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Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets

Draft Report for Public Comment

July 2021

2022 CHILD AND ADULT CORE SET ANNUAL REVIEW STAKEHOLDER WORKGROUP MEMBERS

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Acronyms

ACE	Adverse childhood experiences
ACO	Accountable care organization
ADA	American Dental Association
AHRQ	Agency for Healthcare Research and Quality
AMB-CH	Ambulatory Care: Emergency Department (ED) Visits
AOD	Alcohol and other drug
AUD-CH	Audiological Diagnosis No Later than 3 Months of Age
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CDP-AD	Controlling High Blood Pressure
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CPA-AD	CAHPS Health Plan Survey 5.0H, Adult Version
CPC-CH	CAHPS Health Plan Survey 5.0H, Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items
DQA	Dental Quality Alliance
ECDS	Electronic Clinical Data Systems
ED	Emergency department
EHDI	Early Hearing Detection and Intervention
EHR	Electronic health record
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment

FFY	Federal fiscal year
FIT	Fecal immunochemical test
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow-Up After Emergency Department Visit for Mental Illness
FVA-AD	Flu Vaccinations for Adults Ages 18 to 64
HbA1c	Hemoglobin A1c
HCBS	Home- and community-based services
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HMO	Health maintenance organization
HPC-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
IET-AD	Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment
LBW-CH	Live Births Weighing Less than 2,500 Grams
LTSS	Long-Term Services and Supports
LRCD-CH	Low-Risk Cesarean Delivery
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
NCI-AD	National Core Indicators for Aging and Disabilities
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder
PC01-AD	PC-01: Elective Delivery

PCMH	Patient-Centered Medical Home
PCPI	Physician Consortium for Performance Improvement
PDC	Proportion of Days Covered
PDENT-CH	Percentage of Eligibles Who Received Preventive Dental Services
PQA	Pharmacy Quality Alliance
Q&A	Question and answer
QTAG	Quality Technical Advisory Group
RAS	Renin angiotensin system
SFM-CH	Sealant Receipt of Permanent First Molars
SUD	Substance use disorder
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support
TAF	T-MSIS Analytic Files
TJC	The Joint Commission
T-MSIS	Transformed Medicaid Statistical Information System
URI	Upper respiratory infection
USPSTF	U.S. Preventive Services Task Force
WONDER	Wide-ranging Online Data for Epidemiologic Research

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to 80.5 million people, including eligible children, pregnant women, low-income adults, the elderly, and individuals with disabilities.[1] To help ensure that Medicaid and CHIP beneficiaries receive coverage that promotes access to and receipt of high quality and equitable care, the Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care that beneficiaries receive and to drive improvement in Medicaid and CHIP. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries through state reporting on a uniform set of measures. The measures are used to monitor the performance of state Medicaid and CHIP programs over time and to drive improvements in care delivery and health outcomes for beneficiaries. Although state reporting on the Core Sets is currently voluntary, the Child Core Set measures and the behavioral health measures in the Adult Core Set will become mandatory for state reporting in 2024.[2]

The Secretary of the U.S. Department of Health and Human Services (HHS) is required to review and update the Child and Adult Core Sets each year.[3] The Core Set Annual Review process is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from numerous stakeholders, including but not limited to state Medicaid and CHIP agency representatives, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2022 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup). The Workgroup included 29 members, who represented a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover for a list of the Workgroup members).

The Workgroup was charged with assessing the 2021 Core Sets and recommending measures for removal or addition, in order to strengthen and improve the Core Sets for 2022. Workgroup members were asked to suggest, discuss, and vote on the measures based on whether they could meaningfully drive improvement in care delivery and health outcomes for Medicaid and CHIP

[1] January 2021 Medicaid and CHIP enrollment data highlights are available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. The numbers reflect Medicaid and CHIP enrollment data as of January 2021 (last updated as of April 2, 2021), as reported by 50 states and the District of Columbia.

[2] Bipartisan Budget Act of 2018, P.L. 115-123 and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271.

[3] Annual updates to the Child Core Set are required under the Children's Health Insurance Program Reauthorization Act of 2009. Annual updates to the Adult Core Set are required under the Affordable Care Act of 2010.

beneficiaries. See Exhibit ES.1 for the criteria that Workgroup members considered during the 2022 Core Set Annual Review.

Exhibit ES.1. Criteria Considered for Removal of Existing Measures and Addition of New Measures

Criteria Considered for Removal of Existing Measures	
Technical Feasibility	
1.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3.	The specifications and data source do not allow for consistent calculations across states.
4.	The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP or does not allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).
2.	The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3.	The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out or improvement is outside the direct influence of Medicaid and CHIP programs/providers).
Other Considerations	
1.	The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3.	All states will not be able to produce the measure by FFY 2024.
Criteria Considered for Addition of New Measures	
Minimum Technical Feasibility Requirements (all requirements must be met)	
1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	The measure must have been tested in state Medicaid and CHIP programs or be in use by one or more state Medicaid and CHIP agencies.
3.	An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4.	The specifications and data source must allow for consistent calculations across states.
5.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.

Exhibit ES.1 *(continued)*

Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP and to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).[4]
2.	The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3.	The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP.
Criteria Considered for Addition of New Measures	
Other Considerations	
1.	The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications are aligned with those used in other CMS programs, where possible.
3.	All states must be able to produce the measure by FFY 2024, including all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

Workgroup members convened virtually from May 4 to May 6, 2021, to review 7 existing Core Set measures suggested for removal from the 2022 Core Sets and 14 measures suggested for addition. The 21 measures were presented, discussed, and voted on by domain.[5] For a measure to be recommended for removal from or addition to the Core Sets, at least two-thirds of the Workgroup members eligible to vote on a measure must vote in favor of removal or addition.

In summary, the Workgroup recommended the following:

- **Removal of 3 measures from the Child Core Set** out of a total of 3 measures suggested for removal
- **Removal of 1 measure from the Adult Core Set** out of a total of 4 measures suggested for removal
- **Addition of 7 measures to the Child and Adult Core Sets** out of a total of 14 measures suggested for addition

Exhibit ES.2 shows the measures the Workgroup recommended for removal from and addition to the 2022 Core Sets.

[4] https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

[5] The measures were organized for discussion by the following domains: Behavioral Health Care, Dental and Oral Health Services, Care of Acute and Chronic Conditions, Long-Term Services and Supports, Maternal and Perinatal Health, and Primary Care Access and Preventive Care.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2022 Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Removal from the Child Core Set		
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Centers for Medicare & Medicaid Services (CMS)	Not endorsed
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	National Committee for Quality Assurance (NCQA)	Not endorsed
Audiological Diagnosis No Later than 3 Months of Age (AUD-CH)	Centers for Disease Control and Prevention (CDC)	1360
Measure Recommended for Removal from the Adult Core Set		
PC-01: Elective Delivery (PC01-AD)	The Joint Commission (TJC)	0469/0469e
Measures Recommended for Addition		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17[a]	NCQA	3488
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17[a]	NCQA	3489
Oral Evaluation, Dental Services	American Dental Association (ADA)/Dental Quality Alliance (DQA)	2517
Prevention: Topical Fluoride for Children[b]	ADA/DQA	2528
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058
Long-Term Services and Supports: Comprehensive Care Plan and Update	NCQA	Not endorsed
Colorectal Cancer Screening	NCQA	0034

[a] These measures are currently included in the Adult Core Set (FUA-AD and FUM-AD) for the adult age ranges. The Workgroup recommended these measures for addition to the Child Core Set for the child age ranges.

[b] A Workgroup member suggested a version of this measure that focused on children at elevated caries risk (*Prevention: Topical Fluoride for Children at Elevated Caries Risk)*. In spring 2021, the measure steward modified this measure to include *all* children (not just those at elevated caries risk). Because this change applies to calendar year 2021 reporting, which corresponds to the 2022 Child Core Set, the Workgroup discussed and voted on the modified version of the measure.

This report summarizing the 2022 Core Set Annual Review Workgroup's review process, discussion, and recommendations is available for public comment. Please submit public comments via email by **August 6, 2021, at 8 p.m.** Eastern Time to MACCoreSetReview@mathematica-mpr.com and include "2022 Core Set Annual Review Public Comment" in the subject line. A final version of this report, inclusive of all public comments, will be released in August 2021. CMCS will review the final report to inform

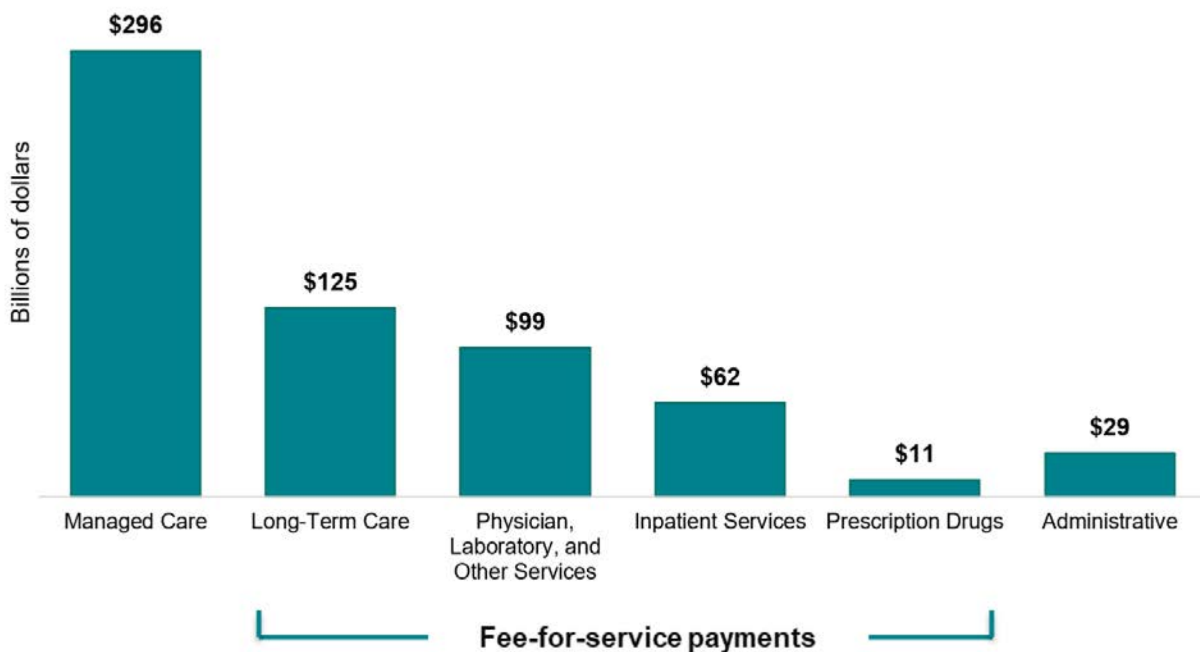
decisions about whether and how to modify the 2022 Child and Adult Core Sets. Additionally, CMCS will obtain stakeholder input from federal agencies and from state Medicaid and CHIP quality leaders to ensure that the Core Set measures are evidence-based and promote measure alignment within CMS and across the federal government.[6] CMCS will release the 2022 Child and Adult Core Sets through a CMCS Informational Bulletin by December 31, 2021.

[6] More information is available in the CMCS fact sheet, Medicaid and CHIP Child and Adult Core Sets Annual Review and Selection Process, at https://www.medicaid.gov/medicaid/quality-of-care/downloads/annual-core-set-review.pdf.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to 80.5 million people, including eligible children, pregnant women, low-income adults, the elderly, and individuals with disabilities.[7] Medicaid and CHIP are the largest single source of health coverage in the United States.[8] Managed care capitation payments are the largest category of Medicaid and CHIP program expenditures, followed by fee-for-service payments for long-term care (Exhibit 1).

Exhibit 1. Annual Medicaid and CHIP Expenditures by Service Category, 2018



Source: CMS. 2020 Medicaid & CHIP Scorecard. Analysis of CMS-64 expenditure reports for FFY 2018 from the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES). Available at https://www.medicaid.gov/state-overviews/scorecard/annual-medicaid-chip-expenditures/index.html.

Notes: Expenditures by service category do not sum to the total expenditures. Total expenditures also include Medicare payments for some beneficiaries and adjustments to prior year payments. Managed care expenditures cover the same services that are delivered via fee-for-service. The data do not permit allocation of managed care expenditures to the different service categories. Data are for FFY 2018.

[7] January 2021 Medicaid and CHIP enrollment data highlights are available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. The numbers reflect Medicaid and CHIP enrollment data as of January 2021 (last updated as of April 2, 2021), as reported by 50 states and the District of Columbia.

[8] Centers for Medicare & Medicaid Services. "New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 million Americans Enrolled in Coverage During the COVID-19 Public Health Emergency." June 21, 2021. Available at: https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during.

The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care that Medicaid and CHIP beneficiaries receive and to drive improvement in care delivery and health outcomes. The Child and Adult Core Sets of health care quality measures are key tools in this effort.

The purpose of the Child and Adult Core Sets is to estimate the national quality of care for Medicaid and CHIP beneficiaries through state reporting on a uniform set of measures. The Core Set measures are intended to cover the continuum of preventive, diagnostic, and treatment services for acute and chronic physical, behavioral, dental, and developmental conditions as well as long-term services and supports. In collaboration with CMCS, state Medicaid and CHIP agencies use these measures to monitor the performance of state Medicaid and CHIP programs and identify where improvements in care delivery and outcomes are needed, and target quality improvement efforts and assess their effectiveness over time.

The Secretary of the U.S. Department of Health and Human Services (HHS) is required to review and update the Child and Adult Core Sets each year.[9] The Core Set Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from numerous stakeholders, including but not limited to state Medicaid and CHIP agency representatives, health care providers, and quality experts. The Child Core Set has undergone these multistakeholder annual reviews since January 2013 and the Adult Core Set since January 2014.

CMCS contracted with Mathematica to convene the 2022 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup). The Workgroup included 29 members, who represent a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover).

The Workgroup was charged with assessing the 2021 Child and Adult Core Sets[10] and recommending measures for removal or addition in order to strengthen and improve the Core Sets for 2022. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Core Sets based on several criteria that support the use of the Core Set measures to meaningfully drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

This report provides an overview of the Child and Adult Core Sets, describes the 2022 Core Set Annual Review process, summarizes the Workgroup's recommendations for improving the Core Sets, and specifies next steps for public comment.

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[9] The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) calls for annual updates to the Child Core Set. The Affordable Care Act calls for annual updates to the Adult Core Set.

[10] More information about the annual multistakeholder review of the 2021 Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview. More information about the 2021 updates to the Child and Adult Core Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf.

Overview of the Child and Adult Core Sets

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions aimed at improving the quality of health care for children enrolled in Medicaid and CHIP. CHIPRA required the Secretary of HHS to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs (referred to as the Child Core Set). The initial Child Core Set, which was released in December 2009, included 24 measures that covered both physical and mental health. The core set of health care quality measures for adults covered by Medicaid (Adult Core Set) was established in 2010 under the Patient Protection and Affordable Care Act (Affordable Care Act) in the same manner as the Child Core Set. The initial Adult Core Set, which was released in January 2012, included 26 measures. Currently, state reporting on the Core Set measures is voluntary. In 2024, the Child Core Set measures and the behavioral health measures in the Adult Core Set become mandatory for state reporting.[11] Each year, CMS publicly reports data for Child and Adult Core Set measures that were reported by at least 25 states and met CMS standards for data quality.

Please refer to Appendix A for tables showing the 2021 Child and Adult Core Set measures and the history of measures included in the Child and Adult Core Sets. Of the 23 measures in the 2021 Child Core Set, about three-fifths were part of the initial Child Core Set. Similarly, of the 32 measures in the 2021 Adult Core Set, about three-fifths were part of the initial Adult Core Set.

The 2021 Child Core Set

The 2021 Child Core Set includes 23 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Dental and Oral Health Services, and (6) Experience of Care.[12] Just over 60 percent of the measures in the 2021 Child Core Set fall into the Primary Care Access and Preventive Care and Maternal and Perinatal Health domains (Exhibit 2). Seventy-five percent (18 measures) are process measures and 83 percent (19 measures) can be calculated using an administrative data methodology.

