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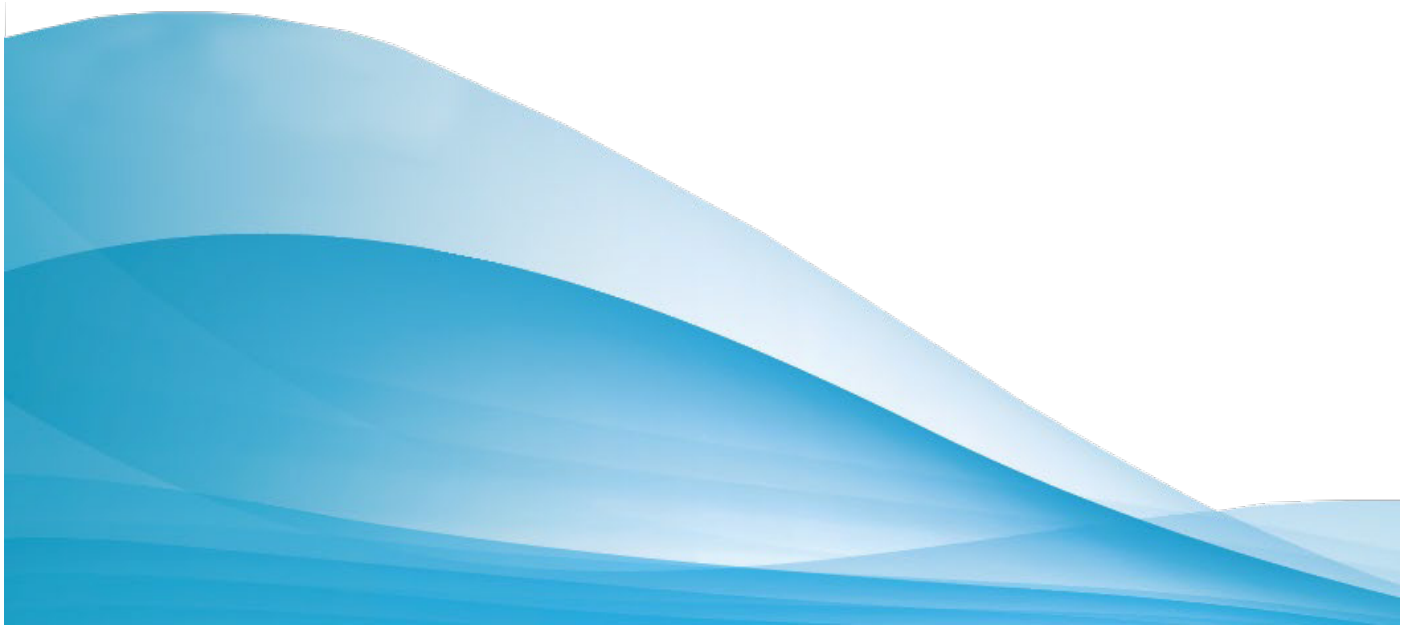
Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

Summary of a Multistakeholder Review of the 2023 Child and Adult Core Sets

Draft Report for Public Comment

July 2022



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Mathematica also acknowledges the contributions of the Child and Adult Core Set Workgroup members. Each member brought an invaluable perspective that informed the recommendations for the 2023 Child and Adult Core Sets. In particular, we thank the Workgroup co-chairs, Kim Elliott and David Kelley, for their insightful leadership. We also appreciate the participation of the federal liaisons, who provided cross-agency insight during the meetings.

In addition, we express our gratitude to the measure stewards who made themselves available throughout the review process. We appreciate the information they provided on the measures under consideration and thank them for responding to questions from the Workgroup during the meeting.

Mathematica also appreciates the comments provided by members of the public during the Workgroup meetings. The diversity of perspectives enriched the discussion about strengthening the Child and Adult Core Sets.

Finally, we thank the staff in the Division of Quality and Health Outcomes at the Center for Medicaid and CHIP Services for their input and guidance.

Contents

Exhibits

Acronyms

AAP	American Academy of Pediatrics
ADA	American Dental Association
AHRQ	Agency for Healthcare Research and Quality
APIs	Application programming interfaces
ASCVD	Clinical atherosclerotic cardiovascular disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CDF-AD	Screening for Depression and Follow-Up Plan: Age 18 and Older
CDF-CH	Screening for Depression and Follow-Up Plan: Ages 12 to 17
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CIS-CH	Childhood Immunization Status
CMCS	Center for Medicaid and CHIP Services
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COB-AD	Concurrent Use of Opioids and Benzodiazepines
DQA	Dental Quality Alliance
ECDS	Electronic Clinical Data Systems
ED	Emergency department
EHE	Ending the HIV Epidemic in the U.S.
EHR	Electronic health record
EPSDT	Early and Periodic, Screening, Diagnostic and Treatment
EVV	Electronic visit verification
FFY	Federal fiscal year
FHIR	Fast Healthcare Interoperability Resources
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	United States Department of Health and Human Services
HIE	Health information exchange
HIV	Human Immunodeficiency Virus
HPC-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
HPCMI-AD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)
HRSA	Health Resources and Services Administration
HVL-AD	HIV Viral Load Suppression
IDD	Intellectual and Developmental Disabilities

LTSS	Long-Term Services and Supports
MIPS	Merit-based Incentive Payment System
MLTSS-8	Long-Term Services and Supports: Successful Transition After Long-Term Institutional Stay
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
NASTAD	National Alliance of State and Territorial AIDS Directors
NCI-AD	National Core Indicators for Aging and Disabilities Adult Consumer Survey
NCIDDS-AD	National Core Indicators Survey
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer
ONC	Office of the National Coordinator for Health Information Technology
PQA	Pharmacy Quality Alliance
Q&A	Question and answer
QTAG	Quality Technical Advisory Group
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support
TEFCA	Trusted Exchange Framework and Common Agreement
T-MSIS	Transformed Medicaid Statistical Information System
USCDI	United States Core Data for Interoperability
USPSTF	U.S. Preventive Services Task Force
WCV-CH	Child and Adolescent Well-Care Visit

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to more than 87 million people, including eligible children, pregnant women, low-income adults, the elderly, and individuals with disabilities.[1] The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various strategies to help ensure that individuals enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high quality and equitable care. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort to measure the quality of care and drive improvement in Medicaid and CHIP.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries based on a uniform set of health care quality measures. CMCS and states use the Child and Adult Core Set measures to monitor access to and quality of health care for beneficiaries, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives. 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 become mandatory for state reporting beginning in federal fiscal year (FFY) 2024.[2]

The Secretary of the U.S. Department of Health and Human Services 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 stakeholder groups, including but not limited to states, managed care plans, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2023 Child and Adult Core Set Annual Review Stakeholder Workgroup. The Workgroup included 27 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 for list of members).

The Workgroup was charged with assessing the 2022 Child and Adult Core Sets and recommending measures for removal or addition to strengthen and improve the 2023 Core Sets. Workgroup members were asked to suggest, discuss, and vote on measures for removal from, or addition to, the Core Sets based on several criteria; these criteria support the adoption of

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[1] The February 2022 Medicaid and CHIP Enrollment Trend Snapshot is available at https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html. Numbers reflect preliminary Medicaid and CHIP enrollment data for February 2022, last updated as of May 4, 2022, 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.

measures that are feasible and viable for state-level reporting, actionable by state Medicaid and CHIP agencies, and represent strategic priorities for improving care delivery and health outcomes for Medicaid and CHIP beneficiaries. See Exhibit ES.1 for the criteria Workgroup members considered during the 2023 Child and Adult Core Set Annual Review.

Exhibit ES.1. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2023 Child and Adult Core Sets

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 (e.g., there is variation in coding or data completeness 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 (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid and CHIP beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
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, trending is not possible, 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 may not be able to produce the measure by the FFY 2024 Core Set reporting cycle or may not be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems). The FFY 2024 Core Set reporting cycle is when mandatory reporting goes into effect for all measures in the Child Core Set and behavioral health measures in the Adult Core Set.
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 and/or CHIP programs.
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).

Exhibit ES.1 *(continued)*

4.	The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
5.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Set.
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 (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid and CHIP programs/providers).
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 (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3.	All states should be able to produce the measure by the FFY 2024 Core Set reporting cycle and be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems). The FFY 2024 Core Set reporting cycle is when mandatory reporting goes into effect for all measures in the Child Core Set and behavioral health measures in the Adult Core Set.

Workgroup members convened virtually from April 5 to April 7, 2022, to review 7 measures suggested for removal from the 2022 Child and Adult Core Sets and 12 measures suggested for addition to the 2023 Child and Adult Core Sets.[4] The 19 measures were presented, discussed, and voted on by domain.[5] For a measure to be recommended for removal from or addition to the Child and Adult Core Sets, at least 67 percent of the Workgroup members eligible to vote had to vote in favor of removal or addition.

In summary, the Workgroup recommended removing one measure from the Child Core Set, removing two measures from the Adult Core Set, and adding four measures to the Child and Adult Core Sets (Exhibit ES.2). Two of the measures recommended for removal were paired with measures recommended for addition.

- The Workgroup recommended removing *Screening for Depression and Follow-Up Plan* from both the Child and Adult Core Sets and recommended adding *Depression Screening and Follow-Up for Adolescents and Adults* as a replacement.

[4] One measure suggested for removal is included in both the Child and Adult Core Sets.

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

- The Workgroup recommended removing *Flu Vaccinations for Adults Ages 18 to 64* from the Adult Core Set and recommended adding *Adult Immunization Status* as a replacement.
- Finally, the Workgroup recommended adding two child health measures–*Lead Screening in Children* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* (ages 3 months to 17 years).[6]

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2023 Child and Adult Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measure Recommended for Removal from the Child Core Set		
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Centers for Medicare & Medicaid Services (CMS)	0418*/0418e*
Measures Recommended for Removal from the Adult Core Set		
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	National Committee for Quality Assurance (NCQA)	0039*
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	CMS	0418*/0418e*
Measures Recommended for Addition[a]		
Adult Immunization Status	NCQA	3620
Depression Screening and Follow-Up for Adolescents and Adults	NCQA	Not endorsed
Lead Screening in Children	NCQA	Not endorsed
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[b]	NCQA	0058

* Measure is no longer endorsed.

[a] CMCS assigns new measures to a Core Set and domain as part of its annual update.

[b] This measure was added to the 2022 Adult Core Set for adults age 18 and older; the Workgroup recommended this measure for addition to the 2023 Child Core Set for children ages 3 months to 17 years.

The Workgroup also discussed two special topics: (1) advancing health equity through the Child and Adult Core Sets and (2) the future of digital measures in the Child and Adult Core Sets. There was broad consensus about the urgency to address health equity by adding drivers of health measures suitable for state-level reporting by Medicaid and CHIP agencies. Workgroup members encouraged CMCS and states to work with measure stewards to develop and test standardized measures of health-related social needs screening, positivity, and follow-up. Workgroup members also emphasized the importance of stratifying Core Set measure performance by race, ethnicity, language, and disability. The digital measures discussion

[6] This measure was added to the 2022 Adult Core Set for adults age 18 and older; the Workgroup recommended adding this measure to the 2023 Child Core Set for children ages 3 months to 17 years.

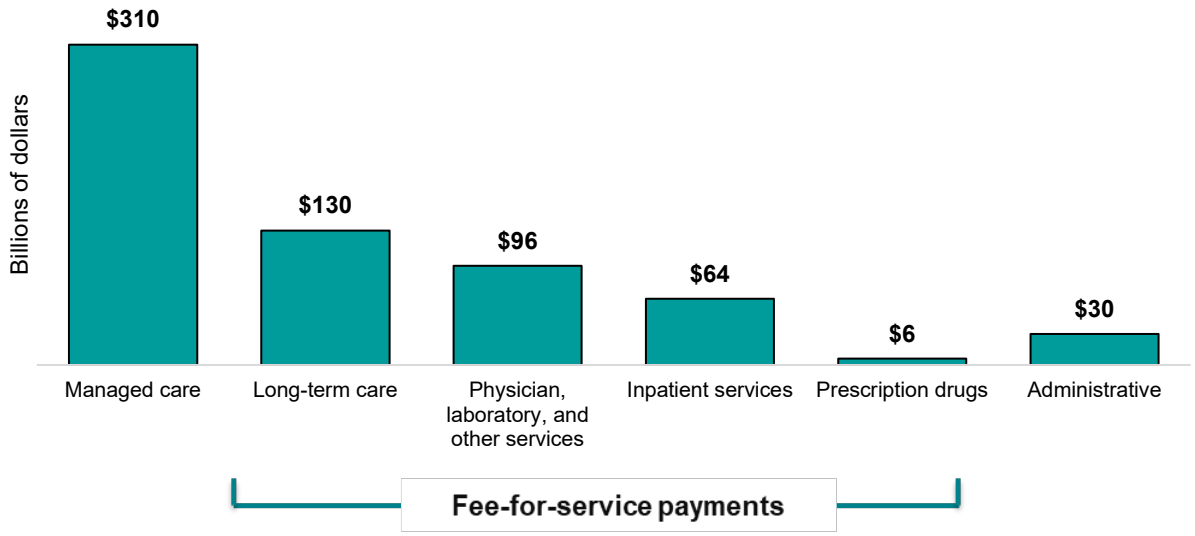
underscored efforts by the Workgroup to modernize, harmonize, and align the Child and Adult Core Sets with other quality measure initiatives. Workgroup members acknowledged that states have different levels of capacity for digital measures, and they encouraged CMCS to consider opportunities for technical assistance to states and to develop a timeline for transitioning to digital measures in the Child and Adult Core Sets.

This report, which is being made available for public comment, summarizes the Workgroup's review process, discussion, and recommendations. CMCS will use the Workgroup's recommendations, public comments, and additional input from CMCS's Quality Technical Advisory Group and federal liaisons to inform decisions about updates to the 2023 Child and Adult Core Sets. CMCS will release the 2023 Child and Adult Core Sets by December 31, 2022. Please submit public comments via email by **August 5, 2022, at 8 p.m. ET** to MACCoreSetReview@mathematica-mpr.com and include "2023 Child and Adult Core Set Annual Review Public Comment" in the subject line.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to more than 87 million people, including eligible children, pregnant women, low-income adults, the elderly, and individuals with disabilities.[7] This represents approximately one in four individuals in the United States.[8] Medicaid and CHIP now cover more individuals than Medicare.[9] 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, FFY 2019



Source: CMS. 2021 Medicaid & CHIP Scorecard. Analysis of CMS-64 reports for federal fiscal year (FFY) 2019 from the Medicaid Budget and Expenditures System/State Children's Health Insurance Program Budget and Expenditures System (MBES/CBES). Available at https://www.medicaid.gov/state-overviews/scorecard/national-context/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 2019.

FFY = Federal Fiscal Year.

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[7] The February 2022 Medicaid and CHIP Enrollment Trend Snapshot is available at https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html. Numbers reflect preliminary Medicaid and CHIP enrollment data for February 2022, last updated as of May 4, 2022, as reported by 50 states and the District of Columbia.

[8] Based on CMS Updated December 2020 Applications, Eligibility, and Enrollment Data (as of November 10, 2021) and U.S. Census Bureau, 2020 Census Redistricting Data (Public Law 94-171), Table P1. Available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html and https://data.census.gov/cedsci/all?q=&y=2020&d=DEC%20Redistricting%20Data%20%28PL%2094-171%29.

[9] https://www.cms.gov/newsroom/news-alert/cms-releases-latest-enrollment-figures-medicare-medicaid-and-childrens-health-insurance-program-chip.

The Center for Medicaid and CHIP Services (CMCS) uses various strategies to help ensure that individuals enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high quality and equitable care. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort to measure the quality of care and drive improvement in Medicaid and CHIP.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries based on a uniform set of health care quality 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 and experience of care. CMCS and states use the Child and Adult Core Set measures to monitor access to and quality of health care for beneficiaries, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives. 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 become mandatory for state reporting in federal fiscal year (FFY) 2024.[10]

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.[11] 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 a variety of stakeholder groups, including but not limited to states, managed care plans, 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 2023 Child and Adult Core Set Annual Review Stakeholder Workgroup. The Workgroup included 27 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 of this report).

