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Child and Adult Core Sets Annual Review Workgroup:

Measures Suggested for Addition to the 2027 Core Sets

Measure Information Sheets

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Measures That Will Be Discussed by the Workgroup

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2027 CORE SETS

Measure Information	
Measure name	**Antibiotic Utilization for Respiratory Conditions**
Description	The percentage of episodes for members three months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. *Note: This measure is designed to capture the frequency of antibiotic utilization for respiratory conditions. Organizations should use this information for internal evaluation only. NCQA [the measure steward] does not view higher or lower service counts as indicating better or worse performance.*
Measure steward	National Committee for Quality Assurance (NCQA)
Meaningful Measures area(s)	Affordability and Efficiency
Measure type(s)	Process
Suggested to replace current measure?	No

Technical Specifications	
Ages	Members who were three months of age or older as of the episode date. Report three age stratifications and a total rate: • Ages 3 months to 17 years. • Ages 18 to 64. • Ages 65 and older. • Total.
Data collection method(s)	Administrative.
Denominator	Episodes for members three months of age and older as of the episode date who had an outpatient, emergency department (ED) visit, telephone visit, e-visit, or virtual check-in during the intake period with a diagnosis of a respiratory condition. Episodes are removed from the denominator if any of the following conditions are met: • The episode results in an inpatient stay. • The member had a claim/encounter with any diagnosis for a comorbid condition during the 365 days prior to or on the episode date.

Technical Specifications	
	• A new or refill prescription for an antibiotic medication was dispensed 30 days prior to the episode date or was active on the episode date. • The member had a claim/encounter with a competing diagnosis on or three days after the episode date.
Numerator	Dispensed prescription for an antibiotic medication from the *Antibiotic Utilization for Respiratory Conditions* Antibiotic Medications List on or three days after the episode date.
Exclusions	Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year.
Continuous enrollment period	30 days prior to the episode date through 3 days after the episode date (34 total days).
Type(s) of codes needed to calculate the measure	The following code sets are used to calculate this measure: • Current Procedural Terminology (CPT) Category I. • International Classification of Diseases (ICD). • SNOMED CT. • Healthcare Common Procedure Coding System (HCPCS) Level II. • Uniform Billing Codes (UB).
Level of reporting for which specifications are available	Plan-level.

Minimum Technical Feasibility and Appropriateness	
Link to current technical specifications	See HEDIS MY 2025 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The measure steward stated that the measure was tested using the IBM MarketScan Multi-State Medicaid Database, which includes claims data from multiple state Medicaid agencies. The populations tested included both adult and child Medicaid beneficiaries who were treated for respiratory conditions within outpatient settings. Since 2023, health plans from all states participating in HEDIS reporting have reported the measure as part of their HEDIS submission. The measure steward clarified that, for HEDIS Measurement Year 2023, this included Medicaid health plans from all states except Alabama, Alaska, Connecticut, Idaho, Maine, Montana, Oklahoma, South Dakota, Vermont and Wyoming.

Minimum Technical Feasibility and Appropriateness	
	The Antibiotic Utilization for Respiratory Conditions first-year results at the health-plan level showed that 19 percent of respiratory condition episodes among Medicaid members resulted in an antibiotic dispensing event. The measure steward noted that, in conjunction with the three additional antibiotic appropriateness measures, this information can help to identify inappropriate use at the plan-level in the context of overall antibiotic use. In addition, the measure is in use in Washington state as part of the Washington State Common Measure Set.[1]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	Both individuals who suggested the measure for addition indicated that all required data sources and data elements for implementing this measure are available across all states through the use of administrative claims data. The measure steward explained that their measure development process takes into consideration how measures will be implemented and interpreted across states to ensure consistency. The measure steward also stated that measures are presented, reviewed and discussed with relevant Measurement Advisory Panels to ensure feasibility of implementation, and instructions on how to code are documented to ensure consistency.
Evidence that measure could lead to improvement in quality of health care delivery and outcomes for Medicaid and CHIP beneficiaries	**Response 1:** One individual who suggested the measure explained that antibiotics are powerful tools to treat bacterial infections. However, misuse can lead to avoidable adverse events, such as antibiotic resistance. Antibiotic-resistant infections affect 2.8 million people and are associated with 35,000 deaths each year.[2] The individual noted that antibiotic resistance is alarming due to the risk of spread and limited treatment options. Antibiotics prescribed for respiratory conditions in outpatient settings are a large driver of antibiotic overuse and demonstrate a higher proportion of events resulting in unnecessary use.[3] Most antibiotic prescribing occurs in outpatient settings.[4] Although outpatient antibiotic prescribing rates have slightly decreased in recent years, marked variation remains across providers and geographic regions.[5] The interplay of such multilevel factors often leads to the misdiagnosis or overdiagnosis of respiratory conditions -- and subsequent antibiotic overtreatment. Measuring antibiotic prescribing can address variation in outpatient prescribing patterns. States and their partners can monitor antibiotic use among their enrolled populations across the various settings in which members receive care. Tracking appropriate and inappropriate prescribing for respiratory conditions together may offer a tool for understanding prescribing in the face of misdiagnosis and overdiagnosis of these conditions.