Highlights for federal fiscal year (FFY) 2019 Child Core Set reporting,[13] the most recent year of publicly available data, include the following:

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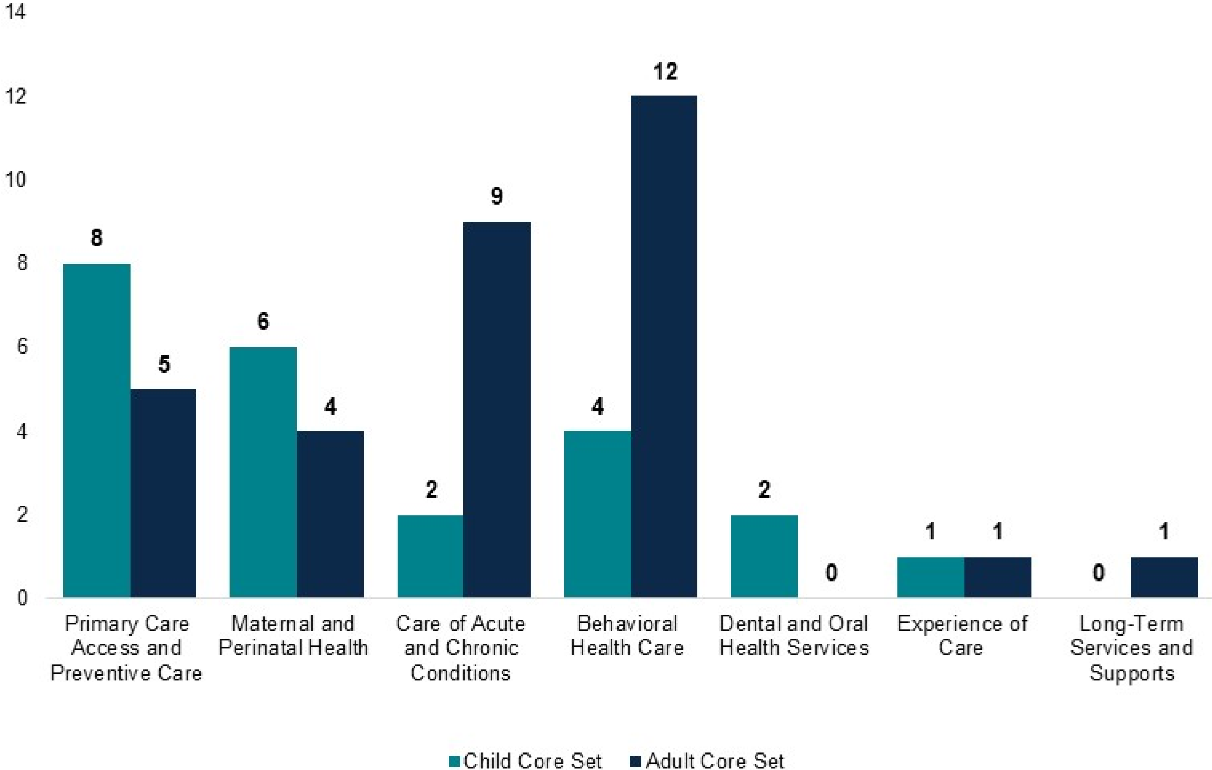
[11] Bipartisan Budget Act of 2018, P.L. 115-123 and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271.

[12] More information about the Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

[13] More information about FFY 2019 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-core-set-reporting.pdf. A chart pack summarizing FFY 2019 Child Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-chart-pack.pdf.

- All states[14] voluntarily reported at least one Child Core Set measure.
- Forty-eight states reported on at least half of the 26 measures in the 2019 Child Core Set.
- Thirty-one states reported on more measures for FFY 2019 than for FFY 2018.
- Forty-eight states reported data on both the Medicaid and CHIP populations.
- The median number of measures reported by states was 20, which was slightly higher than the median number of measures reported for both FFY 2018 and FFY 2017 (18 measures).
- Twenty-three of the 26 Child Core Set measures (88 percent) in the 2019 Child Core Set met CMS's threshold for public reporting of state-specific results.
- The most frequently reported Child Core Set measures for FFY 2019 focused on preventive dental services, low birth weight births, child and adolescent well-care visits, emergency department use, and primary care access. The most frequently reported measures in the Child Core Set are based on existing administrative data sources or are calculated by CMS on behalf of states using alternate data sources.

Exhibit 2. Distribution of 2021 Child and Adult Core Set Measures, by Domain



[14] The term "states" includes the 50 states and the District of Columbia.

The 2021 Adult Core Set

The 2021 Adult Core Set includes 32 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Experience of Care, and (6) Long-Term Services and Supports.[15] The Long-Term Services and Supports domain was added to the Adult Core Set in the 2020 update.[16] Nearly two-thirds of the 2021 Adult Core Set measures fall into the Care of Acute and Chronic Conditions and Behavioral Health Care domains (Exhibit 2). Behavioral Health Care is the largest domain in the 2021 Adult Core Set and the fastest-growing domain over time, with seven measures added to this domain since 2016. Two-thirds (22 measures) are process measures, while 84 percent (27 measures) can be calculated using an administrative data methodology.

Highlights for FFY 2019 Adult Core Set reporting,[17] the most recent year of publicly available data, include the following:

- Forty-six states voluntarily reported at least one Adult Core Set measure.
- Forty states reported on at least half of the 33 measures in the 2019 Adult Core Set, an increase of eight states over FFY 2018 reporting. One state reported all 33 measures for FFY 2019.
- Thirty-six states reported more measures for FFY 2019 than for FFY 2018.
- States reported a median of 22.5 measures, an increase of 2.5 measures over FFY 2018.
- Twenty-five of the 33 measures (76 percent) in the 2019 Adult Core Set met CMS's threshold for public reporting of state-specific results.
- The most frequently reported Adult Core Set measures for FFY 2019 focused on chlamydia screening, follow-up after hospitalization for mental illness, breast and cervical cancer screening, medication management, and diabetes testing. The most frequently reported measures in the Adult Core Set were based on existing administrative data sources.

[15] More information about the Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

[16] More information about the 2020 updates to the Child and Adult Core Sets is available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111919.pdf.

[17] More information about FFY 2019 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-core-set-reporting.pdf. A chart pack summarizing FFY 2019 Adult Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf.

State Challenges with Reporting the Child and Adult Core Set Measures

Understanding state challenges with reporting the Child and Adult Core Set measures is important to assessing the feasibility of calculating existing measures as well as those suggested for addition to the Core Sets. The most common reason states cited for not reporting the Child and Adult Core Set measures for FFY 2019 was lack of access to data to calculate the measure. States' reasons for lack of access to data for Core Set reporting were multifaceted and reflected the pathways through which the data were collected, calculated, and reported (such as through managed care plans or other vendors), as well as the availability of information from sources other than claims or encounter data. For example, common barriers to data availability in FFY 2019 included challenges with accessing the required data sources (including medical records for chart abstraction and linkage to vital records or immunization registries), concerns about the accuracy and completeness of data used in calculating the measure, and resource constraints within the state agencies responsible for Core Set reporting. These challenges were similar to those cited by states for FFY 2018.

Workgroup members were provided with information about states' reasons for not reporting the existing Core Set measures as well as a summary of technical assistance (TA) efforts to improve state reporting on the least-reported measures. These findings informed the Workgroup's discussion of the feasibility of reporting existing measures suggested for removal from the Core Sets and collecting new measures suggested for addition.

Use of the Core Sets for Quality Measurement and Improvement

CMCS and states use the Child and Adult Core Sets to monitor and improve the quality of care provided to Medicaid and CHIP beneficiaries at the national and state levels and to measure progress over time. CMCS publicly reports information on state performance on the Child and Adult Core Sets annually through chart packs and other resources.[18] As noted previously, CMS annually releases Child and Adult Core Set data for measures that were reported by at least 25 states and met CMS standards for data quality. Pillar I of the Medicaid and CHIP Scorecard, State Health System Performance, also uses data for several Child and Adult Core Set measures.[19]

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMCS supports states and their partners in collecting, reporting, and using the Core Set measures to drive improvement in Medicaid and CHIP, while also striving to achieve several goals for state reporting. These goals include maintaining or increasing the number of states that report the Core Set measures, maintaining or increasing the number of measures reported by each state, and

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[18] Chart packs, measure-specific tables, facts sheets, and other Core Set annual reporting resources are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html and https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

[19] More information about the Medicaid and CHIP Scorecard is available at https://www.medicaid.gov/state-overviews/scorecard/index.html.

improving the quality and completeness of the data reported.[20] CMS also continuously explores opportunities to increase the efficiency of reporting and reduce state reporting burden, streamline Core Set reporting for states, and improve the transparency and comparability of the data reported across states. The TA/AS Program offers states various opportunities to address technical issues related to collecting and reporting the Core Set measures, including a TA mailbox, one-on-one consultation, issue briefs, fact sheets, analytic reports, and webinars.

CMCS has also developed initiatives to drive improvement in health care quality and outcomes using Core Set measures—for example, through the Maternal and Infant Health Initiative and the Oral Health Initiative.[21] The TA/AS Program supports CMCS and states in designing and implementing quality improvement initiatives focused on the Core Set measures through affinity groups, online training opportunities, one-on-one and group coaching, and other approaches. The TA/AS Program also supports the annual CMS Quality Conference by providing states with hands-on information and networking opportunities to support their Medicaid and CHIP quality measurement and improvement efforts.

[20] More information about the CMCS TA/AS Program is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/tafactsheet.pdf.

[21] More information about Medicaid and CHIP quality improvement initiatives is available at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/index.html.

Description of the 2022 Core Set Annual Review Process

This section describes the 2022 Core Set Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2022 Core Set Annual Review included 29 voting members from state Medicaid and CHIP agencies, professional associations, universities, hospitals, and other organizations from across the country. The Workgroup was selected through a Call for Nominations issued in December 2018 in conjunction with the 2020 Core Set Annual Review. Changes to the Workgroup composition have occurred due to attrition and career transitions. New Workgroup members have been identified, as needed, through outreach to nominating organizations. The Workgroup members for the 2022 Core Set Annual Review are listed on the inside front cover of this report.

The 2022 Core Set Annual Review Workgroup members offered expertise in primary care access and preventive care, acute and chronic conditions, maternal and perinatal health, behavioral health, dental and oral health, LTSS, and health disparities. Although Workgroup members have individual subject matter expertise and some were nominated by an organization, they were asked to participate as stewards of the Medicaid and CHIP programs as a whole and not from their individual points of view. They were asked to consider what measures would best drive improvement in care delivery and health outcomes for the programs.

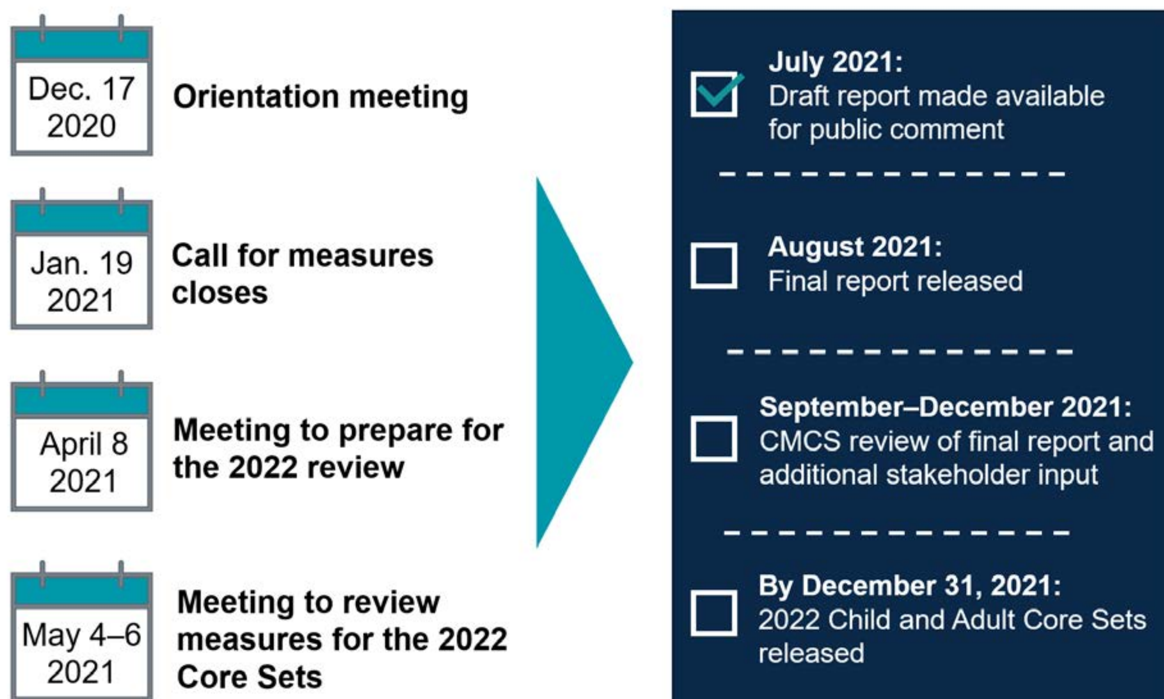
Workgroup members were required to submit a Disclosure of Interest form to report any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict of interest related to the current Child and Adult Core Set measures or other measures reviewed during the Workgroup process. Workgroup members who were deemed to have an interest in a measure recommended for consideration were required to recuse themselves from voting on that measure.

The Workgroup also included nonvoting federal liaisons, who represented eight agencies (see front cover). The inclusion of federal liaisons reflects CMCS's commitment to promoting quality measurement alignment and working in partnership with other agencies to collect, report, and use the Core Set measures to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Workgroup Timeline and Meetings

As shown in Exhibit 3, Mathematica held webinars in December 2020 and April 2021 to orient the Workgroup members to the review process and to prepare them for the 2022 Core Set Annual Review voting meeting, which was convened virtually in May 2021. All meetings were open to the public, and public comment was invited during each meeting.

Exhibit 3. 2022 Core Set Annual Review Stakeholder Workgroup Timeline



Orientation Webinar

During the orientation webinar on December 17, 2020, Mathematica outlined the Workgroup charge, introduced the Workgroup members, and provided background on the Child and Adult Core Sets.

After providing an overview of the process for the 2022 Core Set Annual Review, Mathematica reviewed the outcomes of the previous year's Workgroup. Mathematica described the additional stakeholder input that would be obtained during the 2022 Annual Review process, including input from federal partners, internal stakeholders within CMS, and CMCS's Quality Technical Advisory Group (QTAG).

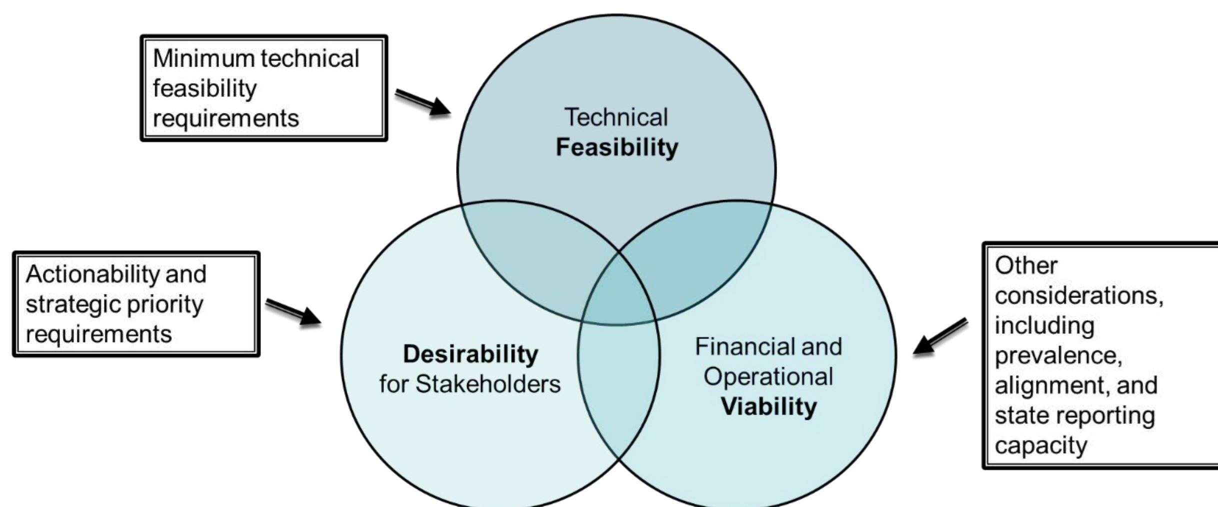
> **Workgroup Charge**
>
> The Child and Adult Core Set Stakeholder Workgroup for the 2022 Annual Review is charged with assessing the 2021 Core Sets and recommending measures for removal or addition, in order to strengthen and improve the Core Sets for Medicaid and CHIP.
>
> The Workgroup should focus on measures that are actionable, aligned, and appropriate for state-level reporting, to ensure that the measures can meaningfully drive improvement in quality of care and outcomes in Medicaid and CHIP.

Mathematica also explained the Call for Measures process, through which Workgroup members suggest measures for removal from or addition to the Child and Adult Core Sets. Mathematica asked Workgroup members to balance three interdependent components when considering measures for removal or addition: (1) the technical feasibility of measures, (2) the desirability of measures for Medicaid and CHIP stakeholders, and (3) the financial and operational viability for states.

To operationalize these three components, Mathematica identified a comprehensive set of criteria used to assess measures during all phases of the Workgroup process. As shown in Exhibit 4, the Workgroup was charged with focusing on measures that met the following criteria:

- **Minimum technical feasibility requirements:** Availability of detailed technical specifications that enable production of the measure at the state level; evidence of field testing or use in a state Medicaid or CHIP program; availability of a data source with all the necessary data elements; and ability to produce consistent calculations across states
- **Actionability and strategic priority requirements:** Contributes to estimating the overall national quality of health care in Medicaid and CHIP together with other Core Set measures, and can be used to perform comparative analyses; addresses a strategic priority for improving health care delivery and outcomes; and assesses state progress in improving health care delivery in Medicaid and CHIP
- **Other considerations:** Sufficient prevalence of the condition or outcome being measured to produce meaningful and reliable results across states; alignment with measures used in other CMS programs; and capacity for all states to report the measure by 2024

Exhibit 4. Framework for Assessing Measures for the 2022 Core Sets



CMCS provided introductory remarks regarding the Workgroup's charge, emphasizing the importance of the Core Sets across CMCS for measuring the delivery of high quality care for the purpose of improving health outcomes. CMCS noted that Core Set measures function like their "North Star," signaling the measures that stakeholders believe are important to understanding how well Medicaid and CHIP programs serve beneficiaries.

