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Child and Adult Core Set Stakeholder Workgroup:

Measures Suggested for Addition to the 2023 Core Sets

Measure Information Sheets

April 2022

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Contents

Primary Care Access and Preventive Care

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Adult Immunization Status**
Description	The percentage of adults 19 years and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, and pneumococcal. Note: The Medicaid rate includes beneficiaries ages 19 to 65 and excludes pneumococcal vaccines.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	3620
Core Set domain	Primary Care Access and Preventive Care
Meaningful Measures area(s)	Wellness and Prevention
Measure type	Process
Recommended to replace current measure?	Flu Vaccinations for Adults Ages 18-64 (FVA-AD)

Technical Specifications	
Ages	Age 19–65 at the start of the Measurement Period.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.)
Denominator	This measure includes denominators for three individual vaccine rates: 1. **Influenza rate:** Members 19 years and older at the start of the Measurement Period who also meet the criteria for Participation,* minus exclusions. 2. **Td/Tdap rate:** Members 19 years and older at the start of the Measurement Period who also meet the criteria for Participation,* minus exclusions. 3. **Zoster rate:** Beneficiaries ages 50–65 at the start of the Measurement Period who also meet criteria for Participation,* minus exclusions. *Participation is defined as the identifiers and descriptors for each organization's coverage used to define beneficiaries' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.

Numerator	This measure includes numerators for three individual vaccine rates: 1. **Influenza rate:** Members who received an influenza vaccine on or between July 1 of the year prior to the Measurement Period and June 30 of the Measurement Period. 2. **Td/Tdap rate:** a. Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the Measurement Period and the end of the Measurement Period, or b. Members with a history of at least one of the following contraindications any time before or during the Measurement Period: i. Anaphylaxis due to the diphtheria, tetanus, or pertussis vaccine. ii. Encephalitis due to the diphtheria, tetanus, or pertussis vaccine. 3. **Zoster rate:** Members who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, anytime on or after the member's 50th birthday and before or during the Measurement Period.
Exclusions	Exclude members with any of the following: • Active chemotherapy any time during the Measurement Period. • Bone marrow transplant any time during the Measurement Period. • History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & HB-S disease, or cerebrospinal fluid leaks any time during the member's history through the end of the Measurement Period. • In hospice or using hospice services any time during the Measurement Period.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who nominated this measure noted the measure is currently in use by state Medicaid plans reporting data to HEDIS. According to a November 2021 NCQA report, 103 Medicaid plans reported results for AIS to NCQA for measurement year (MY) 2020, an increase from 62 plans for MY 2019.[1] NCQA indicated that the following states had at least one health plan submission to NCQA for the AIS measure in 2021:

	Colorado, Delaware, District of Columbia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Nebraska, Rhode Island, Utah, West Virginia, Georgia, Missouri, Ohio, Arizona, Hawaii, Kansas, New Jersey, South Carolina, Tennessee, Florida, Massachusetts, Virginia, Michigan, Washington, California, Pennsylvania, Texas, Wisconsin, and New York. The WGM indicated this measure will be publicly reported beginning with MY 2022 data (corresponding to the 2023 Core Set). Public reporting of a measure using ECDS reporting is a critical step in the use of clinical data systems to measure quality. The WGM stated that using and sharing clinical data will enrich the information available to patients, providers, and health plans. Measures that leverage clinical data captured routinely during care delivery can also reduce the burden on providers to collect data for quality reporting.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM stated that the data required for measure reporting is expected to be available in existing data sources. Immunization doses and administration are identified by nationally standardized sets of codes (CVX, CPT, HCPCS), which have previously been cross-walked so that if different plans choose to use different code sets, calculations can easily be standardized. The November 2021 NCQA report indicates that performance rates for this measure varied by data sources used for reporting, with plans that used claims only having lower performance rates than plans that used any non-claims data.[2]

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM stated national surveillance data show coverage for recommended adult vaccines is generally lower for adults with public health insurance compared to privately insured adults. Use of this measure would help Medicaid programs increase vaccination in their adult beneficiary populations and reduce that disparity.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that NCQA is adding race and ethnicity stratification for five HEDIS ECDS measures in MY 2022. The WGM noted that *Adult Immunization Status* was not one of the five measures selected for race and ethnicity stratification in 2022. However, the HEDIS MY 2022 specifications include general guidance on how plans may stratify measures by race and ethnicity. Race and ethnicity stratification of this measure is currently voluntary within HEDIS. NCQA has proposed adding a required race/ethnicity stratification to this measure beginning in HEDIS MY 2023.[3] This proposed change is pending stakeholder feedback. Note that NCQA requires plans that stratify by race and ethnicity to report the data using the categories defined by the Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM indicated that national surveillance data show coverage for recommended adult vaccines is generally lower for adults with public health insurance compared to privately insured adults. The WGM commented that the inclusion of this measure in the Adult Core Set and potential incorporation into state-managed integrated care models would not only help states to enhance monitoring of adult immunization coverage, but also could reduce morbidity and mortality from vaccine-preventable diseases across the lifespan. As there are corresponding indicators of influenza and zoster vaccination in Healthy People 2030, states can utilize this measure as a benchmark when considering the development of state health plans in support of national targets for adult immunization uptake. For example, 50 percent of adults age 18 and older reported receiving an influenza vaccine during the 2020–2021 flu season, which is 20 percentage points lower than the Healthy People 2030 target of 70 percent influenza vaccination for all persons age 6 months and older.[4]
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM stated that receipt of recommended vaccinations is a critically important intervention to protect the health of adults and reduce illness and death from vaccine-preventable diseases. Over one million people develop herpes zoster in the United States each year, and the lifetime risk of zoster without vaccination is one in three.[5] There are currently no measures of Td/Tdap or zoster vaccines in the Adult Core Set. This measure would help drive improvement of receipt of these critically important vaccines and prevent unnecessary illness. The WGM added that, in addition to influenza, the Advisory Committee on Immunization Practices (ACIP) recommended Td/Tdap and herpes zoster vaccines at various ages for routine adult immunization. However, many adults have not been assessed nor offered ACIP-recommended vaccines, resulting in poor health outcomes and low adult immunization coverage nationally.
How measure can be used to monitor improvement	The WGM noted that the only immunization-related measure in the Adult Core Set is *Flu Vaccination for Adults Ages 18-64* (FVA-AD). Addition of the *Adult Immunization Status* (AIS) measure to the Adult Core Set would close a significant gap in states' ability to monitor uptake of all routinely-recommended adult vaccines in their beneficiary populations. In conjunction with the existing child and adolescent immunization measures in the Child Core Set, this measure can ensure the availability of protection of Medicaid beneficiaries from vaccine-preventable diseases across the lifespan.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM noted that coverage is lower for publicly insured than privately insured adults for each vaccine by insurance type.[6,7] Fifty percent of adults age 18 and older reported receiving an influenza vaccine during the 2020–2021 flu season (compared with the 2019–2020 estimate of 48 percent by the end of May 2020).[8,9]

Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM noted that in 2019 and 2020, NCQA interviewed health plans that have begun reporting HEDIS measures using the ECDS reporting standard. NCQA published an issue brief on strategies to advance the collection and use of clinical data for improving care and quality measurement.[10] NCQA also produced a report summarizing HEDIS reporting results for eight measures that use the ECDS reporting standard, including the *Adult Immunization Status* measure.[11] The WGM indicated that challenges were primarily related to standardized data capture at the point of care and efficient sharing of relevant information between health care systems. NCQA identified communication, provider education, and resources and tools as helpful to facilitate reporting.
Summary of prior Workgroup discussions	During the 2020 Child and Adult Core Set Annual Review, this measure was discussed by the Workgroup but not recommended for addition to the 2020 Core Sets. The *Adult Immunization Status* measure was suggested for addition because it includes more vaccines than the current immunization measure (FVA-AD) and would help states monitor appropriate adult immunization use beyond influenza. The Workgroup discussed the accuracy and reliability of the data needed for immunization measures, many of which rely on administrative data that may be incomplete for people who cycle in and out of Medicaid plans. Furthermore, because influenza vaccines can be administered in a variety of settings, data on them might be incomplete. Workgroup members noted that while all states have immunization registries, there is considerable variability in their completeness. During the 2021 Child and Adult Core Set Annual Review, this measure was discussed by the Workgroup again and not recommended for addition to the 2021 Core Sets. This measure was suggested to replace the FVA-AD measure because it includes more vaccines than the existing FVA-AD measure and would help states reduce immunization rate disparities within their Medicaid populations. The Workgroup discussed variability in state Medicaid programs' coverage of the vaccines included in the measure specifications. Workgroup members expressed concern about measuring a service that states do not cover, providers cannot get reimbursed for, and beneficiaries do not have access to because they cannot pay. WGMs also expressed concern over states' ability to collect immunization information for the adult population; they noted that all states have immunization registries, but those registries vary considerably in their completeness for adult populations. One WGM questioned the feasibility of identifying the eligible population because each vaccine in the measure has different population and exclusion criteria; the WGM suggested allowing more time for this measure to be operationalized by states before bringing it into the Core Set.

Other	NCQA has proposed changes to the measure for the 2023 measurement year (2024 Core Set). The proposed changes include: • Updates to the Pneumococcal Indicator so that it includes adults 65+ who had any of the following between age 18 and end of measurement period: PCV20, PCV15, PCV13 or PPSV23. – Includes adults with chronic medical conditions – Includes adults with immunocompromising conditions • To address concerns that commercial and Medicaid plans report the measure only for younger adults and Medicare plans report only for older adults, NCQA has proposed that all three product lines report the measure for all adults, in accordance with guidelines. In addition, they proposed adding age stratifications to assess measure performance among members 18 to 64, 65 and older, and all ages combined (total rate). Specifically, all product lines would report the following rates: – Influenza indicator: 18–64, 65 and older, total rate – Td/Tdap indicator: 18–64, 65 and older, total rate – Zoster indicator: 50–64, 65 and older, total rate – Pneumococcal indicator: 65 and older Additional information about the proposed changes to the specifications can be found at: https://www.ncqa.org/wp-content/uploads/2022/02/06.-AIS.pdf. The proposed changes are pending stakeholder feedback.

Citations

[1] https://www.ncqa.org/wp-content/uploads/2021/11/Special-Report-Reporting-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.
[2] https://www.ncqa.org/wp-content/uploads/2021/11/Special-Report-Reporting-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.
[3] https://www.ncqa.org/wp-content/uploads/2022/02/10.-RES.pdf?utm_medium=email&utm_campaign=publiccomment&utm_source=sf&utm_term=20220211.
[4] https://www.cdc.gov/flu/fluvaxview/coverage-2021estimates.htm.
[5] https://www.cdc.gov/shingles/index.html.
[6] https://stacks.cdc.gov/view/cdc/105324.
[7] https://www.cdc.gov/mmwr/volumes/70/ss/ss7003a1.htm.
[8] https://www.cdc.gov/flu/fluvaxview/coverage-2021estimates.htm.
[9] https://www.cdc.gov/flu/fluvaxview/coverage-1920estimates.htm.
[10] https://www.ncqa.org/wp-content/uploads/2021/05/20210526_Issue_Brief_Leveraging_Electronic_Clinical_Data_for_HEDIS.pdf.
[11] https://www.ncqa.org/wp-content/uploads/2021/11/Special-Report-Reporting-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Depression Screening and Follow-Up for Adolescents and Adults**
Description	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: • *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument. • *Follow-Up on Positive Screen.* The percentage of members who received follow-up care within 30 days of a positive depression screen finding.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Meaningful Measures area(s)	Behavioral Health
Measure type	Process
Recommended to replace current measure?	Yes, Screening for Depression and Follow-Up Plan (CDF-CH and CDF-AD)

Technical Specifications	
Ages	12 years of age and older at the start of the Measurement Period. The measure contains three age stratifications and a total rate for the Medicaid population: • Ages 12–17 years. • Ages 18–64 years. • Age 65 years and older. • Total (age 12 and older).
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.)

Denominator	• **Denominator 1 – Depression Screening:** Members 12 years of age and older at the start of the Measurement Period (i.e., on January 1st) who also meet criteria for Participation,* minus exclusions. • **Denominator 2 – Follow-Up on Positive Screen:** All members from Numerator 1 with a positive depression screen finding between January 1 and December 1 of the Measurement Period. *Participation is defined as the identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period, which is the same as the Measurement Period (January 1 – December 31).
Numerator	• **Numerator 1 – Depression Screening:** Members with a documented result for depression screening, using an age-appropriate standardized instrument, performed between January 1 and December 1 of the Measurement Period. • **Numerator 2 – Follow-Up on Positive Screen:** Members who received follow-up care on or up to 30 days after the date of the first positive screen (31 total days). Any of the following on or up to 30 days after the first positive screen: – An outpatient, telephone, e-visit, or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition. – A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition. – A behavioral health encounter, including assessment, therapy, collaborative care, or medication management. – A dispensed antidepressant medication. – Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.** **For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.
Exclusions	Exclude members with any of the following: • Members with bipolar disorder in the year prior to the Measurement Period. • Members with depression that starts during the year prior to the Measurement Period. • Members in hospice or using hospice services any time during the Measurement Period.

Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	According to a November 2021 report from NCQA, the number of Medicaid, commercial, and Medicare plans reporting this measure has increased over the last two years.[1] In Measurement Year (MY) 2019, 50 Medicaid managed care plans submitted reportable data to NCQA on this measure, including 15 plans (30 percent) with non-zero rates. In MY 2020, 90 Medicaid managed care plans submitted reportable data, including 34 plans (38 percent) with non-zero rates. The report does not specify the states with Medicaid plans reporting the measure.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The November 2021 NCQA report shows that, performance rates for this measure varied by data sources used for reporting in MY 2020. All Medicaid plans that used claims-only data to report on depression screening rates had performance rates of zero percent. The mean rate for Medicaid plans that used any non-claims data source was 5.7 percent and the median rate was 0.6 percent.[2] The measure steward (NCQA) noted that the measure assesses receipt of depression screening through the presence of a documented result from a standardized screening instrument and acknowledged that this information is typically captured in clinical records and not in claims data. They commented that the low observed performance rates are likely due to health plans' challenges accessing the clinical data needed to produce a valid rate.[3] According to the Workgroup member (WGM) who suggested the measure, non-claims data such as electronic health records (EHR), case management, or health information exchange (HIE) registry data may not be available across states. Technical assistance may be required to help states connect to HIEs.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that identifying depression and providing early intervention can help address comorbid factors including health conditions and social determinants of health. Depression also impacts social functioning, which impacts overall health for both adolescents and adults. The WGM indicated that when a member is deactivated, there are implications for physical health conditions that can go unaddressed or neglected. Social factors that overwhelm and deactivate members can be addressed with non-clinical resources and interventions.

Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM indicated that the measure is approved in the specifications to stratify by age and by health plan. The HEDIS MY 2022 specifications also include general guidance on how plans may stratify measures by race and ethnicity. Race and ethnicity stratification of this measure is currently voluntary within HEDIS. NCQA has proposed adding a required race/ethnicity stratification to this measure beginning in HEDIS MY 2023.[4] This proposed change is pending stakeholder feedback. Note that NCQA requires plans that stratify by race and ethnicity to report the data using the categories defined by the Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM noted that this measure will help identify depression early and will assist in getting people into follow-up care proactively before they can have a major depressive episode.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM cited evidence for the effectiveness of conducting depression screenings in the primary care setting and providing early intervention for depression.[5,6,7] This includes the U.S. Preventive Services Task Force assessment of moderate certainty that there is a net benefit to screening for depression in adults in clinical practices, given adequate systems to ensure accurate diagnosis, treatment, and follow-up.
How measure can be used to monitor improvement	According to the WGM, this measure can be used to ensure populations are screened for depression at a higher rate than they are currently. State Medicaid and CHIP programs can trend this measure over time. The WGM noted that, according to the data released in NCQA's November 2021 report, there is room for improvement on the measure. Finally, they indicated that providers and state programs can work with patients to ensure proper care is received.[8]

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	Nationally, according to the National Survey on Drug Use and Health, approximately 17.0 percent of adolescents ages 12 to 17 and 8.4 percent of adults age 18 and older reported that they experienced a major depressive episode in 2020. Among adolescents and adults with Medicaid or CHIP coverage, these percentages were 14.7 and 12.9 percent, respectively.[9] According to the WGM, depression rates (as indicated through the use of positive screening codes) have increased over the last three years in their state.

Use of measure in other CMS programs	• Medicaid Promoting Interoperability Program for Eligible Professionals • Merit-based Incentive Payment System (MIPS) Program • Care Compare
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM reiterated that a potential barrier states could face is lack of access to EHR or HIE registry data, since calculating the measure using only claims data results in rates of zero. Technical assistance could help facilitate the connections between the state and their HIEs.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.ncqa.org/wp-content/uploads/2021/11/Special-Report-Reporting-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.
[2] https://www.ncqa.org/wp-content/uploads/2021/11/Special-Report-Reporting-Results-for-Measures-Leveraging-Electronic-Clinical-Data-for-HEDIS.pdf.
[3] Health Plans Struggle to Report on Depression Quality Measures That Require Clinical Data: https://pubmed.ncbi.nlm.nih.gov/34648936/.
[4] https://www.ncqa.org/wp-content/uploads/2022/02/10.-RES.pdf?utm_medium=email&utm_campaign=publiccomment&utm_source=sf&utm_term=20220211.
[5] https://www.ahrq.gov/prevention/resources/depression/depsum1.html.
[6] https://www.cdc.gov/workplacehealthpromotion/health-strategies/depression/interventions/benefits.html.
[7] https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/depression-in-adults-screening.
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5835676/.
[9] https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables (Table 9.6B and Table 8.40B).

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Lead Screening in Children**
Description	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Meaningful Measures area(s)	Wellness and Prevention
Measure type	Intermediate Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children who turn 2 years old during the measurement year.
Data collection method	Administrative or hybrid.
Denominator	Children who turn 2 years old during the measurement year.
Numerator	At least one lead capillary or venous blood test on or before the child's second birthday as documented through either administrative data or medical record review. The measure steward indicated that state blood lead registry data are considered an acceptable data source to assess numerator compliance if the data meet the requirements in HEDIS Volume 2 and audit requirements.
Exclusions	Exclude members in hospice or using hospice services any time during the measurement year.
Continuous enrollment period	The member must be continuously enrolled with no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	As of 2018, the following states were using the HEDIS measure to promote lead screening within their Medicaid managed care organizations: DC, DE, IN, KY, LA, MA, NE, NV, NJ, NM, NC, OK, RI, and TN.[1] The Workgroup member (WGM) who suggested the measure for addition noted that other states may also use the HEDIS measure, but it was not captured by the 2018 document or they began using the measure after the report was produced. In addition, 11 states included the measure in performance measure validation in their External Quality Review (EQR) Technical Reports for 2020-2021: DC, FL, IA, KY, MI, MS, NE, PA, RI, SC, and WA.[2]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	According to the WGM, states could report the measure using state Medicaid data. No other data would be required, although supplementing the Medicaid data with state blood lead surveillance data would provide a more complete picture.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that lead exposure remains a significant public health concern for some children because of persistent lead hazards in the environment. There is no safe level of lead for children; even at low levels, lead exposure has the potential to have long-term metabolic and neurologic consequences. Ensuring that all at-risk children are tested for blood lead levels would facilitate connecting them to follow-up services. The WGM further indicated that having consistently reported data on the number of children who have been tested for blood lead levels by their second birthday will allow for tracking improvements over time and identifying which states could benefit from targeted interventions to improve screening rates.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that the data could potentially be stratified by race, ethnicity, and other sociodemographic characteristics if these data were included in state Medicaid and CHIP administrative data systems.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM indicated that children who live in low-income households are at higher risk for lead exposure. Low-income is one of the eligibility criteria to qualify for Medicaid and CHIP benefits.

Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	According to the WGM, a recent unpublished CDC analysis found that states that required reporting of metrics, such as HEDIS measures for lead screening, were more likely to have higher testing rates.
How measure can be used to monitor improvement	The WGM cited a 2017 report on state lead screening policies, and found that 45 states and DC stated they follow the federal requirement on testing all Medicaid-enrolled children for blood lead levels at one and two years of age, or between two and six years of age if there is no record of a previous blood lead test.[3] According to the WGM, that report and a 2021 Office of the Inspector General report found that no state achieved 100 percent compliance with Medicaid or state requirements. More than one-third of one million Medicaid-enrolled children in five states did not receive blood lead screening tests as required.[4] Additionally, 20 percent of the children enrolled in Medicaid from birth were never screened by age 3. The WGM noted that there is substantial room for improvement and that the measure for lead screening can be tracked over time to assess performance and progress. State Medicaid and CHIP programs can directly influence improvement by working with state health departments to enact policies that require reporting of lead screening metrics.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	Millions of children are exposed to lead in the United States, and it is estimated that almost 500,000 children ages 1 to 5 (2.5 percent) have a blood lead level equal to or greater than the CDC's blood lead reference value of 3.5 micrograms/dL.[5] Since the start of the COVID-19 pandemic, blood lead screening rates have declined sharply. In a 2021 CDC study, reports from 34 jurisdictions indicated that between January–May 2020, 34 percent fewer children were screened for lead compared with the same period in 2019.[6] The mean Medicaid HMO performance rate on the HEDIS Lead Screening in Children measure was 68.3 percent in 2020.[7]
Use of measure in other CMS programs	Medicaid agencies are required to submit Early and Periodic Screening, Diagnostic and Treatment (EPSDT) data to CMS annually using the Form CMS-416, including the number of blood lead screening tests for children enrolled in Medicaid, from birth to age six. States may use multiple methods to calculate the number of blood lead screening tests provided, one of which is to include data collected from use of the HEDIS blood lead screening measure developed by NCQA. See the 2016 CMS informational bulletin titled "Coverage of Blood Lead Testing for Children Enrolled in Medicaid and the Children's Health Insurance Program" for more information.[8]

Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM noted that state Medicaid programs would need to establish data sharing arrangements with state childhood lead poisoning prevention programs if they wished to supplement their Medicaid claims data with state blood lead surveillance data. According to the WGM, CDC has encouraged state childhood lead poisoning prevention programs to establish data sharing agreements between health departments and Medicaid agencies in order to report on the number of Medicaid-enrolled children receiving blood lead tests. The WGM commented that adding this measure could prompt data exchange discussions to match lead screening data with Medicaid data and increase screening.
Summary of prior Workgroup discussions	This measure was discussed at the 2020 Core Set Annual Review meeting but was not recommended for addition to the 2020 Core Set. Workgroup members raised concerns about data completeness and consistency of calculations across states, especially in states where there is no linkage between state public health and Medicaid data. Workgroup members also discussed differences between lead screening rates when calculated using EPSDT versus HEDIS specifications. Finally, Workgroup members deliberated whether this measure was more appropriate for public health surveillance programs rather than for Medicaid quality measurement.
Other	The measure steward (NCQA) noted that they are considering retiring this measure in the future, since the U.S. Preventive Services Task Force has given universal lead screening of children age five and younger an "Insufficient Evidence" rating.[9] NCQA has not yet determined the timeline for this potential retirement.

Citations

[1] https://www.nashp.org/wp-content/uploads/2018/05/NASHP-Lead-Policy-Scan-5-21-18_updated.pdf.
[2] An External Quality Review (EQR) is the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid and CHIP beneficiaries. The annual EQR results in the generation of an annual EQR technical report. The summary tables for the 2020-2021 EQR reporting cycle are available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2020-2021-chart-pack.zip. See EQR Table 3 for a list of performance measures included in EQR technical reports.
[3] Dickman, 2017. https://saferchemicals.org/wp-content/uploads/2017/01/saferchemicals.org_children-at-risk-report.pdf.
[4] https://oig.hhs.gov/oei/reports/OEI-07-18-00371.pdf.
[5] Ruckart PZ, Jones RL, Courtney JG, et al. Update of the Blood Lead Reference Value —United States, 2021. MMWR Morb Mortal Wkly Rep 2021;70:1509–1512. DOI: http://dx.doi.org/10.15585/mmwr.mm7043a4.
[6] Courtney JG, Chuke SO, Dyke K, et al. Decreases in Young Children Who Received Blood Lead Level Testing During COVID-19 — 34 Jurisdictions, January–May 2020. MMWR Morb Mortal Wkly Rep 2021;70:155–161. DOI: http://dx.doi.org/10.15585/mmwr.mm7005a2.
[7] https://www.ncqa.org/hedis/measures/lead-screening-in-children/.
[8] https://www.medicaid.gov/federal-policy-guidance/downloads/cib113016.pdf.
[9] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/elevated-blood-lead-levels-in-childhood-and-pregnancy-screening.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Adults' Access to Preventive/Ambulatory Health Services**
Description	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Meaningful Measures area(s)	Wellness and Prevention
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	20 years and older as of December 31 of the measurement year. Report three age stratifications and a total rate: • 20–44 years. • 45–64 years. • 65 years and older. • Total (age 20 and older).
Data collection method	Administrative.
Denominator	Members age 20 years and older as of December 31 of the measurement year.
Numerator	One or more ambulatory or preventive care visits during the measurement year.
Exclusions	Exclude members in hospice or using hospice services any time during the measurement year.
Continuous enrollment period	The member must be continuously enrolled with no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who suggested this measure indicated that it had been tested by the measure steward using standard NCQA procedures. Seventeen states included the measure in performance measure validation in their External Quality Review (EQR) Technical Reports for 2020-2021: CO, DC, FL, HI, IA, IL, MI, MN, MS, NE, NV, OH, PA, RI, SC, VA, and WA.[1]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM did not identify any barriers, limitations, or variations.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that this measure assesses whether adult health plan members had a preventive or ambulatory visit to their physician. It aligns with a CMS health care priority: Working with Communities to Promote Wide Use of Best Practices to Enable Healthy Living.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM was not aware of whether the data source would allow for stratification by racial, ethnic, and sociodemographic characteristics.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	According to the WGM, health care visits are an opportunity for individuals to receive preventive services and counseling on topics such as diet and exercise. These visits also can help them to address acute issues or manage chronic conditions.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM cited the proposed inclusion of this measure in the Marketplace Quality Rating System measure set as evidence for its ability to drive improvement;[2] however, the measure was not supported for inclusion.[3] The WGM also referenced the Medicaid webpage on preventive health care services and improvement initiatives.[4]
How measure can be used to monitor improvement	According to the WGM, wellness visits can subsequently reduce emergency department (ED) visits. There is room for improvement and data are trendable over time. The WGM noted that states can influence improvement by utilizing levers such as managed care organization (MCO) contracts and other initiatives.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The measure steward does not report performance rates for this measure for Medicaid and CHIP beneficiaries.
Use of measure in other CMS programs	No other programs listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	No potential barriers indicated by the WGM.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	The measure steward (NCQA) indicated that they are considering digitalizing this measure (i.e., adding Clinical Quality Language specifications) during a future reporting cycle.

Citations

[1] An External Quality Review (EQR) is the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid and CHIP beneficiaries. The annual EQR results in the generation of an annual EQR technical report. The summary tables for the 2020-2021 EQR reporting cycle are available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2020-2021-chart-pack.zip. See EQR Table 3 for a list of performance measures included in EQR technical reports.

[2] https://www.federalregister.gov/documents/2013/11/19/2013-27649/patient-protection-and-affordable-care-act-exchanges-and-qualified-health-plans-quality-rating#p-62.

[3] https://www.qualityforum.org/Publications/2014/01/MAP_HIX_QRS_Final_Report.aspx.

[4] https://www.medicaid.gov/medicaid/benefits/prevention/index.html.

Care of Acute and Chronic Conditions

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis**
Description	The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0058
Core Set domain	Care of Acute and Chronic Conditions
Meaningful Measures area(s)	Affordability and Efficiency
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 3 months and older as of the episode date. The measure includes three age stratifications and a total rate: • 3 months–17 years. • 18–64 years. • 65 years and older. • Total (3 months and older). Note: This measure was added to the 2022 Adult Core Set for adults age 18 and older as of the episode date. The measure is being suggested for addition to the Child Core Set for children ages 3 months to 17 years as of the episode date.
Data collection method	Administrative.
Denominator	Episodes for members 3 months of age and older as of the episode date who had an outpatient, telephone, e-visit or virtual check-in, an observation visit, or ED encounter with a diagnosis of acute bronchitis/bronchiolitis during the intake period.
Numerator	Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the episode date.
Exclusions	Exclude episodes with the following: • Outpatient, observation, or ED visits that result in an inpatient stay. • Diagnosis for a comorbid condition during the 12 months prior to or on the episode date.