Minimum Technical Feasibility and Appropriateness	
	When used alongside the HEDIS antibiotic overuse measures (such as the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)* measure which is currently included in the Child and Adult Core Sets), the *Antibiotic Utilization for Respiratory Conditions* measure can help paint a better picture of a health plan's overall antibiotic stewardship efforts. **Response 2:** The second individual that suggested the measure stated that inappropriate antibiotic prescribing in outpatient health care settings contributes not only to the development of antibiotic-resistant bacteria but can also cause potential harm to patients due to an increased risk of adverse drug events.[6] Acute respiratory conditions constitute the most common reason for antibiotic prescriptions. Antibiotic prescribing for acute respiratory conditions has shown clear room for improvement, with one study showing that about half of outpatient prescriptions written for these conditions are unnecessary.[7] Additionally, analysis of employer-sponsored commercial claims data demonstrated an increased risk of some adverse drug events, such as the occurrence of C. difficile infections, among patients who received inappropriate antibiotics to treat common respiratory infections.[8] These data demonstrate the importance of improving prescribing practices for all respiratory conditions. Quality measures such as the *Antibiotic Utilization for Respiratory Conditions* measure are critical tools to accomplish this. For example, stewardship leaders at Intermountain Health successfully leveraged a measure similar to the *Antibiotic Utilization for Respiratory Conditions* measure to support improved antibiotic prescribing in urgent care clinics within their network.[9] This work resulted in a 15 percent absolute reduction in antibiotic prescribing for respiratory conditions after 1 year.[10]

Actionability and Strategic Priority	
How measure addresses the most pressing needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	**Response 1:** One individual who suggested the measure said antibiotic stewardship is a priority across all populations, as antibiotic-resistant infections affect millions of people each year. Respiratory conditions are a common reason for outpatient visits among children, highlighting the importance of monitoring antibiotic prescribing in this population to ensure improved patient outcomes and prevent antibiotic resistance. **Response 2:** The second individual who suggested the measure said improving antibiotic prescribing is essential to improving Medicaid and CHIP beneficiary health outcomes by reducing the incidence of adverse drug events.

Actionability and Strategic Priority	
	According to this individual, antibiotics are among the most common class of drugs that lead to ED visits, with an estimated 200,000 ED visits occurring nationally per year due to antibiotic-associated adverse events.[11] The *Antibiotic Utilization for Respiratory Conditions* measure may help reduce ED visits and improve patient health by minimizing the inappropriate use of these drugs. In addition, previous studies have demonstrated disparities in antibiotic prescribing according to different factors, such as geography. For example, antibiotic prescribing in the South remains higher than other areas of the United States.[12] The *Antibiotic Utilization for Respiratory Conditions* measure can provide essential insights into antibiotic prescribing patterns across states, and may aid in reducing prescribing disparities across different populations.
Whether the data source allows for stratification by race, ethnicity, sex, and geography	**Response 1:** One individual who suggested the measure noted the measure uses administrative claims as a data source, which typically includes information for stratifying by race and ethnicity, sex, and geographic location. During measure development, the measure steward examined testing results by sex, which showed that 32.5 percent of respiratory condition outpatient encounters among males (and 35.3 percent of encounters among females) resulted in an antibiotic being prescribed. **Response 2:** The second individual who suggested the measure explained that the measure steward has demonstrated that the *Antibiotic Utilization for Respiratory Conditions* measure can be stratified by geography and sex. In a recent report, the measure steward analyzed *Antibiotic Utilization for Respiratory Conditions* measure performance by census region, census division, and state. This report found that among Medicaid beneficiaries, the Midwest and South census regions had the highest mean measure outcomes, compared to the Northeast and West.[13] The measure steward has also demonstrated that the measure can be stratified by sex, with similar rates of antibiotic prescribing identified across males and females. HEDIS includes a framework for stratifying measures by race and ethnicity. This framework includes categories that are standardized to the Office of Management and Budget's race and ethnicity categories and instructions for categorizing data as directly or indirectly collected.[14] The individual who suggested the measure believes that the *Antibiotic Utilization for Respiratory Conditions* measure has the potential to be stratified by race and ethnicity similar to other HEDIS measures, and that any potential stratification will need to be confirmed by the measure steward. The measure steward confirmed that stratification of HEDIS measures is part of their commitment to advance health equity, and the *Antibiotic Utilization for Respiratory Conditions* measure may be considered for stratification by race and ethnicity in the future.