CMCS explained its decision making on updates to the 2021 Core Sets, noting why Workgroup recommendations were taken or not taken. CMCS noted that it deferred decision making on two measures—Postpartum Depression Screening and Follow-up and Prenatal Immunization Status—due to their use of Electronic Clinical Data Systems (ECDS). CMCS is currently

assessing the feasibility of these proprietary measures and whether the measure specifications can be made available to states free of charge as part of the Core Sets.

Call for Measures for Removal from or Addition to the Core Sets

Following the orientation meeting, the Workgroup members and federal liaisons were invited to suggest measures for removal from or addition to the Core Sets to strengthen and improve the Core Sets for 2022. Workgroup members used an online form to submit their suggestions for removal or addition, along with the following information:

- Rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for removal or addition
- Whether the removal of a measure would leave a gap in the Core Sets
- Whether other measures were proposed to replace measures suggested for removal
- Whether measures suggested for addition were intended to replace current Core Set measures

The Workgroup members and federal liaisons suggested 7 measures for removal and 20 measures for addition. Mathematica conducted a preliminary assessment of these 27 measures and determined that 6 of the 20 measures recommended for addition would not be discussed at the May meeting because they did not meet minimum technical feasibility requirements; 5 measures had not been field tested by state Medicaid and CHIP programs, and 1 measure was not fully specified with a rate, numerator, and denominator.

The Workgroup discussed 21 measures during the May meeting:

- **Seven measures for removal** across five Core Set domains, including 3 of the 23 measures in the 2021 Child Core Set and 4 of the 32 measures in the 2021 Adult Core Set
- **Fourteen measures for addition** across five Core Set domains

Please refer to Appendix B for the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the 2022 Core Sets.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on April 8, 2021. To help Workgroup members prepare for the discussion at the 2022 Annual Review meeting, Mathematica shared a list of the 7 measures to be considered for removal and the 14 measures to be considered for addition. Mathematica also provided a list of the measures suggested for addition that would not be reviewed at the May meeting and noted which feasibility criteria these measures did not meet.

Mathematica provided guidance to the Workgroup about how to prepare for the discussion of the measures at the May meeting, including the criteria that Workgroup members should consider for recommending measures for removal from or addition to the Core Sets and the resources available to facilitate their review. These resources included detailed measure information sheets for each measure, a worksheet to record questions and notes for each measure, the Medicaid and CHIP beneficiary profile, the Core Set history table, reasons for not reporting Core Set measures, chart packs and measure-specific tables, and the Core Set resource manuals and technical specifications. Workgroup members were responsible for reviewing all materials related to the measures; completing the measure worksheet; and coming to the Annual Review meeting prepared with notes, questions, and preliminary votes on each measure proposed for removal or addition.

Annual Review Meeting

The 2022 Core Set Annual Review voting meeting took place virtually from May 4 to May 6, 2021. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

The discussion of measures was organized according to the current Core Set domains. The measures that were discussed spanned six of the seven domains.[22] For each domain, Mathematica described the 2021 Core Set measures in the domain, highlighted the measures suggested for removal first followed by the measures suggested for addition, noted the key technical specifications of each measure proposed for removal or addition, and summarized the rationale that Workgroup members provided for suggesting the measures.

Mathematica then facilitated a discussion of the measures being reviewed within each domain. Mathematica sought comments and questions from Workgroup members about each measure after presentation of a set of measures and asked measure stewards to clarify measure specifications when needed. Workgroup discussion was followed by an opportunity for public comment within each domain.

Voting took place after each Workgroup discussion and opportunity for public comment. Mathematica facilitated the voting on the measures suggested for removal or addition. Workgroup members voted electronically through a secure web-based polling application during specified voting periods. Workgroup members who experienced technical difficulties with the voting tool were permitted to submit votes through the webinar question and answer (Q&A) widget, via phone, or via email. Mathematica presented the voting results immediately after each vote and announced if the results met the two-thirds threshold for the measure to be removed or added to the Core Sets.

[22] The Core Set domains are Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, Dental and Oral Health Services, Experience of Care, and Long-Term Services and Supports. There were no measures suggested for removal from or addition to the Experience of Care domain during the 2022 Annual Review.

Within each domain, the Workgroup generally voted on measures suggested for removal first, followed by measures suggested for addition. However, if a measure suggested for removal had a replacement measure suggested for addition, the measure suggested for addition was voted on first. This process ensured that gaps were not unintentionally created in the Core Sets by removing an existing measure before the Workgroup had an opportunity to vote on the measure being suggested as a replacement.

For each measure suggested for removal, Workgroup members could select either “Yes, I recommend removing this measure from the Core Set” or “No, I do not recommend removing this measure from the Core Set.” For each measure suggested for addition, Workgroup members could select either “Yes, I recommend adding this measure to the Core Set” or “No, I do not recommend adding this measure to the Core Set.”

Measures were recommended for removal or addition if two-thirds of the eligible Workgroup members voted yes. The two-thirds voting threshold was adjusted based on the number of eligible Workgroup members present for each measure vote. No fewer than 27 of the 29 Workgroup members were present for a given vote (including one recusal).[23]

Following voting on the measures in each domain, Workgroup members had an opportunity to discuss gaps in that domain. A summary of the discussion about gaps in the Core Sets is presented later in the report.

[23] Workgroup members who disclosed an interest in a measure were recused from voting on that measure, for example, if they were a measure developer, a measure steward, or paid to promote a measure in some way.

Workgroup Recommendations for Improving the 2022 Core Sets

Criteria Considered for Removal of Existing Measures and Addition of New Measures

To focus the Call for Measures on measures that would be a good fit for the Core Sets, Mathematica specified detailed criteria for the Workgroup to assess measures for removal from or addition to the 2022 Core Sets in three areas: (1) minimum technical feasibility requirements, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

Based on lessons learned from the 2021 Core Set Annual Review, Mathematica refined the criteria for 2022. Notably, for measures suggested for removal, Mathematica added a technical feasibility criterion related to measures that were being retired by a measure steward. For measures suggested for addition, Mathematica added a technical feasibility criterion to require that technical specifications must be provided free of charge for state use in the Core Sets; this criterion, established by CMCS, was not considered by Workgroup members in their decision making. Under the actionability and strategic priority area for additions and removals, Mathematica expanded a criterion to emphasize language in CHIPRA that the Core Set measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries. Mathematica also amended the remaining two actionability and strategic priority criteria to align more closely with the purpose and uses of the Core Sets.

As noted earlier, Mathematica instituted a preliminary screening process to assure that measures discussed by the Workgroup adhered to a set of minimum technical feasibility criteria, including that detailed technical specifications were available for calculating the measures and that the measures had been tested or used by state Medicaid or CHIP programs.

Exhibit 5. Criteria Considered for Removal of Existing Measures and Addition of New Measures

Criteria Considered for Removal of Existing Measures	
Technical Feasibility	
1.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3.	The specifications and data source do not allow for consistent calculations across states.
4.	The measure is being retired by the measure steward and will no longer be updated or maintained.

Exhibit 5 *(continued)*

Criteria Considered for Removal of Existing Measures
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP or does not allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).
2. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3. The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out or improvement is outside the direct influence of Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All states will not be able to produce the measure by FFY 2024.
Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid or CHIP agencies.
3. An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4. The specifications and data source must allow for consistent calculations across states.
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP and to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).
2. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3. The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP.
Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible.
3. All states must be able to produce the measure by FFY 2024, including all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

In addition to the criteria considered for removal or addition, Mathematica also noted other factors the Workgroup should consider, especially with the increasing emphasis on preparing for mandatory reporting of the Child Core Set measures and behavioral health measures in the Adult Core Set beginning in 2024. Mathematica noted that CMS is exploring the use of alternate data sources to calculate current Core Set measures. The goals are to reduce state burden and standardize reporting across states. Current efforts include the following:

- Using data from the Centers for Disease Control and Prevention (CDC) Wide-ranging Online Data for Epidemiologic Research (WONDER) databases to calculate *Low Birth Weight Rate* (LBW-CH, formerly *Live Births Weighing Less Than 2,500 Grams*) and *Low-Risk Cesarean Delivery* (LRCD-CH, formerly *PC-02: Cesarean Birth*)[24]
- Pilot testing the use of data submitted by states and health plans to the Agency for Healthcare Research and Quality (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Database[25] to report four Core Set measures: the *Child and Adult Medicaid CAHPS Health Plan Survey* measures (CPC-CH and CPA-AD), *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD), and *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD)
- Giving eligible states the option to have CMS generate their FFY 2020 Form CMS-416 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) report using CMS's Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF),[26] which includes the *Preventive Dental Services* (PDENT-CH) measure in the Child Core Set[27]
- Testing the feasibility of using TAF to construct other Core Set measures, prioritizing measures subject to mandatory reporting in FFY 2024

In advance of voting, Mathematica advised the Workgroup that there is no target number of measures—maximum or minimum—for the Child and Adult Core Sets and that all measures would be reviewed and discussed in their specified form without conditions or modifications. Mathematica also informed Workgroup members that CMCS assigns measures to Core Sets and domains and that these assignments would not be an area of focus at the meeting.

[24] More information about the natality online databases included in CDC WONDER is available at https://wonder.cdc.gov/natality.html.

[25] More information about the CAHPS Health Plan Survey Database is available at https://cahpsdatabase.ahrq.gov/HPSurveyGuidance.aspx.

[26] More information about TAF is available at https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html.

[27] More information about Form CMS-416 reporting is available at https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

Summary of Workgroup Recommendations

The Workgroup recommended the following (Exhibit 6):

- Removal of three measures from the Child Core Set
- Removal of one measure from the Adult Core Set
- Addition of seven measures to the Child and Adult Core Sets

This section summarizes the discussion and rationale for these recommendations. Please refer to Appendix C for information on the measures discussed but not recommended for removal from or addition to the Core Sets. Measure information sheets about each measure the Workgroup considered are available on the Mathematica Core Set Review website.[28]

Exhibit 6. Summary of Workgroup Recommendations for Updates to the 2022 Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Removal from the Child Core Set		
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Centers for Medicare & Medicaid Services (CMS)	Not endorsed
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	National Committee for Quality Assurance (NCQA)	Not endorsed
Audiological Diagnosis No Later than 3 Months of Age (AUD-CH)	Centers for Disease Control and Prevention (CDC)	1360
Measure Recommended for Removal from the Adult Core Set		
PC-01: Elective Delivery (PC01-AD)	The Joint Commission (TJC)	0469/0469e
Measures Recommended for Addition		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17[a]	NCQA	3488
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17[a]	NCQA	3489
Oral Evaluation, Dental Services	American Dental Association (ADA)/Dental Quality Alliance (DQA)	2517
Prevention: Topical Fluoride for Children[b]	ADA/DQA	2528
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058

[28] The Measure Information Sheets for measures suggested for removal are available at https://www.mathematica.org/-/media/internet/features/2021/coreset/coresetreview_2022removals.pdf. The Measure Information Sheets for measures suggested for addition are available at https://www.mathematica.org/-/media/internet/features/2020/coreset/core-set-review_2021-additions.pdf?la=en.

Exhibit 6 *(continued)*

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Long-Term Services and Supports: Comprehensive Care Plan and Update	NCQA	Not endorsed
Colorectal Cancer Screening	NCQA	0034

[a] These measures are currently included in the Adult Core Set (FUA-AD and FUM-AD) for the adult age ranges. The Workgroup recommended these measures for addition to the Child Core Set for the child age ranges.

[b] A Workgroup member suggested a version of this measure that focused on children at elevated caries risk (*Prevention: Topical Fluoride for Children at Elevated Caries Risk)*. In spring 2021, the measure steward modified this measure to include *all* children (not just those at elevated caries risk). Because this change applies to calendar year 2021 reporting, which corresponds to the 2022 Child Core Set, the Workgroup discussed and voted on the modified version of the measure.

Measures Recommended for Removal

This section summarizes the Workgroup discussion of the four measures recommended for removal from the Child and Adult Core Sets.

Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)

The PDENT-CH measure assesses the percentage of children ages 1 to 20 who received at least one preventive dental service during the reporting period. CMS calculates this measure using data that states submit as part of annual EPSDT reporting (Form CMS-416).

Two Workgroup members suggested removing the measure from the Child Core Set. One Workgroup member noted concerns with the measure's methodology, indicating that it may be subject to inconsistencies in calculations due to the broad set of codes that states use to calculate the measure. This Workgroup member also noted a potential lack of rigorous testing to establish reliable and consistent calculations across states due to their differences in coding, covered benefits, or data completeness. Both Workgroup members noted that removal of this measure would leave a gap in the Child Core Set, with one member suggesting the *Prevention: Topical Fluoride for Children* measure as a replacement and the other recommending the *Oral Evaluation, Dental Services* measure as a replacement.

The PDENT-CH measure was discussed in the context of the two measures suggested as replacements. One Workgroup member who suggested the measure for removal commented that PDENT-CH emphasizes an important aspect of preventive care services, but it is imprecise and difficult to interpret because the measure specifications include a wide range of codes that do not necessarily reflect preventive dental services for children. Notably, the Workgroup member said that one of the codes in the PDENT-CH code set has been used to provide payment for personal protective equipment, which came to the fore during the COVID-19 pandemic. The Workgroup member also noted that the measure assesses only dental services—those provided by or under the supervision of a dentist—leaving out the growing emphasis on topical fluoride application by other types of health care providers, including pediatricians and primary care practitioners. Another Workgroup member expressed support for removing the measure because of concerns with its methodology, specifically that the measure requires only 90 days of eligibility but assesses services throughout the full calendar year.

One Workgroup member questioned whether there would be a gap in the Child Core Set related to optimal oral health for children and adolescents if PDENT-CH was removed but not replaced by the *Oral Evaluation, Dental Services* measure. The member noted that the *Sealant Receipt of Permanent First Molars* (SFM-CH) measure in the Child Core Set focuses on children ages 6 to 9 and suggested that much of the focus on fluoride varnish application is also on a younger age group.

In anticipation of mandatory reporting in 2024, another member expressed concern from a state resource perspective about replacing the reporting mechanism used to calculate PDENT-CH on behalf of states and shifting the responsibility of implementing new oral health measures onto states. The Workgroup member encouraged CMS to explore opportunities to use alternate data sources to calculate the measures so that states could direct resources toward improving care rather than on developing capacity for reporting the new measures.

Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)

The *Ambulatory Care: Emergency Department (ED) Visits* (AMB-CH) measure assesses the rate of ED visits per 1,000 beneficiary months among children up to age 19. This measure was proposed for retirement by the measure steward, the National Committee for Quality Assurance (NCQA), for Healthcare Effectiveness Data and Information Set (HEDIS) measurement year 2020 and was retired from its Medicare and commercial lines of business. However, the measure was retained for the Medicaid line of business due to the inclusion of the measure in the Child Core Set.

The Workgroup member who suggested this measure for removal noted that ED measures that specifically track ED use for high cost and highly prevalent conditions were preferred over general ED measures for quality improvement efforts. The member suggested two potential substitutes for this measure: *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA) and *Follow-Up After Emergency Department Visit for Mental Illness* (FUM). Both measures are currently included in the Adult Core Set and were suggested by the Workgroup member for addition to the Child Core Set.

During the discussion, Workgroup members expressed support for removing the AMB-CH measure, noting that keeping it would detract from alignment efforts because the measure has been removed from NCQA's Medicare and commercial product lines. Workgroup members also indicated that the measure was of limited use because it did not distinguish between avoidable ED visits and those that were truly medically necessary.

Several Workgroup members noted that FUA and FUM are not exact replacements for this measure, given that the measures are focused on behavioral health diagnoses, which are not captured in AMB-CH. Some Workgroup members agreed that while disease-specific measures are helpful, the removal of this measure would leave a gap in the Child Core Set when attempting to look at ED and urgent-care utilization among children. One Workgroup member added that states could continue to use the measure even if it is removed from the Child Core Set (47 states reported this measure in FFY 2019 using Core Set specifications). Another Workgroup

member from a state Medicaid program commented that, while it may be a "blunt instrument," the measure helps them understand how their system is functioning. In addition, the Workgroup member noted that their state stratifies the data by race and ethnicity and that this measure is especially informative for areas with poor access to ambulatory and primary care.

One Workgroup member asked the measure steward, NCQA, if AMB-CH had been replaced by a risk-adjusted measure. The Workgroup member proposed potentially retaining the measure in the Child Core Set another year while the Workgroup considers whether there is another measure that assesses ED utilization across all diagnoses and all age bands and is more actionable. The measure steward responded that while there is a risk-adjusted measure that looks across all ED utilization (*Emergency Department Utilization*) that is under consideration for the Medicaid product line, the measure is not currently specified for Medicaid. NCQA does not have a specific timeline for when the Medicaid measure might be available.

Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)

The *Audiological Diagnosis No Later Than 3 Months of Age* (AUD-CH) measure assesses the percentage of newborns who did not pass hearing screening and have an audiological diagnosis no later than 3 months of age. This measure was suggested for removal by three Workgroup members because of feasibility concerns: the measure requires the use of electronic health record (EHR) data, which many states cannot currently access. Though the measure has been on the Child Core Set since FFY 2016, only two states reported the measure for FFY 2019, and both reported substantial deviations from the Core Set specifications. This raised questions for Workgroup members about whether all states would be able to report the measure when the Child Core Set becomes mandatory for state reporting in 2024.

One Workgroup member who suggested the measure for removal noted that challenges with accessing EHR data may lead to inconsistent calculations across states and incomplete data. Another Workgroup member also questioned the actionability and strategic priority of the measure, commenting that the prevalence of the condition (failed hearing screenings) is very low and may prove difficult for quality improvement activities. Another Workgroup member explained that their state has tried to use administrative claims data to track those who have not received follow-up; however, because the data are transmitted to the CDC by facility or provider and not billed to Medicaid, the state has had challenges identifying gaps in care with this measure. Another Workgroup member commented that hearing screening is generally tracked in public health departments, such that removal of the measure from the Child Core Set would not eliminate monitoring of the issue.

Because the AUD-CH measure was discussed by the Workgroup last year, one Workgroup member who suggested it for removal noted that reconsideration of the measure should assess CMS's progress in working to identify an alternate data source. Mathematica provided an update that CMS had explored whether the measure could be calculated using alternate data sources, including through development of administrative specifications or through the CDC's Early Hearing Detection and Intervention (EHDI) Program, but CMS determined that an alternate data source was not available for the measure. In response to a Workgroup member's suggestion that

CMS explore use of the EHDI data system as an alternate data source, Mathematica clarified that the EHDI system does not stratify by payer, so it could not be used to report on children enrolled in Medicaid or CHIP.

During the Workgroup discussion, members reflected on the tension between desirability and feasibility of the measure, highlighting its importance—specifically, that Medicaid covers 40 percent or more of births in many states—but acknowledging that the measure could not be reported by most states through currently available data sources. Several members emphasized that this measure will be required for states to report in 2024 if it remains in the Child Core Set. The Workgroup encouraged partnerships with CDC and state public health agencies to improve existing data collection mechanisms and strengthen data linkages that would facilitate Core Set reporting of the measure in the future, including adding a payer indicator to the EHDI data system. One member from a state Medicaid program noted improvements being made in their state that may enable future reporting of measures like AUD-CH that require data linkages between Medicaid and public health. The member noted, however, that these collaborations are time and resource intensive.

One member commented that if the measure is removed from the Core Set, efforts will need to be redoubled to determine how to monitor outcomes for children who do not pass hearing screenings. They noted the responsibility to assure equitable and safe outcomes of care for children and families in Medicaid and CHIP, even as it pertains to low-prevalence conditions.

PC-01: Elective Delivery (PC01-AD)

PC-01: Elective Delivery (PC01-AD) measures the percentage of women with elective vaginal deliveries or elective Cesarean sections at 37 weeks or greater and less than 39 weeks of gestation completed. One Workgroup member suggested the measure for removal from the Adult Core Set due to feasibility concerns, because the measure requires chart review to determine whether a delivery was elective and many states do not conduct chart reviews for Core Set reporting. The Workgroup member noted that only nine states reported the measure for FFY 2019 and five of them deviated from the Core Set specifications by not conducting chart reviews to calculate the measure. The Workgroup member also suggested that the measure may no longer be a strategic priority for states, citing calendar year 2019 data from the measure steward, The Joint Commission, showing low rates (a median rate of 0 percent and a mean rate of 1.83 percent among 2,005 hospitals reporting). The member believed these low rates indicated that either elective deliveries were no longer being performed or were being justified by providers through coding and charting practices.

During the discussion, other Workgroup members echoed many of the sentiments expressed by the Workgroup member who suggested the measure for removal. This included (1) noting that payment reform may have impacted rates on the measure such that there may no longer be much room for improvement, (2) discussing the difficulty with the data collection methodology for this measure (chart review), and (3) highlighting the differential results yielded through the use of vital records and medical records data. In response to a comment from a Workgroup member about using vital statistics to calculate the measure, Mathematica noted that CMS's exploration

of using vital records data in CDC WONDER to calculate the measure was unsuccessful because the clinical criteria to determine the appropriateness of an elective delivery were unavailable. One Workgroup member cautioned that removal of the measure could leave a gap in the Adult Core Set and that the Workgroup should consider how this aspect of maternal health care quality would be measured.

Several Workgroup member comments pertained to racial and ethnic disparities in maternal and perinatal care. One Workgroup member asked whether there were other measures in the Core Sets that would assess differences in perinatal outcomes between women of color and white women if the measure were removed. Mathematica confirmed that the *Low Birth Weight* and *Low-Risk Cesarean Delivery* that are being calculated using CDC WONDER allow for stratification by race and ethnicity as well as other demographic characteristics. A Workgroup member added that the low number of states currently reporting the elective delivery measure and the challenges in reporting the measure do not allow for stratification of elective deliveries by race or ethnicity.

Measures Recommended for Addition

This section summarizes the Workgroup discussion of the seven measures recommended for addition to the Child and Adult Core Sets.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

The FUA measure assesses the percentage of ED visits for beneficiaries age 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported for this measure: (1) the percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) and (2) the percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). This measure includes stratifications for ages 13 to 17, age 18 and older, and a total rate. The measure was suggested for addition to the Child Core Set for beneficiaries ages 13 to 17 and is currently being reported as part of the Adult Core Set (age 18 and older) and the Health Home Core Set (age 13 and older). For FFY 2019, 36 states reported the measure in the Adult Core Set.

The measure steward, NCQA, has proposed changes to the measure for the measurement year 2022 (the 2023 Core Sets). Changes include expanding the denominator to include ED visits due to overdose of drugs with common abuse potential in any diagnosis position, expanding the numerator to allow follow-up visits with substance use disorder (SUD) indicated in any diagnosis position, and expanding the numerator to include additional follow-up options that do not require a diagnosis of SUD.

The Workgroup member who suggested this measure for addition indicated that the measure would address a gap in quality of care for adolescents diagnosed with SUD and allow for comparative analyses across various populations. The Workgroup member suggested that this

measure and the *Follow-Up After Emergency Department Visit for Mental Illness* (FUM) measure, which was also suggested for addition, could replace the *Ambulatory Care: Emergency Department Visits* (AMB-CH) measure in the Child Core Set, which was suggested for removal. The Workgroup member stressed that AOD is a serious public health issue and adolescents often present to the ED for treatment of behavioral health issues. The Workgroup member noted that there is significant room for improvement on this measure because NCQA benchmarks indicated that follow-up care within seven days occurred for 13 percent of ED visits, while follow-up within 30 days occurred for 20 percent of ED visits. The Workgroup member acknowledged that for some states, small cell sizes may be an issue in reporting the measure.

During the discussion, several Workgroup members expressed support for adding the measure to the Child Core Set because it would support alignment with the Adult Core Set. Workgroup members also discussed the importance of addressing SUD among adolescents and ensuring appropriate follow-up care. Two Workgroup members shared that, in their experiences, measures such as FUA and FUM allow health systems to identify opportunities for care coordination. One Workgroup member added that follow-up measures could incentivize providers to identify patients with SUD and intervene appropriately, thereby preventing the continuous cycle of ED utilization that occurs in some populations.

Workgroup members acknowledged that small cell sizes may be an issue for some states; however, they seemed to place more value on addressing a gap in the Child Core Set for measures related to substance use. In response to a question, Mathematica clarified the Core Set reporting requirements related to minimum cell sizes and noted that there were very few instances at the state level where results were suppressed for privacy or precision reasons. Mathematica also noted that a third measure in the Core Sets—*Follow-Up After Hospitalization for Mental Illness* (FUH)—tended to have smaller denominators than the ED follow-up measures and was publicly reported without suppression of any results in both the Child and the Adult Core Sets.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

The *Follow-Up After Emergency Department Visit for Mental Illness* (FUM) measure assesses the percentage of ED visits for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported for this measure: (1) the percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) and (2) the percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). This measure includes stratifications for ages 6 to 17, ages 18 to 64, and age 65 and older. This measure was suggested for addition to the Child Core Set for beneficiaries ages 6 to 17 as a replacement for the *Ambulatory Care: Emergency Department Visits* (AMB-CH) measure.

The Workgroup member who suggested this measure for addition indicated that there is significant room for improvement on this measure, citing data for Medicaid managed care beneficiaries of all ages showing that 41 percent of all ED visits had a follow-up within 7 days,

and 56 percent of all ED visits had a follow-up within 30 days. The Workgroup member also noted that, although there may be a concern about small cell sizes for some states, the denominator should be larger than the FUH measure, which is included in both the Child and Adult Core Sets.

The Workgroup discussed the FUM measure in conjunction with the FUA measure and expressed similar support for including the FUM measure in the Child Core Set. Several Workgroup members recognized that the FUM measure addresses a significant gap in the Child Core Set, with one Workgroup member specifically commenting on the lack of follow-up after an ED visit when there is a diagnosis of mental health, SUD, or a behavioral health condition. The Workgroup member added that the inclusion of this measure would send a strong signal to health systems to move toward integrated care. Another Workgroup member noted that, although they support the intent of the measure, there is a need to move beyond process measures and assess outcomes in this area.

Oral Evaluation, Dental Services

Oral Evaluation, Dental Services measures the percentage of enrolled children younger than age 21 who received a comprehensive or periodic oral evaluation within the reporting year. The measure steward is the American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA). The measure was suggested to replace the PDENT-CH measure in the Child Core Set because the PDENT-CH measure includes codes that would not indicate an evaluation of oral health. The Workgroup member who suggested this measure for addition noted that the measure is currently used by state Medicaid and CHIP programs (including in Texas, Florida, and Massachusetts) and could be used to trend access to oral health care.

The measure was discussed by the Workgroup in the context of the suggestion to replace PDENT-CH with this measure and/or the *Prevention: Topical Fluoride for Children* measure. In response to questions from other Workgroup members, a Workgroup member and the measure steward noted that this measure was in the diagnostic versus preventive code series and was a marker that a child was fully evaluated, that a diagnosis was recorded, and that a treatment plan was recorded. The measure includes a narrower set of codes than PDENT-CH and was characterized as providing a more precise measurement. One Workgroup member likened the measure to a well-child visit measure for dental care.

Prevention: Topical Fluoride for Children

Prevention: Topical Fluoride for Children measures the percentage of children ages 1 through 20 years who received at least 2 topical fluoride applications as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year. The measure was suggested for addition to replace the PDENT-CH measure in the Child Core Set.[29]

[29] A Workgroup member suggested a version of this measure that focused on children at elevated caries risk (*Prevention: Topical Fluoride for Children at Elevated Caries Risk*). In spring 2021, the measure steward modified (continued)

The Workgroup member who suggested this measure for addition noted that dental caries (tooth decay) is the most common chronic disease in children in the United States, affecting almost half of all children, and the use of topical fluoride is one of the interventions with the strongest evidence base for reducing tooth decay. The Workgroup member also noted that the prevalence of caries, untreated caries, and disparities are significant, and there is substantial room for improvement within Medicaid and CHIP programs. They suggested that the measure could serve as a complement to the dental sealant measure in the Child Core Set (SFM-CH) by helping states assess the extent to which children are receiving evidence-based preventive services and target quality improvement accordingly.

The Workgroup member who suggested the measure for addition noted that the measure has a strong evidence base, including evidence that patients who receive two applications of fluoride within a 12-month period achieve significant reductions in caries. The Workgroup member cited the growing emphasis on topical fluoride application by other types of health care providers, as well as the United States Preventive Services Task Force (USPSTF) recommendations that children receive topical fluoride application. In addition, the Workgroup member discussed their experience using the measure as part of the California 1115 Medi-Cal 2020 waiver and DQA's experience calculating the measure using T-MSIS data. They noted that T-MSIS data could potentially be used as an alternate data source to help reduce the burden of state reporting.

Much of the Workgroup discussion around the measure involved technical questions about the measure specifications, including the age stratifications integrated into the measure specifications. The Workgroup members confirmed that the upper age range for the measure is children under age 21 in alignment with the population eligible for EPSDT. DQA also confirmed that the lower age range for the measure starts at age 1 because the measure requires at least 12 months of continuous enrollment for a child to be eligible for the measure, and that children under age 1 would not be captured in the numerator because the measure requires two fluoride applications within the reporting year.

During the discussion, the Workgroup also clarified that water fluoridation is an additive benefit to topical fluoride and not a substitute, it does not impact the accuracy of measure results, and children with fluoridated water are at low risk of dental fluorosis with the most common topical application of fluoride (fluoride varnish). They also noted that fluoride varnish is used by both dental and oral health providers and the measure is stratified by both rendering provider type and child age groups. The Workgroup member who suggested the measure for addition commented that the provider stratification built into the measure allows states to understand how various components of their system are functioning, as well as how the system is functioning overall. The Workgroup member also added that the age stratifications integrated into the measure specifications help states understand where there are gaps in performance and target interventions accordingly.

this measure to include all children (not just those at elevated caries risk). Because this change applies to calendar year 2021 reporting, which corresponds to the 2022 Child Core Set, the Workgroup discussed and voted on the modified version of the measure. The modified measure includes an optional stratification by caries risk.

One Workgroup member representing a state Medicaid program noted that they have had difficulty calculating the measure in their state. DQA, the measure steward, noted that they have successfully calculated the measure using T-MSIS data. Two other Workgroup members representing state Medicaid programs commented that it should be feasible to calculate the measure using claims data. They further noted that they do not have difficulty collecting information on fluoride varnish application using claims.

Another Workgroup member asked DQA whether dental management companies implement barriers or limits making it difficult for a child to receive two fluoride varnishes in a year, and whether there was evidence of this in the T-MSIS analyses. The Workgroup member who suggested the measure for addition noted that under the California Section 1115 waiver, children can receive between two and four fluoride applications per year depending on risk. DQA added that while they did not have information about these types of barriers, the rates they found in T-MSIS were consistent with states that provide coverage for topical fluoride application.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure assesses the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. The latest update to the measure expanded the age range to start at 3 months, rather than 18 years, and updated the denominator to an episode-based versus member-based denominator. These changes took effect in measurement year 2019 and are still under consideration for National Quality Forum (NQF) endorsement. The Workgroup member who suggested this measure for addition indicated that states have used this measure to promote appropriate antibiotic dispensing. They also noted that this measure has significant room for improvement, with a bronchitis diagnosis resulting in antibiotic prescriptions in almost half of adult cases and 60 percent of child cases in Medicaid.

This measure was discussed in conjunction with the *Appropriate Treatment for Upper Respiratory Infection* measure, which was also suggested but not recommended for addition to the Core Sets. One Workgroup member noted that the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure is included in the Accountable Care Organizations (ACO)/Patient Centered Medical Homes/Primary Care Consensus Core Set,[30] and would therefore be beneficial to include in the Child and Adult Core Sets for alignment. Two Workgroup members from state Medicaid programs commented that there is considerable room for improvement on the measure among the adult population in their states, however they have seen high performance on a similar antibiotic measure among children. Another Workgroup member noted that the high performance among children may be due to efforts in the pediatric field to avoid unnecessary antibiotic use.

Several Workgroup members voiced support for adding this measure to the Core Sets, indicating that it drives prevention of antimicrobial resistance, as well as avoidance of unnecessary antibiotics. One Workgroup member who supported the measure for addition commented that parents and patients often insist on receiving antibiotics even when they are not necessary. They

[30] More information is available at cqmc_aco_pcmh_core_set.pdf.

noted it would be beneficial to have a measure that balances clinical appropriateness with patient satisfaction scores. Another Workgroup member added that with the recent widespread adoption of telehealth due to the COVID-19 pandemic, they anticipate an increase in the rates of inappropriate use of antibiotics (the measure steward, NCQA, included telehealth settings in the measure). They stressed the importance of having a measure that encourages avoidance of unnecessary antibiotics.

Several Workgroup members questioned whether there was enough data to support the inclusion of the measure in the Core Sets given that NCQA implemented updates to the measure beginning in measurement year 2019 (including expanding the age range to include children). One Workgroup member noted that bronchitis in children is clinically ill-defined and may have potential clinical ramifications for diagnosis and treatment. In response to a question about the potential impact of expanding the age range for both measures, NCQA stated that they do not have a good indication of the direction the performance may trend after the age expansion. One Workgroup member suggested that CMS add the measure without the expanded age range until there is enough data and experience from state Medicaid programs to report the revised measure.

The Workgroup also discussed whether it was necessary to add both the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure and the *Appropriate Treatment for Upper Respiratory Infection* measure to the Core Sets, or if one should be added over the other. Several Workgroup members, as well as NCQA, noted that the acute bronchitis/bronchiolitis measure presents significant room for improvement, with performance on the measure typically lower than on the upper respiratory infection (URI) measure.

Long-Term Services and Supports Comprehensive Care Plan and Update

Long-Term Services and Supports Comprehensive Care Plan and Update measures the percentage of LTSS organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified time frame that includes core elements. The measure steward is NCQA. Two rates are reported for the measure: (1) members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members); and (2) members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members). The measure is calculated using case management records, based on a review of records drawn from a systematic sample with a minimum sample size of 96 beneficiaries.