	• A new or refill prescription for an antibiotic medication filled 30 days prior to the episode date. • A claim/encounter with a competing diagnosis on or 3 days after the episode date. • A previous eligible episode in a 31-day period. Exclude members in hospice or using hospice services any time during the measurement year from the eligible population.
Continuous enrollment period	The member must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through 3 days after the episode date (34 total days).
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who nominated this measure stated that the measure has been used by state Medicaid programs and state public health departments to target antibiotic improvement activities and provide clinician feedback. The WGM noted this measure is currently specified for health-plan level reporting, and the commercial, Medicaid, and Medicare product lines. According to the WGM, the Utah Department of Health, Office of Health Care Statistics utilizes their state All Payers Claims Database to publicly report performance by clinic on quality measures and has included this measure since 2016.[1] New Hampshire,[2] Michigan,[3] and Colorado[4] are also using this measure in their Medicaid/CHIP programs. In addition, nine states included the measure in performance measure validation in their External Quality Review (EQR) Technical Reports for 2020-2021: CO, DC, IA, KY, MI, MS, PA, SC, and VA.[5]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM indicated that the specifications and data source allow for consistent calculations across states.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted states can use this measure to promote appropriate outpatient antibiotic prescribing by providing data to health care providers on their performance on this measure compared with the goal performance and their peer providers who are top performers on this measure. Audit and feedback on antibiotic prescribing is an evidence-based strategy to promote adherence to national guidelines and is recommended in CDC's Core Elements of Outpatient Antibiotic Stewardship.[6] The WGM also indicated that state Medicaid programs can partner with state public health departments to deliver tools and interventions to improve antibiotic use to providers with opportunities to improve performance on this measure. CDC's 6 |18 Initiative recommends audit-and-feedback using this quality measure as an intervention to improve antibiotic use.[7]
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM indicated data would need to be analyzed in parallel with additional information to allow for stratification.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM stated this measure helps quantify the over-prescribing of antibiotics for a common condition for which antibiotics are not indicated. By quantifying this prescribing, health care delivery systems have a benchmark that they can use to work toward quality improvement for their beneficiaries. The WGM also stated that Medicaid and CHIP beneficiaries are particularly vulnerable to COVID-19 infection. The majority of human antibiotic use, an estimated 85-95 percent by volume, occurs among outpatients. CDC estimates that at least 30 percent of outpatient antibiotic use is unnecessary, meaning no antibiotic was needed at all.[8] The WGM also noted that respiratory infections, including acute bronchitis/bronchiolitis, a common syndrome among patients with COVID-19, are key drivers of unnecessary antibiotic use. However, the Child Core Set does not address the appropriate use of antibiotics. The WGM stated this HEDIS measure addresses this key gap by addressing one of the major drivers of unnecessary antibiotic use in the outpatient setting.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM noted that nearly 60 percent of pediatric bronchitis and bronchiolitis visits to emergency departments and physician offices lead to an antibiotic prescription.[9] The WGM added that several studies have shown that interventions aimed at providers improve antibiotic use for respiratory conditions.[10]
How measure can be used to monitor improvement	The WGM noted that data for the previous version of the measure (focused on adults) are available starting in 2006 on the NCQA website.[11] In the future, with the expansion of the measure to include children, state Medicaid and CHIP programs can assess improvement in appropriate outpatient antibiotic use among children.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	Bronchitis and bronchiolitis are common acute respiratory infections. Although antibiotics are not indicated for these conditions, almost 60 percent of children presenting to EDs and physician offices receive antibiotics for these conditions, as do almost half of adults, suggesting the prevalence of inappropriate antibiotic prescriptions for bronchitis and bronchiolitis is quite high.[12,13,14]
Use of measure in other CMS programs	• Merit-Based Incentive Payment System (MIPS) Program • Marketplace Quality Rating System (QRS) • Care Compare • Core Quality Measures Collaborative (CQMC) Accountable Care Organizations/Patient Centered Medical Homes/Primary Care
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM noted as with any measure using claims data, analytic expertise and familiarity with claims data methods and limitations are required to calculate the measure.
Summary of prior Workgroup discussions	During the 2020 Child and Adult Core Set Annual Review, this measure was discussed but not recommended for addition to the 2020 Core Sets. Workgroup members noted the importance of the measure for combating inappropriate antibiotic use. However, Workgroup members raised concerns about the measure methodologies, including whether the conditions are coded accurately in administrative data, and whether changes in coding practices could be mistaken for quality improvement. The measure was discussed again during the 2022 Child and Adult Core Set Annual Review and the Workgroup recommended the measure for addition to the 2022 Core Sets. Workgroup members discussed that the measure encourages avoidance of unnecessary antibiotics. However, some Workgroup members raised concerns about lack of data and experience reporting the measure for the expanded child age group (until MY 2018, the measure was specified for adults only). CMS added the measure to the 2022 Adult Core Set for the adult age group but did not add the measure to the 2022 Child Core Set for the child age group.

Citations

[1] https://opendata.utah.gov/Health/2016-2015-Clinic-Quality-Comparisons-for-Clinics-w/35s3-nmpm.
[2] https://medicaidquality.nh.gov/reports/avoidance-of-antibiotic-treatment-for-acute-bronchitis-bronchiolitis-aab-1.
[3] https://www.michigan.gov/documents/mdhhs/2020_HEDIS_Aggregate_Report_for_Michigan_Medicaid_F1_706165_7.pdf.
[4] https://hcpf.colorado.gov/sites/hcpf/files/CO2020_Medicaid_HEDIS-Aggregate_Report_F1.pdf.

[5] An External Quality Review (EQR) is the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid and CHIP beneficiaries. The annual EQR results in the generation of an annual EQR technical report. The summary tables for the 2020-2021 EQR reporting cycle are available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2020-2021-chart-pack.zip. See EQR Table 3 for a list of performance measures included in EQR technical reports.

[6] https://www.cdc.gov/mmwr/volumes/65/rr/rr6506a1.htm?s_cid=rr6506a1_e.

[7] https://www.cdc.gov/sixeighteen/hai/index.htm.

[8] https://www.cdc.gov/antibiotic-use/data/outpatient-prescribing/index.html.

[9] https://pubmed.ncbi.nlm.nih.gov/33059780/.

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3505412/.

[11] https://www.ncqa.org/hedis/measures/avoidance-of-antibiotic-treatment-in-adults-with-acute-bronchitis/.

[12] Ralston SL, Lieberthal AS, Meissner HC, et al. American Academy of Pediatrics. Clinical practice guideline: the diagnosis, management, and prevention of bronchiolitis. Pediatrics. 2014 Nov;134(5):e1474-502. Available at: http://pediatrics.aappublications.org/content/134/5/e1474.long.

[13] Albert RH. Diagnosis and treatment of acute bronchitis. Am Fam Physician. 2010;82(11):1345-50.

[14] Snyder RL, King L, Hersh AL, Fleming-Dutra KE. Unnecessary antibiotic prescribing in pediatric ambulatory care visits for bronchitis and bronchiolitis in the United States, 2006-2015. Infect Control Hosp Epidemiol. 2020 Oct 16;1-4. doi: 10.1017 /ice.2020.1231. Online ahead of print.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Eye Exam for Patients With Diabetes**
Description	The percentage of members 18–75 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 [CDC] measure. Starting with HEDIS MY 2022 [which corresponds to the 2023 Core Set], this is a standalone HEDIS measure.)
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0055
Core Set domain	Care of Acute and Chronic Conditions
Meaningful Measures area(s)	Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 18–75 as of December 31 of the measurement year.
Data collection method	Administrative, hybrid, electronic health records (EHR).
Denominator	Members 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Numerator	Members who received screening or monitoring for diabetic retinal disease. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year • A negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year • Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year For exams performed in the year prior to the measurement year, a result must be available.
Exclusions	Exclude members who meet any of the following: • Do not have a diabetes diagnosis in any setting during the measurement year or year prior AND who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year (required). • In hospice or using hospice services any time during the measurement year (required). • Receiving palliative care during the measurement year (required).

	• Medicare members age 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (optional). • Medicare members age 66 and older living long-term in an institution any time during the measurement year (optional). • Age 66 and older with frailty and advanced illness (optional).
Continuous enrollment period	The measurement year and the year prior to the measurement year. No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	This measure has been reported by Medicaid managed care plans as part of the HEDIS Comprehensive Diabetes Care measure. Plan level data are available at https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The Workgroup member (WGM) indicated that this HEDIS measure is used by managed care organizations (MCOs) across the country and that the data needed are similar to the existing diabetes measure in the Adult Core Set (Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control [>9.0%] [HPC-AD]). The measure steward confirmed that there were no substantial changes to the measure when it was separated into a standalone measure, and therefore they do not anticipate any impact on how the measure is reported. The measure steward has not received any feedback on difficulty obtaining data elements.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that this measure would give a picture of the overall management for a common chronic condition, including complications, as a way to dig deeper than just who isn't managed well. Patterns of performance could indicate strategies for improvement and ways to innovate in case there is a service that is limited. For example, in the absence of ophthalmology, retinal photos could be taken and then reviewed asynchronously by an ophthalmologist, with only the ones that show abnormalities needing to see the specialist for further evaluation and treatment.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that the data source is claims data and some similar HEDIS measures have a provision for stratifying the data by different racial and ethnic groups. However, this measure is not currently specified for race and ethnicity stratification in HEDIS.

How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM stated that diabetes is a chronic condition that is common in adults with disabilities and those living in poverty. The management of diabetes requires more than measuring an HbA1c level and this measure reflects that complexity as well as offers a window into access to these services.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM member provided a link to benchmark results that showed room for improvement.[1] Medicaid plans reported 50.6 percent of members with diabetes had eye exams in measure year 2020, compared to 57.2 percent in measure year 2019.
How measure can be used to monitor improvement	The WGM noted that the benchmark data show that these data can be trended over time and one can see progress in performance. It can be used to identify lack of access to services or specialists. Better diabetes control may be attainable and people with the condition may become more aware of the complications as they would be sent for testing and consultations to evaluate the impact of their diabetes and further their understanding of the importance of good home management of their blood sugars.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM cited a CDC resource showing that 28.7 million people in the US had diagnosed diabetes in 2019.[2] Furthermore, a meta-analysis of data from 2010 to 2016 estimated 7.5-12.7 percent of adult Medicaid beneficiaries had diabetes.[3] Additionally, according to the CDC, there were more than 17 million emergency department visits with diabetes as any listed diagnosis in 2018.[4]
Use of measure in other CMS programs	• Merit-Based Incentive Payment System (MIPS) Program • Marketplace Quality Rating System (QRS)
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM did not note any barriers, indicating that the measure is already in use in Medicare, and Medicaid reporting entities would be able to calculate the measure using existing data.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/#:~:text=Eye%20Exams%20%20%20%20Measure%20Year%20,%20%2069.6%20%2017%20more%20rows%20.

[2] https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-diabetes.html.

[3] https://pubmed.ncbi.nlm.nih.gov/29153115/.

[4] https://www.cdc.gov/diabetes/data/statistics-report/coexisting-conditions-complications.html.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Blood Pressure Control for Patients With Diabetes**
Description	The percentage of members 18–75 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 [CDC] measure. Starting with HEDIS MY 2022 [which corresponds to the 2023 Core Set], this is a standalone HEDIS measure.)
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0061
Core Set domain	Care of Acute and Chronic Conditions
Meaningful Measures area(s)	Chronic Conditions
Measure type	Intermediate Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 18–75 as of December 31 of the measurement year.
Data collection method	Administrative, hybrid, electronic health records (EHR).
Denominator	Members 18–75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Numerator	Members whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.
Exclusions	Exclude members who meet any of the following: • Do not have a diabetes diagnosis in any setting during the measurement year or year prior AND who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year (required). • In hospice or using hospice services any time during the measurement year (required). • Receiving palliative care during the measurement year (required). • Medicare member age 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (optional). • Medicare member age 66 and older living long-term in an institution any time during the measurement year (optional). • Age 66 and older with frailty and advanced illness (optional).
Continuous enrollment period	The measurement year and the year prior to the measurement year. No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.

Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	This measure has been reported by Medicaid managed care plans as part of the HEDIS Comprehensive Diabetes Care measure. Plan level data are available at https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The Workgroup member (WGM) indicated that this HEDIS measure is used by managed care organizations (MCOs) across the country and that the data needed are similar to the existing diabetes measure in the Adult Core Set (Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control [>9.0%] [HPC-AD]). The measure steward confirmed that there were no substantial changes to the measure when it was separated into a standalone measure, and therefore they do not anticipate any impact on how the measure is reported. The measure steward has not received any feedback on difficulty obtaining data elements.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that this measure would give a picture of the overall management for a common chronic condition, including complications, as a way to dig deeper than just who isn't managed well. Patterns of performance could indicate strategies for improvement and ways to innovate in case there is a service that is limited.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that the data source is claims data and some similar HEDIS measures have a provision for stratifying the data by different racial and ethnic groups. However, this measure is not currently specified for race and ethnicity stratification in HEDIS.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM stated that diabetes is a chronic condition that is common in adults with disabilities and those living in poverty. The management of diabetes requires more than measuring an HbA1c level and this measure reflects that complexity as well as offers a window into access to these services.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM member provided a link to benchmark results that showed room for improvement.[1] Medicaid plans reported 58.2 percent of members with diabetes had blood pressure control in measure year 2020, compared to 62.1 percent in measure year 2019.

How measure can be used to monitor improvement	The WGM noted that the benchmark data show that these data can be trended over time and one can see progress in performance. It can be used to identify lack of access to services or specialists. Better diabetes control may be attainable and people with the condition may become more aware of the complications as they would be sent for testing and consultations to evaluate the impact of their diabetes and further their understanding of the importance of good home management of their blood sugars. It also puts further emphasis on blood pressure which is a complicator of diabetes as well as a condition in and of itself that leads to complications of heart disease, stroke, and kidney failure.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM cited a CDC resource showing that 28.7 million people in the US had diagnosed diabetes in 2019.[2] Furthermore, a meta-analysis of data from 2010 to 2016 estimated 7.5-12.7 percent of adult Medicaid beneficiaries had diabetes.[3] Additionally, according to the CDC, there were more than 17 million emergency department visits with diabetes as any listed diagnosis in 2018.[4]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM did not note any barriers, indicating that the measure is already in use in Medicare, and Medicaid reporting entities would be able to calculate the measure using existing data.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/#:~:text=Eye%20Exams%20%20%20%20Measure%20Year%20,%20%2069.6%20%2017%20more%20rows%20.

