welcome the emeasure option and commend The Joint Commission for their work to develop it.

Exclusive Breast Milk Feeding is optimal for inclusion in the Child Core Set for many reasons. Most notably, breastfeeding is preventive of a large number of shorter- and longer-term infectious and chronic conditions in both women and babies. Benefits of breastfeeding have favorable financial implications for Medicaid and health systems. Breastfeeding benefits are well established for both healthy babies and vulnerable babies facing serious health challenges in the newborn period. This measure is relevant to a very large segment of the large population of childbearing women and newborns. Its performance to date suggests that it has the potential to reduce disparities in breastfeeding among Medicaid beneficiaries and within the general population. Further, exclusive breast milk feeding at hospital discharge is an essential step in helping childbearing women and infants meet established professional standards for duration of both exclusive breast milk feeding and any breast milk feeding.

The National Partnership for Women & Families strongly supports the Child Task Force recommendation to add NQF 2902 Contraceptive Care – Postpartum. The Perinatal and Reproductive

Health Standing Committee has strongly supported this measure within the concurrent consensus development process. This newly available measure fills an important gap in contraception access and counseling. Of the over 300 measures currently endorsed by NQF, none pertain to family planning.

Postpartum contraceptive access and counseling is a vital health tool for women to plan and space healthy pregnancies, which improves health outcomes for both mother and child long term. All too often, postpartum care in hospitals and offices is a missed opportunity for counseling and informed choice of provision of a relatively effective method of contraception. This measure will help improve the quality of postpartum care in an area that is relevant to almost all women after giving birth.

Reproductive coercion has a troubling history and remains an ongoing reality for many. We hope this measure will soon be paired with a woman-reported "balancing measure" of experience of receiving contraceptive care. Such a measure can be expected to help identify and/or check inappropriate pressure from the health care system at this time. We understand that the Office of Population Affairs (#2902 developer/steward) has issued a contract for developing such a measure and encourage its rapid completion and submission for endorsement. We hope that a strong endorsed measure of experience of receiving contraceptive care will soon be available for inclusion in the MAP Medicaid Core Sets.

Pennsylvania Department of Human Services

Jennifer Johnson

Pennsylvania's Department of Human Services' (DHS) Office of Medical Assistance Programs (OMAP) would like to comment on MAP: Strengthening the Core Set of Healthcare Quality Measures for Children Enrolled in Medicaid and CHIP, 2016 report that supported the addition of five measures and the elimination of two measures believed to be ineffective to the Child Core Set to cover quality measurement gaps. Medicaid and CHIP play an integral role across the United States through covering health care expenses for the low-income children and adolescent population. It is a difficult task to ensure that this subset of the population remains healthy and engages in behaviors that address, maintain, and treat threats to their health and Pennsylvania thanks MAP for their ongoing work on researching, analyzing, and selecting key performance measures that evaluate and advance the quality of care provifded to children enrolled in the Medicaid and CHIP programs.

1. Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia Level of Care: DHS will not support this measure.
2. PC-05 Exclusive Breast Milk Feeding: DHS will not support this measure.
3. PC-05 Exclusive Breast Milk Feeding (eMeasure): DHS will not support this measure.
4. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics: DHS believes that this is an important endeavor and measure but at the present time more details and specifications are needed for further review.
5. Contraceptive Care -- Postpartum: This measure is something that DHS is working on and lists as a priority. However, more specifications are needed before we can offer our support on this measure.

MAP recommends that two measures be removed from the Child Core Set. DHS respectfully disagrees with this stance and would argue that they are valuable inclusions that should be maintained. We do not support this recommendation. In conclusion, DHS needs to see more specifications for two of the suggested performance measure selections in order to make a determination of support. DHS does not support the first three suggestions for inclusion nor does it support removing the two measures.

Planned Parenthood Federation of America

Emily Stewart

Planned Parenthood Federation of America ("Planned Parenthood") and Planned Parenthood Action Fund ("the Action Fund") are pleased to submit these comments to two draft reports regarding core sets of health care quality measures for adults and children enrolled in Medicaid. We appreciate the opportunity to provide feedback on the draft recommendations and have submitted the same comments to MAP's Adult Task Force.