The Workgroup was charged with assessing the 2022 Child and Adult Core Sets[12] and recommending measures for removal or addition to strengthen and improve the 2023 Core Sets. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Child and Adult Core Sets based on several criteria that support the use of the

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[10] 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.

[11] 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.

[12] More information about the annual multistakeholder review of the Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview. More information about the 2022 updates to the Child and Adult Core Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121021.pdf.

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 2023 Core Set Annual Review process, summarizes the Workgroup's recommendations for improving the Core Sets, and specifies next steps for public comment.

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 of the Child and Adult Core Set measures is voluntary. The Child Core Set measures and the behavioral health measures in the Adult Core Set become mandatory for state reporting beginning in FFY 2024.[13]

Appendix A includes tables listing the 2022 Child and Adult Core Set measures and the history of measures included in the Child and Adult Core Sets. Of the 25 measures in the 2022 Child Core Set, about half were part of the initial Child Core Set. Of the 33 measures in the 2022 Adult Core Set, about three-fifths were part of the initial Adult Core Set.

The 2022 Child Core Set

The 2022 Child Core Set includes 25 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.[14] Just over 75 percent of the measures in the 2022 Child Core Set fall into the Primary Care Access and Preventive Care, Maternal and Perinatal Health, and Behavioral Health Care domains (Exhibit 2). Eighty-eight percent of measures (22 measures) can be calculated using an administrative data collection methodology.

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[13] 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.

[14] 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.

Highlights of FFY 2020 Child Core Set reporting,[15] the most recent year for which data are publicly available, include the following:

- All states[16] voluntarily reported at least one Child Core Set measure.
- Forty-eight states reported on at least half of the 24 measures in the 2020 Child Core Set.
- Twenty states reported on more measures for FFY 2020 than for FFY 2019.
- Fifty states reported data on both the Medicaid and CHIP populations, an increase from 48 states for FFY 2019.
- The median number of measures reported by states was 19, which is higher than the number of measures reported for FFY 2018 (18 measures) but slightly lower than the median number of measures reported for FFY 2019 (20 measures).
- Twenty-one of the 24 measures in the 2020 Child Core Set (88 percent) met CMCS's threshold for public reporting of state-specific results.[17]
- The most frequently reported Child Core Set measures for FFY 2020 focus on primary care access and preventive care, emergency department use, preventive dental service use, and behavioral health care.
- The Child Core Set measures reported by fewer states for FFY 2020 focus on Cesarean birth, screening for depression and follow-up, and audiological diagnosis.[18] These measures may require electronic health record (EHR) data, medical records review, or data linkages when claims/encounter data sources are incomplete.

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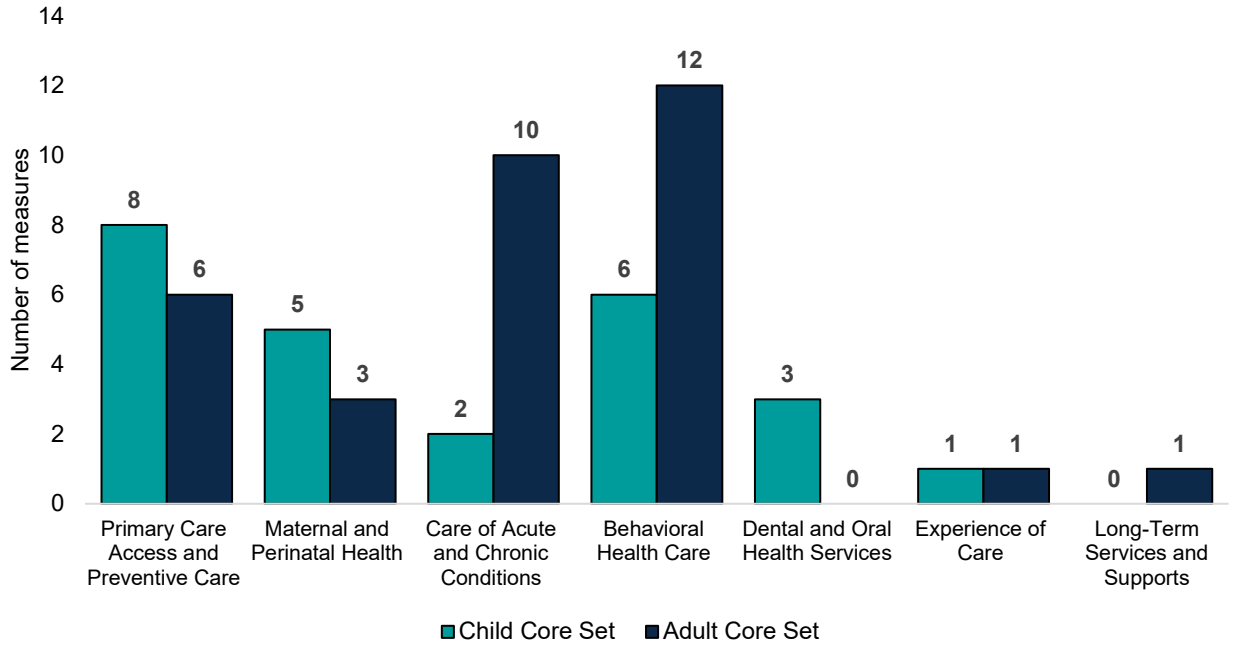
[15] More information about FFY 2020 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2020-core-set-reporting.pdf. A chart pack summarizing FFY 2020 Child Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-child-chart-pack.pdf.

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

[17] CMCS publicly reports Child and Adult Core Set measures that were reported by at least 25 states and met CMCS standards for data quality.

[18] The 2020 Child Core Set contained a low-risk Cesarean birth measure that required the hybrid methodology (PC02-CH). Beginning with the 2021 Child Core Set, this measure has been replaced with an alternative specification that can be calculated administratively (LRCD-CH). CMCS will calculate this measure on states' behalf using vital records submitted by states and compiled by the National Center for Health Statistics. CMCS removed the *Audiological Diagnosis No Later than 3 Months of Age* (AUD-CH) measure from the 2022 Core Set because of state challenges with reporting.

Exhibit 2. Distribution of 2022 Child and Adult Core Set Measures, by Domain



The 2022 Adult Core Set

The 2022 Adult Core Set includes 33 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.[19] Slightly over half of the 2022 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 2022 Adult Core Set and the fastest-growing domain over time, with 7 measures added to this domain since 2016. Seventy-nine percent of measures (26 measures) can be calculated using an administrative data collection methodology.

Highlights of FFY 2020 Adult Core Set reporting,[20] the most recent year for which data are publicly available, include the following:

- Fifty states voluntarily reported at least one Adult Core Set measure, an increase from 46 states for FFY 2019.

[19] 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.

[20] More information about FFY 2020 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2020-core-set-reporting.pdf. A chart pack summarizing FFY 2020 Adult Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2021-adult-chart-pack.pdf.

- Idaho, Maine, North Dakota, and Puerto Rico are included in Adult Core Set reporting for the first time.
- Forty-three states reported on at least half (16) of measures in the 2020 Adult Core Set.
- Twenty-three states reported more measures for FFY 2020 than for FFY 2019.
- States reported a median of 22 measures, similar to 22.5 measures for FFY 2019 and an increase from 20 measures for FFY 2018.
- Twenty-eight of the 33 measures in the 2020 Adult Core Set (85 percent) met CMCS's threshold for public reporting of state-specific results.
- The most frequently reported Adult Core Set measures for FFY 2020 focus on access to primary and preventive care, behavioral health care, asthma management, and postpartum care visits.
- The measures less frequently reported for FFY 2020 focus on screening for depression and follow-up, HIV viral load suppression, diabetes care for people with serious mental illness, and elective delivery.[21] These measures may require EHR data, medical records review, or data linkages when claims/encounter data sources are incomplete.

Use of the Child and Adult 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.[22] Pillar I of the Medicaid and CHIP Scorecard, State Health System Performance, also includes data for several Child and Adult Core Set measures.[23]

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 striving to achieve several goals for state reporting. These goals include maintaining or increasing the number of states that report the Core Set

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[21] CMS removed the *PC-01: Elective Delivery* (PC01-AD) measure from the 2022 Adult Core Set because of state challenges with reporting and concerns that the measure was topped out.

[22] Chart packs, measure-specific tables, facts sheets, and other Core Set annual reporting resources are available for the Child Core Set 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 for the Adult Core Set 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.

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

measures, maintaining or increasing the number of measures reported by each state, and improving the quality and completeness of the data reported.[24] CMCS 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 technical assistance (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.[25] 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.

Description of the 2023 Child and Adult Core Set Annual Review Process

This section describes the 2023 Child and Adult Core Set Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2023 Child and Adult Core Set Annual Review included 27 voting members from state Medicaid agencies, professional associations, universities, hospitals, and other organizations across the country. The Workgroup members for the 2023 Child and Adult Core Set Annual Review are listed on the inside front cover of this report. The Workgroup was initially selected through a Call for Nominations issued in December 2018 in conjunction with the 2020 Child and Adult Core Set Annual Review. The Workgroup roster has changed slightly each year because of resignations due to career transitions. New Workgroup members have been identified, as needed, through outreach to nominating organizations.

The 2023 Child and Adult Core Set Annual Review Workgroup members offered expertise in behavioral health and substance abuse, dental and oral health, care of acute and chronic conditions, long-term services and supports, maternal and perinatal health, primary care access and preventive care, and health equity. Although Workgroup members have individual subject matter expertise, and some were nominated by an organization, Workgroup members were asked to participate as stewards of the Medicaid and CHIP programs as a whole and not represent their

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

[25] 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.

individual organizational points of view. They were asked to consider what measures would best drive improvement in care delivery and health outcomes for both Medicaid and CHIP.

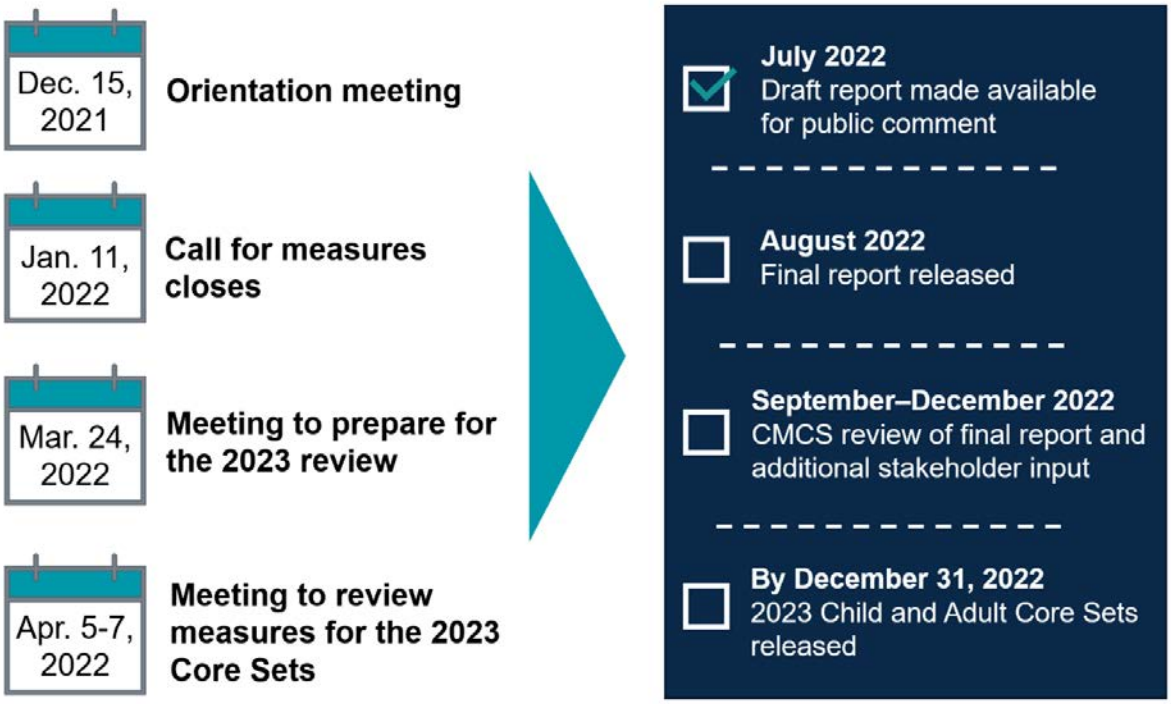
Workgroup members were required to submit a Disclosure of Interest form to report any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict of interest related to the current Child and Adult Core Set measures or other measures reviewed during the Workgroup process. Workgroup members 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 representing nine agencies (see inside front cover of this report). The inclusion of federal liaisons reflects CMCS's commitment to promoting quality measurement alignment and working in partnership with other federal 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 2021 and March 2022 to orient Workgroup members to the review process and to prepare them for the 2023 Child and Adult Core Set Annual Review voting meeting, which took place virtually in April 2022. The two webinars and the 2023 Annual Review voting meeting were open to the public, with public comment invited during each meeting.

Exhibit 3. 2023 Child and Adult Core Set Annual Review Stakeholder Workgroup Timeline



Orientation Webinar

During the orientation webinar on December 15, 2021, Mathematica outlined the Workgroup charge, introduced the Workgroup members, discussed the Disclosure of Interest process, described the timeline for the 2023 Child and Adult Core Set Annual Review, and provided background on the Child and Adult Core Sets.

Workgroup Charge

The Child and Adult Core Set Stakeholder Workgroup for the 2023 Annual Review is charged with assessing the 2022 Child and Adult 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.

After providing an overview of the 2023 Core Set Annual Review process, Mathematica reviewed the outcomes of the 2022 Annual Review and discussed gaps identified during previous meetings. Mathematica described the additional stakeholder input that CMCS will obtain during the 2023 Annual Review process, including input from federal partners, internal stakeholders within CMS, and CMCS's Quality Technical Advisory Group (QTAG).

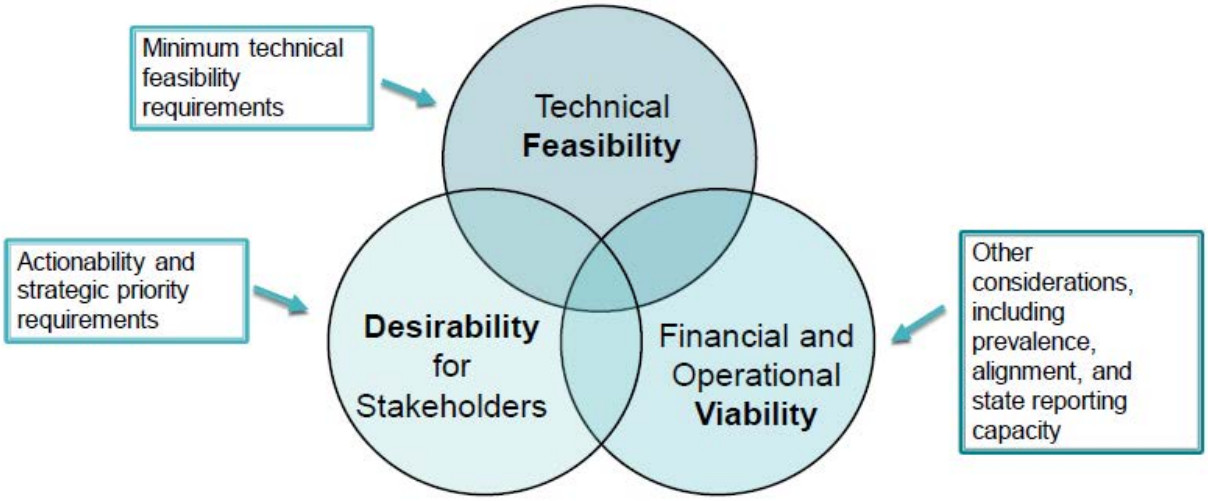
Mathematica also explained the Call for Measures process, through which Workgroup members suggest measures for removal from or addition to the Child and Adult Core Sets. Mathematica asked Workgroup members to balance three interdependent components when considering measures for removal or addition: (1) 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 presented the 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 data elements needed to produce consistent calculations across states, and technical specifications provided at no charge for state use.
- **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; allows for comparative analyses of racial, ethnic, and socioeconomic disparities; provides useful and actionable results to drive improvement in care delivery and health outcomes; and addresses a strategic performance measurement priority.