[2] https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-diabetes.html.

[3] https://pubmed.ncbi.nlm.nih.gov/29153115/.

[4] https://www.cdc.gov/diabetes/data/statistics-report/coexisting-conditions-complications.html.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Kidney Health Evaluation for Patients With Diabetes**
Description	The percentage of members 18–85 years of age with diabetes (types 1 and 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Care of Acute and Chronic Conditions
Meaningful Measures area(s)	Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 18–85 as of December 31 of the measurement year.
Data collection method	Administrative.
Denominator	Members 18–85 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
Numerator	Members who received both an eGFR and a uACR during the measurement year on the same or different dates of service.
Exclusions	Exclude members who meet any of the following: • With evidence of ESRD or dialysis any time during the member's history (required). • In hospice or using hospice services any time during the measurement year (required). • Receiving palliative care during the measurement year (required). • Do not have a diabetes diagnosis in any setting during the measurement year or year prior AND who had a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year (optional). • Medicare member age 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year (optional). • Medicare member age 66 and older living long-term in an institution any time during the measurement year (optional). • Age 66 and older with frailty and advanced illness (optional). • Age 81 and older with frailty during the measurement year (optional).

Continuous enrollment period	The measurement year and the year prior to the measurement year. No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2022 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	This measure is used by Medicaid managed care plans in various states, including Pennsylvania.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The Workgroup member (WGM) indicated that this HEDIS measure is used by MCOs across the country and that the data needed are similar to the existing diabetes measure in the Adult Core Set (Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control [>9.0%] [HPC-AD]). The measure steward indicated that they have not received any feedback on difficulty obtaining data elements for this administrative measure.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that this measure would give a picture of the overall management for a common chronic condition, including complications, as a way to dig deeper than just who isn't managed well. Patterns of performance could indicate strategies for improvement and ways to innovate in case there is a service that is limited.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that the data source is claims data and some similar HEDIS measures have a provision for stratifying the data by different racial and ethnic groups. However, this measure is not currently specified for race and ethnicity stratification in HEDIS.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM stated that diabetes is a chronic condition that is common in adults with disabilities and those living in poverty. The management of diabetes requires more than measuring an HbA1c level and this measure reflects that complexity as well as offers a window into access to these services.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM member provided a link to benchmark results that showed room for improvement for other measures of care for individuals with diabetes.[1] However, benchmark results are not available for this measure.

How measure can be used to monitor improvement	The WGM noted that this measure can be used to identify lack of access to services or specialists. Better diabetes control may be attainable and people with the condition may become more aware of the complications as they would be sent for testing and consultations to evaluate the impact of their diabetes and further their understanding of the importance of good home management of their blood sugars. It also puts further emphasis on kidney health, which is a complicator of diabetes as well as a condition in and of itself that leads to complications of heart disease, stroke, and kidney failure.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM cited a CDC resource showing that 28.7 million people in the US had diagnosed diabetes in 2019.[2] Furthermore, a meta-analysis of data from 2010 to 2016 estimated 7.5-12.7 percent of adult Medicaid beneficiaries had diabetes.[3] Additionally, according to the CDC, there were more than 17 million emergency department visits with diabetes as any listed diagnosis in 2018.[4]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM did not note any barriers.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.ncqa.org/hedis/measures/comprehensive-diabetes-care/#:~:text=Eye%20Exams%20%20%20%20Measure%20Year%20,%20%2069.6%20%2017%20more%20rows%20.

[2] https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-diabetes.html.

[3] https://pubmed.ncbi.nlm.nih.gov/29153115/.

[4] https://www.cdc.gov/diabetes/data/statistics-report/coexisting-conditions-complications.html.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**
Description	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: • *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 • *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 • *Population 3.* Patients ages 40 to 75 years with a diagnosis of diabetes
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Care of Acute and Chronic Conditions
Meaningful Measures area(s)	Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	• **Population 1:** All ages. • **Population 2:** Age 20 years and older at the beginning of the measurement period. • **Population 3:** Ages 40 to 75 years at the beginning of the measurement period.
Data collection method	Electronic health records (EHR) or clinical registry.
Denominator	• **Population 1**: All patients who were previously diagnosed with or currently have an active diagnosis of clinical ASCVD, including an ASCVD procedure. • **Population 2**: Patients age 20 years and older at the beginning of the measurement period who have ever had a laboratory result of LDL-C at or above 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia. • **Population 3**: Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes.

	This measure is intended to have one reporting rate, which aggregates all three populations into a single performance rate for reporting purposes.
Numerator	Patients who are actively using or who receive an order (prescription) for statin therapy at any time during the measurement period.
Exclusions	Exclude patients with any of the following: • Patients who have a diagnosis of pregnancy at any time during the measurement period. • Patients who are breastfeeding at any time during the measurement period. • Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period. Exclude patients with any of the following *only* if the patients do not meet the criteria for inclusion in the numerator: • Patients with statin-associated muscle symptoms or an allergy to statin medication. • Patients who are receiving palliative or hospice care. • Patients with active liver disease or hepatic disease or insufficiency. • Patients with end-stage renal disease (ESRD).
Continuous enrollment period	None.
Level of reporting for which specifications were developed	Provider-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	Specifications for the eCQM version of the measure are available at: https://ecqi.healthit.gov/ecqm/ep/2022/cms347v5 Specifications for the MIPS clinical registry version of the measure are available at: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2022_Measure_438_MIPSCQM.pdf
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who nominated this measure noted that the measure has gone through extensive testing, per CMS requirements for e-specifications. Texas currently uses the Merit-based Incentive Payment System (MIPS) version of this measure in its Delivery System Reform Incentive Payment (DSRIP) program.[1] The 38 clinics and hospitals participating in the DSRIP program report the measure to the Texas Health and Human Services Commission (TX HHSC) on the provider level, typically using their EHRs as the data source. TX HHSC publicly reports the measure results, which are stratified by provider and by payer, on their website.[2] The median Medicaid performance rate on the measure among TX's DSRIP providers was 73.6 percent in performance year 3 (ending 12/30/2020).[3]

	The MIPS Performance Year 2022 historical benchmark data show a mean performance rate of 82.95 percent for the CQM version of the measure, and 71.54 percent for the eCQM version of the measure.[4]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM noted that the data source for this measure is electronic health records. Diagnosis codes, lab values, prescription information, and demographic data are needed for this measure. The WGM did not describe any barriers or limitations in the required data source and data elements for calculating this measure. There is also a clinical registry version of the measure specifications available for use within the MIPS program. MIPS clinical registry-based measures typically require manual review and abstraction from the medical record.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM stated that 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). The WGM noted that this measure is included in the Million Hearts initiative as one of four nationally supported clinical quality measures known as the "ABCs" of cardiovascular health. The WGM stated that statin use is a major factor in cardiovascular disease prevention. In a recent analysis, study authors estimated that 25.2 million people ages 35-64 are recommended to be taking a statin, according to clinical guidelines, but are not, putting them at a greatly increased risk of having an atherosclerotic cardiovascular event (ASCVD).[5] An unknown proportion are Medicaid beneficiaries.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM explained that the data source for this measure is electronic health records which, theoretically, collect data on race, ethnicity, and socioeconomic status; however, those data are not collected as part of this clinical quality measure at this time.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM indicated that states that adopt this measure can use it to drive improvements in quality of care and beneficiary outcomes in a number of ways. States can examine the results at different levels of aggregation (e.g., overall and by MCO, health system, clinic, and even individual provider levels) and use these results to identify potential opportunities for targeted outreach and technical assistance to drive performance improvement. The WGM also suggested that states can compare their performance (overall and at different levels of aggregation, as desired) to that of their state peers and use differences to potentially identify higher-performing states from whom they might learn best practices for improving statin therapy implementation across their Medicaid-enrolled populations.

	Finally, states can use changes in performance over time to evaluate the effectiveness of specific performance or quality improvement activities and initiatives. States could further incentivize efforts to translate measured performance into measured improvements by adopting the statin measure as part of the quality measures they use to structure value-based payments (e.g., incentive payments, whether in the form of withholds or bonuses) for MCOs, ACOs, etc. The WGM indicated that because the measure is an eCQM and has been validated at the provider/clinic level, states have an opportunity to simultaneously roll it out at multiple (and ideally mutually reinforcing) levels, including provider, clinic, system, plan, and state.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM indicated according to the latest clinical guidelines for managing blood cholesterol and supported by numerous randomized controlled trials and meta-analyses, a lowering of LDL-C levels of one percent gives about a one percent reduction in the risk of ASCVD — slightly more at higher baseline LDL-C levels and slightly less at lower baseline levels.[6] According to the WGM, high-intensity and moderate-intensity statins lower LDL cholesterol values by 50 or more percent and 30-49 percent, respectively. The WGM noted that even low-intensity statins lower LDL-C values. Thus, the WGM suggests that being on a statin of any kind or intensity has the ability to reduce risk of ASCVD events and associated morbidity and mortality. The WGM mentioned that heart disease and stroke are the first and fifth leading causes of death, respectively, in the U.S. Studies show that, despite prior decades-long declines in heart disease mortality, from 2010 to 2017 heart disease mortality increased among adults ages 35 to 64 years in almost 70 percent of counties in the U.S.[7] The WGM noted that a similar trend can be seen in stroke mortality; from 2010-2016, stroke mortality increased among adults ages 35 to 64 years in 61 percent of counties in the U.S.[8] For people at high risk of having an ASCVD event, including heart attacks and strokes, taking a high- or moderate-intensity statin, as appropriate, can greatly reduce risk of having a primary or secondary event. The WGM concluded because of their generic status, statins are relatively inexpensive and readily available, making this highly effective cardiovascular risk reduction strategy accessible to many and an intervention that states should be tracking.
How measure can be used to monitor improvement	The WGM explained that in a recent analysis of National Health and Nutrition Examination Survey (NHANES) data, over 25 million adults ages 35-64 were not taking a statin as recommended. An unknown proportion are Medicaid beneficiaries.

	The WGM indicated that the CDC is currently working on a project with several health centers, in conjunction with the National Association of Community Health Centers, to find at-risk patients who could benefit from being on a statin but are not currently taking one. At the beginning of the current project year, there were over 15,000 high-risk patients from 23 health centers who could benefit from taking a statin but were not taking one. More broadly, HRSA Uniform Data System (UDS) data on this measure show only 70 percent performance across all health centers in 2019.[9] The WGM suggested that many of these patients are Medicaid beneficiaries, given that almost 50 percent of patients seen by health centers are Medicaid/CHIP beneficiaries.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM noted the lack of prevalence data among Medicaid beneficiaries. There are 25.2 million people in the U.S. ages 35-64 who are not currently taking a statin though it is recommended they do so. HRSA UDS data shows that about 30 percent of their pertinent high-risk adult population is not currently taking a statin.[10]
Use of measure in other CMS programs	• Merit-Based Incentive Payment System (MIPS) Program • Medicare Shared Savings Program • Care Compare • Million Hearts[11] According to the WGM, Million Hearts has worked with partners to have this measure included in a variety of other quality reporting initiatives. The WGM pointed out that the measure is included in the MIPS Program, HRSA Uniform Data System, and the Indian Health Service (IHS) Patient Management System.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM acknowledged that access to all needed components of electronic health record data could be a barrier for states. However, many states have Health Center Controlled Networks and other health information exchanges or clinical data repositories that could assist.
Summary of prior Workgroup discussions	This measure was discussed during the 2020 Child and Adult Core Set Annual Review meeting but was not recommended by the Workgroup for inclusion in the 2020 Core Sets. The measure was suggested for addition given the high prevalence of cardiovascular disease and the relative availability and affordability of statins. Discussion of the measure centered on concerns that the measure assessed whether a statin was ordered, rather than whether it was filled or taken. As with other EHR and registry-based measures, Workgroup members also raised concerns about feasibility due to limited access to the necessary data at the state level.

	The measure was suggested again during the 2022 Child and Adult Core Set Annual Review; however, it was not reviewed by the Workgroup because Mathematica was unable to find evidence that the measure had been field tested in Medicaid and CHIP, and therefore determined that it did not meet the minimum technical feasibility requirements for consideration by the Workgroup. (Note that these criteria were specified beginning with the 2021 Child and Adult Core Set Annual Review.)
Other	To align with the 2019 American College of Cardiology (ACC)/American Heart Association (AHA) Guideline on the Primary Prevention of Cardiovascular Disease, CMS is exploring adding a fourth measure population to capture patients that are at risk for ASCVD.

Citations

[1] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/dy7-10-final-mbp.pdf.
[2] https://www.hhs.texas.gov/regulations/policies-rules/waivers/medicaid-1115-waiver/rhp-summary-information.
[3] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/catc-rhp-summary-workbook-20210611.xlsx.
[4] https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2022.
[5] Wall HK, Ritchey MD, et al. Vital Signs: Recent Prevalence of Key Cardiovascular Disease Risk Factors for Million Hearts 2022 — 2011–2016. MMWR. 2018; 67(35);983–991.
[6] Grundy SM, et al. J Am Coll Cardiol. 2019 Jun 25;73(24):e285-e350.
[7] Ritchey MD, Wall HK, George MG, Wright JS. US trends in premature heart disease mortality over the past 50 years: Where do we go from here? Trends in Cardiovasc Med. 2020 Aug;30(6):364–374.
[8] Hall EW, Vaughan AS, Ritchey MD, Schieb L, Casper M. Stagnating National Declines in Stroke Mortality Mask Widespread County-Level Increases, 2010–2016. Stroke. 2019;50:3355–3359.
[9] https://data.hrsa.gov/tools/data-reporting/program-data/national#fn17.
[10] https://data.hrsa.gov/tools/data-reporting/program-data/national#fn17.
[11] https://millionhearts.hhs.gov/data-reports/measures.html.