The Workgroup member who suggested the measure for addition noted that while LTSS constitutes a third of all Medicaid spending, there are no LTSS measures in the Core Sets that assess the quality of care management. They further explained and that this measure addresses whether beneficiaries are engaged in a care planning process that incorporates person-centered principles and looks at all of their needs. The Workgroup member also noted that this measure is currently in use in several states, including Pennsylvania and Florida. As this is a relatively new measure, the Workgroup member suggested that TA may be needed to ensure the measure is

calculated consistently and to help states aggregate data across plans and other entities to report at the state level.

The Workgroup provided broad support for adding the measure to the Core Set, with several members discussing their experience using the measure. One member admitted that the measure is a lot of work, but liked that it addresses elements that are used in LTSS, including home- and community-based services (HCBS), and can be inclusive of behavioral health. A Workgroup member representing a managed care entity also acknowledged that the measure was challenging but said it was worth the effort. They added that a measure of care planning is key, as it examines whether people are getting the services they need in a cost-effective way. In addition, the member noted that the measure can be used to understand what elements of the care planning process are working for different populations to ensure equity. Another member liked that this measure strengthens the person- and family-engagement aspects of care, allowing many opportunities to improve care and outcomes for LTSS members. A Workgroup member from a state Medicaid agency commented that they are working on implementing the measure in their state and support inclusion of the measure as a means to close gaps in the Core Sets. They commented that the state receives stakeholder requests regarding care plan issues and this measure addresses the types of care plan issues raised, especially those related to development of care plans by managed care organizations.

Several Workgroup members stated that they like that this measure can be used in both managed care and fee-for-service settings. One Workgroup member asked a technical question about how the sampling methodology is applied in states (versus health plans), including for fee-for-service members. They added that states would likely need TA with the measure to ensure the representativeness of the sample and standardization of the data collection process for comparability of the measure across states. NCQA responded that the sample size requirement was temporarily reduced from 411 to 96 to relieve the high level of burden of manual data abstraction and lower the entry barrier to reporting, but they are hoping to raise it back up to 411 to make statistically significant comparisons in the future. The Workgroup member also commented that the Workgroup has raised considerations throughout the meeting about stratification for purposes of examining disparities and ensuring health equity, and one concern is that the sample size may not allow for this.

The Workgroup also discussed how the measure pairs with patient-reported outcomes information, such as information from CAHPS. One Workgroup member who is currently using this measure in their state Medicaid program noted that their state looks at the measure in conjunction with HCBS CAHPS data and believes they go hand-in-hand. However, they noted that it could be difficult to link the measure to CAHPS because of the small sample sizes for each measure. Another Workgroup member said that states would ideally use this measure with the National Core Indicators for Aging and Disabilities Adult Consumer Survey and the HCBS CAHPS Survey to understand where the process is intact or where it may need improvement. Another workgroup member said they had looked at this measure in the past in conjunction with the National Core Indicators for Aging and Disabilities to ensure members were being served and that it was not a "checkbox" exercise. The Workgroup member cautioned that the measure would not truly serve LTSS members if it is turned into a "checkbox" opportunity. In response,

another Workgroup member commented that it would be important to receive guidance form CMS to avoid the "checkbox" concern, ensure comparability across states, and ensure that states' assessment tools are collecting the information needed to report the measure.

One public commenter asked whether this measure could be used for fee-for-service populations. NCQA confirmed that any organization that coordinates Medicaid-covered LTSS is eligible to report the measure, including community-based organizations and Area Agencies on Aging.

Colorectal Cancer Screening

Colorectal Cancer Screening assesses the percentage of patients ages 50 to 75 who had appropriate screening for colorectal cancer. The measure is specified for administrative, hybrid, and HEDIS ECDS data collection methods. Three Workgroup members suggested the measure for addition to the 2022 Core Sets. While the measure steward, NCQA, has not specified the measure for Medicaid, they have indicated that they plan to specify and test the measure for Medicaid in the upcoming year. In addition, the Workgroup members indicated that several states currently use the measure in their Medicaid programs.

The Workgroup members who suggested the measure for addition noted that colorectal cancer is the second leading cause of cancer death in the United States and that colorectal cancer screening effectively identifies precancerous lesions and reduces mortality. They cited data indicating disparities in cancer screening rates for Medicaid beneficiaries compared to those commercially insured, and highlighted evidence that colorectal cancer screening rates have improved in several states that were monitoring and reporting the measure.

Several Workgroup members from state Medicaid agencies discussed their experiences collecting and reporting the measure. A Workgroup member noted that their state has been reporting the measure in several program areas within Medicaid, and that they are discussing alignment on this measure with other programs in the state. One Workgroup member also discussed the approach their state had taken to address the required 10-year look-back period, which has been a concern for the Medicaid population due to churn. They explained that their state coordinates with managed care plans to help identify colorectal cancer screenings through their Medicaid claims and encounter system. They have also seen improvements in collecting and reporting the measure through increased claims-sharing and the use of health information exchanges.

Workgroup members also asked technical questions about the types of screening tests that count toward the measure, including whether all screening modalities, specifically fecal immunochemical testing (FIT), carry equal evidence. Workgroup members, as well as NCQA, confirmed that the measure is in alignment with USPSTF recommendations and that the modalities included in the measure denominator, including FIT, are evidence based. Another Workgroup member asked about whether the majority of community-based members who are dually eligible for Medicare and Medicaid are included in the measure, and how states have been able to obtain data for this population. One Workgroup member noted that they are working with CMS to try to obtain the Medicare data. NCQA noted that members who are dually eligible for

Medicare and Medicaid are not excluded from the measure; however, the measure is not yet specified for Medicaid and that they will need to explore guidelines for reporting on this population when it is.

Several Workgroup members commented that the measure is valuable for addressing disparities in the Medicaid population. A Workgroup member from a state Medicaid program stated that they believe the measure touches upon the social determinants of health. In addition, they have made great strides in performance on the measure for the Medicaid population over the past 10 years; they see a nearly 20-point difference between Medicaid and commercial members. In response to a question about whether this measure had been stratified by race, ethnicity, or language, NCQA replied that they are proposing to include racial/ethnic stratification as part of the measure in the next iteration. Another Workgroup member raised the importance of monitoring the race and gender of Medicaid members who are screened to ensure that all members have equitable access to all appropriate screening tests, regardless of concerns about whether the test screens positive, becomes diagnostic, and may confer out-of-pocket costs for beneficiaries. One Workgroup member commented that state payment policies had addressed this issue in their state. Several Workgroup members also voiced support for addition of a screening measure that includes the male Medicaid population.

One Workgroup member cautioned that some health plans write the orders for and send out the FIT-DNA kits to their members without involving their primary care provider, which they described as not very good medicine and a potential opportunity for gaming the system. They asked if NCQA had considered implementing guardrails against this as part of the measure specifications. They suggested that NCQA add standards to their specifications that health plans must obtain an order from a member's treating provider to order a test. NCQA noted that the measure specifications require that the FIT test was done, not just sent to a member, and that this would also be part of NCQA's audit. However, the specifications do not currently require an order from a primary care provider.

During the public comment period, representatives of colorectal cancer organizations, health care providers, researchers, and patient advocates spoke in favor of adding the measure to the Core Set. They commented that including the measure would help address disparities in colorectal cancer screening among the Medicaid population, citing evidence of improvements seen in screening rates and cancer outcomes in states that have adopted the measure. They also spoke to the evidence around FIT as being comparable to other modalities of colon cancer screening.

The measure received unanimous support from the Workgroup for inclusion in the Core Set.

Cross-Cutting Themes in Measure Discussions

Several cross-cutting themes emerged from the Workgroup's review of the 7 existing measures suggested for removal from the Core Sets, the 14 new measures suggested for addition, and the Workgroup's reflections about gaps in the Core Sets. The Workgroup discussion revealed an effort to balance the feasibility of state reporting with actionability and strategic priority to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Actionability and Strategic Priority to Drive Improvement in Care Delivery and Health Outcomes

Workgroup members consistently underscored the importance of driving improvement in Medicaid and CHIP through the Core Sets, particularly in support of measures that address health disparities and social determinants of health. During their discussion, Workgroup members routinely encouraged the identification and inclusion of measures that take a whole-person approach to beneficiary health, and consider factors such as housing, food insecurity, and social isolation. In addition, while discussing gaps in the Behavioral Health Care domain, one Workgroup member noted that ACOs and Medicare are exploring this area in their work, highlighting the momentum for addressing the social determinants of health as part of improving population health. Workgroup members noted that given the socioeconomic challenges that Medicaid and CHIP beneficiaries often face, improving health care delivery and health outcomes will require focusing not just on clinical care, but also on factors outside the medical system.

Similarly, Workgroup members frequently expressed a desire to stratify measures by demographic factors, including race, ethnicity, language, and disability. They encouraged measure stewards to include demographic stratifications in their measure specifications to allow states to identify inequities among Medicaid and CHIP populations and opportunities for improvement. Mathematica indicated that states are able to report stratified data for Core Set measures in the CMS web-based reporting system, regardless of whether the stratifications are included in the measure technical specifications. One Workgroup member encouraged CMS to publicly report the stratified Core Set data that states already report and urged CMS to consider requiring all states to report stratified data for a subset of population health measures. Another Workgroup member commented that failing to look at the measures through a health equity lens may perpetuate disparities.

Workgroup members also encouraged the identification of outcomes-based measures for the Core Sets. For example, during discussion of the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* and *Follow-Up After Emergency Department Visit for Mental Illness* measures, Workgroup members noted that while these measures address a significant gap in care, they would prefer measures that identify beneficiaries before their condition leads them to the ED. A similar comment was made about the *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* measure, which was not recommended by the Workgroup for addition.

In recommending measures for addition to the Core Sets, the Workgroup often emphasized the strategic priority and actionability of a measure, sometimes over the resource demands a measure may entail. For example, the *Long-Term Services and Supports Comprehensive Care Plan and Update* measure was described by several Workgroup members as challenging but worth the effort, because the measure assesses important aspects of the care planning process for LTSS members and families. The Workgroup also recommended the *Colorectal Cancer Screening* measure despite the 10-year look-back period required for one screening test, emphasizing the potential for the measure to reduce disparities in cancer screening and outcomes for Medicaid beneficiaries.

For those measures that were suggested to replace current Core Set measures, the Workgroup often prioritized the addition of measures that may help states act upon a strategic priority, over the feasibility of reporting existing measures. For example, the Workgroup recommended the removal of the preventive dental services measure (PDENT-CH), which CMS calculates on behalf of states using an alternate data source. The Workgroup recommended that the PDENT-CH measure be replaced with two measures they believe would more accurately reflect the receipt of evidence-based dental and oral health preventive care in children: *Oral Evaluation, Dental Services* and *Prevention: Topical Fluoride for Children*.

Similarly, the Workgroup recommended removal of the AMB-CH measure despite its feasibility (47 states reported the measure for FFY 2019), in favor of replacement measures deemed more actionable for states: *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA) and *Follow-Up After Emergency Department Visit for Mental Illness* (FUM).

Finally, Workgroup members encouraged moving toward the use of electronic data collection in Medicaid and CHIP. While they agreed that a significant investment is required for states to transition to electronic data sources, they noted that activities such as the implementation of interoperability rules and the development of state and federal partnerships may help drive Medicaid and CHIP programs toward increased use of electronic data sources. The Workgroup ultimately voted to retain two CAHPS-based survey measures on smoking cessation and influenza immunization instead of replacing them with measures that can be reported using EHR or registry data. However, Workgroup members acknowledged the increasing importance of electronic data and looked forward to additional evidence to support states' readiness to report these measures.

Feasibility and Viability for State Reporting

The Workgroup discussed the ability of states to collect and report the Core Set measures suggested for removal and addition. As CMS and states approach mandatory reporting in 2024, Workgroup members considered longstanding feasibility issues on existing measures. Workgroup members who represent state Medicaid programs, in particular, expressed concern about retaining measures in the Child Core Set if most states are unable to report or an alternate data source is not identified. For example, while several Workgroup members underscored the importance of early hearing screening, they recommended the removal of the *Audiological Diagnosis, No Later Than 3 Months of Age* measure due to feasibility concerns (the measure was reported by only two states for FFY 2019). The Workgroup raised concerns over the lack of an alternate data source for the measure, coupled with the mandatory reporting of Child Core Set measures. The Workgroup similarly voted to remove the *PC-01: Elective Delivery* measure—a measure that has been in the Adult Core Set since its inception—due to difficulties associated with the measure's chart review data collection methodology, the lack of an alternate data source, and limited opportunities for improvement on the measure.

Workgroup members, especially those from state Medicaid programs, often expressed a preference for measures that allowed states to leverage existing data sources to reduce reporting

burden, while also emphasizing the need for data linkages at the federal and state levels to build state capacity for reporting. Workgroup members also noted the need to centralize data, with some state Medicaid representatives highlighting that their programs are often constrained by limited resources, thereby necessitating more streamlined data collection processes.

Some Workgroup members noted the low and decreasing survey response rates on CAHPS surveys, and the impact of these declining rates on future directions for quality measurement where another data source may exist. Workgroup members were hesitant to replace or remove two CAHPS-based measures, *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD) and *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD). However, they noted the increasing potential of EHRs and registries to report electronic measures in the future.

Lastly, throughout the measure discussions, Workgroup members were mindful of the burden of state reporting and the capacity of states for reporting. The Workgroup's recommendation of the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure over the *Appropriate Treatment for Upper Respiratory Infection* measure is a reflection of their careful deliberation in recommending measures for the addition to the 2022 Core Sets. Workgroup members often vocalized their attempt to balance state capacity and burden concerns with the actionability and strategic priority of measures.

Discussion of Core Set Measure Gaps

During the 2022 Core Set Annual Review, the Workgroup discussed Core Set measure gaps by domain and overall. Within each domain, Mathematica asked the Workgroup to identify what types of measures or measure concepts are missing, whether there are any existing measures that could fill the gaps, or whether new measures would need to be developed. After completing domain-specific discussions, the Workgroup had a cross-cutting discussion focused on what measure gaps should be considered for future Core Sets, as well as the implications for developing new quality measures for Medicaid and CHIP, followed by a final opportunity for public comment.

Exhibit 7 synthesizes the gaps mentioned during Workgroup discussions and the public comment period. The gaps are organized first by cross-cutting themes and then by Core Set domain. The exhibit does not attempt to prioritize the suggested gaps or assess their feasibility or fit for the Child and Adult Core Sets.

Across nearly every discussion about Core Set gaps, Workgroup members expressed a desire to use the Core Set measures to better identify and address health disparities among Medicaid and CHIP beneficiaries. Many of the gaps identified by the Workgroup spoke to this priority, including suggestions to stratify measures by demographic characteristics such as race and ethnicity and a suggestion to emphasize stratification and public reporting of existing measures, rather than adding new health disparity measures to the Core Sets. The Workgroup also suggested focusing on social determinants of health, including whether a domain focused on social factors should be included as a new Core Set domain in the future.

In addition, the Workgroup identified opportunities for improving care integration through measurement, both within Medicaid and CHIP programs and across the health care system as a whole. Recognizing the role of Medicaid and CHIP in the health care system, the Workgroup identified gaps in measures and measure concepts that promote health system collaboration across different sectors and settings. Examples include the integration of behavioral health and primary care, and care for children and youth with complex care needs.

The Behavioral Health Care domain is the largest domain in the Adult Core Set and some Workgroup members discussed the need to streamline and prioritize the current measures in this domain and better balance the existing measures. Other Workgroup members identified gaps in this domain that address more whole-person care, such as measures of adverse childhood experiences and trauma-informed care.

Workgroup members also proposed several methodological considerations, including the concept of multi-generational measurement and the bundling of associated measures across a family unit, and global measures of treatment outcomes for chronic conditions.

The Workgroup's reflections about gaps in the Child and Adult Core Sets provide a strong starting point for future discussions about updates to the Core Sets as well as longer-term planning for the Core Sets.