Actionability and Strategic Priority	
	The measure steward explained they paused the rollout of the race and ethnicity stratification to additional measures while they work to align with the Office of Management and Budget's recently released updates to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.[15] The measure steward will notify partners, if and when they decide to move forward with stratifying the measure.
Whether there is evidence of a performance gap for Medicaid and/or CHIP beneficiaries on the measure	**Response 1:** One individual who suggested the measure said that the *Antibiotic Utilization for Respiratory Conditions* measure rates vary across health plans and populations based on age, gender, and geographic region. On average, measure testing showed that antibiotic prescribing for respiratory conditions in Medicaid was higher among children (33.2 percent) and adults ages 18 to 64 (36.9 percent) when compared to prescribing among adults in Medicare (30.4 percent). **Response 2:** The second individual who suggested the measure also noted that Medicaid rates on the *Antibiotic Utilization for Respiratory Conditions* measure are slightly higher than Medicare rates on the measure.[16] Previous studies have also shown that antibiotic prescribing for Medicaid and CHIP beneficiaries is higher than other populations. A review of prescribing among the New York Medicaid population found that the potential rate of inappropriate prescribing for acute respiratory infections was greater than 50 percent.[17] Further interventions are needed to reduce the burden of inappropriate antibiotic prescribing in Medicaid and CHIP populations. Subpopulations within Medicaid have also been shown to experience gaps in antibiotic prescribing performance, especially across geographic regions. For example, researchers demonstrated that children in rural areas of Tennessee received more antibiotic prescriptions for acute respiratory infections than children in urban areas.[18] Researchers in Kentucky also found similar prescribing disparities among children prescribed antibiotics for any diagnosis in rural versus urban areas.[19] Implementing measures like the *Antibiotic Utilization for Respiratory Conditions* measure may help highlight disparities in antibiotic prescribing across different regions of the state.
How the measure can be used to monitor improvement	**Response 1:** One individual who suggested the measure explained that monitoring of prescribing practices is important for antibiotic stewardship and quality improvement initiatives. HEDIS maintains three measures of appropriate antibiotic use focused on specific conditions for which antibiotics should not be used (bronchitis/bronchiolitis, pharyngitis, and upper respiratory infection). The *Antibiotic Utilization for Respiratory Conditions* measure can be used in conjunction with the three antibiotic appropriateness measures to understand whether lower inappropriate use occurs in the context of lower antibiotic use overall.

Actionability and Strategic Priority	
	(Note, of these three HEDIS measures focused on specific conditions, the measure focused on antibiotic use for bronchitis/bronchiolitis is currently on the Child and Adult Core Sets.) **Response 2:** The second individual who suggested the measure explained the *Antibiotic Utilization for Respiratory Conditions* measure can be used to monitor the impact of targeted antibiotic stewardship interventions by providing trends over time to assess Medicaid and CHIP program performance and progress. State Medicaid and CHIP programs can also directly influence improvement on this measure by expanding antibiotic stewardship efforts through a variety of activities, including incentivizing quality improvement programs focused on antibiotic stewardship and using data to provide feedback to providers about their prescribing patterns with peer comparisons. Medicaid and CHIP providers and practices can also influence improvement on the *Antibiotic Utilization for Respiratory Conditions* measure by implementing antibiotic stewardship activities, including displaying commitment posters, supporting communication trainings for clinicians, and other stewardship interventions recommended by public health agencies, such as the Core Elements of Outpatient Antibiotic Stewardship from the Centers for Disease Control and Prevention.[20,21]
Whether the measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets	**Response 1:** One individual who suggested the measure stated the *Antibiotic Utilization for Respiratory Conditions* measure will facilitate tracking of appropriate and inappropriate prescribing of antibiotics for respiratory conditions. The measure is also episode-based which presents more of an opportunity to identify areas of improvement and aligns with existing HEDIS antibiotic measures for improved comparability and usage. **Response 2:** The second individual who suggested the measure stated the current antibiotic prescribing-related measure on the Core Sets, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*, focuses solely on antibiotic use associated with a specific diagnosis, which may provide limited insight into how providers are prescribing for patients with acute respiratory conditions overall. The *Antibiotic Utilization for Respiratory Conditions* measure will provide a more comprehensive view of overall prescribing practices for a key group of diagnoses that significantly contribute to overall prescribing.[22] The *Antibiotic Utilization for Respiratory Conditions* measure will minimize concerns that changes in measure performance are due to "diagnosis shifting." This occurs when health care providers are more likely to diagnose a patient with an antibiotic-appropriate diagnosis when prescribing an antibiotic—even if it is possible that a patient has a viral infection. Previous studies have shown that some providers appear to modify diagnoses to justify antibiotic prescriptions.[23]