We applaud MAP's recommendation to add post-partum contraceptive care to the 2017 Core Set for children, recognizing the importance of family planning and birth spacing to birth outcomes. We agree the measure considered is an important quality measure for child health, and support MAP's recommendation, conditional on endorsement.

However, it is disappointing that MAP is not supporting, as it has in the past, other contraceptive care measures, especially provision of a most or moderately effective method to women at risk of unintended pregnancy. This measure is highly appropriate for inclusion. There are compelling reasons to add it to both Core Sets, and to add the similar post-partum measure to the Adult Set.

In promulgating the Adult Core Set in 2012, the Centers for Medicare and Medicaid Services (CMS) gave particular emphasis to measures currently in use in federal programs, and continues to prioritize alignment with federal partners. The contraceptive care measure is currently in developmental use by CMS in the Medicaid Maternal and Infant Health Initiative, including 13 state grantees reporting on the measure. The federal Title X family planning program has also piloted the measure and initiated programs to assist grantees with contraceptive care quality measurement and improvement. The measure is now pending NQF endorsement, but it is important to note that CMS does not require it for inclusion in the Core Sets.

Reducing unintended pregnancy is an objective of national initiatives such as Health People 2020, and the Institute of Medicine has identified a need to measure contraception as a core health indicator. Adding this contraceptive measure to the Core Sets will fill a critical gap in Medicaid quality measurement, ensure future Medicaid payment reforms reflect the majority of the Medicaid population, and improve women's access to care. Across all ages, the majority of Medicaid enrollees are female. The vast majority of women enrolled in Medicaid are of reproductive age (18-44), and Medicaid funds nearly one half of U.S. births. It is critical that the Core Sets adequately reflect the people the Medicaid program serves and their basic health care needs, which absolutely include access to contraceptives. We thank MAP for its dedication to improving access to quality care, and we look forward to working with MAP and NQF in this important work.

Sally E. Turbyville

Thank you for the opportunity to comment. These comments represent my comments as a member of the public and are not in any way tied to any current or previous employment relationships.

I am very concerned about recommending measures of contraceptive actual use for women to be reported as part of a State Medicaid quality core measure set. While I am a big public health advocate and support public health goals, including the knowledge of and real access to contraception a critical and basic health care service, these measures are not patient-centric; and this in an area where we should be leaning heavily toward patient-centric measures and not simply a count of the number of contraceptive services rendered. I myself have a family member who was sterilized without being told she had been sterilized; she did not find out until years later. This happened in my lifetime and in my family.

My comment focuses on the recommended measure (2902) that assesses how many women (15 – 44 years) who had a live birth AND who within 3 to 60 days of the live birth was administered one of the following contraceptive methods: sterilization, implants, intrauterine devices or systems (IUD/IUS)—labeled most effective--; injectables, oral pills, patch, ring, or diaphragm (FDA-approved methods of contraception)—labeled moderately effective; or long-acting reversible method of contraception (LARC). Being proposed as a measure for inclusion in the Medicaid Core set means that women on Medicaid who deliver a live birth will be in the denominator statement and that performance is measured by how many of these women actually undertake one of these methods. It is not a measure that assesses how knowledgeable these women are about these treatments, and whether the information was delivered in a patient-centric fashion.

While the measure itself may be scientifically valid and provide information that is useful, proposing it as part of the Medicaid Core Set implies that states should strive to perform well in this measure—and in this case, performing well is to increase the number of women that undergo one of the listed contraceptive methods. Having NQF endorsement does not speak to whether the measure is suitable for such a core set. Further, the suitability for this measure for payment in Medicaid is highly questionable, and requires extensive vetting—including with Medicaid moms and advocates. While inclusion in the Core Set does not imply suitability for payment, it is a risk that is very much one I think should err on the side of caution.

These measures in a Medicaid core set fly in the face of what we know to have been an area fraught with coercion and deception, including forced sterilization or paying women with few financial services to use a contraception that may or may not align with their beliefs. I encourage work group members and others to take note of even recent forced sterilization accounts, as well as other documented coercive approaches to reduce the number of babies born to women of less financially advantaged homes, or for other opinions about who is fit to have children

I would like to suggest that what is needed is a patient-centric measure that assesses the woman's knowledge of her options and her access to options (including cost and other access barriers). However, the measure fails to assess whether the woman, who is the recipient of these services, has been provided adequate information in a manner that allows her to make a decision with full understanding of the consequences and alignment with her beliefs. I agree that adequate access to these services is of urgency, but that there are other ways to assess how well we are delivering the information and ease of access that are more patient-centric and not strictly based on whether the woman receives the service.