Exhibit 7. Synthesis of Workgroup Discussions About Potential Gaps in the Child and Adult Core Sets

Themes from Cross-Cutting and Domain-Specific Gap Discussions
Cross-Cutting Gap Areas
• Stratification of new and existing measures by race, ethnicity, language, and disability • Social determinants of health, including housing insecurity, social isolation, and poverty status • Integration and data linkages across sectors and settings, particularly for beneficiaries with complex needs and social risk factors • Impact of telehealth on access, utilization, disparities, and identification of social risks • Continuity of coverage for beneficiaries
Cross-Cutting Methodological Considerations
• Electronic measures that leverage data sources beyond claims and encounters (e.g., EHRs, registries) • Leveraging existing data sources to realize efficiencies in reporting and reduce state burden (e.g., T-MSIS) • Technical assistance from CMS to help states link Medicaid and Medicare data for dually eligible beneficiaries • Measurement considerations for conditions with small populations • Consideration of how to improve response rates for patient experience surveys, like CAHPS
Primary Care Access and Preventive Care
• Integration of behavioral health care into primary care • Preventive care and access measures for the LTSS population, or ability to stratify by disability status • Prevention and access to care for male beneficiaries
Maternal and Perinatal Health
• Content of prenatal and postpartum care: mental health and substance use, immunizations, and dental care • Interagency and health care system collaboration on screenings and social needs • Multi-generational care and measurement, including bundled measures for the family unit

Exhibit 7 *(continued)*

Themes from Cross-Cutting and Domain-Specific Gap Discussions
Care of Acute and Chronic Conditions
• Appropriate emergency department utilization for children, including development of a risk-adjusted measure • Identification and intervention for adverse childhood experiences and health-related social needs • Injuries, injury prevention, and mitigation • Global measure(s) of treatment outcomes for chronic conditions
Behavioral Health Care
• Integration of behavioral health and physical health, particularly through primary care • Suicide deaths, suicidal ideation and self-harm, and suicide prevention • Child social-emotional screenings, child welfare, and adverse childhood experiences • Anxiety disorders • Prioritization and balance of measures within this domain
Dental and Oral Health Services
• Adult oral health and access to dental care
Long-Term Services and Supports
• Outcome measures that address whether programmatic goals and beneficiary care needs are being met • Beneficiary experience of care measures for all LTSS populations • Access to care for vulnerable or socially isolated beneficiaries • Predictors or indicators of elder abuse • Integrated care for children with complex care needs

Additional Suggestions for Improving the Core Sets and the Annual Review Process

In addition to recommending specific measures to remove from or add to the Core Sets, Workgroup members were asked to provide input about TA opportunities to support state reporting of the Core Sets as well as suggestions for improving the Core Set Annual Review process.

Technical Assistance to Support State Reporting of the Core Sets

Workgroup members identified several TA opportunities to support states in reporting the Core Set measures. The opportunities focused primarily on building a data infrastructure to address the current gaps in data availability and completeness, as well as support for reporting new or updated measures.

Workgroup members encouraged CMS to continue exploring the use of alternate data sources to support states in Core Set reporting—and strengthening these systems where needed—as well as helping states develop partnerships to support reporting capacity. For example, when discussing the *Colorectal Cancer Screening* measure, one Workgroup member encouraged CMS to work with states and provide linkages at the federal level to allow them to more accurately report on individuals who are dually eligible for Medicare and Medicaid. They also suggested CMS and other federal partners provide TA to support infrastructure for quality measurement, including building capacity to use data from health information exchanges, moving toward electronic quality measurement, and leveraging immunization registries. One Workgroup member also

suggested TA on how to accurately collect and report beneficiary data by race and ethnicity. For future planning, several Workgroup members requested that CMS provide further information on plans and priorities for LTSS measurement, and guidance about requirements for mandatory reporting in 2024.

In addition, Workgroup members suggested that CMS provide a "glide path" for states as they navigate the adoption of new or updated Core Set measures and move toward mandatory reporting. They stressed that states often need time, guidance, and other resources to prepare for reporting new measures and using data collection methods, while still maintaining the data collected through current reporting mechanisms. As described by one Workgroup member, this "glide path" would reduce barriers to reporting new measures and allow for a more seamless process while transitioning to new reporting mechanisms.

Improving the Core Set Annual Review Process

Workgroup members also suggested enhancements to the Core Set Annual Review process. One Workgroup member requested that Mathematica provide information on whether measures have been or can be stratified by demographic characteristics, including race, ethnicity, language, and disability status. This suggestion complements the language in the "Call for Measures," which notes that states should be able to use measures to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries. As the Workgroup member noted, adding this component to the review process would help ensure that the Core Set measures are used to promote health equity in Medicaid and CHIP. The Workgroup also suggested ensuring that the beneficiary voice and perspectives are incorporated into the Annual Review process.

In addition, Workgroup members suggested enhancements to the Workgroup meeting format and logistics. This included adding a video component to the virtual meetings to allow for a more robust discussion and adding a chat function to virtual meetings to allow for members to communicate with one another during meetings. Some Workgroup members also expressed a preference to reconvene in person when safe to do so.

Next Steps

The 2022 Core Set Annual Review Workgroup considered 7 measures for removal from the Core Sets and 14 measures for addition. Workgroup members recommended removing four measures and adding seven measures to the Core Sets for 2022. The Workgroup considered multiple factors when making their recommendations, including the feasibility for state reporting, alignment with strategic priorities, and opportunities to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries. The measures recommended for addition focus on strategic priorities related to preventive care, children's oral health, behavioral health care, antibiotic stewardship, and LTSS.

During the discussions, Workgroup members frequently expressed a desire to use the Core Set measures to better identify and address health disparities in Medicaid and CHIP, such as by stratifying measures by demographic characteristics such as race, ethnicity, disability status, and language, and increasing the focus on social determinants of health.

As CMS and states move one year closer to 2024, Workgroup members consistently raised the issue of mandatory reporting for the Child Core Set and the behavioral health measures in the Adult Core Set. They recommended removing measures from the Core Sets that were less feasible for states to report. They also advocated for continued opportunities to leverage existing alternate data sources for reporting. Looking ahead, they suggested transitioning to electronic data sources, such as EHRs and clinical registries, when state capacity to capture data from these sources has improved.

This report summarizing the 2022 Core Set Annual Review Workgroup's review process, discussion, and recommendations is available for public comment. Please submit public comments via email by **August 6, 2021, at 8 p.m.** Eastern Time to MACCoreSetReview@mathematica-mpr.com and include "2022 Core Set Annual Review Public Comment" in the subject line. A final version of this report, inclusive of all public comments, will be released in August 2021. CMCS will review the final report to inform decisions about whether and how to modify the 2022 Child and Adult Core Sets. Additionally, CMCS will obtain stakeholder input from federal agencies and from state Medicaid and CHIP quality leaders to ensure that the Core Set measures are evidence-based and promote measure alignment within CMS and across the federal government.[31] CMCS will release the 2022 Child and Adult Core Sets through a CMCS Informational Bulletin by December 31, 2021.

[31] More information about the decision making process is available in the CMCS fact sheet, Medicaid and CHIP Child and Adult Core Sets Annual Review and Selection Process, at https://www.medicaid.gov/medicaid/quality-of-care/downloads/annual-core-set-review.pdf.

APPENDIX A:
Child and Adult Core Set Measures

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Exhibit A.1. 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418*/0418e*	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)^	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)**	Administrative
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)***	Administrative
Maternal and Perinatal Health			
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	EHR
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW- CH)	State vital records
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
NA	CDC	Low-Risk Cesarean Delivery (LRCD-CH)****	State vital records
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)^	Administrative

Exhibit A.1 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)^	Administrative
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)^	Administrative
Dental and Oral Health Services			
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Administrative (Form CMS-416)
NA	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)*****	Administrative
Experience of Care			
0006******	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

More information on 2021 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

* This measure is no longer endorsed by NQF.

** The Well-Child Visits in the First 15 Months of Life (W15-CH) measure was modified by the measure steward. It now includes two rates: (1) six or more well-child visits in the first 15 months and (2) two or more well-child visits from 15 to 30 months. The NQF number refers to the endorsement of the W15-CH measure.

*** The Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH) and Adolescent Well-Care Visits (AWC-CH) measures were modified by the measure steward into a combined measure that includes rates for Ages 3 to 11, 12 to 17, 18 to 21, and a total rate. The NQF number refers to the endorsement of the W34-CH measure.

**** The Low-Risk Cesarean Delivery (LRCD-CH) measure replaced the PC-02: Cesarean Birth measure in the 2021 Child Core Set. To reduce state burden and report a cesarean birth measure consistently across all states, CMS will calculate the LRCD-CH measure on behalf of states using National Vital Statistics System Natality data that are submitted by states and obtained through CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) starting in FFY 2021.

***** This measure was added to the 2021 Child Core Set. It replaces the Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH) measure, which was retired by the measure steward.

****** AHRQ is the measure steward for the survey instrument in the Child Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

^ This measure is part of the Behavioral Health Core Set. The complete list of 2021 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-bh-core-set.pdf.

AHRQ = Agency for Healthcare Research & Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs.

Exhibit A.2. 2021 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418*/0418e*	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR
Maternal and Perinatal Health			
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	Hybrid or EHR
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC- AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW- AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768*	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR

Exhibit A.2 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)^	Administrative or EHR
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)^	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)^	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)^	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)^	Administrative or hybrid
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)^	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)^	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)^	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)^	Administrative
NA**	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)^	Administrative
Experience of Care			
0006***	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)	Survey
Long-Term Services & Supports			
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)	Survey

More information on 2021 Updates to the Child and Adult Core Set Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

* This measure is no longer endorsed by NQF.

Exhibit A.2 *(continued)*

** The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure (NQF #1879).

*** AHRQ is the measure steward for the survey instrument in the Adult Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

^ This measure is part of the Behavioral Health Core Set. The complete list of 2021 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-bh-core-set.pdf.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

Exhibit A.3. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2012–2021

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Primary Care Access and Preventive Care														
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)[a]	X	X	X	X	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	X	X	X	X	X	X	X	X	X	X	X	X
0038	NCQA	Childhood Immunization Status (CIS-CH)	X	X	X	X	X	X	X	X	X	X	X	X
0418*/0418e*	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)[b]	--	--	--	--	--	--	--	--	X	X	X	X
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)[c]	X	X	X	X	X	X	X	X	X	X	X	X
1407	NCQA	Immunizations for Adolescents (IMA-CH)	X	X	X	X	X	X	X	X	X	X	X	X
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	X	X	X	X	X	X	X	X	X	X	X	X
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)[d]	X	X	X	X	X	X	X	X	X	X	X	X
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV-CH)[e]	--	--	--	X	X	X	X	--	--	--	--	--
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)[d]	X	X	X	X	X	X	X	X	X	X	X	--
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)[f]	X	X	X	X	X	X	X	X	X	X	--	--

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Maternal and Perinatal Health														
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)[g]	X	X	X	X	X	X	X	X	X	X	--	--
0471	TJC	PC-02: Cesarean Birth (PC02-CH)[h]	X	X	X	X	X	X	X	X	X	X	X	--
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)[i]	--	--	--	--	--	--	X	X	X	X	X	X
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)[j]	X	X	X	X	X	X	X	X	X	X	X	X
1391*	NCQA	Frequency of Ongoing Prenatal Care (FPC-CH)[k]	X	X	X	X	X	X	X	X	--	--	--	--
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	X	X	X	X	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)[l]	--	--	--	--	--	--	--	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)[m]	--	--	--	--	--	--	--	--	X	X	X	X
NA	No current measure steward	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)[n]	--	--	--	X	X	X	X	X	--	--	--	--
NA	CDC	Low-Risk Cesarean Delivery (LRCD-CH)[h]	--	--	--	--	--	--	--	--	--	--	--	X
Care of Acute and Chronic Conditions														
0002*	NCQA	Appropriate Testing for Children with Pharyngitis (CWP-CH)[o]	X	X	X	X	--	--	--	--	--	--	--	--
0060*	NCQA	Annual Pediatric Hemoglobin A1C Testing (PA1C-CH)[p]	X	X	X	X	--	--	--	--	--	--	--	--
0657	AAOH-HNSF	Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children: Ages 2 to 12 (OME-CH)[q]	X	X	X	--	--	--	--	--	--	--	--	--

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
1381*	Alabama Medicaid	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One of More Asthma-Related Emergency Room Visits (ASMER-CH)[r]	X	X	X	X	--	--	--	--	--	--	--	--
1799*	NCQA	Medication Management for People with Asthma (MMA-CH)[s]	--	--	--	X	X	X	X	X	--	--	--	--
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)[s]	--	--	--	--	--	--	--	--	X	X	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Health Care														
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	X	X	X	X	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)[t]	X	X	X	X	X	X	X	X	X	X	X	X
1365	PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)[u]	--	--	--	--	--	X	X	X	--	--	--	--
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)[v]	--	--	--	--	--	--	--	--	--	--	X	X
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[w]	--	--	--	--	--	--	--	X	X	X	X	X
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[v]	--	--	--	--	--	--	X	X	X	X	--	--

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Dental and Oral Health Services														
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)[x]	--	--	--	--	--	X	X	X	X	X	X	--
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	X	X	X	X	X	X	X	X	X	X	X	X
NA	CMS	Percentage of Eligibles That Received Dental Treatment Services (TDENT-CH)[y]	X	X	X	X	X	--	--	--	--	--	--	--
NA	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)[z]	--	--	--	--	--	--	--	--	--	--	--	X
Experience of Care														
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)[aa]	X	X	X	X	X	X	X	X	X	X	X	X

X = Included in Child Core Set; -- = Not Included in Child Core Set.

AAO-HNSF = American Academy of Otolaryngology-Head and Neck Surgery; AMA = American Medical Association; CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; PCPI = Physician Consortium for Performance Improvement; TJC = The Joint Commission.

More information on 2021 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf.

*This measure is no longer endorsed by NQF.

[a] The Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure was modified for the 2020 Child Core Set. CMS added the Counseling for Nutrition and Counseling for Physical Activity components to this measure for the 2020 Child Core Set. Prior Core Sets included only the Body Mass Index (BMI) Percentile Documentation component.

[b] The Screening for Depression and Follow-Up Plan: Ages 12 to 17 measure was added to the 2018 Child Core Set to align with the Adult Core Set and replaced the Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure as a broader measure of behavioral health.

[c] The Well-Child Visits in the First 15 Months of Life (W15-CH) measure was modified by the measure steward. It now includes two rates: (1) six or more well-child visits in the first 15 months and (2) two or more well-child visits from 15 to 30 months. The NQF number refers to the endorsement of the W15-CH measure.

Exhibit A.3 *(continued)*

[d] The Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH) and Adolescent Well-Care Visits (AWC-CH) measures were modified by the measure steward into a combined measure that includes rates for Ages 3 to 11, 12 to 17, 18 to 21, and a total rate. The NQF number refers to the endorsement of the W34-CH measure.

[e] The stand-alone HPV Vaccine for Female Adolescents measure was retired by the measure steward and added as a rate to the Immunizations for Adolescents measure beginning with the 2017 Child Core Set.

[f] The Child and Adolescents' Access to Primary Care Practitioners measure was retired from the 2020 Child Core Set because it is more of a utilization measure than a quality measure, with high rates for most age ranges resulting in a limited ability for states to take action on the results.

[g] The Pediatric Central Line-Associated Bloodstream Infections measure was retired from the 2020 Child Core Set because the measure is reported by hospitals directly to the CDC, and therefore state Medicaid and CHIP programs have had limited ability to take action on the results.

[h] The California Maternal Quality Care Collaborative Cesarean Rate for Nulliparous Singleton Vertex measure was replaced by The Joint Commission PC-02: Cesarean Birth measure beginning with the 2014 Child Core Set. The PC-02: Cesarean Birth measure was replaced in the 2021 Child Core Set with the Low-Risk Cesarean Delivery (LRCD-CH) measure. To reduce state burden and report a cesarean birth measure consistently across all states, CMS will calculate the LRCD-CH measure on behalf of states using National Vital Statistics System Natality data that are submitted by states and obtained through CDC Wide-ranging Online Data for Epidemiologic Research (CDC WONDER) starting in FFY 2021.

[i] The Audiological Diagnosis No Later Than 3 Months of Age measure was added to the 2016 Child Core Set due to opportunities for quality improvement on the measure and its alignment with the electronic health record incentive program.

[j] The Live Births Weighing Less Than 2,500 Grams measure was modified for the 2021 Core Set. To reduce burden on states and increase the feasibility of assessing performance across all states, CMS will calculate the measure on behalf of states starting in FFY 2021 using National Vital Statistics System Natality data that are submitted by states and obtained through CDC WONDER.

[k] The Frequency of Ongoing Prenatal care measure was retired from the 2018 Child Core Set because it does not assess the content of the prenatal care visit.

[l] The Contraceptive Care – Postpartum Women Ages 15 to 20 measure was added to the 2017 Child Core Set because it measures the provision of contraception to mothers in the postpartum period, which can help women space pregnancies to their desired interpregnancy interval and help to improve future birth outcomes.

[m] The Contraceptive Care – All Women Ages 15 to 20 measure was added to the 2018 Child Core Set to assess access to contraceptive care, which has an important role in promoting health equity.

[n] The Behavioral Health Risk Assessment (for Pregnant Women) measure was removed from the 2018 Child Core Set due to implementation and data collection challenges. AMA-PCPI was the measure steward for the 2013-2016 Child Core Sets; the measure had no steward for the 2017 Child Core Set.

[o] The Appropriate Testing for Children with Pharyngitis measure was retired from the 2014 Child Core Set because the clinical evidence for the measure was obsolete.

[p] The Annual Pediatric Hemoglobin A1C Testing measure was retired from the 2014 Child Core Set because it affects a small number of children, has a weak evidence base, and was approaching the improvement ceiling.

[q] The Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2 to 12) measure was retired from the 2013 Child Core Set because of significant state reporting challenges. The measure was not collected by CMS for the 2012 Child Core Set. AMA-PCPI was the measure steward for the 2010-2012 Child Core Sets.

[r] The Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits measure was retired from the 2014 Child Core Set due to data quality concerns and lack of an active measure steward.

[s] Beginning with the 2018 Child Core Set, the Asthma Medication Ratio: Ages 5 to 18 measure replaces the Medication Management for People with Asthma measure, which was included in the 2013-2017 Child Core Sets.

[t] The age group for the Follow-Up After Hospitalization for Mental Illness measure changed from ages 6 to 20 to ages 6 to 17 for the 2019 Child Core Set.