- **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 FFY 2024.

Exhibit 4. Framework for Assessing Measures for the 2023 Child and Adult Core Sets



CMCS also provided introductory remarks regarding the Workgroup's charge, underscoring the importance of ensuring a robust, relevant, and reportable set of measures to drive improvements in health outcomes and the delivery of high quality care to Medicaid and CHIP beneficiaries. CMCS noted that Core Set data provide valuable information about the services delivered to beneficiaries and allow CMCS to respond to Administration priorities, such as maternal and infant health. CMCS added that the data help them to identify areas for performance improvement and target quality improvement efforts. Finally, CMCS urged the Workgroup members to be thoughtful in their consideration of measures, especially as mandatory reporting of Child Core Set measures and behavioral health measures in the Adult Core Set launches in FFY 2024.

Call for Measures

Following the orientation meeting, Workgroup members and federal liaisons were invited to suggest measures for removal from or addition to the Child and Adult Core Sets. Workgroup members used an online form to submit their suggestions for removal or addition, and were asked to provide the following information about the measure(s):

- The rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for removal or addition

- Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics
- Whether the measure previously was reviewed by the Workgroup and, if so, information that justifies discussing the measure again
- Whether removal of the measure would leave a gap in the Core Sets
- Whether another measure was proposed to replace the measure suggested for removal
- Whether a measure suggested for addition was intended to replace a current Core Set measure
- Potential barriers states could face in calculating the measures suggested for removal or addition by the FFY 2024 reporting cycle

The Call for Measures was open from December 16, 2021, to January 11, 2022. Workgroup members and federal liaisons suggested 7 measures for removal and 23 measures for addition. Mathematica conducted a preliminary assessment of the 23 measures suggested for addition and determined that 11 of the 23 measures recommended for addition would not be discussed by the Workgroup because they were already included in the Core Set (one measure), had previously been recommended and deferred (one measure), or did not meet minimum technical feasibility requirements (nine measures). The 11 measures suggested for addition but not discussed by the Workgroup are as follows:

- The *Hemoglobin A1c Control for Patients With Diabetes* was suggested for addition along with three other diabetes measures. However, this measure was not discussed because it incorporates *Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)*, which is already in the Adult Core Set (HPC-AD). The existing measure will be updated to include both the <8.0% rate and the >9.0% rate for 2023 Adult Core Set reporting.
- The *Long-Term Services and Supports: Comprehensive Care Plan and Update* measure was not discussed because it was previously recommended for addition by the 2022 Child and Adult Core Set Annual Review Workgroup. CMCS is deferring a decision on this measure to support measure alignment with other CMCS initiatives. CMCS is in the process of finalizing a set of quality measures for Home and Community Based Services.[26]
- The *Long-Term Services and Supports Expenditures on Home and Community Based Services* measure was not discussed because it is not fully developed for consistent calculation of the numerator and denominator across states.
- Eight Drivers of Health measures were suggested for addition to both the Child and Adult Core Sets (four measures per Core Set). These measures were not discussed at the April

[26] More information is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121021.pdf.

meeting because the measure specifications are not fully developed to allow for consistent calculations across states and to enable production of measures at the state level. In addition, the measures have not been tested or used by one or more Medicaid and/or CHIP programs. The measures are as follows:

- *Drivers of Health Screening Rate for Medicaid Managed Care Organizations and Provider-Led Accountable Entities (Child and Adult)*
- *Drivers of Health Screening Rate for Providers (Child and Adult)*
- *Drivers of Health Screen Positive Rate for Medicaid Managed Care Organizations and Provider-Led Accountable Entities (Child and Adult)*
- *Drivers of Health Screen Positive Rate for Providers (Child and Adult)*

The Workgroup considered 19 measures during the April meeting:

- **Seven measures for removal** across three Core Set domains, including 6 of the 33 measures in the 2022 Adult Core Set and 1 measure in both the 2022 Child and Adult Core Sets
- **Twelve measures for addition** across three Core Set domains

Appendix B provides the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the 2023 Child and Adult Core Sets.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on March 24, 2022. To help Workgroup members prepare for the discussion at the 2023 Annual Review meeting, Mathematica provided a list of the 7 measures to be considered for removal and the 12 measures to be considered for addition. Mathematica also identified the 11 measures suggested for addition that would not be reviewed at the May meeting and noted why they would not be discussed by the Workgroup.

Mathematica provided guidance to the Workgroup about how to prepare for the measure discussions, 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 Reporting History Table, Core Set 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 attending the Annual Review meeting prepared with notes, questions, and preliminary votes on the 19 measures proposed for removal or addition.

Annual Review Meeting Webinar

The 2023 Child and Adult Core Set Annual Review voting meeting took place virtually from April 5 to April 7, 2022. 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.[27] For each domain, Mathematica described the 2022 Child and Adult Core Set measures, highlighted the measures suggested for removal and the measures suggested for addition, noted the key technical specifications of each measure proposed for removal or addition, and summarized the rationale provided by Workgroup members for removal or addition.

Mathematica then facilitated a discussion of the measures within each domain. Mathematica sought comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. For ease of discussion, if a measure suggested for removal had a replacement measure suggested for addition, the measures were "paired" and discussed together. For each domain, an opportunity for public comment followed the Workgroup discussion.

Voting took place by domain after the Workgroup discussion and public comment period. 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 submitted their vote through the webinar Q&A feature (which was visible only to the Mathematica team) or via email.

Within each domain, the Workgroup generally voted first on measures suggested for removal, followed by measures suggested for addition. However, if measures were "paired," the Workgroup voted first on the measure suggested for addition and then on the measure suggested for removal. This process guarded against the unintentional creation of a gap in the Core Sets caused by removing an existing measure before the Workgroup voted on the measure suggested for 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."

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[27] 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. No measures were suggested for removal from or addition to the Maternal and Perinatal Health, Dental and Oral Health Services, or Experience of Care domains during the 2023 Annual Review.

Measures were recommended for removal or addition if two-thirds of the eligible Workgroup members voted yes. The two-thirds voting threshold was adjusted according to the number of eligible Workgroup members present for each measure vote. Mathematica presented the voting results immediately after each vote and reported if the results met the two-thirds threshold for a measure to be recommended for removal or addition.

Following voting on the measures in each domain, Workgroup members had an opportunity to discuss gaps in that domain. For domains without measures considered for removal or addition, the discussion of gaps took place on Day 3 of the meeting. A summary of the discussion about potential gaps in the Core Sets is presented later in the report.

The Workgroup also discussed two special topics during the Annual Review meeting: (1) advancing health equity through the Child and Adult Core Sets and (2) strategies for including digital measures in the Child and Adult Core Sets. Public comment was invited after the Workgroup discussions. A summary of the discussions appears later in this report.

Workgroup Recommendations for Improving the 2023 Child and Adult Core Sets

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

To focus the Workgroup discussion on measures that would be a good fit for the Core Sets, Mathematica specified detailed criteria for removal of existing measures and addition of new measures. These criteria are classified into three areas: (1) technical feasibility, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

To be considered by the Workgroup, all measures suggested for addition must meet minimum technical feasibility criteria. As noted earlier, Mathematica conducted a preliminary assessment of suggested measures before the Annual Review meeting to ensure that measures discussed by the Workgroup adhered to the minimum technical feasibility criteria. Appendix B contains the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the 2023 Child and Adult Core Sets, including those not discussed by the Workgroup during the Annual Review meeting.

Mathematica mentioned additional contextual factors to inform the Workgroup discussion.

- The Workgroup should consider whether states have the capacity for reporting the measures by FFY 2024, when mandatory reporting goes into effect for the Child Core Set and behavioral health measures in the Adult Core Set. CMCS asked Mathematica to notify the Workgroup that, due to rulemaking and mandatory Core Set reporting beginning in 2024, the potential changes recommended by the Workgroup during the 2023 Core Set Annual Review could apply to the 2023 Core Set, the 2024 Core Set, or both Core Sets.

- The Workgroup should consider each measure on its own merits according to the criteria. There is no target number of measures—maximum or minimum—for the Child and Adult Core Sets.
- The Workgroup should review, discuss, and vote on all measures as they are currently specified by the measure steward.
- The Workgroup should not focus on assignment of measures to a Core Set or domain because these assignments are determined by CMCS.

Exhibit 5. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2023 Child and Adult Core Sets

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 (e.g., there is variation in coding or data completeness 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 (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid and CHIP beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
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, trending is not possible, 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 may not be able to produce the measure by the FFY 2024 Core Set reporting cycle or may not be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems). The FFY 2024 Core Set reporting cycle is when mandatory reporting goes into effect for all measures in the Child Core Set and behavioral health measures in the Adult Core Set.
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).

Exhibit 5 *(continued)*

2.	The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP programs.
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 (e.g., coding and data completeness).
5.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Set.
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 (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid and CHIP programs/providers).
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 (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3.	All states should be able to produce the measure by the FFY 2024 Core Set reporting cycle and be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems). The FFY 2024 Core Set reporting cycle is when mandatory reporting goes into effect for all measures in the Child Core Set and behavioral health measures in the Adult Core Set.

Summary of Workgroup Recommendations

The Workgroup recommended removing one measure from the Child Core Set, removing two measures from the Adult Core Set, and adding four measures to the Child and Adult Core Sets (Exhibit 6). Two of the measures recommended for removal were paired with measures recommended for addition.

- The Workgroup recommended removing *Screening for Depression and Follow-Up Plan* from both the Child and Adult Core Sets and recommended adding *Depression Screening and Follow-Up for Adolescents and Adults* as a replacement.
- The Workgroup recommended removing *Flu Vaccinations for Adults Ages 18 to 64* from the Adult Core Set and recommended adding *Adult Immunization Status* as a replacement.

- Finally, the Workgroup recommended adding two child health measures: *Lead Screening in Children* and *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* (ages 3 months to 17 years).[28]

This section summarizes the discussion and rationale for these recommendations. Appendix C provides information about the measures discussed, but not recommended for removal from or addition to the Child and Adult Core Sets. Measure Information Sheets for each measure the Workgroup considered are available on the Mathematica Core Set Review website.[29]

Exhibit 6. Summary of Workgroup Recommendations for Updates to the 2023 Child and Adult Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measure Recommended for Removal from the Child Core Set		
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Centers for Medicare & Medicaid Services (CMS)	0418*/0418e*
Measures Recommended for Removal from the Adult Core Set		
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	National Committee for Quality Assurance (NCQA)	0039*
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	CMS	0418*/0418e*
Measures Recommended for Addition[a]		
Adult Immunization Status	NCQA	3620
Depression Screening and Follow-Up for Adolescents and Adults	NCQA	Not endorsed
Lead Screening in Children	NCQA	Not endorsed
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis[b]	NCQA	0058

* Measure is no longer endorsed.

[a] CMCS assigns new measures to a Core Set and domain as part of its annual update.

[b] This measure was added to the 2022 Adult Core Set for adults age 18 and older; this measure is recommended for addition to the 2023 Child Core Set for children ages 3 months to 17 years.

[28] This measure was added to the 2022 Adult Core Set for adults age 18 and older; the Workgroup recommended adding this measure to the 2023 Child Core Set for children ages 3 months to 17 years.

[29] 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.

Measures Recommended for Removal

Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)

Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD) is based on self-reported data collected through the Consumer Assessment of Healthcare Providers and Systems (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 measure has been in the Adult Core Set since its inception and was publicly reported for the first time for FFY 2020. The measure steward, NCQA, has proposed retiring the FVA-AD measure for the Healthcare Effectiveness Data and Information Set (HEDIS®) measurement year 2023, which corresponds to the 2024 Core Set.

The Workgroup member who suggested this measure for removal indicated a concern about the validity, reliability, and representativeness of the measure given low CAHPS survey response rates. The Workgroup member acknowledged states' progress in reporting the measure and CMCS's efforts to calculate the measure on states' behalf in the future using data submitted by states and managed care plans to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database. However, the Workgroup member noted that the data in the CAHPS Database are incomplete due to lack of submissions by states and plans.

The Workgroup discussed the FVA-AD measure in the context of the *Adult Immunization Status* measure, which was suggested as a replacement. One Workgroup member said it seemed like the appropriate time to remove FVA-AD from the Adult Core Set because the measure steward is proposing to retire the measure and keeping it in the Core Set would put a burden on states to report it. The Workgroup member added that because the *Adult Immunization Status* measure was suggested as a replacement, removing FVA-AD would not result in a Core Set gap. Several Workgroup members concurred with removing FVA-AD, given that there is a suitable replacement in the *Adult Immunization Status* measure.

The Workgroup members' comments supporting removal of FVA-AD were expressed in the context of challenges with conducting the CAHPS survey, the data source for the measure. For example, one Workgroup member expressed concern about survey non-response because the response rate of the CAHPS survey has declined significantly. Another Workgroup member noted that not all states conduct CAHPS and supported replacement of the measure with *Adult Immunization Status*.

Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) and Age 18 and Older (CDF-AD)

The *Screening for Depression and Follow-Up Plan: Ages 12 to 17* (CDF-CH) *and Age 18 and Older* (CDF-AD) measures assess the percentage of beneficiaries age 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an

age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter. Both of these measures will be subject to mandatory reporting in FFY 2024; CDF-CH is included in the Child Core Set and CDF-AD is a behavioral health measure in the Adult Core Set. A Workgroup member recommended both of these measures for removal from the Core Sets.

The Workgroup member who suggested these measures for removal noted that states report significant challenges with accessing an available data source that contains all the data elements necessary to calculate the measures, and that the specifications and data source do not allow for consistent calculations across states. They added that states may not be able to produce the measures for mandatory reporting by FFY 2024. Furthermore, they noted that depression screening for children could be covered under the *Child and Adolescent Well-Care Visit* (WCV-CH) measure in the Child Core Set.

The Workgroup discussed CDF-CH and CDF-AD in conjunction with the *Depression Screening and Follow-Up For Adolescents and Adults* measure, which was suggested as a replacement. During the discussion, many Workgroup members did not express strong preferences for either measure but emphasized that if CDF-CH and CDF-AD are recommended for removal, it is critical that a gap is not left in the Core Sets. Workgroup members were outspoken about the importance of depression screening among children and adolescents, noting that the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association have declared a national emergency in mental health among children and adolescents.

One Workgroup member countered the point that depression screening could be covered under the WCV-CH measure, noting that although well-child visits may include screening for psychosocial issues, the measure specifications for CDF-CH, CDF-AD, and *Depression Screening and Follow-Up For Adolescents and Adults* go a step further by requiring use of a standardized screening tool, which is associated with higher-quality care. Another Workgroup member added that, unlike WCV-CH, the depression screening measures capture screenings that occur outside of a primary care encounter.

Another Workgroup member commented that the CDF-CH and CDF-AD measures were added to the Core Sets in alignment with Medicare and Health Resources and Services Administration (HRSA) programs, and to be mindful of this when deciding whether to keep or remove the measures.

Measures Recommended for Addition

Adult Immunization Status

Adult Immunization Status measures the percentage of adults age 19 years and older who are up-to-date on recommended vaccinations for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, and pneumococcal. The measure includes

denominators for three individual vaccine rates with different age ranges for the Medicaid population. The measure is specified for the HEDIS Electronic Clinical Data Systems (ECDS) data collection method and was suggested as a replacement for FVA-AD.

The Workgroup member who suggested this measure for addition indicated that national surveillance data showed that the rate of recommended adult vaccines is generally lower for adults with public insurance than for those who are privately insured. They commented that inclusion of this measure in the Adult Core Set would not only help states enhance monitoring of adult immunizations but could also reduce morbidity and mortality from vaccine-preventable diseases across an individual's lifespan. They also noted that FVA-AD is currently the only immunization measure in the Adult Core Set, and the addition of the *Adult Immunization Status* measure would close a gap in states' ability to monitor uptake of all routinely recommended adult vaccines (other than those for COVID-19).