Long-Term Services and Supports

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Long-Term Services and Supports: Shared Care Plan with Primary Care Physician**
Description	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.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Meaningful Measures area(s)	Person-Centered Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older as of December 31 of the measurement year.
Data collection method	Case management record review.
Denominator	This measure is based on review of LTSS case management records drawn from a sample of the eligible population. The minimum required sample size is 96 members identified using a systematic sampling methodology.
Numerator	Members whose care plan was transmitted to their PCP or to another documented medical care practitioner identified by the member within 30 days of the date when the member agreed to the care plan (31 days total). Documentation must show transmission at least once between August 1 of the year prior to the measurement year and December 31 of the measurement year. Evidence of care plan transmission includes: • To whom the care plan was transmitted. • The date of transmission. • A copy of the transmitted plan or plan sections.
Exclusions	Exclude members who refuse to allow the care plan to be shared. There must be documentation in the record that the member refused to allow the care plan to be shared. Notation of verbal refusal is sufficient.

Continuous enrollment period	Enrollment in the LTSS organization for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For members with multiple distinct continuous enrollment periods during the measurement year, look at the care plan completed in the last continuous enrollment period of 150 days or more during the measurement year.
Level of reporting for which specifications were developed	Medicaid managed LTSS plan-level and LTSS case management organization-level. Any type of organization that provides or coordinates Medicaid-covered LTSS is eligible to report the measure.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2021 and MY 2022 *Technical Specifications for LTSS Measures* for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) noted that the following states are currently using this measure: Florida, Iowa, Indiana, Kentucky, Michigan, New Jersey, Pennsylvania, Tennessee, Texas, and Virginia.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM shared that, while not all state Medicaid agencies dictate a specific assessment tool, all LTSS organizations that participate in NCQA's LTSS Distinction program are required to provide evidence of a sufficient and complete assessment tool that is used to determine the needs of the individuals supported. These assessment tools, be they state ordered or proprietary, are validated by NCQA to ensure compliance with the LTSS Distinctions specifications. These assessments are housed in case management systems that allow for data extraction at the administrative level for consistent reporting.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that, since approximately 30 percent of Medicaid funding is allocated to LTSS spending,[1] tracking compliance with assessments and care planning goals will improve the national quality of health care. The WGM also noted that monitoring the elements of the care plan and sharing the plan with an individual's provider supports continuity of care.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that stratification should be possible because LTSS organizations document demographic information in case management systems.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM expressed that tracking person-centered assessments and care planning assures that individuals are meeting and exceeding both physical health and social drivers of care.

Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM did not provide this information.
How measure can be used to monitor improvement	The WGM noted that health plans can use this data as a benchmark for improvements in the provision of LTSS services. The care coordinators that support the individual are directly responsible for the assessments and subsequent care planning processes. Low scores on the measure are indicative of poor performing LTSS programs. Low scores could possibly predict the need for higher levels of care, including more costly institutional services.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The LTSS population accounted for 32 percent of overall Medicaid spending in 2018.[2]
Use of measure in other CMS programs	The WGM indicated that this measure is included by CMS in a list of eight quality measures for states to considering when using a managed care delivery system for providing LTSS.[3]
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM noted that there should be no barriers to health plans as it pertains to reporting these measures. All health plans have assessment and care planning tools that should capture the elements indicated within the measure.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.
[2] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf.
[3] https://www.medicaid.gov/medicaid/downloads/mltss_assess_care_plan_tech_specs.pdf.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Long-Term Services and Supports: Successful Transition After Long-Term Institutional Stay (MLTSS-8)**
Description	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.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Meaningful Measures area(s)	Affordability and Efficiency
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older as of July 1 of year prior to the measurement year.
Data collection method	Administrative (claims only).
Denominator	A New Institutional Facility Admission (IFA, an admission to the institutional setting directly from the community) with a length of stay 101 days or more between July 1 of the year prior to the measurement year and June 30 of the measurement year. OR A Prior Institutional Facility Admission (PIFA, an admission for MLTSS plan members who resided in the institutional facility on July 1 of the year prior to the measurement year) where the length of stay was at least 101 days inclusive of July 1 of the year prior to the measurement year. For example, a PIFA would be considered a stay of at least 101 days for a member identified as residing in an institutional facility on July 1 of the year prior to the measurement year, who was admitted to the facility on June 1 of the year prior to the measurement year and remained in the facility through September 15 of the year prior to the measurement year.

	The denominator for this measure is based on discharges, not members. Institutional facilities are defined as: 1. A Medicaid- or Medicare-certified nursing facility providing skilled nursing/medical care; rehabilitation needed due to injury, illness, or disability; or long-term care (also referred to as "custodial care"); or 2. A Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
Numerator	The count of discharges from an institutional facility to the community from July 1 of the year prior to the measurement year through October 31 of the measurement year that result in successful transition to the community for 60 consecutive days. Discharges that result in death, hospitalization, or re-admission to the institution within 60 days of discharge from the institution do not meet the numerator criteria.
Exclusions	None.
Continuous enrollment period	Continuously enrolled in the MLTSS plan for at least 365 days from July 1 of the year prior to the measurement year through December 31 of the measurement year. If the member dies after discharge to the community, the continuous enrollment period does not include the period after death.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The May 2019 technical specifications for this measure are available at: https://www.medicaid.gov/media/3396. An update of the *Measures for Medicaid MLTSS Plans Technical Specifications and Resource Manual* is planned for summer 2022. The May 2019 technical specifications are the most current version at this time.
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who suggested this measure noted that the measure is included by CMS in a list of eight LTSS quality measures for states to consider when using a managed care delivery system for providing LTSS.[1] The measure steward indicated that testing of this measure was completed in 2018, in partnership with four test plans. These 4 plans included a mix of large and small plans (3 national plans and 1 local plan), representing 14 health plan product lines from 10 states, located in geographically diverse regions of the country. Data for 189,722 enrollees across these 14 health plan product lines in 10 states were used to test the measure's reliability and validity. Measure reliability was tested at the score level, demonstrating moderate reliability using a

	beta-binomial model. Measure validity was evaluated using a convergent validity assessment, showing moderate validity when compared to two measures that evaluate similar quality actions. The measure steward was unable to provide information on the current use of this measure by states. However, the measure steward noted that the MLTSS measures are voluntary and available to states in the public domain; reporting on the use of the MLTSS-8 measure is not required. CMS shared that they are aware of anecdotal information that the MLTSS measures are in use by managed care plans and contractors working with Medicaid states through feedback from MLTSS measure technical assistance.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM did not describe any barriers, limitations, or variations in the required data source that could affect consistency of calculations and noted that this is an administrative measure using claims data.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that this measure prioritizes the overall national quality of health care by ensuring individuals are receiving care in the setting of their choosing. Transitions from institutional settings to the community support appropriate levels of care and use of resources.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that this should be possible because sociodemographic information can be pulled from administrative records.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM stated that transitioning an individual from institutional care allows for the delivery of home and community-based services (HCBS), supporting self-directed and person-centered care planning best practices.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM noted that for the overall HCBS population, the level of restrictiveness of their program is directly related to negative health outcomes.[2] Additionally, individuals receiving HCBS services are less likely to have emergency department visits, injuries, and instances of abuse and neglect when given appropriate community supports.[3]
How measure can be used to monitor improvement	The WGM stated that this measure can be trended over time, and performance can be compared across health plans and states. They noted that payers and providers can directly influence improvement on this measure by collaborating together for transition incentive programs and alternative payment arrangements.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	In FY 2019, total institutional LTSS costs were over $67.1 billion.[4] In 2014, 1,406,220 individuals lived in nursing homes in the United States, 97.8 percent of whom were enrolled in Medicaid.[5]
Use of measure in other CMS programs	The WGM noted that this measure is included by CMS in a list of eight quality measures for states to consider when using a managed care delivery system for providing LTSS.[1] Additionally, the measure is included as part of the HCBS measure set. The measure steward noted that states are encouraged to use the HCBS measure set to assess quality and outcomes in their HCBS programs, regardless of federal authority. The HCBS measure set is intended to support more consistent use of HCBS quality measures within and across states and to create opportunities for CMS and states to have comparative quality data on HCBS programs and services.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM noted that there could be potential claims delays between Medicaid and Medicare programs for LTSS beneficiaries that are dually eligible.
Summary of Prior Workgroup Discussions	This measure was discussed during the 2020 annual review. WGMs noted that this measure is an outcome measure designed to assess progress in transitioning people to the community, which would facilitate state-to-state comparisons. The Workgroup felt that increasing successful transitions from institutions is an important priority and this measure is one of the few ways to assess this in a comprehensive, consistent way. However, the WGMs noted that the measure was developed for managed LTSS delivery systems (about 24 states at the time) and questioned whether the measure could be used with fee-for-service delivery of LTSS.
Other	CMS is currently respecifying MLTSS-8 for Medicaid Fee-for-Service (FFS) LTSS participants. The updates to MLTSS-8 (and testing and development of the FLTSS-8 measure) are in process and scheduled for completion in 2022. Changes to the specifications currently under review include (1) expanding the definition of institutional facility to include psychiatric facilities and specialty hospitals, (2) including any payers in the count of discharges, (3) removing the medical benefit requirement from the benefit eligible population, and (4) adding stratification by Medicare and Medicaid (dual-eligible) participants and Medicaid-only participants.

	When respecification is complete, the *Measures for Medicaid MLTSS Plans Technical Specifications and Resource Manual* will include both the MLTSS-8 and the FLTSS-8 measures. States that furnish Medicaid services through MLTSS and FFS LTSS delivery systems will be able to access the technical specifications for the MLTSS-8 and FLTSS-8 measures in one document.

Citations

[1] https://www.medicaid.gov/media/3396.
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[3] https://www.c-q-l.org/resources/articles/the-hcbs-settings-rule-can-improve-health-and-safety-of-people-with-idd/.
[4] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.
[5] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**National Core Indicators for Aging and Disabilities (NCI-AD) Adult Consumer Survey**
Description	NCI-AD is a voluntary effort by state Medicaid, aging, and disability agencies to measure and track the performance of their long-term services and supports (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.
Measure steward	ADvancing States and Human Services Research Institute (HSRI)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Meaningful Measures area(s)	Person-Centered Care
Measure type	Patient experience
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	In-person survey.
Denominator	Individuals who respond to the survey question or questions from which the indicator is drawn. The sampling frame includes older adults (age 65 or older) or adults 18 years and older with a physical disability (including acquired or traumatic brain injury [ABI/TBI]) who receive publicly funded LTSS at least two to three times a week. There should be no a priori exclusions based on geography, place of residence, level of disability, or any other personal and demographic factors. Individuals receiving LTSS through intellectual and developmental disabilities (IDD)-specific or mental health (MH)-specific waivers or programs are excluded from the sampling frame.

Numerator	Varies based on indicator. Examples of indicators include: • Percentage of people whose service plan includes their preferences and choices. • Percentage of people who know whom to contact if they want to make changes to their services. • Percentage of people who had someone follow-up with them after being discharged from a hospital or rehabilitation facility in the past year. • Percentage of people with concerns about falling or being unstable (risk-adjusted). • Percentage of people who always or almost always like how they spend their time during the day (risk-adjusted). • Percentage of people who have a backup plan if their paid support staff do not show up. • Percentage of people whose paid support staff change too often. • Percentage of people who have adequate support for everyday activities. • Percentage of people who have adequate support for self-care. • Percentage of people who feel in control of their life. • Percentage of people who can eat their meals when they want to. • Percentage of people who have transportation when they want to do things outside of their home (non-medical). • Percentage of people who often feel lonely (risk-adjusted).
Exclusions	Varies based on indicator.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	State-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The survey instrument is proprietary and is not available online. An implementation guide is available at https://nci-ad.org/resources/implementation-guides/. A memorandum of agreement is available at https://nci-ad.org/images/uploads/2019-21_NCI-AD_MOA_with_TA_Year.pdf. A project overview is available at https://nci-ad.org/images/uploads/NCI-AD_Project_Overview_2019-2021_FINAL_2-19-20.pdf. The 2021-2022 NCI-AD Indicator Crosswalk is available at https://nci-ad.org/images/uploads/NCI-AD_Indicators_w_NCI_and_PCP.pdf.

Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who nominated this measure noted that 29 states have used NCI-AD in the past, are currently using it, or plan to use it starting in 2022. Sixteen states collected data using this tool in 2018-2019; 10 states had state-specific results for 2019-2020 (because data collection was unexpectedly abbreviated due to COVD); and 7 states participated in a remote survey pilot in 2020-2021.[1] More information is available at https://nci-ad.org/states/. Nineteen states are fully participating in the in the 2021-2022 data collection cycle: Alabama, Colorado, Delaware, Georgia, Indiana, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, New Jersey, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Washington, and Wisconsin. All fully participating states for the 2021-2022 data collection cycle are expected to meet the minimum sampling threshold.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	Technical assistance and training are provided by the NCI-AD Project Team. The implementation guide is available at https://nci-ad.org/resources/implementation-guides/. The NCI-AD Project Team provides technical assistance to states to promote completeness and validity of data. State samples may vary based on the state's populations of interest and analysis goals; however, the basic eligibility requirements remain the same across states. NCI-AD also uses risk-adjustment procedures to control for differences in the individual characteristics of people interviewed across states. The following personal characteristics are used for risk adjustment: age, gender, race, rurality, living arrangement (whether the person lives in their own home versus somewhere else), whether the person lives alone, mobility, amount of assistance needed for everyday activities, amount of assistance needed for self-care, overall health, level of hearing, level of vision, presence of a mental health diagnosis, whether the person has been forgetting things, and whether the proxy version of the survey was used. Outcome measures that may be affected by these characteristics are risk-adjusted by the NCI-AD Project Team.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that, given the lack of Core Set measures for older adults and people with disabilities, the NCI-AD would close that gap. This measure can be used by states to measure quality of care nationally and across states for a population that is responsible for 23 percent of Medicaid expenditures.[2]
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM noted that the survey collects racial, ethnic, and sociodemographic characteristics.