[u] The Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure was added to the 2015 Child Core Set to target a high prevalence mental health condition that has severe consequences without appropriate treatment. The measure was removed from the 2018 Child Core Set because of the need for a broader measure of behavioral health.

[v] The Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure was added to the 2016 Child Core Set to target inappropriate prescribing of antipsychotic medications, which may have adverse health effects. The measure was retired from the 2020 Child Core Set because it was retired by the measure steward. It was replaced by the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure, which was added to the 2020 Child Core Set to monitor medication safety for children on psychotropic medications by identifying any gaps in their metabolic follow-up.

Exhibit A.3 *(continued)*

[w] The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure was added to the 2017 Child Core Set to promote the use of nonpharmacologic, evidence-informed approaches to the treatment of mental and behavioral health problems of Medicaid and CHIP insured children on psychotropic medications.

[x] The Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk measure was added to the 2015 Child Core Set because it is linked to improved oral health outcomes and responds to a legislative mandate to measure the use of dental sealants in this age group. The measure was removed from the 2021 Child Core Set because it was retired by the measure steward.

[y] The Percentage of Eligibles That Received Dental Treatment Services measure was retired from the 2015 Child Core Set because it is not an effective tool for quality improvement; it is unclear if an increase or a decrease in the rate is desirable, and therefore the results are not actionable.

[z] The Sealant Receipt on Permanent First Molars measure was added to the 2021 Child Core Set to provide data on the percentage of children who have ever received sealants on permanent first molar teeth by their 10th birthdate. This measure replaces the SEAL-CH measure.

[aa] AHRQ is the measure steward for the survey instrument in the Child Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

Exhibit A.4. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2013–2021

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
Primary Care Access and Preventive Care											
0032	NCQA	Cervical Cancer Screening (CCS-AD)	X	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	X	X	X	X	X	X	X	X	X
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	X	X	X	X	X	X	X	X	X
0418*/0418e*	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	X	X	X	X	X	X	X	X	X
2372	NCQA	Breast Cancer Screening (BCS-AD)	X	X	X	X	X	X	X	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)[a]	X	X	X	X	X	X	X	X	--
Maternal and Perinatal Health											
0469/ 0469e	TJC	PC-01: Elective Delivery (PC01-AD)	X	X	X	X	X	X	X	X	X
0476	TJC	PC-03: Antenatal Steroids (PC03-AD)[b]	X	X	X	X	X	X	--	--	--
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	X	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)[c]	--	--	--	--	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)[d]	--	--	--	--	--	X	X	X	X
Care of Acute and Chronic Conditions											
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	X	X	X	X	X	X	X	X	X
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)[e]	X	X	X	X	X	X	X	--	--

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)[f]	--	--	X	X	X	X	X	X	X
0063*	NCQA	Comprehensive Diabetes Care: LDL-C Screening (LDL-AD)[f]	X	X	--	--	--	--	--	--	--
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	X	X	X	X	X	X	X	X	X
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	X	X	X	X	X	X	X	X	X
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	X	X	X	X	X	X	X	X	X
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	X	X	X	X	X	X	X	X	X
0403*	NCQA	Annual HIV/AIDS Medical Visit (HMV-AD)[g]	X	--	--	--	--	--	--	--	--
1768*	NCQA	Plan All-Cause Readmissions (PCR-AD)	X	X	X	X	X	X	X	X	X
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)[h]	--	--	--	--	--	X	X	X	X
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)[g]	--	X	X	X	X	X	X	X	X
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)[i]	X	X	X	X	X	X	X	--	--
Behavioral Health Care											
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	X	X	X	X	X	X	X	X	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	X	X	X	X	X	X	X	X	X
0105	NCQA	Antidepressant Medication Management (AMM-AD)	X	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[j]	X	X	X	X	X	X	X	X	X
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)[k]	--	--	--	X	X	X	X	X	X
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[l]	--	--	--	--	X	X	X	X	X
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[k]	--	--	--	X	X	X	X	X	X
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)[m]	--	--	--	--	--	X	X	X	X
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)[n]	--	--	--	--	--	--	--	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)[o]	--	--	--	--	X	X	X	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)[o]	--	--	--	--	X	X	X	X	X
NA	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)[p]	X	X	X	X	X	X	X	X	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
Care Coordination											
0648*	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR-AD)[q]	X	X	X	X	--	--	--	--	--
Experience of Care											
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)[r]	X	X	X	X	X	X	X	X	X
Long-Term Services and Supports											
NA	NASDDDS/HSRI	National Core Indicators Survey (NCIDDS-AD)[s]	--	--	--	--	--	--	--	X	X

X = Included in Adult Core Set; -- = Not Included in Adult Core Set.

AHRQ = Agency for Healthcare Research & Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NASDDDS = National Association of State Directors of Developmental Disabilities Service; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

More information on 2021 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf.

*This measure is no longer endorsed by NQF.

[a] The Adult Body Mass Index Assessment measure was retired from the 2021 Adult Core Set because it was retired by the measure steward.

[b] The Antenatal Steroids measure was retired from the 2019 Adult Core Set due to the low number of states reporting this measure and the challenges states have reported in collecting it.

[c] The Contraceptive Care – Postpartum Women Ages 21 to 44 measure was added to the 2017 Adult Core Set because it measures the provision of contraception to mothers in the postpartum period, which can help women space pregnancies to their desired interpregnancy interval and help to improve future birth outcomes.

[d] The Contraceptive Care – All Women Ages 21 to 44 measure was added to the 2018 Adult Core Set to assess access to contraceptive care, which has an important role in promoting health equity.

[e] The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing measure was retired from the 2020 Adult Core Set because there is another publicly reported diabetes measure on the Adult Core Set, Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9 percent), which is an outcome measures that also assesses whether testing is being conducted.

[f] The Comprehensive Diabetes Care: LDL-C Screening measure was replaced by the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure beginning with the 2015 Adult Core Set. The Comprehensive Diabetes Care: LDL-C Screening measure was retired from the Adult Core Set because clinical guidelines underpinning this measure were in flux and because NCQA removed it from HEDIS 2015. The Comprehensive Diabetes Care:

Exhibit A.4 *(continued)*

Hemoglobin A1c Poor Control (>9.0%) measure addresses the prevalent condition of diabetes and facilitates state efforts to drive quality improvement on the risk factor of poor HbA1c control.

[g] The Annual HIV Medical Visit measure was replaced by the HIV Viral Load Suppression measure beginning with the 2014 Adult Core Set. The Annual HIV Medical Visit measure lost NQF endorsement after the 2013 Adult Core Set was published. The HIV Viral Load Suppression measure is a regularly collected clinical indicator that is predictive of overall outcomes.

[h] The Asthma Medication Ratio: Ages 19 to 64 measure was added to the 2018 Adult Core Set and aligns with changes made to the 2018 Child Core Set.

[i] The Annual Monitoring for Patients on Persistent Medications measure was retired from the 2020 Adult Core Set because it was retired by the measure steward.

[j] The age group for the Follow-Up After Hospitalization for Mental Illness measure changed from age 21 and older to age 18 and older for the 2019 Adult Core Set.

[k] Two measures focused on quality of care for adults with substance use disorders and/or mental health disorders were added to the 2016 Adult Core Set: (1) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population; and (2) Use of Use of Opioids at High Dosage in Persons Without Cancer is a measure of potential overuse that addresses the epidemic of narcotic morbidity and mortality.

[l] The Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure was added to the 2017 Adult Core Set because it addresses chronic disease management for people with serious mental illness and assesses integration of medical and behavioral services by reinforcing shared accountability and linkage of medical and behavioral healthcare services.

[m] The Concurrent Use of Opioids and Benzodiazepines measure was added to the 2018 Adult Core Set because it addresses early opioid use and polypharmacy.

[n] The Use of Pharmacotherapy for Opioid Use Disorder measure was added to the 2020 Adult Core Set to fill a gap in the Core Sets by tracking the appropriate treatment of opioid use disorders and improving the understanding of the quality of care for substance use disorders.

[o] The Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (FUA/FUM-AD) measure was added to the 2017 Adult Core Set because it addresses priority areas of access and follow-up of care for adults with mental health or substance use disorders. In the 2017 and 2018 Adult Core Sets, this was included as a single measure (FUA/FUM-AD). For the 2019 Adult Core Set, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) and Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) are included as two separate measures. For the 2020 Adult Core Set, these two measures have separate NQF numbers (previously they were both endorsed under 2605).

[p] The Adult Core Set includes the NCQA version of the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure, which is adapted from the CMS measure (NQF #1879).

[q] The Timely Transmission of Transition Record measure was retired from the 2017 Adult Core Set due to the low number of states reporting this measure, a decrease in the number of states reporting over time, and the challenges states reported in collecting it.

[r] AHRQ is the measure steward for the survey instrument in the Adult Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

[s] The National Core Indicators Survey was added to the 2020 Adult Core Set to fill a gap in the Core Sets related to long-term services and supports, including home and community-based services.

APPENDIX B:
Measures Suggested for Review at the 2022 Core Set Annual Review, by Domain

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Exhibit B.1. Measures Suggested for Review at the 2022 Child and Adult Core Set Annual Review, by Domain

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Primary Care Access and Preventive Care				
Removal	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	NCQA	0039	Survey
Addition	Preventive Care and Screening: Influenza Immunization (Suggested as a replacement for FVA-AD)	NCQA (formerly PCPI)	0041 /0041e	EHR or clinical registry
Addition	Colorectal Cancer Screening	NCQA	0034	Administrative, hybrid, or ECDS[a]
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Prediabetes: Screening for Abnormal Blood Glucose	AMA	NA	EHR
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Intervention for Prediabetes	AMA	NA	EHR
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Retesting of Abnormal Blood Glucose in Patients with Prediabetes	AMA	NA	EHR
Maternal and Perinatal Health				
Removal	PC-01: Elective Delivery (PC01-AD)	TJC	0469/ 0469e	Hybrid or EHR
Removal	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	CDC	1360	EHR
Care of Acute and Chronic Conditions				
Removal	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	NCQA	NA	Administrative
Addition	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058	Administrative
Addition	Appropriate Treatment for Upper Respiratory Infection	NCQA	0069	Administrative
Addition	Proportion of Days Covered: Diabetes All Class	PQA	0541	Administrative
Addition	Proportion of Days Covered: Renin Angiotensin System Antagonists	PQA	0541	Administrative
Addition	Proportion of Days Covered: Statins	PQA	0541	Administrative

Exhibit B.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	NA	EHR or clinical registry
Behavioral Health Care				
Removal	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	NCQA	0004	Administrative or EHR
Removal	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	NCQA	0027	Survey
Addition	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (suggested as a replacement for MSC-AD)	NCQA (formerly PCPI)	0028/ 0028e	Administrative, EHR, or clinical registry
Addition	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA, suggested for addition to the Child Core Set for ages 13-17 as a replacement for AMB-CH)	NCQA	3488	Administrative
Addition	Follow-Up After Emergency Department Visit for Mental Illness (FUM, suggested for addition to the Child Core Set for ages 6-17 as a replacement for AMB-CH)	NCQA	3489	Administrative
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Tobacco Use and Help with Quitting Among Adolescents	NCQA	2803 (No longer endorsed)[b]	Administrative or EHR
Dental and Oral Health Services				
Removal	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	CMS	NA	Administrative (Form CMS-416)[c]
Addition	Oral Evaluation, Dental Services (suggested as a replacement for PDENT-CH)	ADA/DQA	2517	Administrative
Addition	Prevention: Topical Fluoride for Children at Elevated Caries Risk (suggested as a replacement for PDENT-CH)	ADA/DQA	2528	Administrative
Addition	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	ADA/DQA	NA	Administrative

Exhibit B.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Long-Term Services and Supports				
Addition	Long-Term Services and Supports Comprehensive Care Plan and Update	NCQA	NA	Case management record review
Addition: Measure will not be reviewed because it has not been fully specified	State Use of Experience of Care Surveys for Beneficiaries Using Long-Term Services and Supports	CMCS	NA	CMS count of surveys administered

Notes: Data collection methods for each measure are current as of April 2021. The methods may change as measures undergo specification updates and maintenance.

Measures specified for administrative data collection may use code sets that are not available for state-level reporting, such as LOINC, SNOMED, or CPT-II codes. More information is available in the detailed measure specifications.

[a] ECDS data collection method includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries. More information about ECDS is available at https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/.

[b] NQF endorsement was removed because the committee did not reach consensus on evidence. In 2020, the U.S. Preventive Services Taskforce released an updated recommendation related to tobacco use in adolescents. The updated recommendation rated evidence related to tobacco cessation interventions in adolescents as “Insufficient” due to the lack of high-powered studies looking at cessation interventions in this population.

[c] Beginning with federal fiscal year (FFY) 2020 Form CMS-416 reporting due April 1, 2021, states may opt to use the Form CMS-416T report generated by CMS on behalf of states using Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF).

ADA = American Dental Association; AMA = American Medical Association; CDC = Centers for Disease Control and Prevention; CHIP = Children’s Health Insurance Program; CMCS = Center for Medicaid and CHIP Services; CMS = Centers for Medicare & Medicaid Services; DQA = Dental Quality Alliance; ECDS = Electronic Clinical Data System; EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PCPI = Physician Consortium for Performance Improvement; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

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APPENDIX C:
Summary of 2022 Child and Adult Core Set Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

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This appendix summarizes the discussion of measures considered by the Workgroup and not recommended for removal from or addition to the 2022 Child and Adult Core Sets. The discussion took place during the Workgroup meeting that was held May 4 to May 6, 2021. The summary is organized by Core Set domain. For more information about the measures discussed and not recommended for removal or addition, please refer to Exhibit C.1 at the end of this appendix. Exhibit C.1 includes the measure name, measure steward, National Quality Forum (NQF) number (if endorsed), measure description, data collection method, and key points of discussion about each measure.

Primary Care Access and Preventive Care

Workgroup members discussed two immunization measures: *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD), which was suggested for removal from the Adult Core Set; and *Preventive Care and Screening: Influenza Immunization*, which was suggested as a replacement for the FVA-AD measure. The FVA-AD measure is based on self-reported data collected through the CAHPS survey. The measure is defined as the percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS survey was completed. The FVA-AD measure was suggested for removal because survey completion varies widely across demographic groups, and the measure may not be representative of the population across counties and states. The Workgroup member who suggested the measure for removal also acknowledged that, while the Centers for Medicare & Medicaid Services (CMS) pilot has shown it is feasible to calculate the measure using data from the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database, the data are incomplete due to lack of submissions from some states and health plans. During the Workgroup meeting, Mathematica noted that while 25 states reported the FVA-AD measure for Federal Fiscal Year (FFY) 2019, it was not publicly reported due to CMS concerns about data quality. However, preliminary results from FFY 2020 Core Set reporting suggest that this measure may have reached the public reporting threshold for FFY 2020.

The *Preventive Care and Screening: Influenza Immunization* measure is defined as the percentage of patients ages 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization or who reported previous receipt of an influenza immunization. The measure was suggested to replace FVA-AD and is collected using electronic health records (EHRs) or clinical registries. The Workgroup member who suggested adding this measure to the Core Sets noted that the measure had been tested at the provider level using Medicare data. They also noted that the measure is currently used in selected Medicaid and Children's Health Insurance Program (CHIP) value-based purchasing programs in their state; however, it has not been used statewide in Medicaid and CHIP. In addition, the Workgroup member stated that the flu vaccine is important for reducing morbidity and mortality in Medicaid and CHIP beneficiaries, and that it could be stratified to perform comparative analyses. They also noted that the measure could be calculated using immunization registry data, and that states could benefit from technical assistance in this area, which would also benefit other immunization measurement efforts.

During the discussion, some Workgroup members expressed concern about the validity, reliability, and representativeness of the FVA-AD measure given the low CAHPS response rates. One Workgroup member, however, challenged this assertion suggesting that they have not seen evidence that CAHPS results substantially under-report influenza immunization rates, noting that CAHPS results still appear to benchmark well with other data sources. While several Workgroup members noted that the wider age range of the *Preventive Care and Screening: Influenza Immunization* measure is an improvement over FVA-AD, the Workgroup also discussed potential difficulties collecting the measure, including variation in states' use of immunization registries, especially for adult populations. Workgroup members noted this was in contrast to the availability of CAHPS, and the progress seen in more states being able to report the measure.

Some Workgroup members suggested the need for a glide path to encourage movement toward newer data collection methods, such as utilizing EHRs, while not losing insight into current reporting mechanisms, like CAHPS. Some Workgroup members noted the increasing potential of EHRs and immunization registries. One Workgroup member highlighted that immunization registries are being used with the administration of COVID-19 vaccines and the possibility of a forthcoming COVID-19 vaccine measure that could be leveraged for measuring flu vaccination in the future.

Care of Acute and Chronic Conditions

The Workgroup discussed the *Appropriate Treatment for Upper Respiratory Infection* measure but did not recommend it for addition to the Core Sets. This measure assesses the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. The Workgroup considered this measure alongside the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure, which they recommended for addition to the Core Set.