Much of the Workgroup discussion on the *Adult Immunization Status* measure focused on comparing it to the FVA-AD measure it was suggested to replace. For example, one Workgroup member noted that *Adult Immunization Status* encompasses a broader set of adult immunizations than FVA-AD. Another Workgroup member concurred, adding that states have been improving their immunization registries as a result of the COVID-19 pandemic and they may have improved their capacity for reporting the broader measure. A federal liaison echoed both points, commenting that the *Adult Immunization Status* measure is more comprehensive than FVA-AD (capturing five adult vaccinations versus one). They also noted that managed care plans have more experience reporting the measure since it was last discussed by the Workgroup during the 2021 Core Set Annual Review.

Some of the Workgroup support for the *Adult Immunization Status* measure was provided in the context of state challenges in reporting FVA-AD. For example, one Workgroup member noted that the *Adult Immunization Status* was administratively easier than the CAHPS-based FVA-AD measure and would be feasible for states that do not conduct the CAHPS survey.

The Workgroup also discussed implications of state variation in Medicaid coverage of adult immunizations. Although one Workgroup member said they supported *Adult Immunization Status* as a replacement for FVA-AD, they said that public reporting of the measure should include a caveat that not all Medicaid programs cover adult immunizations. A Workgroup member added that, even if a state Medicaid program does not cover adult immunizations, there may be other ways for adults to receive immunizations, such as through public health departments. They also said that because this is a digital measure, there are ways to capture immunization data by leveraging public health department and other data sources.

One Workgroup member stated that although they are a proponent of adult immunizations, there are challenges with relying on public health departments to provide immunizations to the adult population in states where the vaccines are not covered by Medicaid. They noted that the programs available to support children's vaccinations (such as Vaccines for Children) are not

available to adults. They also indicated that adults may face significant out-of-pocket costs for immunizations if vaccines are not covered by Medicaid.

Several Workgroup members discussed the pairing of the Workgroup voting to remove the FVA-AD measure and to add the *Adult Immunization Status* measure. A federal liaison remarked that the Workgroup could potentially create a gap in the Core Sets around adult immunizations by recommending removal of FVA-AD without a replacement and voiced their support for the *Adult Immunization Status* measure. Another Workgroup member questioned whether the Workgroup could potentially create a gap in the Core Sets by recommending addition of the *Adult Immunization Status* measure, which is specified for the ECDS data collection method, while also recommending removal of FVA-AD. They noted that, to date, CMCS has deferred on adding ECDS measures to the Core Sets. Mathematica advised the Workgroup to vote on the merits of the individual measures.

A Workgroup member asked about experience stratifying the *Adult Immunization Status* measure by race, ethnicity, language, and disability status. Mathematica noted there is no current experience with stratification of the measure in the context of Core Set reporting. However, a Workgroup member noted that NCQA has proposed adding a race/ethnicity stratification to this measure beginning in HEDIS measurement year 2023 (which corresponds to the 2024 Core Set).

During the public comment period, a representative from the Adult Vaccine Access Coalition spoke in support of adding the *Adult Immunization Status* measure to the Core Set. They indicated that the measure would encourage better reporting of adult immunizations, which could result in increased adult immunization coverage rates, as well as identify gaps in immunization coverage.

Depression Screening and Follow-Up for Adolescents and Adults

Depression Screening and Follow-Up for Adolescents and Adults shows the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. Two rates are reported: (1) depression screening: the percentage of members who were screened for clinical depression using a standardized instrument; and (2) follow-up on a positive screen: the percentage of members who received follow-up care within 30 days of a positive depression screen finding.

The measure is specified for HEDIS ECDS, and was suggested to replace CDF-CH and CDF-AD. The Workgroup member who suggested the measure for addition noted that there has been an increase in the number of Medicaid, commercial, and Medicare plans reporting the measure over the last two years. However, the measure steward acknowledged the low observed performance rates across Medicaid managed care plans and commented that it was likely due to challenges that managed care plans encounter with accessing clinical data. The Workgroup member cited evidence of the effectiveness of conducting depression screenings in the primary

care setting and providing early intervention for depression. They acknowledged that states will likely need technical support to collect data for this measure because non-claims data (e.g., EHRs, case management records, and Health Information Exchange [HIE] data) may not be available to all states.

The Workgroup discussed the *Depression Screening and Follow-Up for Adolescents and Adults* measure in conjunction with CDF-CH and CDF-AD, which were recommended for removal. Much of the discussion reflected the tension between the feasibility and strategic priority of electronic measures, given that not all states have the capability to effectively collect data through HIEs. A Workgroup member representing a state Medicaid program noted that the measure provided an opportunity for states to shift toward electronic measures, especially given the prevalence of depression among Medicaid and CHIP populations. However, another Workgroup member expressed concern around mandatory reporting requirements given the challenges around data collection and reporting. They noted that the lack of universal HIEs may lead to a less meaningful measure as many states struggle to collect and report the data. They emphasized the importance of providing technical support to states. They added that, in their experience, they are unsure of where screenings may be documented outside of an EHR as this information is not captured through claims. Another Workgroup member responded that they have been working with providers in their state to collect the data using the administrative method (e.g., claims), and acknowledged that the move toward digital measurement will be a challenging but feasible and valuable effort.

Two Workgroup members from state Medicaid programs discussed their experiences working to adopt *Depression Screening and Follow-Up for Adolescents and Adults* in their states. One expressed their support for adding the measure and shared that their state is planning to use the measure with their managed care plans. The other Workgroup member highlighted the differences between this measure and the CDF measures. For example, they indicated that, in contrast to the CDF measures, the *Depression Screening and Follow-up for Adolescents and Adults* measure does not require that a Medicaid or CHIP beneficiary have a face-to-face medical visit to be included in the denominator, making it more of a population-based measure.

Noting the increasing prevalence of suicide among teens, one Workgroup member asked the measure steward, NCQA, if mental-health follow-up services occurring in school-based health settings are counted in the follow-up on a positive screen measure rate. NCQA responded that the measure captures visits occurring across a broad range of settings.

One Workgroup member asked about experience stratifying the measure by race, ethnicity, language, or disability status. Another Workgroup member noted that NCQA proposed stratification for measurement year 2023 (corresponding to the 2024 Core Sets). Mathematica added that both NCQA and CMCS use the standards for race/ethnicity reporting set by the Office of Management and Budget.

Lead Screening in Children

Lead Screening in Children measures the percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. The measure steward, NCQA, is considering retiring the measure because the U.S. Preventive Services Task Force (USPSTF) has given universal lead screening of children age five and younger an insufficient evidence rating. However, NCQA has not yet determined the timeline for potential retirement.

The Workgroup member who suggested the measure for addition noted that lead exposure among children remains a significant public health concern and that there is no safe level of lead for children. They noted that there is substantial room for improvement on blood lead screening by age three. Despite a federal requirement that all children covered by Medicaid[30] are tested for blood lead levels at one and two years of age, or between two and six years if there is no record of a previous blood lead test, a 2021 report found that 20 percent of children enrolled in Medicaid from birth in select states were never screened by age three.[31]

The Workgroup voiced strong support for inclusion of the measure in the Core Sets, noting the clinical importance of lead screening given the long-term, lifelong impacts of lead exposure. A Workgroup member stated that adding the measure to the Core Sets would give more visibility to the importance of blood lead testing in Medicaid and CHIP.

Several Workgroup members highlighted the importance of the measure in addressing health inequities and social determinants of health. One Workgroup member stated that *Lead Screening in Children* can be used as a measure of disparities in safe housing and safe communities. Another Workgroup member added that the measure is linked to social determinants of health and supports clinical intervention if a problem is identified. Another Workgroup member asserted that this measure gets to the heart of inequities, as lead poisoning disproportionately affects the Medicaid population. In response to a question about whether the measure has been stratified by race, ethnicity, and language, NCQA noted that it has not because it is slated for retirement.

Workgroup members also discussed that the measure could improve state reporting of lead screening data. Two Workgroup members noted that all state Medicaid programs report lead screening data on Form CMS-416 (the annual Early and Periodic, Screening, Diagnostic, and Treatment [EPSDT] report), but there are limitations. For example, the Form CMS-416 measure specifications are less standardized than those of the HEDIS *Lead Screening in Children*

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[30] Universal blood lead screening at 12 and 24 months is required for children covered by Medicaid (including CHIP Medicaid expansion programs). If a separate CHIP program opts to follow EPSDT, then the Medicaid universal screening requirement would apply. In addition, if the state or local jurisdiction requires universal lead screening, then CHIP would cover it.

[31] https://oig.hhs.gov/oei/reports/OEI-07-18-00371.pdf.

measure. In addition, Form CMS-416 has less visibility than mandatory Core Set reporting. A Workgroup member from a state Medicaid agency said that *Lead Screening in Children* would enable their state to better focus on the Medicaid population, noting that their public health agency currently does not have a good way to measure lead screening. Another Workgroup member commented that this measure provides an opportunity to develop data linkages with public health.

A liaison from the Centers for Disease Control and Prevention (CDC) voiced the CDC's support for adding the measure as it would prompt data exchange discussions to match lead screening data with Medicaid data and increase screening. However, one Workgroup member highlighted the misalignment between the *Lead Screening in Children* measure and lead reporting to the CDC. They suggested future discussion about aligning the measures for reporting by Medicaid and public health programs.

Another Workgroup member questioned whether the measure aligns with CDC and AAP clinical recommendations for children's blood lead screening in Medicaid, which recommend testing at 12 and 24 months. NCQA noted that, generally, when there are new clinical guidelines, they reevaluate the measure to ensure alignment. They added that one of the challenges with the measure is that there are differences between the USPSTF recommendation and other clinical guidelines, and that the measure represents a compromise. NCQA also indicated that because they are considering retiring the measure, they do not plan to reevaluate the measure criteria.

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 age 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. The measure was added to the 2022 Adult Core Set for adults age 18 and older, and is now suggested for addition to the Child Core Set for children ages 3 months to 17 years. The Workgroup member who suggested this measure for addition to the Child Core Set stated that the measure has been used by state Medicaid programs and public health departments, and that almost 60 percent of pediatric bronchitis and bronchiolitis emergency department and office visits lead to inappropriate antibiotic prescription.

Workgroup members generally supported adding the measure but had questions for the measure steward about the measure technical specifications. One Workgroup member asked how the measure accounts for appropriate use of antibiotics for co-occurring illnesses. The measure steward, NCQA, responded that the measure specifies exclusions for conditions in which antibiotic use may be appropriate. Another Workgroup member expressed concern about the possibility of "gaming" the measure or using coding practices to improve measurement rates. The Workgroup member asked NCQA about another measure, *Antibiotic Utilization for Acute Respiratory Conditions*, which the Workgroup member said may be less susceptible to gaming. NCQA noted that *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* and

Antibiotic Utilization for Acute Respiratory Conditions are intended as complementary measures, with the utilization measure capturing both appropriate and inappropriate prescribing. Another Workgroup member appreciated that the measure denominator includes a three-day period after the episode date, which provides a better understanding of a clinician's intent to prescribe and thus a better view of the quality of care delivered to patients.

One Workgroup member noted that the measure promotes alignment, highlighting the existing collaborative efforts around antibiotic stewardship, and the inclusion of the measure in other programs. Two Workgroup members noted that, due to the COVID-19 pandemic, fewer patients are accessing care through in-person visits, and that this measure may be important for monitoring access to appropriate care, including through telehealth visits. A CDC federal liaison expressed CDC's support for the measure; they underscored the importance of appropriate antibiotic prescribing and cited the overuse of antibiotics for pediatric bronchitis and bronchiolitis as well as other viral illnesses. They also noted that inappropriate prescribing of antibiotics is more common during telehealth visits, which have increased in recent years.

Special Topics Discussed at the 2023 Child and Adult Core Set Annual Review

Opportunities to Advance Health Equity Through the Child and Adult Core Sets

Recognizing that health equity is a priority area for CMCS and Workgroup members, Mathematica opened the Workgroup meeting on Day 1 with a discussion on opportunities to advance health equity through the Core Sets. This special topic addressed drivers of health measurement, stratification of current and proposed Core Set measures, and future directions for quality measurement related to health equity.

CMCS leadership provided introductory remarks to frame the conversation, emphasizing health equity as one of three major goals, along with coverage and access, and innovation and whole-person care.[32] They acknowledged the desire of the Workgroup to address social determinants of health in the Core Sets and the need to align efforts across federal agencies to develop, test, and adopt standardized quality measures for

> **"When we think about equity, when we think about whole person care, we really do also think about many of the upstream social determinants of health and how we, from a Medicaid standpoint, can be involved from an expectation for care delivery, from a quality measurement and performance standpoint, and then, certainly also from an investment and accountability standpoint."**
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> ***— Dan Tsai, CMS Deputy Administrator and CMCS Director***

[32] More information on the strategic vision for Medicaid and CHIP is available at https://www.healthaffairs.org/do/10.1377/forefront.20211115.537685/full/.

state-level reporting. Highlighting social factors like housing instability and food insecurity as drivers of health outcomes, CMCS Director Dan Tsai discussed moving toward a state in which the health care system assumes collective responsibility for integrating social determinants of health screenings and referrals into care delivery.

Following CMCS's remarks, the Workgroup discussed opportunities to advance health equity through the Core Sets. The Workgroup expressed urgency to identify state-level drivers of health measures for the Core Sets, encourage stratification of Core Set measures, and pursue other future directions to fill the gap.

Drivers of Health Measures

Workgroup members collectively supported adding measures of drivers of health screenings and follow-up to the Core Sets. They expressed urgency given that the Workgroup has identified social determinants of health as a gap for several years. They highlighted the importance of these measures for children in particular, emphasizing the link between drivers of health and children's long-term socioemotional health, development, and attachment.

The Workgroup acknowledged that further investment will be required to develop measures that meet the minimum technical feasibility requirements to be considered for the Core Sets. They raised the need for state-level testing of standardized drivers of health measures, moving from implementing screenings and interventions at the provider or plan level to collecting complete and accurate data for measurement at the state level. Workgroup members suggested that CMCS consider developing an innovation accelerator to test drivers of health measures and measurement approaches. The intent would be to give states the opportunity to test and refine new measures aligned with CMCS's strategic goals and speed up their readiness for state-level reporting through the Core Sets.

Stratification of Core Set Measures

Several Workgroup members expressed support for the ability to stratify by race, ethnicity, language, and disability status as explicit criteria for the addition of new measures to the Core Sets. They also encouraged stratification by geography (urban/rural) and socioeconomic status. They specifically emphasized the importance of stratifying for disability status, given the intersectionality between disability status and other demographic characteristics.

Mathematica noted that the Core Set reporting system gives states the option to stratify Core Set measures by race, ethnicity, sex, language, disability status, geography, and adult Medicaid expansion status. Workgroup members indicated that more work may be needed to produce consistent results including: (1) using standardized definitions of sociodemographic characteristics across states; (2) testing by measure stewards to ensure measure stratification produces reliable and valid information; and (3) improving data quality and completeness for optional fields such as race and ethnicity, including through public education about how the data will be used.

Other Future Directions

Workgroup members highlighted several considerations to inform future directions for quality measurement related to health equity.

- **Measure alignment.** Several Workgroup members suggested that drivers of health measures and other health equity approaches be aligned across CMS and other federal programs. Federal liaisons agreed and noted that Medicare is currently considering several measures of health equity and drivers of health measures (though testing is still required for state-level reporting).
- **Person-centeredness.** Several Workgroup members advised taking a holistic, whole-person perspective to understand beneficiaries' overall experience and outcomes in the health care system. They emphasized that addressing drivers of health requires care integration outside of the medical sphere and the responsibility for driving improvement goes beyond the primary care provider. Moreover, they noted that health equity interventions must be adapted to local contexts to be meaningful at the community level.
- **Other considerations for quality measurement.** One Workgroup member stated the importance of measuring conditions that impact a small proportion of Medicaid and CHIP beneficiaries, but disproportionately affect people of color and vulnerable populations. Workgroup members also noted equity issues around geography (urban, suburban, and rural) and health literacy.

After the discussion, Mathematica invited public comment on the health equity topic. Several public commenters supported the inclusion of drivers of health measures in the Core Sets, highlighting that the low-income population served by Medicaid and CHIP is more likely to experience social barriers to health. They provided examples of how the measures can be used to support assessment of social risk factors among Medicaid and CHIP beneficiaries.