Further, I recommend that CMS consider emphasizing the role of the patient voice…in this case, women (15 to 44 years) who have given birth and were Medicaid beneficiaries at the time of delivery. I was not able to identify if this important stakeholder group was included in the measure topic and prioritization, and the construct of the measures themselves.

Again, thank you for all the hard work and allowing me the opportunity to comment as part of the public.

TX HHSC

Denbigh Shelton

With regard to the measures supported by MAP for addition to the core set, there are several measures that require medical records or electronic health records (EHR), including:

- National Healthcare Safety Network (NHSN) Central Line- Associated Bloodstream Infection (CLABSI) Outcome Measure
- PC-02 Cesarean Section
- Audiological Evaluation No Later Than 3 Months of Age (AUD)
- Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
- Maternity Care: Behavioral Health Risk Assessment
- PC-05 Exclusive Breast Milk Feeding
- PC-05 Exclusive Breast Milk Feeding (Conditionally Support)

While Texas is working on several projects related to EHR, we do not currently have the systems in place or the resources to calculate these measures.

In terms of the additional measures that NQF is considering, more information is needed on the Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Disease, and Duration of first observed enrollment measures in order to evaluate the feasibility of reporting them. Texas has run the Contraceptive Care – Most & Moderately Effective Methods and found that the rate for children is very low.

With regard to the Adolescent Assessment of Preparation for Transition (ADAPT) to Adult-Focused

Health Care measure, adding survey measures is challenging because we do not want to over-burden our members by making the surveys too lengthy. Additionally, we alternate the programs we survey each year so we would not have complete survey data on an annual basis. However, transition from pediatric to adult focused health care is important to Texas and will likely be a part of our caregiver surveys in the future.

The Pediatric All-Condition Readmission Measure is one that Texas has an interest in tracking. Currently the HEDIS version is for adults only, however we would like to see an analogous measure for children and would be interested in tracking and reporting if the specifications were standardized and the measure endorsed.

Again, thank you for the opportunity to comment.

WellCare Health Plans, Inc.

Howard Shaps

WellCare strongly supports phasing in NQF #2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics. Psychosocial care is effective evidence-based care which often averts the need for antipsychotic medications. These medications are associated with a number of side effects that may lead to other conditions as these children and adolescents age. Phasing in this measure helps ensure that the most appropriate and conservative care is given to the patient.

WellCare commends the MAP for continuing to identify measure gaps and its attempts to eliminate them. We agree that care coordination is a significant measure gap, particularly transitions between primary care to specialists and primary care to behavioral health providers. Increased communication and accountability between these groups of providers is essential for ensuring collaboration between providers.

Strategic Recommendations

American Academy of Pediatrics

Caitlin Van Sant

AAP would respectfully remind the MAP and CMS that the pediatric core set was never designed by Congress to be limited to the Medicaid/CHIP population. The care of fewer than half of children in the US is financed by Medicaid and CHIP, and most low income children are covered by private insurance. Congress realized this fact when enacting CHIPRA Title IV, which calls for the core set to be established both for the use of all child health care providers and also to reach beyond publicly financed programs (See CHIPRA §401(a)(1-2)). Nevertheless, the MAP has only focused on the Medicaid and CHIP programs. Beyond Congress's statutory direction, such a focus is even less persuasive as each plan that will list in the Marketplace must now include a quality improvement strategy (See ACA §1311). As is obvious, CHIP and Medicaid are not listed as plans that can be purchased for children in the Marketplace, but by harmonizing measures deployed by Medicaid, CHIP and Marketplace plans, the pediatric quality improvement enterprise stands a better chance to generate data that can be compared across payers and focus on children rather than be siloed by financing schemes. AAP urges the MAP to widen its focus to all children and not just children whose care is financed by Medicaid and CHIP.