A Workgroup member suggested the *Appropriate Treatment for Upper Respiratory Infection* measure for addition to help identify the inappropriate over-prescribing of antibiotics for a common condition (URI). They added that the Core Sets currently do not address appropriate use of antibiotics. During the discussion, other Workgroup members agreed that appropriate antibiotic use and prevention of antimicrobial resistance were important issues to address, however they questioned whether it was necessary to add both measures to the Core Sets, or if one measure was sufficient to address the issue. One Workgroup member raised concerns about the potential to game the URI measure, explaining that there are ways to subvert measure performance through coding. Other Workgroup members pointed out that when looking at commercial and Medicaid health maintenance organization (HMO) data from the National Committee for Quality Assurance (NCQA), URI measure performance is high relative to performance on *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*. This indicates that improvement on the bronchitis/bronchiolitis measure would be more impactful than on the URI measure.

The Workgroup also considered three measures related to medication management for chronic conditions: *Proportion of Days Covered: Diabetes All Class; Proportion of Days Covered:*

Renin Angiotensin System Antagonists; and *Proportion of Days Covered: Statins. Proportion of Days Covered: Diabetes All Class* measures the percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for diabetes medications during the measurement year. One Workgroup member suggested this measure for addition because non-adherence to diabetes medications leads to higher rates of hospitalization and places a cost burden on the health care system. The Workgroup member also noted that the inclusion of this measure in the Core Set may drive patient education at the provider, pharmacy, and health plan levels. They added that this measure is included in the Medicare Part D Star Ratings program, and adherence rates in the Medicare population are higher than those in the Medicaid population.

Proportion of Days Covered: Renin Angiotensin System Antagonists measures the percentage of individuals 18 years and older who met the PDC threshold of 80 percent for renin angiotensin system (RAS) antagonists during the measurement year. The Workgroup member who suggested this measure for addition to the Core Set provided similar reasons as those for the *Proportion of Days Covered: Diabetes All Class* measure, with the intent of improving adherence to hypertension medications in Medicaid. *Proportion of Days Covered: Statins* measures the percentage of individuals 18 years and older who met the PDC threshold of 80 percent for statins during the measurement year. The Workgroup member who suggested the measure for addition presented many of the same reasons as those listed for the previous two measures, with a focus on medication adherence to statins for high cholesterol. They added that high cholesterol, hypertension, and diabetes are prevalent conditions among the adult Medicaid population.

During the Workgroup discussion, several Workgroup members expressed concern about the appropriateness of adding the three measures mentioned above to the Core Set. As one Workgroup member noted, the measures only indicate if the patient picked up the medication, not whether they adhered to taking it or whether the medication was prescribed appropriately. Furthermore, Workgroup members were hesitant to add more process measures to the Core Set, with one Workgroup member emphasizing that CMS is moving toward more outcome-based measures. The Workgroup member who suggested the three measures for addition noted that they are outcome measures with considerable room for improvement.

Several Workgroup members also raised concerns about implementing measures that calculate the rate at which prescriptions are filled; they noted that some beneficiaries struggle to afford or fill their prescriptions. For example, one Workgroup member stated that some providers prescribe a higher dosage than necessary and tell patients to split their medications, so they last longer and cost less. A few Workgroup members added that physicians may adjust medications frequently, which can interfere with adherence measurement. In addition, one Workgroup member questioned why insulin is excluded from the diabetes measure. The measure steward, Pharmacy Quality Alliance (PQA), responded that insulin requires frequent dosage adjustments, complicating data collection.

One Workgroup member questioned if it was necessary to add the *Diabetes All Class* measure when the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* (HPC-AD) measure is already in the Adult Core Set. The Workgroup member who suggested the

measure responded that the *Diabetes All Class* measure would complement the HPC-AD measure, adding that both measures are in the Health Insurance Exchange Quality Rating System. In addition, Workgroup members noted that there is already an outcome measure that addresses hypertension (*Controlling High Blood Pressure [CBP-AD]*).

Workgroup members stated that the statins measure may be a better fit for the Core Set, given the generality of the population included in the measure, the prevalence of high cholesterol among Medicaid beneficiaries, and the lack of existing measures related to cholesterol in the Core Set. They noted that this is particularly important for beneficiaries with behavioral health disorders, especially for those on antipsychotics. However, another Workgroup member said that other measures may be better suited to address high cholesterol among specific populations, such as those with behavioral health conditions.

Behavioral Health Care

The *Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment* (IET-AD) measure assesses the percentage of beneficiaries ages 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: (1) initiation of AOD treatment, which captures the percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis; and (2) engagement of AOD treatment, which captures the percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This measure is stratified into four diagnosis cohorts: alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence, and total alcohol and other drug abuse or dependence.

One Workgroup member suggested removing the IET-AD measure because they felt it was duplicative of other measures, such as the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA-AD) and the *Use of Pharmacotherapy for Opioid Use Disorder* (OUD-AD) measures. Therefore, they noted, the removal of the IET-AD measure would not leave a gap in the Adult Core Set. They added that the FUA-AD and OUD-AD measures are more specific to the treatment of substance use disorders (SUD), whereas IET-AD measures new substance use events and does not consider an existing substance use event. The Workgroup member stated that it often takes more than the initial engagement to treat patients with SUD and they find it difficult to get patients to come in after the initial screening. As a result, they have not seen significant improvement in their state on the measure. They acknowledged that SUD is a critical issue to address but questioned whether IET-AD was the best measure to achieve the best possible outcome.

During the discussion, Workgroup members voiced concern about removing the IET-AD measure from the Core Set given the prevalence of alcohol and drug misuse in the Medicaid population. Many Workgroup members thought that given the breadth of settings captured through the measure, removal of the measure would leave a gap in the Core Set that could not be replaced by measures with a narrower focus. Some Workgroup members acknowledged that

components of the IET-AD measure overlap with other measures in the Core Set. However, they also noted that there are important differences. For example, they noted that the IET-AD measure addresses treatment for the general population, while the FUA-AD measure addresses follow-up care for the population that ends up in the emergency department (ED).

One Workgroup member commented that many clinicians (such as primary care providers and general psychiatrists) often treat SUD inadequately because they are not addiction specialists. They suggested that the IET-AD measure motivates health systems to ensure that patients receive proper care when they are identified as having AOD abuse or dependence. On the other hand, a federal liaison suggested that the IET-AD measure could potentially discourage providers from reporting a diagnosis of SUD to "activate" the measure, and the measure is difficult to meet (i.e., 7-day follow up), especially in areas where the diagnosis is prevalent. Several Workgroup members agreed that while the IET-AD measure was not necessarily the best measure, it is a fundamentally good measure that looks beyond what happens in the ED, and supplements the existing follow-up measures in the Core Set.

Workgroup members discussed two tobacco use cessation measures: *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD), which was suggested for removal from the Adult Core Set; and *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention*, which was suggested as a replacement for the MSC-AD measure. The MSC-AD measure is based on self-reported data collected through the CAHPS survey. It includes three components: (1) advising smokers and tobacco users to quit, (2) discussing cessation medications, and (3) discussing cessation strategies. One Workgroup member suggested the removal of this measure from the Adult Core Set. They noted that survey response rates for the CAHPS survey are low and rates overall have been decreasing over time, with their own state having a 20 percent response rate. They acknowledged that it may be feasible to calculate the measure using data from the AHRQ CAHPS Database; however, the data are incomplete due to lack of submissions for some states or plans. They then expressed concerns about the feasibility of mandatory reporting for this measure based on the CAHPS survey.

As a replacement for the MSC-AD measure, the Workgroup member suggested adding the *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention* measure, which assesses the percentage of patients ages 18 and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user. The measure has three rates: (1) percentage of patients ages 18 years and older who were screened for tobacco use one or more times within 24 months, (2) percentage of patients ages 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention, and (3) percentage of patients ages 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user. This measure can be calculated using administrative, EHR, and registry data. The measure is being used in California at the program level, but due to COVID-19, it has not yet been implemented at the state level.

The Workgroup discussed data collection of both measures. Despite concerns expressed about low CAHPS response rates, some Workgroup members felt that the MSC-AD measure is more feasible for states to report given that CAHPS is already collected by many states. The *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention* measure allows for use of claims, EHR, or registry data. This measure would have a larger denominator than MSC-AD and could allow for stratification by race, ethnicity, and other characteristics to better understand disparities. However, one Workgroup member asked if there was concern that the use of different data sources could introduce variability across states. The Workgroup member who suggested the measure for addition noted that other programs, such as Medicare, are working toward EHR measures, and more states will soon be adopting EHR data into their Medicaid and CHIP programs. Some Workgroup members did not believe there was enough evidence to support state-level reporting of the measure, questioning whether the measure met the criteria for having been tested in a state Medicaid and/or CHIP program. They noted that they did not have concerns about the merit of the *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention* measure and encouraged follow-up from California after the measure has been implemented at the state level.

Dental and Oral Health Services

The *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* measure focuses on dental and oral health of adults. This measure was suggested for addition to the Core Set but was not recommended. The measure is defined as the number of ED visits for ambulatory care sensitive non-traumatic dental conditions, per 100,000 beneficiary months. The measure was suggested to address a gap in oral health care for adults in the Core Set, and was described as an indicator of state Medicaid program performance in minimizing acute dental conditions in adults. The Workgroup member who suggested the measure for addition noted that ED use for non-traumatic dental conditions has been a growing public health concern across the United States. They further noted that Medicaid is a primary payer of dental-related ED visits. The measure aims to divert dental care out of the ED by increasing preventive care, early identification of disease, treatment of acute dental issues, and appropriate follow-up after ED visits. The Workgroup member acknowledged that dental benefits for adults enrolled in Medicaid vary across states and this may lead to variation in state performance on the measure. They noted this should not result in any inconsistencies in calculations, given that dental claims are not required to calculate the measure.

The Workgroup discussed whether the measure is appropriate for the Core Sets, given that some state Medicaid programs do not have an adult dental benefit, and the benefit varies among the states that do. The Workgroup member who suggested the measure indicated that about a third of states provide comprehensive benefits (including routine dental care), and the remainder provide limited benefits or emergency-only dental care, except for three states that provide no coverage at all.

While Workgroup members agreed on the importance of equitable access to dental care for adults, some felt that the Core Set should focus on services that have more consistent benefits across states so that data are more comparable and actionable. For example, one Workgroup

member noted that the measure would not be actionable in their state due to limited adult dental coverage.

Workgroup members discussed whether the intention was to add the measure to the Core Set to promote a change in Medicaid policy around adult dental benefits, and questioned whether this was an appropriate purpose of the Core Set. One Workgroup member believed that adding the measure was appropriate to draw attention to address a Core Set gap in adult dental care, while another disagreed. Another Workgroup member mentioned that having an adult dental ED measure would be a starting place toward better integration of dental and medical care; would serve to identify variability, gaps, and disparities; and would ideally be used to drive preventive efforts aimed at reducing dental-related ED visits. Additionally, they noted that given challenges with integrating dental and medical data, this measure is a more feasible starting place for addressing the gap in the Core Set.

Exhibit C.1. Measures Discussed by the 2022 Core Set Annual Review Workgroup and Not Recommended for Removal or Addition, by Domain

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Primary Care Access and Preventive Care			
Measure discussed and not recommended for removal from the 2022 Core Sets			
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD) Measure steward: NCQA	0039	Percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the survey was completed Data collection method: Survey (CAHPS 5.0H/5.1H Adult Medicaid Survey)	• Suggested for removal due to concern about the validity, reliability, and representativeness of the measure given low CAHPS response rates • Concern about variation in survey responses across demographic groups may result in rates that are not consistent across states • Concern that data in the AHRQ CAHPS Database are incomplete due to lack of submissions from states and plans • Comment that there is no evidence that CAHPS data are under-reporting flu vaccination rates • Acknowledgment that states are making progress in reporting the measure; measure may meet threshold for public reporting for FFY 2020
Measure discussed and not recommended for addition to the 2022 Core Sets			
Preventive Care and Screening: Influenza Immunization Measure steward: NCQA (formerly PCPI)	0041/0041e	Percentage of patients ages 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization Data collection method: EHR or clinical registry	• Suggested to replace FVA-AD • Suggested for addition because the measure can be calculated using electronic data and could be stratified to perform comparative analysis by race, ethnicity, or other characteristics • Concern about availability of electronic data, including immunization registry; although data may become more complete as a result of the emphasis on gathering COVID-19 vaccination data • The measure captures a wider age range than FVA-AD

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Care of Acute and Chronic Conditions			
Measures discussed and not recommended for addition to the 2022 Core Sets			
Appropriate Treatment for Upper Respiratory Infection Measure steward: NCQA	0069	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event Data collection method: Administrative	• Suggested for addition because URI is a common condition for which antibiotics are commonly prescribed, even though they may not be an appropriate treatment • Suggested alongside the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure; however, some Workgroup members felt that only one measure was necessary • Commercial and Medicaid HMO data show that performance among children on this measure is high, relative to adult performance on the bronchitis/bronchiolitis measure, indicating there is more room for improvement on the bronchitis/bronchiolitis measure • Concern that the measure could be gamed by providers through coding practices
Proportion of Days Covered: Diabetes All Class Measure steward: PQA	0541	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for diabetes medications during the measurement year Data collection method: Administrative	• Suggested for addition because non-adherence to diabetes medications could lead to higher hospitalization rates and place a cost burden on the health care system • Comment that the measure could drive patient education at the provider, pharmacy, and health plan levels • Hesitation in adding this measure because the Adult Core Set currently includes two measures that address diabetes • Comment that medication adherence in Medicare is higher than in Medicaid, suggesting room for improvement • Concern that the measure does not indicate if the prescription is appropriate or whether the patient took the medication

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Proportion of Days Covered: Renin Angiotensin System Antagonists Measure steward: PQA	0541	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for renin angiotensin system (RAS) antagonists during the measurement year Data collection method: Administrative	• Suggested for addition to improve adherence to hypertension medications in Medicaid • Comment that Medicare rates are higher than those for Medicaid, suggesting room for improvement • Hesitation in adding this measure because the Adult Core Set currently includes another measure that addresses high blood pressure • Concern that the measure does not indicate if the prescription is appropriate or whether the patient took the medication
Proportion of Days Covered: Statins Measure steward: PQA	0541	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for statins during the measurement year Data collection method: Administrative	• Suggested for addition to improve medication adherence to statins for high cholesterol • No measures in the Core Set address high cholesterol, but a suggestion that there may be better measures that address more specific conditions • Comment that Medicare rates are higher than those for Medicaid, suggesting room for improvement • Concern that the measure does not indicate if the prescription is appropriate or whether the patient took the medication

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Behavioral Health Care			
Measures discussed and not recommended for removal from the 2022 Core Sets			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Measure steward: NCQA	0004	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit Data collection method: Administrative or EHR	• Suggested for removal because the measure is duplicative of other Core Set measures, such as FUA-AD and OUD-AD. Measure focuses on new substance use events and does not consider an existing substance use event • Concern that removing the measure could leave a gap in the Core Set because it is broader in scope and settings than the FUA-AD and OUD-AD measures. IET-AD measure addresses treatment for the general population, while the FUA-AD measure addresses follow-up care for the population that ends up in the ED • Comment that the measure could incentivize health systems to ensure that patients are receiving proper care when they are identified as having AOD use or dependence

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) Measure steward: NCQA	0027	The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: 1. Advising Smokers and Tobacco Users to Quit. A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who received advice to quit during the measurement year. 2. Discussing Cessation Medications. A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. 3. Discussing Cessation Strategies. A rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year. Data collection method: Survey (CAHPS 5.0H/5.1H Adult Medicaid Survey)	• Suggested for removal due to low CAHPS survey response rates, incomplete CAHPS data from some states and health plans, and concerns about feasibility for mandatory reporting in 2024 • Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention was suggested as a replacement • Comment that there is not yet enough data to support state-level reporting of the Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention measure • Acknowledgment that states are making progress in reporting the measure; measure may meet threshold for public reporting for FFY 2020 • Hesitation to remove this measure since CAHPS is already collected by many states. Discussion that more states may report the MSC measure through the CAHPS Database

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measure discussed and not recommended for addition to the 2022 Core Sets			
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Measure steward: NCQA (formerly PCPI)	0028/0028e	Percentage of patients 18 and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: 1. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Data collection method: Administrative, EHR, or clinical registry	• Suggested as a replacement for MSC-AD • Question about whether differences in the data collection method may lead to variation in measure results across states • Concern around lack of reporting at the state level. Used at the program level in California but has not yet been implemented at the state level • Comment that the data could allow for stratification across demographic characteristics to better understand disparities • Comments encouraging follow-up from California after the measure has been implemented at the state level

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Dental and Oral Health Services			
Measure discussed and not recommended for addition to the 2022 Core Sets			
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults Measure steward: ADA/DQA	Not endorsed	Number of ED visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 beneficiary months for adults Data collection method: Administrative (enrollment and medical claims)	• Suggested for addition to address a gap area in the Core Set around oral health care for adults. Could promote diversion of dental care out of the emergency department through increased preventive care and treatment of acute dental issues • Comment that the measure could be used to identify variation, gaps, and disparities in adult oral health care quality • Concern about the appropriateness of the measure in the Core Set as not all states provide dental coverage for adults. Comment that the Core Set should focus on measures with consistent benefits across states for comparability and actionability • Suggestion that the measure can be used as a starting place toward better integration of dental and medical care and to drive efforts aimed at reducing the occurrence of dental-related ED visits

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