Some commenters said the pace of addressing health equity and the social determinants of health in Medicaid and CHIP was slow. They remarked that the program is not keeping pace with Medicare and other payers in terms of health equity measurement and expressed urgency about efforts to measure drivers of health. They encouraged CMCS to work with states, many of which already require screening for social determinants of health, to develop measures around a common set of screening domains, such as housing, food access, transportation, and safety.

Strategies for Including Digital Measures in the Child and Adult Core Sets

Mathematica invited the Workgroup to discuss strategies for including digital measures in the Child and Adult Core Sets. Before opening the discussion on Day 2, Mathematica summarized

the aims of CMS's digital strategy as part of the Meaningful Measures 2.0 Initiative.[33] Mathematica also provided an overview of the implications of the HEDIS ECDS strategy for the Child and Adult Core Sets, including the 2022 Child and Adult Core Set measures that are also specified for reporting using HEDIS ECDS,[34] measures specified only for the ECDS reporting method that were previously recommended for addition to the Core Sets but were deferred by CMCS, and ECDS measures under consideration for addition to the 2023 Core Sets. Mathematica shared comments from CMCS requesting that the Workgroup consider ECDS measures under the same criteria outlined for the addition of all measures to the Core Sets. They added that although CMCS has not yet added ECDS-only measures to the Core Sets, as they work to determine the feasibility and viability of the measures and next steps for ECDS adoption, this does not reflect the merits of the measures themselves.

Opportunities for Digital Measurement

Workgroup members encouraged CMCS to work toward including digital measures in the Core Sets. A Workgroup member noted that although it may be a heavy lift, moving toward digital measurement is an opportunity to strengthen the quality of reporting and create efficiencies across states. One Workgroup member stated that an ECDS-specified measure would not prevent a state from using administrative data sources for reporting. They added that it would be helpful to better understand how many states are currently reporting measures using administrative data only, an electronic method, or a hybrid of the two, noting that states should be given the flexibility to collect measures using methods that are most appropriate for their state.

Another Workgroup member commented on the increased use of electronic measures in other programs, such as Medicare. Given differences in states' ability to report digital measures, the Workgroup encouraged CMCS to prioritize adding measures that are impactful, where states can benefit from capturing data through electronic means. One Workgroup member stated that the *Adult Immunization Status* measure (recommended for addition to the 2023 Core Sets) is an example of an ECDS measure that would add value to the Core Sets because it would encourage linkages between public health departments and immunization registries.

Mindful of the challenges states may face in reporting ECDS measures, another Workgroup member suggested looking at ECDS measures that would not be subject to mandatory reporting in FFY 2024. They said that these measures would provide states with latitude to build their capacity for digital measurement without the pressure of mandatory reporting. A CMS representative concurred that using ECDS measures could help familiarize Medicaid and CHIP programs with reporting digital measures, adding that the COVID-19 pandemic underscored the importance of interoperability and timely access to data. They also added that with the

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[33] More information about the Meaningful Measures Initiative is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/CMS-Quality-Strategy.

[34] ECDS specifications are not currently available for these measures for Core Set reporting.

implementation of Fast Healthcare Interoperability Resources (FHIR) and FHIR-based Application Program Interfaces (APIs) as part of CMS requirements, there are plenty of opportunities for states working with HIEs. Furthermore, with the publication of the Trusted Exchange Framework and Common Agreement (TEFCA) by the Office of the National Coordinator for Health Information Technology (ONC), the CMS representative noted that entities will be able to connect and exchange data across states.

Using Alternative Data Sources

Workgroup members discussed opportunities to capture patient data through other data sources, especially those not typically used for performance measure reporting. For example, one Workgroup member encouraged the use of data from the Transformed Medicaid Statistical Information System (T-MSIS), which states are required to submit to CMS. However, another Workgroup member cited a challenge with T-MSIS conversions because some states still use local codes that could prevent reliable and accurate national comparisons if these codes are excluded.

A Workgroup member mentioned electronic visit verification (EVV) systems as an opportunity to capture personal care and home health service data. Another Workgroup member agreed, noting that EVV may be leveraged to capture additional data, such as discharges, hospitalizations, and incident reporting, and that EVV data can allow for input from caregivers and enrollees, increasing the ability to capture social drivers of health. Two Workgroup members also suggested that using electronic means to capture patient experience would help providers respond more quickly. A few Workgroup members added that it would be valuable to incorporate social determinants of health into HIEs, particularly for Medicaid and CHIP.

Challenges of Digital Measurement and Technical Assistance Opportunities

Workgroup members were conscious of the challenges associated with varying digital measurement capabilities across providers and states, and the need for technical assistance (TA). To help states prepare for reporting of digital measures, a Workgroup member noted it would be helpful to understand the overall vision, direction, and timeline for CMCS's digital measurement strategy as well as how it aligns with other quality initiatives.

Workgroup members also raised the challenges some health care providers (e.g., nursing homes, dental providers, behavioral health providers, intermediate care facilities, and community-based service providers) experience when exchanging data. They noted that these providers may not have interoperable EHRs and are often excluded from the conversations about Meaningful Use. For example, one Workgroup member noted that when considering long-term services and supports (LTSS) measures, community-based organizations often do not have the same level of administrative capability as other providers. Workgroup members said that as organizations move toward more integrated delivery systems and universal usage of electronic records, it is important to recognize that the data infrastructure may vary across different types of providers

and clinical settings. One Workgroup member, along with a federal liaison, cautioned about the possibility of a digital divide. They emphasized the need for accessible, equitable, and interoperable EHRs and ensuring that patients and providers have access to internet and necessary technologies to receive and provide care.

The Workgroup was mindful of the effort and challenges associated with data standardization, underscoring the work that is needed around EHR functionality to ensure meaningful measurement and outcomes. In response to concerns around standardization, a Workgroup member raised ONC's oversight of the United States Core Data for Interoperability (USCDI) standard, which defines standardized data elements to achieve FHIR-enabled interoperability. The Workgroup member further noted that UCSDI+ allows connections between health systems and public health agencies. A CMS representative emphasized the importance of USCDI and USCDI+, adding that standardized data is critical to digital measurement.

To support states in building their capacity to report digital measures, one Workgroup member advocated for quality grants and other funding streams to help states and providers work with their HIEs. For example, one Workgroup member noted that an HIE pilot has been launched in a metropolitan area in their state, but the state does not have the technical feasibility to adopt this on a broader scale. A CMS representative concurred that quality grants or other funding stream may provide an opportunity to support digital measurement efforts in Medicaid and CHIP.

Cross-Cutting Themes in Measure Discussions

Several cross-cutting themes emerged from the Workgroup's review of the 7 existing Core Set measures suggested for removal from the 2022 Core Sets and the 12 measures suggested for addition, as well as the Workgroup's reflections about gaps in the Core Sets. The discussions revealed an effort to balance the feasibility of state reporting with actionability and strategic priority for driving improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries. The backdrop of mandatory reporting beginning in FFY 2024 was present throughout the discussions.

Actionability and Strategic Priority for Driving Improvement in Care Delivery and Health Outcomes

Workgroup members discussed how to ensure that Core Set measures can be used to address social determinants of health and advance health equity. Throughout discussions on measures across the domains, a Workgroup member consistently inquired whether measures could be stratified by race, ethnicity, language, and disability status. The comments focused the Workgroup on aligning with the actionability and strategic priority criterion for stratification of new measures. Workgroup members also voiced support for adding and retaining measures that could be used to advance health equity in Medicaid and CHIP, including *Lead Screening in Children* and *Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)* (HPCMI-AD).

The Workgroup also highlighted opportunities to leverage the use of digital measures in the Core Sets. For example, much of the Workgroup discussion about whether to replace the *Screening for Clinical Depression and Follow-Up Plan* measures (CDF-CH and CDF-AD) with *Depression Screening and Follow-Up for Adolescents and Adults* reflected the tension between the feasibility of using administrative measures and the strategic priority of transitioning to electronic measures. Some Workgroup members suggested that *Depression Screening and Follow-Up for Adolescents and Adults*, which is specified for the HEDIS ECDS data collection method, would help facilitate the shift toward digital measurement. They also recognized states' persistent challenges with calculating the CDF-CH and CDF-AD measures. As a result, the Workgroup recommended CDF-CH and CDF-AD for removal, and the ECDS-only depression screening measure was recommended for addition.

The Workgroup also demonstrated a strong commitment to the role of the Core Sets in promoting public health priorities related to childhood lead screening, HIV treatment, and tobacco cessation. Although the Form CMS-416 EPSDT report collects lead screening data, the Workgroup recommended the addition of the *Lead Screening in Children* measure as a more standardized and reliable source of lead screening data that could support data linkages and program alignment. The Workgroup chose to retain the *HIV Viral Load Suppression* (HVL-AD) measure in the Core Set due to its clinical importance, though only nine states currently report the measure. Similarly, the Workgroup voted to retain the CAHPS-based *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD) measure given the prevalence of smoking in the Medicaid and CHIP population, despite noted challenges with the survey-based data collection method. They encouraged finding a suitable replacement for MSC-AD in the future.

Workgroup members also frequently advocated for a balance of measures, both within and across domains, to ensure the Core Sets comprise an actionable and well-rounded set of measures for CMCS and states. For example, during the discussion about whether to remove the *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD) and *Concurrent Use of Opioids and Benzodiazepines* (COB-AD) measures, a Workgroup member highlighted that a third of the measures in the Adult Core Set are in the Behavioral Health Care domain, with four measures focused on opioids. Ultimately, the Workgroup voted to retain both measures because of ongoing concerns about opioid use. When considering three new diabetes measures for addition, the Workgroup expressed similar concerns about the number of diabetes-focused measures in the Core Sets. These measures were not recommended by the Workgroup for addition because they did not add value to the other diabetes measures already in the Core Sets. Similarly, the Workgroup did not recommend addition of the *Statin Therapy for the Prevention and Treatment of Cardiovascular Disease* measure because some Workgroup members expressed hesitancy toward adding another measure of medication management, especially one with a data collection method that is resource-intensive.

To focus resources and support strategic priorities, Workgroup members also expressed a desire to align the Core Set measures with measures used in other programs. The Workgroup often sought to understand the use of current or potential Core Set measures in other programs,

including the experience of entities currently reporting the measures. For example, when considering removal of the CDF-CH and CDF-AD measures from the Core Sets, one Workgroup member reminded others that these measures were added to the Core Sets in alignment with other programs, such as Medicare. Similarly, another Workgroup member noted that the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure, recommended for addition to the Child Core Set, was previously added to the Adult Core Set and the measure is also used in public health departments. During discussion of the *Adults' Access to Preventive/Ambulatory Health Services* measure, which was suggested, but not recommended for addition, a Workgroup member remarked that the differences in the measure's technical specifications across payers would preclude states from meaningfully comparing access to care in Medicaid and other programs.

The Workgroup often prioritized retaining measures focused on care integration and coordination. Although several Workgroup members discussed challenges with the feasibility of reporting the HPCMI-AD measure, one Workgroup member shared their experience leveraging their HIE to improve data collection. They encouraged the Workgroup to keep the measure in the Core Set because it promotes care integration. A Workgroup member provided similar comments during discussion of removing the OHD-AD and COB-AD measures from the Core Sets, remarking that the measures capture care integration in support of pain management. The Workgroup voted to retain both measures.

Finally, Workgroup members continued to stress the need to incorporate measures into the Core Sets in areas that have been identified as long-standing gaps. For example, several Workgroup members expressed disappointment at the decision not to recommend any of the three LTSS measures that were suggested for addition, noting the lack of measures in the Core Sets for this population. In addition, although the Workgroup did not propose any measures of dental and oral health for addition to the 2023 Core Sets, some Workgroup members emphasized the importance of assessing the dental and oral health of adult Medicaid beneficiaries through the Core Sets.

Feasibility and Viability for State Reporting

The Workgroup frequently discussed whether measures suggested for removal and addition were feasible for state-level reporting. They often noted that measures requiring chart reviews and survey data collection methods were more resource intensive and therefore, less preferable, than those using administrative methods. For example, during a discussion of the *Long-Term Services and Supports: Shared Care Plan with Primary Care Physician* measure, one Workgroup member expressed concern about the feasibility of data collection given the measure's data collection methodology using case management record review and questioned the feasibility of sampling across larger state Medicaid programs. This measure was ultimately not recommended for addition. Similarly, although the Workgroup did not recommend MSC-AD for removal, they stressed the need to identify a replacement tobacco cessation measure that is not survey-based, so the measure is more representative, actionable, and easier for states to collect.

Workgroup members also favored measures that promote partnership, data exchange, and data linkage between Medicaid and other programs. During discussion of the *Adult Immunization Status* measure, which was recommended by the Workgroup for addition, a Workgroup member indicated that the measure encourages linkages with public health departments and immunization registries. Moreover, the Workgroup recommended replacing the CAHPS survey-based *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD) with the *Adult Immunization Status* measure because the latter can be calculated using administrative data and includes additional vaccines.

When discussing *Lead Screening in Children*, which was also recommended for addition, a Workgroup member suggested the measure could provide an opportunity to develop data linkages with public health, noting that the health department in their state does not currently have a good source of data for lead screening. Workgroup members from state Medicaid programs also shared their experiences collaborating with HRSA and their public health departments to report the HVL-AD measure, and subsequently voted to retain this measure in the Adult Core Set.

Discussion of Child and Adult Core Set Measure Gaps

During the 2023 Child and Adult Core Set Annual Review, the Workgroup discussed measure gaps overall and by Core Set domain. Within each domain, Mathematica asked the Workgroup to identify what types of measures or measure concepts are missing, whether any existing measures could fill the gaps, or whether new measures would need to be developed. After completing the domain-specific discussions, the Workgroup had a cross-cutting discussion focused on what measure gaps should be considered in the future. They also discussed the implications for developing new measures for Medicaid and CHIP, followed by a final opportunity for public comment. Exhibit 7 synthesizes the gaps mentioned during the 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 prioritize the suggested gaps or assess their feasibility or fit for the Child and Adult Core Sets.

Throughout the discussion of gaps, Workgroup members raised opportunities to advance health equity through the Core Sets. They asserted the importance of stratifying new and existing Core Set measures by race, ethnicity, language, and disability status. They underscored the urgency to develop and test measures of screenings and follow-up around drivers of health. They also emphasized gaps with known disparities in health outcomes, such as maternal mortality. They discussed reframing poverty and other drivers of health as chronic conditions, and defining social factors, such as housing and employment, as long-term outcomes of behavioral health care.

In addition, the Workgroup emphasized the need for measures of care coordination and management across domains, particularly for beneficiaries with complex needs and those receiving LTSS. They discussed opportunities to move beyond process-oriented measures of care coordination to more holistic measures, such as experience of care and readmissions.

The Workgroup noted that LTSS measures remain a gap on the Core Sets. One measure in the Adult Core Set—*National Core Indicators Survey* (NCIDDS-AD)—is focused on beneficiaries with intellectual and developmental disabilities (IDD). Workgroup members emphasized the need for additional measures focused on LTSS users' experience of care, community integration, and quality of life, along with measures of health and safety events. They suggested that CMCS provide technical assistance to states to support the testing and adoption of LTSS measures. Other strategies they proposed include the stratification of existing Core Set measures by LTSS users, and the development of experience of care measures that allow for flexibility, given that states use various tools.