How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM stated that this instrument is focused on the complex needs of older adults and people with disabilities receiving LTSS.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM did not provide this information.
How measure can be used to monitor improvement	The WGM stated that this instrument provides states with specific information as it pertains to LTSS outcomes, beneficiary experience, and quality of life measures that span beyond service provision. The responses can and are trended nationally and at the state level and the states use their indicators to compare performance across programs.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM noted that the Baby Boom generation is turning age 65 at a rate of 10,000 persons a day[3] and 42 percent of noninstitutionalized adults over age 65 have a self-reported disability.[4] According to the 2017 CMS Actuarial Report, adults age 65 and older and people with disabilities accounted for 23 percent of Medicaid enrollment and 55 percent of Medicaid expenditures in FFY 2016.[2]
Use of measure in other CMS programs	The WGM noted that the NCI-AD was added to the 2019 Medicaid & CHIP Scorecard as a component of the measure indicating "State Use of Experience of Care Surveys for Beneficiaries Using Long-Term Services and Supports." The measure steward indicated that states have used the measures to demonstrate waiver assurances. CMS included NCI-AD measures in the proposed HCBS recommended measure set released for public comment in 2020.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGM shared that some states have cited cost as a barrier to implementation and a reason for not reporting measures that require data collection via survey. States participating in the NCI-AD receive significant technical assistance from the NCI-AD Project Team in using and reporting. More information is available in the Memorandum of Agreement.[5]
Summary of prior workgroup discussions	The measure has been discussed twice by the Workgroup, during the 2020 and 2021 annual reviews. The measure was recommended by the Workgroup for addition to the 2020 Adult Core Set CMS did not add the measure. The measure was not recommended by the Workgroup for addition to the 2021 Adult Core Set. During the 2021 review, it was noted that 16 states collected NCI-AD data in the 2018-2019 year and a total of 28 states had ever conducted the NCI-AD survey.

	During both reviews, WGMs noted that the NCI-AD survey would complement the National Core Indicators (NCI) Survey, which was added to the 2020 Adult Core Set and is focused on the experiences and outcomes of beneficiaries with intellectual and developmental disabilities. Several WGMs spoke to the value of the NCI-AD tool and data in measuring the experience of a broader population receiving LTSS, including older adults and those with physical disabilities. The WGMs expressed concerns about the need for in-person data collection, especially in light of the challenges associated with in-person data collection during the COVID-19 pandemic. States have indicated they would prefer other modalities in addition to in-person surveys. During the 2021 review, the measure steward noted that they were considering alternative modes of data collection. WGMs acknowledged that adding a new survey-based measure to the Core Set would require states to either add requirements for this survey to managed care contracts or to field them directly.

Citations

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[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf.
[3] https://www.pewresearch.org/social-trends/2010/12/20/baby-boomers-approach-65-glumly/.
[4] http://www.advancingstates.org/sites/nasuad/files/Prevalence%20of%20Disabilities%20and%20Health%20Care%20Access.pdf.
[5] https://nci-ad.org/images/uploads/2019-21_NCI-AD_MOA_with_TA_Year.pdf.

Measures That Will Not Be Reviewed

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Long-Term Services and Supports Expenditures on Home & Community-Based Services**
Description	The proportion of state long-term services and supports (LTSS) expenditures that are spent on home- and community-based services (HCBS) rather than institutional LTSS.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Meaningful Measures area(s)	Affordability and Efficiency, Person-Centered Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	All ages.
Data collection method	Administrative.
Denominator	Total amount of state spending on all LTSS as calculated using the methods described in the 2019 Medicaid LTSS Annual Expenditures Report.[1] Note that there are no formal specifications for calculating the denominator for this measure.
Numerator	Total amount of state spending on HCBS as calculated using the methods described in the 2019 Medicaid LTSS Annual Expenditures Report.[1] Four data sources were used to calculate the numerator: 1. CMS-64 Medicaid FMR Net Services data, 2. CMS-64 Waiver Report data, 3. Money Follows the Person (MFP) Worksheet for Proposed Budget data, and 4. State-Reported managed long-term services and supports (MLTSS) data. HCBS expenditures included spending on section 1915(c) waiver programs, section 1915(i) State Plan HCBS, section 1915(j)/self-directed personal assistance, section 1915(k) Community First Choice, case management, Health Homes, home health, MFP demonstration, Program of All-Inclusive Care for the Elderly (PACE), personal care, private duty nursing, rehabilitative services (non-school based), and other HCBS.

	Note that there are no formal specifications for calculating the numerator.
Exclusions	None.
Continuous enrollment period	Not applicable.
Level of reporting for which specifications were developed	State-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	There are no formal specifications for this measure. A summary of the methods used in the analysis is available at: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) did not share examples of specific states using this measure but shared references from the Medicaid and CHIP Payment and Access Commission (MACPAC) and Kaiser Family Foundation (KFF) that indicate that this measure is a way that rebalancing has been evaluated over time. [2,3] Additionally, this metric is included in the annual Medicaid & CHIP Scorecard.[4] In addition, the WGM indicated that Tennessee uses similar measures of the rebalancing of LTSS in the state. The WGM indicated that including it in the Child and Adult Core Set would bring regular attention across the country rather than periodically or just in a few states.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM noted that the 2017-2018 LTSS Expenditures report presents data on the percentage of total LTSS spending on HCBS for all states except four, which were excluded because they did not report any MLTSS data (California, Illinois, New York, and Virginia). South Carolina did not report any MLTSS data but was included in the calculation because the state's MLTSS data represented a relatively small amount of the state's LTSS spending. Similarly, for the 2019 LTSS Expenditures report, four states were excluded from the percentage of total LTSS spending on HCBS calculation because they did not report any MLTSS data (California, Delaware, Illinois, and Virginia). Arkansas did not report any MLTSS data but was included in the calculation because the state's MLTSS data represented a relatively small amount of the state's LTSS spending. The WGM commented that states have access to their fiscal data and to data on their total spending amounts for both HCBS and total LTSS.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that the benefits of HCBS over institutional care include improved quality of life, improved mental health, and reduced complications of dementia.

Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	The WGM suggested that stratification by racial, ethnic, and sociodemographic characteristics should be possible. However, this analysis used aggregated, state level data based on standardized reporting forms that do not include sociodemographic data. The measure steward noted that, as the data source for this report shifts to Transformed Medicaid Statistical Information System (T-MSIS) in future years, stratification by some sociodemographic characteristics may become possible.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM noted that rebalancing LTSS to move people into the community and out of institutions is a CMS priority. Measures have been done in multiple ways including numbers of participants living in each setting and numbers of participants moving across settings. A measure of proportion of spending controls for magnitude of dollars (e.g., spending in 2000 was likely less than in 2020 because of inflation and other factors) and allows for comparisons over time. The WGM reiterated that the benefits of HCBS over institutional care include improved quality of life, improved mental health, and reduced complications of dementia.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM stated that there is evidence that higher spending on HCBS decreases institutional placement.[5] Increased HCBS spending has been shown to reflect the movement of services over time and there is still room to move services in many states.
How measure can be used to monitor improvement	The WGM shared a MACPAC resource that links to a graph of the total spending on HCBS versus institutional services from 2000 to 2016 and shows a decrease in institutional services with an increase in HCBS.[6] The suggested measure would be able to show continued progress toward HCBS.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM stated that this measure could be applied to all people in a state receiving LTSS. In 2019, spending on LTSS made up 34 percent of all Medicaid expenditures.[1]
Use of measure in other CMS programs	This metric is included in the annual Medicaid & CHIP Scorecard.[4]
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	This measure is calculated using state data obtained by CMS from various sources. Little is known about the barriers to obtaining consistent data across states.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.
[2] https://www.macpac.gov/subtopic/home-and-community-based-services/.
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[6] https://www.macpac.gov/subtopic/home-and-community-based-services/.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Drivers of Health Screening Rate for Medicaid Managed Care Organizations and Provider-Led Accountable Entities**
Description	Percentage of beneficiaries 0–64 screened for all of the following: food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
Measure steward	Manatt
NQF number (if endorsed)	Not endorsed
Core Set domain	Other
Meaningful Measures area(s)	Equity
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 0 to 64, with separate rates reported for ages 0–17 and ages 18–64.
Data collection method	Other. The measure steward indicated that states may develop measure-specific data collection instruments or specify the use of administrative codes and collect data through routine claims or encounter submission. This measure allows states to select the most feasible data collection approach.
Denominator	For Managed Care Organizations (MCOs): Number of beneficiaries ages 0–64 enrolled in a Medicaid Managed Care Organization for at least 90 consecutive days during the measurement interval. For Provider-Led Accountable Entities: Number of beneficiaries ages 0–64 assigned to the reporting entity based on the reporting state's assignment rules for at least 90 consecutive days during the measurement interval.
Numerator	Number of beneficiaries 0–64 screened by the reporting entity or a delegate during the measurement period for all five of the following elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety, or for which the reporting entity has recorded information from an otherwise eligible screening performed by another entity in the beneficiary record.

	• Note that an MCO or other reporting entity serving multiple members of the same household can use information gathered from one household member to populate a screening for another household member, where appropriate, while still meeting the numerator criteria. • Note that if beneficiaries refuse to answer any or all of drivers of health (DOH) screening questions the screen will still meet numerator criteria. Reporting entities may use any assessment tool that includes questions related to all five required domains that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized DOH screening tool utilized must be documented in the medical record. Examples of DOH screening tools that meet these criteria include the American Academy of Family Practice screening tool, the Accountable Health Communities screening tool, the Arlington screening tool, the Health Leads screening tool, the North Carolina Medicaid program's list of screening questions, the PRAPARE tool, the WellRx screening tool, and the Your Current Life Situation survey.
Exclusions	None.
Continuous enrollment period	The beneficiary must be enrolled in a Medicaid Managed Care Organization or Provider-Led Accountable Entity for at least 90 consecutive days during the measurement interval (one year).
Level of reporting for which specifications were developed	Medicaid Managed Care Organization-level and Provider-Led Accountable Entity-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The specifications are not publicly available.
Information on testing or use at state Medicaid/CHIP level	The DOH Screening Rate measure has not been tested or used by state Medicaid or CHIP programs. The Workgroup members (WGMs) who suggested the measure provided several examples of state Medicaid programs measuring rates of DOH screening using state-developed specifications. • North Carolina requires Medicaid MCOs to screen all adults within 90 days of enrollment. Plans may use any screening instrument that includes required DOH domains. The state measures the proportion of eligible enrollees who have been screened.[1]

	• Massachusetts measures the proportion of eligible Medicaid accountable care organization (ACO) enrollees with a health-related social needs screening completed within the past year in their medical record. This measure will be available for voluntary reporting by private payers and providers in global risk contracts in 2022.[2] • Rhode Island measures the proportion of eligible Medicaid ACO enrollees who have documentation from their primary care provider of performance of a DOH screening as well as the results of the screening.[3]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGMs indicated that reporting entities will provide an attestation to state Medicaid programs stating the percent of eligible Medicaid enrollees they have screened for DOH in the measurement interval. The WGMs did not note any barriers, limitations, or variations in the data source. The WGMs indicated that reporting entities may benefit from technical assistance in calculating rates and performing stratifications.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGMs indicated that state and federal policymakers, leaders in quality measurement, and health care providers concur on the role DOH play in shaping health outcomes, and on the goal of understanding and addressing DOH in the health care setting.[4] This goal can be facilitated through universal screening for DOH among Medicaid enrollees and systematic identification of enrollees with positive responses on DOH screening. These measures contribute to measuring the quality of health care in Medicaid and CHIP by assessing state Medicaid and CHIP programs' progress toward gathering complete information about the needs of communities that the providers serve. This information can help states more effectively direct resources toward providers who serve patients facing the most substantial DOH-related challenges. To maximize feasibility for states and reporting entities, the WGMs noted that these measures do not require use of a specific screening instrument, and instead require that the screening instruments used assess five required domains. These five domains are based on the Accountable Health Communities (AHC) screening tool, which was developed after an extensive expert review.[5] As subsequent measures are developed and as states adopt screening more broadly, the measure steward expects to refine the specifications of these initial measures to narrow the number of permitted instruments and further increase comparability.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	Reporting entities should stratify results by beneficiaries' race and ethnicity using OMB standards for race and ethnicity,[6] as well as their language and disability status.[7] States may elect to add further stratifications based on their priorities and needs.

How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGMs noted that CMCS has issued guidance encouraging states to incorporate DOH measures into Medicaid and CHIP.[8] The 2021 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP specifically cite DOH measures, including housing insecurity, social isolation, and poverty, as cross-cutting gap areas in the Core Sets. The Center for Medicare and Medicaid Innovation identifies "incorporating screening and referral for social needs, coordination with community-based organizations, and processes to collect social needs data in standardized formats" as key to advance equity.[9] There are no measures in the Core Sets that address this critical gap, which has grown more significant in light of COVID and HHS/CMS's commitment to equity and whole-person care. The WGMs added that these measures promote effective care delivery within Medicaid and CHIP by providing insights into rates at which enrollees are screened for DOH, as well as screening patterns among subpopulations. The measures also support states to identify subpopulations undergoing screening at lower than expected rates, providing states with data to incentivize wider adoption of screening, as well as to develop follow-on interventions related to addressing enrollees' DOH needs. These interventions can help enrollees prevent, or prevent exacerbations of, chronic health problems, and can make them more able to benefit from medical providers and therapies, improving their outcomes and in some cases reducing costs. They can also inform states' and reporting entities' future investment needs.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGMs stated that identifying DOH needs through screening and capturing positive results are necessary steps in addressing them, and addressing needs in the five identified DOH fields (food, housing, transportation, utilities, and intimate partner violence [IPV]) has been associated with a range of improved outcomes. Addressing DOH needs related to food, housing, and transportation have been associated with improved health care outcomes or reduced costs in a number of trials.[10] Interventions related to IPV have been associated with a number of improvements, including improved safety behaviors and increased uptake of services.[11] Support for utility payments has been associated with improved child nutritional status and reduced likelihood of hospital admission after emergency department visits, among other outcomes.[12] In the AHC model, use of a screening tool assessing the five domains required by this measure was associated with high rates of opting in for navigation services across sites, suggesting this screening approach can identify appropriate candidates for support interventions.[13]
How measure can be used to monitor improvement	The WGMs noted that this measure can be used to monitor improvement by comparing rates of screening over time within state Medicaid programs, within state Medicaid program subpopulations, and between state Medicaid managed care organizations and other reporting entities.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	• Housing: In 2019, the majority (57 percent) of Medicaid enrollees lived in a home that was inadequate or unaffordable.[14] • Food: Among Medicaid-insured adults, 20 percent reported food insufficiency. The majority (65 percent) of Medicaid enrollees reporting food insufficiency in March also did so in July.[15] • Utilities: Around a quarter of all households with children reported forgoing expenditures for essentials to pay an energy bill (Medicaid-specific rates not available). [16] • IPV: More than 40 percent of women and around 25 percent of men experience interpersonal violence in their lifetime, with 4.7 percent of women and 3.5 percent of men experiencing violence in the last 12 months (Medicaid-specific rates not available). [17] • Transportation: Forty-six percent of Medicare and Medicaid beneficiaries participating in AHC reported transportation needs.[18] Studies in older populations have suggested transportation support is associated with improved quality of life.[19] • The AHC model revealed that beneficiaries who screen positive for DOH needs are disproportionately racial/ethnic minorities. These disparities have been worsened by the COVID-19 pandemic.[20]
Use of measure in other CMS programs	No programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGMs noted that efforts to expand screening in the past have been limited by concerns about whether providers will have enough time to incorporate screening into encounters, and whether they will have the resources to address concerns once needs are identified.[21] In addition, researchers have noted that the rapidly-evolving nature of the evidence base around screening argues for flexibility in screening requirements to ensure screeners can continue to use best practices.[22] Technical assistance could support states in developing information-sharing resources to reduce duplicative screening.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	This measure is part of a suite of related DOH measures intended to address DOH-related barriers to better health through measurement of rates of screening and positive screens, with separate specifications for managed care and fee-for-service state Medicaid programs. Manatt is temporarily stewarding the DOH measures and is engaged in discussions to transfer stewardship of the measures for the 2023 measurement year. The measures may be updated to align with changes to the Drivers of Health Screening and Screen Positive measures currently under consideration for Merit-based Incentive Payment System (MIPS) and Hospital Inpatient Quality Reporting (HIQR) Program.