AAP would strongly urge CMS to consider allocating more resources towards development, testing and validation of child health measures. Social and economic determinants of health are critical for protecting and supporting children and families, but unfortunately these domains do not have validated high quality measures associated with them. AAP would urge that CMS target more resources to focus on these domains. To best achieve this focus, AAP would urge that the MAP and CMS explore producing a mandatory core set for reporting by States, with appropriate resources and technical assistance provided to States to support implementation and reporting. CMS could consider two sets of measures for mandatory reporting: a “foundational set” on which all States must report which would reflect national priorities and a ”supplemental set” from which States might choose to measure progress under their own priorities. There is precedent for this kind of structure in the context of Home Visiting programs and Meaningful Use requirements, but currently CMS’s limited resources appear to be misallocated.

Anthem, Inc.

Amy Ingham

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

It is vital that measures include detailed technical specifications. Specifically:

- If claims information should be used, then Dx/CPT codes should be provided,
- If medical record review should be used, then denominator/numerator components of medical record review should be defined,
- Specific definitions and clear guidelines should always be provided. For example, the Pediatric Central Line- Associated Blood Stream Infections measure is problematic due to lack of definition. We do not know how to report the measure.

We would like better alignment with NCQA measures and the Core set. The non-HEDIS measures are difficult to run because of software, benchmarking, and process challenges making the audit of the accuracy of the rates difficult

Mental Health America

Nathaniel Counts

Mental Health America (MHA) applauds the work of the MAP Medicaid Child Task Force. While the measures in the current Child Core Set offer a strong start, they also point to another high priority need in measure development.

Consider a child, whose mother is screened for behavioral risks when she is born, and then she receives her developmental screen at age two, and then begins receiving behavioral health screens starting at age twelve during each periodic well visit. Both she and her parents might exhibit some behavioral health symptoms at some visits, but all screen below the diagnostic threshold each time and she does not show clinically significant developmental delays during the developmental screen. When she goes for her visit at age nineteen, she now screens positive for depression. At that point quality measurement would begin capturing her experience of care. During the previous years, her providers could have provided anticipatory guidance and preventive interventions for her and her parents, which might have prevented or mitigated her depression but the effectiveness of these efforts are not captured in measurement.

Quality measurement struggles to capture outcomes related to prevention throughout the course of an individual’s development. Effective prevention will need to be measured to achieve the greatest gains in the triple aim.

Necessarily short periods of patient attribution to individual health care systems, as well as churn on and off of Medicaid, make this a difficult problem to solve with current outcome measures. Outcome measures are needed that the health care system could reasonably affect within a short timeframe, but predict health outcomes later in life.

The Institute of Medicine began to address this in Children’s Health, the Nation’s Wealth, which highlighted the importance of measuring “health potential” in addition to functioning and health conditions. In the context of mental development, health potential refers to developmental competencies (such as self-regulation and verbal skills). Decades of prevention science have found interventions that build on developmental competencies within a short time-frame to prevent long-term problems, including many of those on which the USPSTF focuses. These interventions allow for greater gains in the triple aim of health care than focusing on preventing or treating a single health condition, such as depression, and require only a few aspects of development to be measured, rather than measuring each condition.

MHA urges the MAP to recommend inclusion of life-course developmental competencies as a remaining high priority gap. Filling this gap would ensure that quality measurement addresses the issue outlined above, and encompasses many other priority gaps, such as ACEs, mental health, maltreatment and neglect, and substance use. MHA thanks you for your time and consideration.

National Association of Pediatric Nurse Practitioners

Laura Searcy

NAPNAP shares the Task Force’s concern regarding alignment of goals across federal, state, and local agencies, and strengths and limitations related to data collection related to the overall goal of quality improvement. We agree that flexibility is important since the Core Sets are relatively new and states are at various stages of developing the infrastructure needed for measure adoption and reporting, particularly with the expansion of coverage and the recent growth of the Medicaid population.

Further, NAPNAP strongly encourages the development of more adolescent health measures focused on mental and behavioral health; delivery of preventive health care and health education; and mental health care measures in all ages of pediatric patients. We also strongly reiterate the importance of care coordination and the role of APRNs in that coordination, including communication and coordination among acute care, urgent care, and primary care providers.

This highlights the need for interoperability of health information technology (HIT). NAPNAP would also underscore the need for initial and ongoing financing to support HIT interoperability. Without such support, APRNs are unlikely to be able to optimize data collection, evidence based practice, and quality improvement.

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