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 Discussion 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 status • Subgroup analyses of existing measures for pregnant beneficiaries, beneficiaries with IDD, and LTSS users • Assessment of social determinants/drivers of health, including housing status, food insecurity, interpersonal safety, access to transportation, and poverty status • Coordination of care across sectors and settings, particularly for LTSS users and beneficiaries with complex needs and those with developmental disabilities • Continuity of coverage for Medicaid and CHIP beneficiaries • Referral, follow-up, and outcomes associated with screening measures
Cross-Cutting Methodological Considerations
• Electronic measures that leverage data sources beyond claims and encounters (e.g., EHRs, registries, HIEs) • Leveraging existing data sources to increase efficiency and reduce state burden (e.g., T-MSIS) • Inclusion of telehealth in new and existing quality measures • Alignment and standardization of measurement across federal programs • Development of alternative data sources and methods for survey-based measures (e.g., administrative data, focus groups)
Primary Care Access and Preventive Care
• Identification of and intervention for adverse childhood experiences • Care planning and care coordination for children and young adults with complex needs • Children's social-emotional development, such as school readiness • Patient-centered measurement of access to preventive care and experience of care • Screening for HIV and viral hepatitis for beneficiaries with substance use disorders
Maternal and Perinatal Health
• Prenatal screenings for mental health, substance use, and interpersonal violence • Postpartum follow-up and care coordination (such as blood pressure) • Maternal morbidity and mortality, stratified by race and ethnicity • Measure of patient preferences and experiences

Exhibit 7 *(continued)*

Themes from Cross-Cutting and Domain-Specific Gap Discussions
Care of Acute and Chronic Conditions
• Acute conditions, including accidents and injuries • Global measure(s) of treatment outcomes and quality of care for chronic conditions • Health outcomes, patient-reported outcomes, and care team integration for beneficiaries with IDD
Behavioral Health Care
• Diagnosis of and treatment for multi-substance and polysubstance use disorder • Continuity of treatment for opioid use disorder • Long-term management of behavioral health conditions, including social outcomes • Integration of behavioral health and physical health, particularly through primary care
Dental and Oral Health Services
• Access to preventive dental care for adults • Inappropriate emergency department use for dental conditions
Long-Term Services and Supports
• Beneficiary experience of care, community integration, and quality of life measures • Adverse health and safety events, such as pressure ulcers, falls, unnecessary transfers, and readmissions • Care coordination and management • Experience of care measures that allow for flexibility in the use of survey tools

Suggestions for Technical Assistance to Support State Reporting of the Child and Adult Core Sets

Workgroup members discussed opportunities for technical assistance to support states in reporting the Child and Adult Core Set measures. The opportunities primarily centered around preparing for mandatory reporting of the Child Core Set and behavioral health measures in the Adult Core Set, which will be required beginning in FFY 2024. The Workgroup urged CMCS to support states as they prepare for mandatory reporting and made the following suggestions:

- One Workgroup member expressed concern about states' preparedness for mandatory reporting and asked CMCS to be mindful of how mandatory reporting will take time and resources from states' other priorities and demands. They encouraged CMCS to be clear about how this information will be used to improve the quality of care and the lives of beneficiaries.
- One Workgroup member asked CMCS to provide clear guidance about what would be required of states for mandatory reporting, so they can assess their reporting capabilities and potential constraints at the individual state level, rather than taking a one size fits all approach. They worried that any punitive actions for non-compliance would ultimately be felt by beneficiaries.
- One Workgroup member added that it may be more efficient for CMCS to calculate some measures centrally (e.g., leveraging T-MSIS data), while states focus on calculating other measures.

- One Workgroup member encouraged CMCS to work with states to facilitate linkages across databases, such as registries and health information exchanges, to support Core Set reporting.
- One Workgroup member suggested that CMCS facilitate more opportunities for learning collaboratives across states so that states could share best practices and lessons learned from reporting.
- One Workgroup member encouraged CMCS to harmonize reporting requirements between Medicaid Section 1115 waivers and mandatory Core Set reporting, to the extent possible.

Suggestions for Improving the Child and Adult Core Set Annual Review Process

Workgroup members suggested two enhancements to the Core Set Annual Review process: (1) developing strategies to address Core Set measure gaps identified by the Workgroup and (2) gaining a better understanding of why Workgroup members did not support adding or removing a measure.

A Workgroup member noted that quality measurement gaps have been identified each year and it is unclear what has been done to address the gaps, such as developing new measures or testing measures under development. Another Workgroup member suggested that a Workgroup subcommittee could conduct an assessment of gaps in the Core Sets; they could work with measure stewards, state Medicaid agencies, and other stakeholders to explore potential measures and other opportunities to address these gaps.

In addition, Workgroup members suggested exploring ways to gather more systematic feedback on why Workgroup members may not support measures for removal or addition. They said it would allow the Workgroup to discuss concerns or issues about the measures before voting or after a close vote.

Next Steps

In summary, the 2023 Child and Adult Core Set Annual Review Workgroup recommended adding 4 of the 12 suggested measures to the 2023 Child and Adult Core Sets and removing 3 of the 7 suggested measures. The measures recommended by the Workgroup for addition focus on immunizations for adults, depression screening and follow-up for adolescents and adults, lead screening for children, and appropriate antibiotic prescribing for children. The measures they recommended for removal reflect replacement of existing measures with alternative measures for adult immunizations and depression screening and follow-up.

During the Annual Review meeting, the Workgroup underscored opportunities to use the Child and Adult Core Sets to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries. Workgroup members expressed a desire to promote health equity through the Core Sets and voiced support for stratification of Core Set measures by race,

ethnicity, language, and disability. They also supported the development and testing of measures related to health-related social needs screening, positivity, and follow-up. They emphasized opportunities to leverage the Child and Adult Core Sets to promote digital measurement, as evidenced by the recommended replacement of existing measures with digital measures for adult immunizations and depression screening and follow-up.

The 2023 Child and Adult Core Set Annual Review took place against the backdrop of mandatory reporting of the Child Core Set and the behavioral health measures in the Adult Core Set beginning in FFY 2024. The Workgroup emphasized the feasibility of state reporting for existing and suggested measures, while still seeking to address strategic priorities. They championed measures that promote partnership and alignment between Medicaid and public health programs to focus resources, support priority areas, and increase the feasibility of reporting. The Workgroup also advocated for technical assistance to help states prepare for mandatory reporting, opportunities to streamline reporting, and support to build state capacity for reporting (especially for digital measures).

This report summarizing the process and recommendations of the 2023 Child and Adult Core Set Annual Review Workgroup is available for public comment. Please submit public comments via email by **August 5, 2022, at 8 p.m. ET** to MACCoreSetReview@mathematica-mpr.com and include "2023 Child and Adult 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 2022.

CMCS will review the final report to inform decisions about whether and how to modify the 2023 Child and Adult Core Sets. In addition, 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 federal agencies. CMCS will release the 2023 Child and Adult Core Sets by December 31, 2022.

Appendix A:
Child and Adult Core Set Measures

Exhibit A.1. 2022 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			
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[a]
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)^	Administrative
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)^	Administrative

Exhibit A.1 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)^	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH)^**	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)^**	Administrative
Dental and Oral Health Services			
2517	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)***	Administrative
2528****	DQA (ADA)	Topical Fluoride for Children (TFL-CH)***	Administrative
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 2022 Updates to the Child and Adult Core Health Care Quality Measurement Sets 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. 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.

** This measure was added to the 2022 Child Core Set.

*** This measure was added to the 2022 Child Core Set. It replaces the Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) measure.

**** This measure has three rates corresponding to topical fluoride applications provided as (1) dental OR oral health services, (2) dental services, or (3) oral health services. The NQF number corresponds to rate 2 (dental services).

***** 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 2022 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-bh-core-set.pdf.

[a] The Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure is also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Child Core Set reporting.

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. 2022 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
0034	NCQA	Colorectal Cancer Screening (COL-AD)*	Administrative or EHR[a]
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[a]
Maternal and Perinatal Health			
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
0058	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)*	Administrative
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

Exhibit A.2 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
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: Age 18 and Older (FUA-AD)^	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (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 and Supports			
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)	Survey

Exhibit A.2 *(continued)*

More information on 2022 Updates to the Child and Adult Core Health Care Quality Measurement Sets 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. 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 was added to the 2022 Adult Core Set.

** This measure is no longer endorsed by NQF.

*** 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 2022 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-bh-core-set.pdf.

[a] The Colorectal Cancer Screening and Breast Cancer Screening measures are also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Adult Core Set reporting.

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.

Exhibit A.3. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2010–2022

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
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	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	X
0038	NCQA	Childhood Immunization Status (CIS-CH)	X	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	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	X
1407	NCQA	Immunizations for Adolescents (IMA-CH)	X	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	X
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)[d]	X	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	--	--	--
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	X

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
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	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)[l]	--	--	--	--	--	--	--	X	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)[m]	--	--	--	--	--	--	--	--	X	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	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	--	--	--	--	--	--	--	--	--	--
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	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	X	X	X	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	2022
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	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	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	X
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[w]	--	--	--	--	--	--	--	X	X	X	X	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 (FUA-CH)[x]	--	--	--	--	--	--	--	--	--	--	--	--	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)[x]	--	--	--	--	--	--	--	--	--	--	--	--	X
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[v]	--	--	--	--	--	--	X	X	X	X	--	--	--
Dental and Oral Health Services															
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)[y]	--	--	--	--	--	X	X	X	X	X	X	--	--
2517	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)[z]	--	--	--	--	--	--	--	--	--	--	--	--	X
2528	DQA (ADA)	Topical Fluoride for Children (TFL-CH)[z]	--	--	--	--	--	--	--	--	--	--	--	--	X

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)[z]	X	X	X	X	X	X	X	X	X	X	X	X	--
NA	CMS	Percentage of Eligibles That Received Dental Treatment Services (TDENT-CH)[aa]	X	X	X	X	X	--	--	--	--	--	--	--	--
NA	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)[bb]	--	--	--	--	--	--	--	--	--	--	--	X	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)[cc]	X	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 2022 Updates to the Child and Adult Core Health Care Quality Measurement Sets 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.

* 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.

[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.

Exhibit A.3 *(continued)*

[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. The measure was retired from the 2022 Child Core Set due to state-reported challenges in reporting.

[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 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 and Follow-up After Emergency Department Visit for Mental Illness: Ages 6 to 17 measures were added to the 2022 Child Core Set to address a gap in quality of care for adolescents diagnosed with substance use disorder, allow for comparative analyses across various populations, and allow health systems to identify opportunities for care coordination. These measures are currently being reported as part of the Adult Core Set and the addition of these measures to the Child Core Sets creates further alignment across the Core Sets.

[y] 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.

[z] The Percentage of Eligibles Who Received Preventive Dental Services measure was retired from the 2022 Child Core Set. In recognition of the importance of oral health to overall health, CMS replaced it with two measures: Oral Evaluation, Dental Services and Topical Fluoride for Children. The Topical Fluoride for Children measure has three rates corresponding to topical fluoride applications provided as (1) dental OR oral health services, (2) dental services, or (3) oral health services. The NQF number corresponds to rate 2 (dental services).

[aa] 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.

[bb] 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.

[cc] 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), 2013–2022

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Primary Care Access and Preventive Care												
0032	NCQA	Cervical Cancer Screening (CCS-AD)	X	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	X
0034	NCQA	Colorectal Cancer Screening (COL-AD)[a]	--	--	--	--	--	--	--	--	--	X
0039*	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	X	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	X
2372	NCQA	Breast Cancer Screening (BCS-AD)	X	X	X	X	X	X	X	X	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)[b]	X	X	X	X	X	X	X	X	--	--
Maternal and Perinatal Health												
0469/ 0469e	TJC	PC-01: Elective Delivery (PC01-AD)[c]	X	X	X	X	X	X	X	X	X	--
0476*	TJC	PC-03: Antenatal Steroids (PC03-AD)[d]	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	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)[e]	--	--	--	--	X	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)[f]	--	--	--	--	--	X	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	X
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)[g]	X	X	X	X	X	X	X	--	--	--
0058	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)[h]	--	--	--	--	--	--	--	--	--	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)[i]	--	--	X	X	X	X	X	X	X	X
0063*	NCQA	Comprehensive Diabetes Care: LDL-C Screening (LDL-AD)[i]	X	X	--	--	--	--	--	--	--	--
0272*	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	X	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	X
0277*	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	X	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	X
0403*	NCQA	Annual HIV/AIDS Medical Visit (HMV-AD)[j]	X	--	--	--	--	--	--	--	--	--
1768*	NCQA	Plan All-Cause Readmissions (PCR-AD)	X	X	X	X	X	X	X	X	X	X
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)[k]	--	--	--	--	--	X	X	X	X	X
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)[j]	--	X	X	X	X	X	X	X	X	X
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)[l]	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	X
0027*	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	X	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	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[m]	X	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	2022
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)[n]	--	--	--	X	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)[o]	--	--	--	--	X	X	X	X	X	X
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[n]	--	--	--	X	X	X	X	X	X	X
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)[p]	--	--	--	--	--	X	X	X	X	X
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)[q]	--	--	--	--	--	--	--	X	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)[r]	--	--	--	--	X	X	X	X	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)[r]	--	--	--	--	X	X	X	X	X	X
NA	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)[s]	X	X	X	X	X	X	X	X	X	X
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)[t]	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)[u]	X	X	X	X	X	X	X	X	X	X
Long-Term Services and Supports												
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)[v]	--	--	--	--	--	--	--	X	X	X

Exhibit A.4 *(continued)*

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 2022 Updates to the Child and Adult Core Health Care Quality Measurement Sets 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.

* This measure is no longer endorsed by NQF.

[a] The Colorectal Cancer Screening measure was added to the 2022 Adult Core Set to assess appropriate receipt of colorectal cancer screenings.

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

[c] The PC-01: Elective Delivery measure was retired from the 2022 Adult Core Set due to state-reported challenges in reporting.

[d] The PC-03: 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.

[e] 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.

[f] 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.

[g] 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.

[h] The Avoidance of Antibiotic Treatment With Acute Bronchitis/Bronchiolitis measure was added to the 2022 Adult Core Set to assess inappropriate use of antibiotics.

[i] 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: 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.

[j] 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.

[k] 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.

[l] 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.

[m] 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.

[n] 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.

Exhibit A.4 *(continued)*

[o] 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.

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

[q] 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.

[r] 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).

[s] 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).

[t] 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.

[u] 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.

[v] 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 2023 Child and Adult Core Set Annual Review, by Domain

Exhibit B.1. Measures Suggested for Review at the 2023 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 18-64 (FVA-AD)	NCQA	0039[a]	Survey
Removal	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) and Age 18 and Older (CDF-AD)	CMS	0418/0418e[a]	Administrative or EHR
Addition	Adult Immunization Status	NCQA	3620	ECDS[b]
Addition	Depression Screening and Follow-Up for Adolescents and Adults	NCQA	NA	ECDS[b]
Addition	Lead Screening in Children	NCQA	NA	Administrative or hybrid
Addition	Adults' Access to Preventive/Ambulatory Health Services	NCQA	NA	Administrative
Care of Acute and Chronic Conditions				
Removal	HIV Viral Load Suppression (HVL-AD)	HRSA	2082/3210e	Administrative or EHR
Addition	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Ages 3 Months–17 Years) (Note: This measure was added to the 2022 Adult Core Set; this measure is being suggested for addition to the 2023 Child Core Set.)	NCQA	0058	Administrative
Addition	Eye Exam for Patients With Diabetes (Note: This measure was part of Comprehensive Diabetes Care and is now a standalone measure.)	NCQA	0055	Administrative, hybrid, EHR
Addition	Blood Pressure Control for Patients With Diabetes (Note: This measure was part of Comprehensive Diabetes Care and is now a standalone measure.)	NCQA	0061	Administrative, hybrid, EHR
Addition	Kidney Health Evaluation for Patients With Diabetes (Note: This measure was part of Comprehensive Diabetes Care and is now a standalone measure that replaces Medical Attention for Nephropathy.)	NCQA	NA	Administrative
Addition	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	NA	EHR or clinical registry

Exhibit B.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Addition Note: This measure will not be discussed because it is already in the Adult Core Set.	Hemoglobin A1c Control for Patients With Diabetes (Note: This measure incorporates Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%), which is already in the Adult Core Set.)	NCQA	0575/0059	Administrative, hybrid, EHR
Behavioral Health Care				
Removal	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	NCQA	0027[a]	Survey
Removal	Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	NCQA	2607	Administrative or hybrid
Removal	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	PQA	2940	Administrative
Removal	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	PQA	3389	Administrative
Long-Term Services and Supports				
Addition	Long-Term Services and Supports: Shared Care Plan with Primary Care Physician	NCQA	NA	Case management record review
Addition	Long-Term Services and Supports: Successful Transition After Long-Term Institutional Stay	CMS	NA	Administrative
Addition	National Core Indicators for Aging and Disabilities (NCI-AD) Adult Consumer Survey	ADvancing States and HSRI	NA	Survey
Addition Note: This measure will not be discussed because the measure was recommended by the Workgroup previously and CMCS deferred a decision.	Long-Term Services and Supports: Comprehensive Care Plan and Update	NCQA	NA	Case management record review
Addition Note: This measure will not be discussed because it does not meet minimum technical feasibility criteria.	Long-Term Services and Supports Expenditures on Home & Community-Based Services	CMS	NA	Administrative

Exhibit B.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Other				
Addition Note: These measures will not be discussed because they do not meet minimum technical feasibility criteria.	Drivers of Health Screening Rate and Screen Positive Rate 1. Drivers of Health Screening Rate for Medicaid Managed Care Organizations and Provider-Led Accountable Entities (Child and Adult) 2. Drivers of Health Screening Rate for Providers (Child and Adult) 3. Drivers of Health Screen Positive Rate for Medicaid Managed Care Organizations and Provider-Led Accountable Entities (Child and Adult) 4. Drivers of Health Screen Positive Rate for Providers (Child and Adult)	Manatt	NA	Other

Notes: Data collection methods are current as of March 2022. The methods may change as measures undergo specification updates and maintenance. Measures specified for administrative data collection may use code sets that may not be available for state-level reporting, such as LOINC, SNOMED, or CPT-II codes. More information is available in the measure specifications.