Citations

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[22] https://catalyst.nejm.org/doi/full/10.1056/CAT.19.1037.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Drivers of Health Screening Rate for Providers**
Description	Percentage of beneficiaries 0–64 screened for all of the following: food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
Measure steward	Manatt
NQF number (if endorsed)	Not endorsed
Core Set domain	Other
Meaningful Measures area(s)	Equity
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 0 to 64, with separate rates reported for ages 0–17 and ages 18–64.
Data collection method	Other. The measure steward indicated that states may develop measure-specific data collection instruments or specify the use of administrative codes and collect data through routine claims or encounter submission. This measure allows states to select the most feasible data collection approach.
Denominator	For hospitals or Institutions for Mental Disease (IMD): Number of beneficiaries ages 0–64 with at least one inpatient discharge from a general acute care hospital or IMD. For ambulatory providers: Number of beneficiaries ages 0–64 for which the practice is the assigned primary care practice based on the reporting state's assignment rules for at least 90 consecutive days during the measurement interval, or for which the beneficiary had at least one encounter with the codes included in the technical specifications.
Numerator	Number of beneficiaries ages 0–64 screened by the reporting entity or a delegate during the measurement period for all five of the following elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety, or for which the reporting entity has recorded information from an otherwise eligible screening performed by another entity in the beneficiary record.

	• Note that a reporting entity serving multiple members of the same household can use information gathered from one household member to populate a screening for another household member, where appropriate, while still meeting the numerator criteria. • Note that if beneficiaries refuse to answer any or all of drivers of health (DOH) screening questions the screen will still meet numerator criteria. Reporting entities may use any assessment tool that includes questions related to all five required domains that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized DOH screening tool utilized must be documented in the medical record. Examples of DOH screening tools that meet these criteria include the American Academy of Family Practice screening tool, the Accountable Health Communities screening tool, the Arlington screening tool, the Health Leads screening tool, the North Carolina Medicaid program's list of screening questions, the PRAPARE tool, the WellRx screening tool, and the Your Current Life Situation survey.
Exclusions	None.
Continuous enrollment period	For hospitals or IMDs: Not specified. For ambulatory providers: 90 days.
Level of reporting for which specifications were developed	Provider-level (hospitals, IMDs, and ambulatory providers at the level of the TIN).

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The specifications are not publicly available.
Information on testing or use at state Medicaid/CHIP level	As currently specified, the DOH Screening Rate measure has not been tested or used by state Medicaid or CHIP programs. The Workgroup members (WGMs) who suggested the measure provided several examples of state Medicaid programs currently measuring rates of DOH screening by providers using state-developed specifications. • Colorado requires participants in its Hospital Transformation Program to screen adult and pediatric enrollees with an inpatient admission. Colorado measures the proportion of eligible enrollees with screening results and, if appropriate, referrals, documented in their medical records and notification of Regional Accountable Entities. This requirement has not yet been implemented.[1] • Arizona required its pediatric primary care practices to screen assigned families for health-related social needs. The state measured practices' attestation that at least 85 percent of eligible enrollees underwent screening and individuals who screened positive were connected to services. [2]

	• The Integrated Care for Kids (InCK) and Maternal Opioid Misuse (MOM) models (funded through the Center for Medicare and Medicaid Innovation) require participants to use structured screening tools to assess needs including food/ housing. [3] • The Accountable Health Communities (AHC) model required DOH screening for community-dwelling Medicare and Medicaid beneficiaries receiving care from community care delivery sites. As documented in the AHC evaluation, screening for the five required domains reliably identified beneficiaries with 1+ health-related social needs (HRSNs).[4]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGMs indicated that reporting entities will provide an attestation to state Medicaid programs stating the percent of eligible Medicaid enrollees they have screened for DOH in the measurement interval. The WGMs did not note any barriers, limitations, or variations in the data source. The WGM indicated that reporting entities may benefit from technical assistance in calculating rates and performing stratifications.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGMs indicated that state and federal policymakers, leaders in quality measurement, and health care providers concur on the role DOH play in shaping health outcomes, and on the goal of understanding and addressing DOH in the health care setting.[5] This goal can be facilitated through universal screening for DOH among Medicaid enrollees and systematic identification of enrollees with positive responses on DOH screening. These measures contribute to measuring the quality of health care in Medicaid and CHIP by assessing state Medicaid and CHIP programs' progress toward gathering complete information about the needs of communities that the providers serve. This information can help states more effectively direct resources toward providers who serve patients facing the most substantial DOH-related challenges. To maximize feasibility for states and reporting entities, the WGMs noted that these measures do not require use of a specific screening instrument, and instead require that the screening instruments used assess five required domains. These five domains are based on the AHC screening tool, which was developed after an extensive expert review.[6] As subsequent measures are developed and as states adopt screening more broadly, the measure steward expects to refine the specifications of these initial measures to narrow the number of permitted instruments and further increase comparability.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	Reporting entities should stratify results by beneficiaries' race and ethnicity using OMB standards for race and ethnicity,[7] as well as their language and disability status.[8] States may elect to add further stratifications based on their priorities and needs.

How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGMs noted that CMCS has issued guidance encouraging states to incorporate DOH measures into Medicaid and CHIP.[9] The 2021 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP specifically cite DOH measures, including housing insecurity, social isolation, and poverty, as cross-cutting gap areas in the Core Sets. The Center for Medicare and Medicaid Innovation identifies "incorporating screening and referral for social needs, coordination with community-based organizations, and processes to collect social needs data in standardized formats" as key to advance equity.[10] There are no measures in the Core Sets that address this critical gap, which has grown more significant in light of COVID and HHS/CMS's commitment to equity and whole-person care. The WGMs added that these measures promote effective care delivery within Medicaid and CHIP by providing insights into rates at which enrollees are screened for DOH, as well as screening patterns among subpopulations. The measures also support states to identify subpopulations undergoing screening at lower than expected rates, providing states with data to incentivize wider adoption of screening, as well as to develop follow-on interventions related to addressing enrollees' DOH needs. These interventions can help enrollees prevent, or prevent exacerbations of, chronic health problems, and can make them more able to benefit from medical providers and therapies, improving their outcomes and in some cases reducing costs. They can also inform states' and reporting entities' future investment needs.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGMs stated that identifying DOH needs through screening and capturing positive results are necessary steps in addressing them, and addressing needs in the five identified DOH fields (food, housing, transportation, utilities, and intimate partner violence [IPV]) has been associated with a range of improved outcomes. Addressing DOH needs related to food, housing and transportation have been associated with improved health care outcomes or reduced costs in a number of trials.[11] Interventions related to IPV have been associated with a number of improvements, including improved safety behaviors and increased uptake of services.[12] Support for utility payments has been associated with improved child nutritional status and reduced likelihood of hospital admission after emergency department visits, among other outcomes.[13] In the AHC model, use of a screening tool assessing the five domains required by this measure was associated with high rates of opting in for navigation services across sites, suggesting this screening approach can identify appropriate candidates for support interventions.[14]
How measure can be used to monitor improvement	The WGMs noted that this measure can be used monitor improvement by comparing rates of screening over time within state Medicaid programs, within state Medicaid program subpopulations, and between state Medicaid managed care organizations and other reporting entities.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	• Housing: In 2019, the majority (57 percent) of Medicaid enrollees lived in a home that was inadequate or unaffordable.[15] • Food: Among Medicaid-insured adults, 20 percent reported food insufficiency. The majority (65 percent) of Medicaid enrollees reporting food insufficiency in March also did so in July.[16] • Utilities: Around a quarter of all households with children reported forgoing expenditures for essentials to pay an energy bill (Medicaid-specific rates not available). [17] • IPV: More than 40 percent of women and around 25 percent of men experience interpersonal violence in their lifetime, with 4.7 percent of women and 3.5 percent of men experiencing violence in the last 12 months (Medicaid-specific rates not available). [18] • Transportation: Forty-six percent of Medicare and Medicaid beneficiaries participating in AHC reported transportation needs.[19] Studies in older populations have suggested transportation support is associated with improved quality of life.[20] • The AHC model revealed that beneficiaries who screen positive for DOH needs are disproportionately racial/ethnic minorities. These disparities have been worsened by the COVID-19 pandemic.[21]
Use of measure in other CMS programs	No programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGMs noted that efforts to expand screening in the past have been limited by concerns about whether providers will have enough time to incorporate screening into encounters, and whether they will have the resources to address concerns once needs are identified.[22] In addition, researchers have noted that the rapidly-evolving nature of the evidence base around screening argues for flexibility in screening requirements to ensure screeners can continue to use best practices.[23] Technical assistance could support states in developing information-sharing resources to reduce duplicative screening.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	This measure is part of a suite of related DOH measures intended to address DOH-related barriers to better health through measurement of rates of screening and positive screens, with separate specifications for managed care and fee-for-service state Medicaid programs. Manatt is temporarily stewarding the DOH measures and is engaged in discussions to transfer stewardship of the measures for the 2023 measurement year. The measures may be updated to align with changes to the Drivers of Health Screening and Screen Positive measures currently under consideration for Merit-based Incentive Payment System (MIPS) and Hospital Inpatient Quality Reporting (HIQR) Program.

Citations

[1]https://hcpf.colorado.gov/sites/hcpf/files/2021%20March%20HTP%20Measure%20Specifications%20for%20Hospitals.pdf.
[2] https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/PediatricPCP_webpage.pdf.
[3] https://www.grants.gov/web/grants/view-opportunity.html?oppId=312759; https://innovation.cms.gov/webinars-and-forums/mom-model-nofo-application-review.
[4] https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt.
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[16]https://www.urban.org/sites/default/files/publication/99521/what_explains_the_widespread_material_hardship_among_low-income_families_with_children_0.pdf.
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[19] https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt.
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[21] https://blueshieldcafoundation.org/newsroom/press-releases/20210323/survey-documents-uneven-impact-covid-19-californias-communities.
[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6721844/.
[23] https://catalyst.nejm.org/doi/full/10.1056/CAT.19.1037.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2023 CORE SET

Measure Information	
Measure name	**Drivers of Health Screen Positive Rate for Medicaid Managed Care Organizations and Provider-Led Accountable Entities**
Description	Percentage of beneficiaries 0–64 with a positive screen for one or more of the following: food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
Measure steward	Manatt
NQF number (if endorsed)	Not endorsed
Core Set domain	Other
Meaningful Measures area(s)	Equity
Measure type	Intermediate Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 0 to 64, with separate rates reported for ages 0–17 and ages 18–64.
Data collection method	Other. The measure steward indicated that states may develop measure-specific data collection instruments or specify the use of administrative codes and collect data through routine claims or encounter submission. This measure allows states to select the most feasible data collection approach.
Denominator	For managed care organizations (MCOs): Number of beneficiaries ages 0–64 enrolled in a Medicaid Managed Care Organization for at least 90 consecutive days during the measurement interval and who have been screened for all five of the following drivers of health (DOH) elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety. For Provider-Led Accountable Entities: Number of beneficiaries ages 0–64 assigned to the reporting entity based on the reporting state's assignment rules for at least 90 consecutive days during the measurement interval and who have been screened for all five of the following drivers of health (DOH) elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety.

	Reporting entities may use any assessment tool that includes questions related to all five required domains that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized DOH screening tool utilized must be documented in the medical record. Examples of DOH screening tools that meet these criteria include the American Academy of Family Practice screening tool, the Accountable Health Communities screening tool, the Arlington screening tool, the Health Leads screening tool, the North Carolina Medicaid program's list of screening questions, the PRAPARE tool, the WellRx screening tool, and the Your Current Life Situation survey.
Numerator	Number of beneficiaries who have positive screening results for one or more of the following DOH elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety (reported as five separate rates). • Note that an MCO or other reporting entity serving multiple members of the same household can use information gathered from one household member to populate a screening for another household member, where appropriate, while still meeting the numerator criteria. • Note that if beneficiaries refuse to answer any or all of DOH screening questions the screen will still meet numerator criteria.
Exclusions	None.
Continuous enrollment period	The beneficiary must be enrolled in a Medicaid managed care organization or provider-led accountable entity for at least 90 consecutive days during the measurement interval (one year).
Level of reporting for which specifications were developed	Medicaid Managed Care Organization-level and Provider-Led Accountable Entity-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The specifications are not publicly available.
Information on testing or use at state Medicaid/CHIP level	The DOH Screen Positive Rate measure has not been tested or used by state Medicaid or CHIP programs.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The Workgroup members (WGMs) who suggested the measure indicated that reporting entities will provide an attestation to state Medicaid programs stating the percent of eligible Medicaid enrollees they have screened for DOH in the measurement interval. The WGMs did not note any barriers, limitations, or variations in the data source. The WGM indicated that reporting entities may benefit from technical assistance in calculating rates and performing stratifications.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGMs indicated that state and federal policymakers, leaders in quality measurement, and health care providers concur on the role DOH play in shaping health outcomes, and on the goal of understanding and addressing DOH in the health care setting.[1] This goal can be facilitated through universal screening for DOH among Medicaid enrollees and systematic identification of enrollees with positive responses on DOH screening. These measures contribute to measuring the quality of health care in Medicaid and CHIP by assessing state Medicaid and CHIP programs' progress toward gathering complete information about the needs of communities that the providers serve. This information can help states more effectively direct resources toward providers who serve patients facing the most substantial DOH-related challenges. To maximize feasibility for states and reporting entities, the WGMs noted that these measures do not require use of a specific screening instrument, and instead require that the screening instruments used assess five required domains. These five domains are based on the Accountable Health Communities (AHC) screening tool, which was developed after an extensive expert review.[2] As subsequent measures are developed and as states adopt screening more broadly, the measure steward expects to refine the specifications of these initial measures to narrow the number of permitted instruments and further increase comparability.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	Reporting entities should stratify results by beneficiaries' race and ethnicity using OMB standards for race and ethnicity,[3] as well as their language and disability status.[4] States may elect to add further stratifications based on their priorities and needs.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGMs noted that CMCS has issued guidance encouraging states to incorporate DOH measures into Medicaid and CHIP.[5] The 2021 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP specifically cite DOH measures, including housing insecurity, social isolation, and poverty, as cross-cutting gap areas in the Core Sets. The Center for Medicare and Medicaid Innovation identifies "incorporating screening and referral for social needs, coordination with community-based organizations, and processes to collect social needs data in standardized formats" as key to advance equity.[6] There are no measures in the Core Sets that address this critical gap, which has grown more significant in light of COVID and HHS/CMS's commitment to equity and whole-person care.

	The WGMs added that these measures promote effective care delivery within Medicaid and CHIP by providing insights into rates at which enrollees are screened for DOH, as well as screening patterns among subpopulations. The measures also support states to identify subpopulations undergoing screening at lower than expected rates, providing states with data to incentivize wider adoption of screening, as well as to develop follow-on interventions related to addressing enrollees' DOH needs. These interventions can help enrollees prevent, or prevent exacerbations of, chronic health problems, and can make them more able to benefit from medical providers and therapies, improving their outcomes and in some cases reducing costs. They can also inform states' and reporting entities' future investment needs.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGMs stated that identifying DOH needs through screening and capturing positive results are necessary steps in addressing them, and addressing needs in the five identified DOH fields (food, housing, transportation, utilities, and intimate partner violence [IPV]) has been associated with a range of improved outcomes. Addressing DOH needs related to food, housing and transportation have been associated with improved health care outcomes or reduced costs in a number of trials.[7] Interventions related to IPV have been associated with a number of improvements, including improved safety behaviors and increased uptake of services.[8] Support for utility payments has been associated with improved child nutritional status and reduced likelihood of hospital admission after emergency department visits, among other outcomes.[9] In the AHC model, use of a screening tool assessing the five domains required by this measure was associated with high rates of opting in for navigation services across sites, suggesting this screening approach can identify appropriate candidates for support interventions.[10]
How measure can be used to monitor improvement	The WGMs noted that this measure can be used monitor improvement by comparing rates of screening over time within state Medicaid programs, within state Medicaid program subpopulations, and between state Medicaid managed care organizations and other reporting entities.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	• Housing: In 2019, the majority (57 percent) of Medicaid enrollees lived in a home that was inadequate or unaffordable.[11] • Food: Among Medicaid-insured adults, 20 percent reported food insufficiency. The majority (65 percent) of Medicaid enrollees reporting food insufficiency in March also did so in July.[12] • Utilities: Around a quarter of all households with children reported forgoing expenditures for essentials to pay an energy bill (Medicaid-specific rates not available). [13] • IPV: More than 40 percent of women and around 25 percent of men experience interpersonal violence in their lifetime, with 4.7 percent of women and 3.5 percent of men experiencing violence in the last 12 months (Medicaid-specific rates not available). [14]

	• Transportation: Forty-six percent of Medicare and Medicaid beneficiaries participating in AHC reported transportation needs.[15] Studies in older populations have suggested transportation support is associated with improved quality of life.[16] • The AHC model revealed that beneficiaries who screen positive for DOH needs are disproportionately racial/ethnic minorities. These disparities have been worsened by the COVID-19 pandemic.[17]
Use of measure in other CMS programs	No programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGMs noted that efforts to expand screening in the past have been limited by concerns about whether providers will have enough time to incorporate screening into encounters, and whether they will have the resources to address concerns once needs are identified.[18] In addition, researchers have noted that the rapidly-evolving nature of the evidence base around screening argues for flexibility in screening requirements to ensure screeners can continue to use best practices.[19] Technical assistance could support states in developing information-sharing resources to reduce duplicative screening.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	This measure is part of a suite of related DOH measures intended to address DOH-related barriers to better health through measurement of rates of screening and positive screens, with separate specifications for managed care and fee-for-service state Medicaid programs. Manatt is temporarily stewarding the DOH measures and is engaged in discussions to transfer stewardship of the measures for the 2023 measurement year. The measures may be updated to align with changes to the Drivers of Health Screening and Screen Positive measures currently under consideration for Merit-based Incentive Payment System (MIPS) and Hospital Inpatient Quality Reporting (HIQR) Program.

Citations

[1] https://www.commonwealthfund.org/blog/2021/measuring-what-matters-social-drivers-health.
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[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6721844/.
[19] https://catalyst.nejm.org/doi/full/10.1056/CAT.19.1037.

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Measure Information	
Measure name	**Drivers of Health Screen Positive Rate for Providers**
Description	Percentage of beneficiaries 0–64 with a positive screen for one or more of the following: food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
Measure steward	Manatt
NQF number (if endorsed)	Not endorsed
Core Set domain	Other
Meaningful Measures area(s)	Equity
Measure type	Intermediate Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 0 to 64, with separate rates reported for ages 0–17 and ages 18–64.
Data collection method	Other. The measure steward indicated that states may develop measure-specific data collection instruments or specify the use of administrative codes and collect data through routine claims or encounter submission. This measure allows states to select the most feasible data collection approach.
Denominator	For hospitals or Institutions for Mental Disease (IMD): Number of beneficiaries ages 0–64 with at least one inpatient discharge from a general acute care hospital or IMD who have been screened by the reporting entity or a delegate during the measurement interval for all five of the following drivers of health (DOH) elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety. For ambulatory providers: Number of beneficiaries ages 0–64 for which the practice is the assigned primary care practice based on the reporting state's assignment rules for at least 90 days, or for which the beneficiary had at least one encounter with the codes listed in the specifications who have been screened by the reporting entity or a delegate during the measurement interval for all five of the following DOH elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety.

	Reporting entities may use any assessment tool that includes questions related to all five required domains that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized DOH screening tool utilized must be documented in the medical record. Examples of DOH screening tools that meet these criteria include the American Academy of Family Practice screening tool, the Accountable Health Communities screening tool, the Arlington screening tool, the Health Leads screening tool, the North Carolina Medicaid program's list of screening questions, the PRAPARE tool, the WellRx screening tool, and the Your Current Life Situation survey.
Numerator	Number of beneficiaries who have positive screening results for one or more of the following DOH elements: food insecurity, housing instability, transportation needs, utility assistance, and interpersonal safety (reported as five separate rates). • Note that a reporting entity serving multiple members of the same household can use information gathered from one household member to populate a screening for another household member, where appropriate, while still meeting the numerator criteria. • Note that if beneficiaries refuse to answer any or all of DOH screening questions the screen will still meet numerator criteria.
Exclusions	None.
Continuous enrollment period	For hospitals or IMDs: Not specified. For ambulatory providers: 90 days.
Level of reporting for which specifications were developed	Provider-level (hospitals, IMDs, and ambulatory providers at the level of the TIN).

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The specifications are not publicly available.
Information on testing or use at state Medicaid/CHIP level	The DOH Screen Positive Rate measure has not been tested or used by state Medicaid or CHIP programs.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The Workgroup members (WGMs) who suggested the measure indicated that reporting entities may require claims or encounter data to identify their denominator population for the measure. Reporting entities will provide an attestation to state Medicaid programs stating the percent of eligible Medicaid enrollees they have screened for DOH in the measurement interval. The WGMs did not note any barriers, limitations, or variations in the data source. The WGM noted that reporting entities may benefit from technical assistance in calculating rates and performing stratifications.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGMs indicated that state and federal policymakers, leaders in quality measurement, and health care providers concur on the role DOH play in shaping health outcomes, and on the goal of understanding and addressing DOH in the health care setting.[1] This goal can be facilitated through universal screening for DOH among Medicaid enrollees and systematic identification of enrollees with positive responses on DOH screening. These measures contribute to measuring the quality of health care in Medicaid and CHIP by assessing state Medicaid and CHIP programs' progress toward gathering complete information about the needs of communities that the providers serve. This information can help states more effectively direct resources toward providers who serve patients facing the most substantial DOH-related challenges. To maximize feasibility for states and reporting entities, the WGMs noted that these measures do not require use of a specific screening instrument, and instead require that the screening instruments used assess five required domains. These five domains are based on the AHC screening tool, which was developed after an extensive expert review.[2] As subsequent measures are developed and as states adopt screening more broadly, the measure steward expects to refine the specifications of these initial measures to narrow the number of permitted instruments and further increase comparability.
Whether the data source allows for stratification by racial, ethnic, and sociodemographic characteristics	Reporting entities should stratify results by beneficiaries' race and ethnicity using OMB standards for race and ethnicity,[3] as well as their language and disability status.[4] States may elect to add further stratifications based on their priorities and needs.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGMs noted that CMCS has issued guidance encouraging states to incorporate DOH measures into Medicaid and CHIP.[5] The 2021 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP specifically cite DOH measures, including housing insecurity, social isolation, and poverty, as cross-cutting gap areas in the Core Sets. The Center for Medicare and Medicaid Innovation identifies "incorporating screening and referral for social needs, coordination with community-based organizations, and processes to collect social needs data in standardized formats" as key to advance equity.[6] There are no measures in the Core Sets that address this critical gap, which has grown more significant in light of COVID and HHS/CMS's commitment to equity and whole-person care.

	The WGMs added that these measures promote effective care delivery within Medicaid and CHIP by providing insights into rates at which enrollees are screened for DOH, as well as screening patterns among subpopulations. The measures also support states to identify subpopulations undergoing screening at lower than expected rates, providing states with data to incentivize wider adoption of screening, as well as to develop follow-on interventions related to addressing enrollees' DOH needs. These interventions can help enrollees prevent, or prevent exacerbations of, chronic health problems, and can make them more able to engage with and benefit from medical providers and therapies, improving their outcomes and in some cases reducing costs. They can also inform states' and reporting entities' future investment needs.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGMs stated that identifying DOH needs through screening and capturing positive results are necessary steps in addressing them, and addressing needs in the five identified DOH fields (food, housing, transportation, utilities, and intimate partner violence [IPV]) has been associated with a range of improved outcomes. Addressing DOH needs related to food, housing and transportation have been associated with improved health care outcomes or reduced costs in a number of trials.[7] Interventions related to IPV have been associated with a number of improvements, including improved safety behaviors and increased uptake of services.[8] Support for utility payments has been associated with improved child nutritional status and reduced likelihood of hospital admission after emergency department visits, among other outcomes.[9] In the AHC model, use of a screening tool assessing the five domains required by this measure was associated with high rates of opting in for navigation services across sites, suggesting this screening approach can identify appropriate candidates for support interventions.[10]
How measure can be used to monitor improvement	The WGMs noted that this measure can be used monitor improvement by comparing rates of screening over time within state Medicaid programs, within state Medicaid program subpopulations, and between state Medicaid managed care organizations and other reporting entities.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	• Housing: In 2019, the majority (57 percent) of Medicaid enrollees lived in a home that was inadequate or unaffordable.[11] • Food: Among Medicaid-insured adults, 20 percent reported food insufficiency. The majority (65 percent) of Medicaid enrollees reporting food insufficiency in March also did so in July.[12] • Utilities: Around a quarter of all households with children reported forgoing expenditures for essentials to pay an energy bill (Medicaid-specific rates not available). [13]

	• IPV: More than 40 percent of women and around 25 percent of men experience interpersonal violence in their lifetime, with 4.7 percent of women and 3.5 percent of men experiencing violence in the last 12 months (Medicaid-specific rates not available). [14] • Transportation: Forty-six percent of Medicare and Medicaid beneficiaries participating in AHC reported transportation needs.[15] Studies in older populations have suggested transportation support is associated with improved quality of life.[16] • The AHC model revealed that beneficiaries who screen positive for DOH needs are disproportionately racial/ethnic minorities. These disparities have been worsened by the COVID-19 pandemic.[17]
Use of measure in other CMS programs	No programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure by FFY 2024 reporting cycle and recommended technical assistance resources	The WGMs noted that efforts to expand screening in the past have been limited by concerns about whether providers will have enough time to incorporate screening into encounters, and whether they will have the resources to address concerns once needs are identified.[18] In addition, researchers have noted that the rapidly-evolving nature of the evidence base around screening argues for flexibility in screening requirements to ensure screeners can continue to use best practices.[19] Technical assistance could support states in developing information-sharing resources to reduce duplicative screening.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	This measure is part of a suite of related DOH measures intended to address DOH-related barriers to better health through measurement of rates of screening and positive screens, with separate specifications for managed care and fee-for-service state Medicaid programs. Manatt is temporarily stewarding the DOH measures and is engaged in discussions to transfer stewardship of the measures for the 2023 measurement year. The measures may be updated to align with changes to the Drivers of Health Screening and Screen Positive measures currently under consideration for Merit-based Incentive Payment System (MIPS) and Hospital Inpatient Quality Reporting (HIQR) Program.

Citations

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