[a] Measure is no longer endorsed.

[b] The 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/.

CHIP = Children's Health Insurance Program; CMCS = Center for Medicaid and CHIP Services; CMS = Centers for Medicare & Medicaid Services; ECDS = Electronic Clinical Data System; EHR = Electronic Health Record; HRSA = Health Resources & Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PQA = Pharmacy Quality Alliance.

Appendix C:
Summary of 2023 Child and Adult Core Set Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

This appendix summarizes the discussion of measures considered by the Workgroup and not recommended for removal from or addition to the 2023 Child and Adult Core Sets. The discussion took place during the Workgroup meeting from April 5 to April 7, 2022. The summary is organized by domain. Exhibit C.1 at the end of this appendix includes the measure name, measure steward, National Quality Forum (NQF) number (if endorsed), measure description, data collection method, and key points of discussion about the measures discussed and not recommended for removal or addition.

Behavioral Health Care

The Workgroup discussed but did not recommend removal of four behavioral health measures from the Adult Core Set. The *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD) measure assesses components of medical assistance with smoking and tobacco use cessation: (1) advising smokers and tobacco users to quit, (2) discussing cessation medications, and (3) discussing cessation strategies. The measure is calculated based on data collected through the Consumer Assessment of Healthcare Providers & Systems (CAHPS) Health Plan Survey. The Workgroup member who suggested this measure for removal from the Adult Core Set noted that states report considerable challenges in collecting the data for the measure, including low response rates, administrative burden, and financial constraints. They added that, with mandatory reporting of all behavioral health measures in the Adult Core Set beginning in federal fiscal year (FFY) 2024, states will be required to report the measure each year. Finally, the Workgroup member noted that the number of states reporting MSC-AD for FFY 2020 (28 states) is lower than the number of states reporting for most other measures.[35]

During the discussion, the Workgroup considered the tension between the importance of measuring smoking cessation interventions and the existing measure's limitations and administrative burden. Workgroup members underscored the prevalence of smoking, end-stage lung disease, and end-stage heart failure in the Medicaid population (especially the behavioral health population) and highlighted the importance of measuring tobacco use cessation. They also commented on the significant health impact of smoking and the strength of the Medicaid-public health partnership. Several Workgroup members (including the Centers for Disease Control and Prevention [CDC] liaison) expressed concern about creating a gap by removing MSC-AD without a replacement, as it is the only tobacco cessation measure in the Adult Core Set. One public commentor from the American Lung Association also supported retention of MSC-AD, adding that individuals with behavioral health and substance use disorders smoke at higher rates than the general population.

However, several Workgroup members noted the limitations of MSC-AD for driving improvement. One Workgroup member noted that the measure determines only whether a discussion took place, and not whether the discussion followed a standardized, evidence-based

[35] Another state reported the measure, but data were suppressed due to small cell sizes.

protocol. Two other Workgroup members raised concerns about the actionability and representativeness of the CAHPS survey data. Another suggested that removing the measure would not have any detrimental impacts on patient care because the medical community would still screen for tobacco use and conduct cessation activities.

Acknowledging these challenges, some Workgroup members suggested retaining the measure in the Adult Core Set while considering alternatives. For example, two Workgroup members discussed using the Behavioral Risk Factor Surveillance System (BRFSS) to collect information on smoking cessation. However, some states do not collect information on health insurance status through BRFSS, which is required for state-level Core Set reporting. Another Workgroup member suggested that switching to BRFSS would create an additional workflow and burden on states, given that they already collect CAHPS data for the Core Sets. Finally, two Workgroup members suggested that the Workgroup should consider replacing MSC-AD in the future with NQF #0028: *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*, which would align with other federal programs.

Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD) measures the percentage of beneficiaries ages 18 to 75 years with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%). Two Workgroup members suggested this measure for removal, citing that only seven states publicly reported the measure for FFY 2020 and that states reported significant challenges in accessing the data needed to calculate the measure.

During the discussion, several Workgroup members discussed challenges states face in reporting the measure and expressed concern about mandatory reporting of the measure beginning in FFY 2024. One Workgroup member, in favor of removing the measure, noted that their state has been unable to report HPCMI-AD because of the need for chart review to obtain the required elements; they reminded the Workgroup that some states have more limited data collection capabilities than others. Another Workgroup member asked Mathematica if CMCS was continuing to explore the potential of using electronic health records (EHR) through a Health Information Exchange (HIE) to calculate the measure (as mentioned during a previous Core Set Review Workgroup meeting). Mathematica responded that CMCS's efforts have not yet been fruitful. A Workgroup member from a state Medicaid program reported that they stratify *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* (HPC-AD) to look at the measure among the population with serious mental illness. Mathematica reminded the Workgroup that HPC-AD is not currently specified for stratification and that the Workgroup should consider the measure as currently specified.

One Workgroup member expressed support for retaining HPCMI-AD in the Core Set, emphasizing that individuals with serious mental illness are at a higher risk for morbidity and mortality. They described their state's experience in moving toward integrated care and leveraging its HIE to improve data collection. They encouraged the Workgroup to retain the measure because it addresses critical health disparities and supports integration.

The Workgroup considered the removal of two opioid-related measures from this domain: the *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD), which assesses the percentage of beneficiaries age 18 years and older who receive prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents, over a period of 90 days or more; and *Concurrent Use of Opioids and Benzodiazepines* (COB-AD), which measures the percentage of beneficiaries age 18 years and older with concurrent use of prescription opioids and benzodiazepines. The Workgroup member who suggested OHD-AD for removal noted that the measure may not be leading to improvements in quality of care and outcomes and that the opioid epidemic is no longer driven by prescription opioids. The Workgroup member who suggested COB-AD for removal was concerned that the actions providers take to try to improve performance on the measure may put patients at risk, such as discontinuing or tapering medications or being hesitant to serve chronic opioid users, all of which can lead to adverse patient outcomes.

During the discussion, Workgroup members expressed concern about removing both measures, citing rising rates of opioid overdoses and deaths during the COVID-19 pandemic. Three Workgroup members stressed that the measures are not intended to capture opioid abuse, but rather measure appropriate pain management and integration between pharmacies and providers. Moreover, one Workgroup member suggested that the OHD-AD measure should be shifted from the Behavioral Health Care domain to the Care of Acute and Chronic Conditions domain, given its focus on appropriate prescribing for physical health conditions. One Workgroup member added that, despite the possibility that some providers could unnecessarily taper medications for patients, far more patients will be protected from high-risk dosages. A Workgroup member reminded the Workgroup that the Behavioral Health Care domain encompasses a third of the total measures in the Adult Core Set, with four measures focused on opioids, and encouraged the Workgroup to prioritize actionable measures.

Primary Care Access and Preventive Care

The Workgroup discussed but did not recommend the addition of *Adults' Access to Preventive/Ambulatory Health Services*, which measures the percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. The Workgroup member who suggested the measure for addition to the Core Sets noted that wellness visits can reduce emergency department visits, providing individuals with an opportunity to receive preventive services and counseling on topics such as diet and exercise while helping them address acute issues or manage chronic conditions. They also noted that the measure has room for improvement and that states can influence improvement by using levers such as managed care organization contracts.

During the discussion, Workgroup members focused on the scope of the measure. One Workgroup member said that the measure was very broad, describing it as a "low bar" that lacks a precise focus on primary care and questioning whether it was a quality measure versus a measure of access to care. Another Workgroup member agreed about the measure's breadth,

suggesting that the measure could capture services that are not truly preventive. They also noted that, in terms of health outcomes, the value of routine visits for younger people without chronic conditions is questionable. The Workgroup member also questioned the measure's emphasis on a practitioner visit, contending that there are potentially other innovative ways to approach health, health literacy, and prevention of chronic conditions for this population. A Workgroup member also pointed to different measure specifications for commercially insured beneficiaries versus the Medicaid population, making it difficult to compare performance across payers to assess whether Medicaid beneficiaries have equitable access to care.

Long-Term Services and Supports

The Workgroup discussed but did not recommend three measures for addition to the Long-Term Services and Supports (LTSS) domain. *Long-Term Services and Supports: Shared Care Plan with Primary Care Physician* assesses the percentage of LTSS organization members with a care plan that was transmitted to their primary care provider or other documented medical care practitioner identified with the plan member within 30 days of plan development. The measure is based on a review of LTSS case management records drawn from a sample of the eligible population. The Workgroup member who suggested the measure for addition indicated that, because approximately 30 percent of Medicaid spending goes to LTSS, tracking compliance in assessing care plan goals will improve the national quality of health care. They also noted that monitoring the elements of the care plan and sharing the plan with the primary care provider supports continuity of care.[36]

During the discussion, one Workgroup member commented that the measure plays an important part in continuity of care by going beyond the medical aspects of care and helping physicians understand the needs and goals of their patients. Another Workgroup member noted that the measure emphasizes the importance of all those involved in the planning process for an individual's care. One Workgroup member pointed out that the measure supports the National Committee for Quality Assurance's (NCQA) LTSS Distinction accreditation program and that the addition of the measure to the Core Set would support plans with the accreditation process.

One Workgroup member expressed concern that the measure may be "rudimentary" and not ready for inclusion in the Core Sets because it counts only transmission of the care plan, not whether the primary care physician acknowledged or reviewed it once received. Another Workgroup member agreed that the measure was rudimentary, but they believed that it provided a start in thinking about care coordination in the often-fragmented environment in which people use Home and Community Based Services (HCBS). A Workgroup member asked how the

[36] The Workgroup member who suggested this measure had also suggested the Long-Term Services and Supports: Comprehensive Care Plan and Update measure as a companion. The Workgroup did not discuss the latter measure because it previously recommended the measure for addition during the 2022 Child and Adult Core Set Annual Review. CMS is deferring a decision on the measure to support measure alignment with other CMS initiatives. CMS is in the process of finalizing a set of quality measures for Home and Community Based Services. More information is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib121021.pdf.

measure can be used to assess the care planning process, including whether the care plan was prescriptive or patient- and family-driven. The measure steward, NCQA, responded that the measure includes two rates: the first looks at the care planning elements that NCQA believes should be documented for all LTSS members; the second assesses whether supplemental elements were documented, which can assess individualized patient preferences and goals. Noting the complexity of needs in the LTSS population, a Workgroup member asked whether the measure would necessitate continual transmission of a care plan upon each update. NCQA responded that the measure currently looks at whether the care plan was transmitted within 30 days of development or within 30 days of an annual plan update.

Workgroup members also discussed the measure's technical specifications. A Workgroup member from a state Medicaid program expressed concern about the resource requirements for collecting the measure, noting that the measure requires case management record review. Another Workgroup member noted that the measure currently includes a sample of 96 members and commented that the results would not be representative of a state their size. They further questioned how states would approach sampling across a large Medicaid program. In response to a question from another Workgroup member, the measure steward, NCQA, said that they are planning to revisit the sample size and potentially increase it to its previous size of 411. In response to another question from a Workgroup member about current performance on the measure and opportunity for improvement, NCQA responded that average performance was 60 percent for measurement year 2020.

One Workgroup member asked about the experience of stratifying the measure by race, ethnicity, and language. Another Workgroup member responded that, based on their experience, if a member could be identified by an internal subscriber identification number, then stratification should be possible because the care plan is housed within a comprehensive case management system.

The *LTSS: Successful Transition After Long-Term Institutional Stay* measure (also known as MLTSS-8) calculates the proportion of long-term institutional facility stays, defined as stays of 101 days or more, among Medicaid Managed Long Term Services and Supports (MLTSS) plan members age 18 years and older that result in a successful transition to the community (a successful transition is defined as community residence for 60 or more days). The measure steward, Centers for Medicare & Medicaid Services (CMS), is currently updating the managed care version of the measure and also respecifying the measure for Medicaid fee-for-service LTSS participants, with updates scheduled for completion in 2022. The Workgroup member who suggested the measure for addition noted that individuals receiving HCBS are less likely to have emergency department visits, injuries, and instances of abuse and neglect when they receive appropriate community supports. In addition, the Workgroup member indicated three benefits of the measure: it can be trended over time, it lends itself to comparisons of performance across managed care plans and states, and payers and providers can directly influence improvement on the measure by collaborating on transition incentive programs and alternative payment arrangements.

During the discussion, a Workgroup member described MLTSS-8 as vitally important because it gives individuals the ability to reside in the least restrictive setting of their choice. They also said that the measure supports community integration, potentially reducing Medicaid spending. Another Workgroup member agreed, stating that the measure "embodies the values of rebalancing" and may prevent long-term stays in nursing facilities. In response to a question about whether the measure was limited to states with MLTSS plans, the measure steward noted that they are respecifying the measure for fee-for-service LTSS delivery systems and that testing and development of the fee-for-service version will be completed this year.

The *National Core Indicators for Aging and Disabilities* (NCI-AD) *Adult Consumer Survey* is a voluntary effort by state Medicaid, Aging, and Disability agencies to measure and track the performance of LTSS programs. The data source is an in-person survey, and the survey's sampling frame includes adults age 65 years and older or adults age 18 years and older with a physical disability, who receive LTSS at least two to three times a week. When suggesting the measure for addition to the Core Sets, a Workgroup member indicated that adding the NCI-AD survey would close the gap associated with the lack of measures focused on older adults and people with disabilities. They stated that the survey provides information on LTSS outcomes, beneficiary experience, and quality-of-life measures that extend beyond service provision.

During the discussion, a Workgroup member from a state Medicaid agency described the NCI-AD as a strong outcomes-based tool, similar to the *National Core Indicators Survey (NCIDDS-AD)* for individuals with intellectual and developmental disabilities (IDD), which was added to the 2020 Adult Core Set. They noted that administering the NCI-AD survey along with the NCI survey provides their state with a holistic view of their entire HCBS program. They also reported that their state sometimes surveys at various levels, such as managed care plans or programs. Another Workgroup member concurred that the survey allows states to understand and improve their members' experience of care and noted that NCI-AD augments the process-oriented care measures developed through administrative data sources. One Workgroup member asked if the measure is intended to be reported annually and about the implications for Core Set reporting. The measure steward indicated that states determine the frequency of the survey, with some states administering it every year and others alternating between NCI-AD and NCI. Mathematica said that, like other Core Set measures, the threshold for public reporting of 25 states would apply to NCI-AD if the measure is added to the Core Sets.

During the public comment period, several individuals spoke in support of adding NCI-AD to the Core Sets. One commented that it is outcome-based and can be used across all HCBS programs, Programs for All-Inclusive Care for the Elderly (PACE), and non-Medicaid programs funded by the Older Americans Act and would fill a gap in LTSS measures discussed by the Workgroup in previous years. Another noted that older adults and people with disabilities represent the largest number of LTSS users and that NCI-AD reports outcomes from the perspective of the people receiving LTSS. They also noted that NCI-AD can be used to understand disparities by race, ethnicity, disability types, gender, and other characteristics that can affect service users' experience. They acknowledged that it is not a small undertaking but is

important for understanding the quality of services and experiences across several domains. Another individual commented that state participation in NCI-AD has been increasing and that 19 states are fully participating in the current cycle. They also noted that, starting in 2022, the survey is offered in person, by phone, and by video.

Care of Acute and Chronic Conditions

The Workgroup discussed but did not recommend removal of one measure and addition of four measures related to Care of Acute and Chronic Conditions. The *HIV Viral Load Suppression* (HVL-AD) measure assesses the percentage of beneficiaries age 18 years and older with a diagnosis of Human Immunodeficiency Virus (HIV) with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. The Workgroup member who suggested removal of the measure from the Adult Core Set cited that, although the measure has been in the Core Set since 2014, only nine states reported the measure for FFY 2020. States have noted challenges in obtaining the data needed to calculate the measure, including lack of LOINC codes and restrictions on data sharing because of privacy laws. To address such challenges, the measure steward, the Health Resources Services Administration (HRSA), recently launched a four-year technical assistance initiative to increase state capacity to collect high quality data and report the measure.

During the discussion, Workgroup members voiced strong support for keeping HVL-AD in the Core Set, stressing the importance of addressing viral load among the Medicaid population and lauding the measure as a "gold standard" outcome measure toward which Core Set measures should be moving. Even so, several Workgroup members acknowledged the difficulties with collecting data for the measure, and one Workgroup member voiced concern about the potential for small sample sizes. Workgroup members from several state Medicaid programs reported their states' challenges and progress in collecting the data needed to calculate the measure, including collaborating with their public health departments, participating in learning collaboratives, and working with the HRSA initiative. They noted that, because the measure will not be subject to mandatory reporting beginning in 2024, states can continue to build their capacity for reporting the measure. In the meantime, one Workgroup member suggested that states explore other opportunities to assess the care provided to the population living with HIV, such as using claims-based data to look at receipt of blood tests and medications.

The CDC federal liaison expressed CDC's support for the measure, noting that the U.S. Department of Health and Human Services (HHS) recently launched Ending the HIV Epidemic in the U.S. (EHE), a 10-year initiative that aims to reduce new HIV infections in the United States to fewer than 3,000 per year by 2030. Increasing the percentage of people with HIV who are virally suppressed is a core indicator of progress under the EHE initiative. During the public comment period, representatives from the National Alliance of State and Territorial AIDS Directors (NASTAD) and HRSA, the measure steward, also voiced support for the measure, highlighting the work NASTAD and HRSA are doing to help states report the measure and their plans for sharing lessons from these efforts.

The Workgroup discussed three diabetes measures suggested but not recommended for addition to the Core Sets: *Eye Exam for Patients with Diabetes*, *Blood Pressure Control for Patients with Diabetes*, and *Kidney Health Evaluation for Patients with Diabetes*. *Eye Exam for Patients with Diabetes* measures the percentage of members ages 18 to 75 years with diabetes (types 1 and 2) who had a retinal eye exam. *Blood Pressure Control for Patients with Diabetes* measures the percentage of members ages 18 to 75 years with diabetes (types 1 and 2) whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. *Kidney Health Evaluation for Patients with Diabetes* assesses the percentage of members ages 18 to 85 years with diabetes (types 1 and 2) who received a kidney health evaluation, defined by receiving both an estimated glomerular filtration rate and a urine albumin-creatinine ratio during the measurement year. The eye exam and blood pressure control measures were previously part of the Healthcare Effectiveness Data and Information Set (HEDIS) Comprehensive Diabetes Care measure; the kidney measure is new and replaces the Medical Attention for Nephropathy indicator. A Workgroup member suggested these measures for addition to the Core Sets because they provide an overall view of the management of diabetes, a common chronic condition among the Medicaid population.

During the discussion, Workgroup members recognized the burden of diabetes among the Medicaid population, the importance of careful management of the condition, and the opportunities for improving performance in this area. However, they noted that the Adult Core Set already includes several diabetes-focused measures and questioned whether the suggested measures capture additional information. One Workgroup member noted that, among the three suggested diabetes measures, they would consider the *Eye Exam for Patients with Diabetes* measure because it is included in other programs; in addition, it is a disparities-sensitive measure and requires effective coordination to ensure appropriate care delivery. One Workgroup member asked the measure steward, NCQA, why the measures were disaggregated from the HEDIS Comprehensive Diabetes Care measure into three standalone measures. NCQA responded that separate measures allow NCQA to maintain each measure over time, keeping them in alignment with their use in different programs. In addition, NQF endorses each measure individually.

The *Statin Therapy for the Prevention and Treatment of Cardiovascular Disease* measure assesses the percentage of patients at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement year. The measure looks at three populations: (1) all patients who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; (2) patients age 20 years and older who have ever had a low-density lipoprotein cholesterol level at or above 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; or (3) patients age 40 to 75 years with a diagnosis of diabetes. A Workgroup member suggested the measure for addition because statins are an effective and accessible strategy for cardiovascular disease risk reduction. Furthermore, several quality reporting initiatives, including the Merit-based Incentive Payment System (MIPS) and Million Hearts, use the measure.

During the discussion, Workgroup members acknowledged the importance of statins as a medical intervention for cardiovascular disease and the value of a measure focused on cardiovascular disease. They also appreciated that the measure looked broadly across three populations. The CDC liaison supported adding the measure to the Core Sets, reiterating that cardiovascular disease and stroke are the leading causes of death in the United States and that statins are an effective way to address such conditions. They stated that the measure has undergone improvement over time and is included in several quality reporting programs.

One Workgroup member expressed hesitation about adding a medication management measure to the Core Sets in place of an outcome measure focused on cardiovascular disease. Another Workgroup member expressed concern that the measure requires EHR or clinical registries, noting that this data collection methodology would impose additional administrative burden on clinicians and states.

A representative of the measure steward responded to questions from two Workgroup members. They indicated that the measure was updated to align with the 2019 American Heart Association and American College of Cardiology guidelines and that CMS updates the measure annually. They also confirmed that the measure is included in MIPS but noted that data are collected differently in Medicare than in Medicaid.

Exhibit C.1. Measures Discussed by the 2023 Child and Adult 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
Behavioral Health Care			
Measures discussed and not recommended for removal from the 2022 Adult Core Set			
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) Measure steward: NCQA	0027 (no longer endorsed)	The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: **1.** 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.** 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.** 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 because states reported considerable challenges with data collection, including low response rates on the CAHPS survey, administrative burden, and financial constraints; concerns about mandatory reporting beginning in FFY 2024; and a lower number of states reporting MSC-AD than most other Core Set measures • Support for retaining the measure given the burden of smoking in the Medicaid population and concern about removing the measure without a replacement measure • Discussion of the potential of alternate data sources and measures in the future, including use of BRFSS and NQF #0028: *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention* • Concerns about use of BRFSS instead of CAHPS given lack of a Medicaid and CHIP indicator in BRFSS in some states and creation of a separate workflow when CAHPS workflow is already established

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD) Measure steward: NCQA	2607	The percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%). Note: A lower rate indicates better performance. Data collection method: Administrative or hybrid	• Suggested for removal because only seven states reported the measure for FFY 2020, and states reported challenges with accessing data • Discussion around reporting challenges, including the need for chart review to obtain required elements, lack of progress using HIE data, and concerns with readiness for mandatory reporting beginning in FFY 2024 • Support to retain the measure because of the higher risk for morbidity and mortality among individuals with diabetes and serious mental illness, the measure addresses health disparities, and it supports care integration • Suggestion to consider whether the HPC-AD measure could be modified to stratify for people with serious mental illness
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) Measure steward: Pharmacy Quality Alliance (PQA)	2940	The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. Data collection method: Administrative	• Suggested for removal because the measure may not be driving improvements in quality of care and outcomes, and that the opioid epidemic is no longer driven by prescription opioids • Comment that a third of the measures in the Adult Core Set fall under Behavioral Health Care, with four measures focused on opioids, and a suggestion to prioritize measures that are actionable • Hesitation to remove the measure because of rising rates of opioid overdoses and deaths during the COVID-19 pandemic • Discussion that OHD-AD measures appropriateness of pain management and integration between pharmacies and providers, rather than opioid abuse • Comment that although there may be some instances of physicians unnecessarily tapering patients' medications to improve performance on the measure, far more patients will be protected from high-risk dosages

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Concurrent Use of Opioids and Benzodiazepines (COB-AD) Measure steward: PQA	3389	The percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. Data collection method: Administrative	• Suggested for removal because of concerns around the actions providers may take to improve performance on the measure that may put patients at risk, such as discontinuing or tapering medications, hesitation to serve chronic opioid users, and possible negative patient outcomes • Comment that a third of the measures in the Adult Core Set fall under Behavioral Health Care, with four measures focused on opioids, and a suggestion to prioritize measures that are actionable • Hesitation to remove the measure because of rising rates of opioid overdoses and deaths during the COVID-19 pandemic • Discussion that COB-AD measures appropriateness of pain management and integration between pharmacies and providers, rather than opioid abuse
Primary Care Access and Preventive Care			
Measure discussed and not recommended for addition to the 2023 Core Sets			
Adults' Access to Preventive/Ambulatory Health Services Measure steward: NCQA	Not endorsed	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year. Data collection method: Administrative	• Suggested for addition because wellness visits can reduce emergency department visits, provide an opportunity for preventive services and counseling (such as diet and exercise), address acute issues, and manage chronic conditions • Comment that the measure is broad and is a measure of access rather than quality • Concern that the measure lacks focus on primary care and could capture services that are not preventive care • Comment that the measure specifications differ between Medicaid and commercial payers, precluding assessment of equitable access between Medicaid beneficiaries and those who are commercially insured

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Long-Term Services and Supports			
Measures discussed and not recommended for addition to the 2023 Core Sets			
Long-Term Services and Supports: Shared Care Plan with Primary Care Physician Measure steward: NCQA	Not endorsed	The percentage of long-term services and supports (LTSS) organization members with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days of its development. Data collection method: Case management record review	• Suggested for addition because monitoring and sharing the care plan supports continuity of care • Comment that the measure plays an important part in continuity of care because it goes beyond the medical aspects of care and helps physicians understand the needs and goals of their patients, including what is important to individual patients • Comment that the shared care plan emphasizes the importance of all those involved in the planning process for an individual's care • Concern that the measure counts only if the care plan has been shared, not if the PCP acknowledged or reviewed it once received • Concern about the resources required to collect the data (case management record review) • Concern about how larger state Medicaid programs would approach sampling and the representativeness of results with a sample of 96
LTSS: Successful Transition After Long-Term Institutional Stay (MLTSS-8) Measure steward: Centers for Medicare & Medicaid Services (CMS)	Not endorsed	The proportion of long-term (101 days or more) institutional facility stays among Medicaid Managed Long-Term Services and Supports (MLTSS) plan members aged 18 and older, which result in successful transitions to the community (community residence for 60 or more days). This measure is reported as an observed rate and a risk-adjusted rate. Data collection method: Administrative (claims only)	• Suggested because the measure prioritizes HCBS, which may be associated with fewer emergency department visits, injuries, and instances of abuse and neglect when given appropriate community supports; the measure can be trended over time, performance can be compared across managed care plans and states, and payers and providers can directly influence improvement • Comment that the measure supports individuals in living in the least restrictive setting of their choice and supports community integration • Comment that the measure may encourage prevention of long-term stays in nursing facilities • The measure steward (CMS) is currently updating the measure for MLTSS and respecifying the measure for fee-for-service delivery systems; testing and development are scheduled to be completed in 2022.

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
National Core Indicators for Aging and Disabilities (NCI-AD) *Adult Consumer Survey* Measure steward: ADvancing States and Human Services Research Institute (HSRI)	Not endorsed	NCI-AD is a voluntary effort by state Medicaid, aging, and disability agencies to measure and track the performance of their LTSS programs. The core indicators are standard measures used across states to assess the outcomes of publicly funded services provided to older adults and adults with physical disabilities. Indicators address 18 areas: (1) service coordination, (2) rights and respect, (3) community participation, (4) choice and control, (5) health care, (6) safety, (7) relationships, (8) satisfaction, (9) care coordination, (10) access to community, (11) access to needed equipment, (12) wellness, (13) medications, (14) self-direction, (15) work, (16) everyday living, (17) affordability, and (18) person-centered planning. Data collection method: In-person survey	• Suggested for addition to close a gap in the Core Sets around measures for older adults and people with disabilities, and would provide states with information on LTSS outcomes, beneficiary experience, and quality of life • Described as a strong outcomes-based tool • Comment that the measure allows states to understand their overall HCBS program and improve their members' experience of care • Some states choose to alternate with the NCI and administer this survey every other year, which may impact whether the measure meets the 25-state threshold for public reporting.
Care of Acute and Chronic Conditions			
Measure discussed and not recommended for removal from the 2022 Adult Core Set			
HIV Viral Load Suppression (HVL-AD) Measure steward: HRSA	2082/3210e	The percentage of beneficiaries age 18 and older with a diagnosis of Human Immunodeficiency Virus (HIV) who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year. Data collection method: Administrative or EHR	• Suggested for removal because only nine states reported the measure for FFY 2020 and states faced challenges with accessing data • Comments acknowledging data challenges, including small sample sizes, lack of LOINC codes, and restrictions on data sharing because of privacy laws • Strong support for keeping the measure because it is a "gold-standard" outcome measure • Measure steward launched a technical assistance initiative to improve state capacity for reporting • Alignment with federal Ending the HIV Epidemic in the U.S. (EHE) 10-year initiative

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measures discussed and not recommended for addition to the 2023 Core Sets			
Eye Exam for Patients with Diabetes Measure Steward: NCQA	0055	The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) who had a retinal eye exam. Note: This measure was previously included as an indicator in the HEDIS Comprehensive Diabetes Care measure. Starting with HEDIS MY 2022 (which corresponds to the 2023 Core Set), this is a standalone HEDIS measure. Data collection method: Administrative, hybrid, or EHR	• Suggested as part of a suite of three measures for addition to the Core Sets because it provides an overall view of diabetes management in Medicaid • Recognition of the burden of diabetes among the Medicaid population, the importance of careful management of the condition, and the opportunities for improving performance • Comment that there are already several diabetes-focused measures in the Core Sets • Comment that the measure requires effective care coordination to ensure appropriate care delivery • Described as a disparities-sensitive measure that is included in other programs
Blood Pressure Control for Patients with Diabetes Measure Steward: NCQA	0061	The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. Note: This measure was previously included as an indicator in the HEDIS Comprehensive Diabetes Care measure. Starting with HEDIS MY 2022 (which corresponds to the 2023 Core Se), this is a standalone HEDIS measure. Data collection method: Administrative, hybrid, or EHR	• Suggested as part of a suite of three measures for addition to the Core Sets because it provides an overall view of diabetes management in Medicaid • Recognition of the burden of diabetes among the Medicaid population, the importance of careful management of the condition, and the opportunities for improving quality of care • Comment that there are already several diabetes-focused measures in the Core Sets
Kidney Health Evaluation for Patients with Diabetes Measure Steward: NCQA	Not endorsed	The percentage of members 18 to 85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate and a urine albumin-creatinine ratio, during the measurement year. Data collection method: Administrative	• Suggested as part of a suite of three measures for addition to the Core Sets because it provides an overall view of diabetes management in Medicaid • Recognition of the burden of diabetes among the Medicaid population, the importance of careful management of the condition, and the opportunities for improving quality of care • Comment that there are already several diabetes-focused measures in the Core Sets

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease Measure Steward: CMS	Not endorsed	Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: **1.** Population 1: All patients who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; OR **2.** Population 2: Patients age 20 years and older who have ever had a low-density lipoprotein cholesterol (LDL-C) level at or above 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR **3.** Population 3: Patients ages 40 to 75 years with a diagnosis of diabetes Data collection method: EHR or clinical registry	• Suggested for addition because statins are an effective and accessible strategy for reducing cardiovascular disease risk and is used in several federal quality reporting initiatives • Hesitation to add a medication management measure rather than an outcome measure • Comment that reporting the measure would require access to EHRs or clinical registry data, and would add administrative burden to states and providers • Comment that the measure is included in other programs, but that Medicare and Medicaid data are collected differently

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