Actionability and Strategic Priority	
	This can affect prescribing feedback that only focuses on one diagnosis, such as bronchitis, because providers may be more likely to use a different diagnosis—such as pneumonia—if they prescribe an antibiotic for that patient. Leveraging measures such as the *Antibiotic Utilization for Respiratory Conditions* measure helps to overcome these limitations by looking at the full range of potential diagnoses for patients with similar symptoms.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	**Response 1:** One individual who suggested the measure shared that a recent study showed that almost 70 percent of antibiotics prescribed for respiratory tract conditions were inappropriate.[24] Given that a large proportion of all antibiotics prescribed are for respiratory conditions, this highlights the importance of focusing measures on antibiotic utilization. **Response 2:** The second individual who suggested the measure stated that acute respiratory conditions are common outpatient conditions that affect patients of all ages. Acute respiratory conditions include both upper and lower respiratory infections that are bacterial or viral, and encompass diagnoses such as the common cold, bronchitis, influenza, pharyngitis, and pneumonia, among others. Antibiotic prescribing for these conditions is also common. One study of outpatient antibiotic prescribing from 2010-2011 found that acute respiratory conditions were associated with an estimated 221 antibiotic prescriptions per 1,000 Americans.[25] When looking specifically at Medicaid populations, one study found the rate of antibiotic prescriptions to be 464 per 1,000 Medicaid beneficiaries in 2019.[26] Acute respiratory conditions are also common among Medicaid beneficiaries. One study identified 1.3 million acute respiratory infections from 2011-2015 among Medicaid beneficiaries in New York, with 58 percent of those patients receiving an antibiotic prescription as a result.[27]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Whether provider workflows will have to be modified to collect additional data needed to report the measure	Not applicable. The measure steward indicated that the measure imposes no data entry burden on providers, either because the measure uses data that are routinely generated (i.e. administrative data and claims), the data are collected by someone other than the provider, or the measure repurposes existing data sets to calculate the measure.

Additional Information for Consideration	
Potential barriers states could face in calculating measure and recommended technical assistance resources	**Response 1:** One individual who suggested the measure said that since the measure is reported using data that are readily available in administrative claims, there should not be significant barriers for reporting the measure. The individual noted that the measure steward, maintains a portal (my.ncqa.org) where entities can submit questions or seek technical assistance with reporting if necessary. **Response 2:** The second individual who suggested the measure noted that similar to other HEDIS measures included on the Core Sets, the claims data used are available to all states, so no potential barriers exist in calculating the measure. The individual also noted that the measure steward, provides technical resources through HEDIS.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.hca.wa.gov/assets/program/washington-state-common-measures.pdf.

[2] CDC. (2019). Antibiotic Resistance Threats in the United States, 2019. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2019.

[3] CDC. (2019). Antibiotic Use in Outpatient Settings. Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Division of Healthcare Quality Promotion (DHQP). https://archive.cdc.gov/www_cdc_gov/antibiotic-use/data/report-2019.html.

[4] Public Health England. (2019, November) English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Report 2018 – 2019. London, England: Public Health England; 2019. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843129/English_Surveillance_Programme_for_Antimicrobial_Utilisation_and_Resistance_2019.pdf.

[5] Palms DL, Hicks LA, Bartoces M, et al. Comparison of Antibiotic Prescribing in Retail Clinics, Urgent Care Centers, Emergency Departments, and Traditional Ambulatory Care Settings in the United States. JAMA Intern Med. 2018;178(9):1267–1269. doi:10.1001/jamainternmed.2018.1632.

[6] Doi.org/10.1001/jama.2016.4151.

[7] Doi.org/10.1093/cid/ciac879.

[8] https://bit.ly/3XKqU36.

[9] Doi.org/10.1093/cid/ciz910.

[10] https://bit.ly/4e5PMIk.

[11] https://www.cdc.gov/antibiotic-use/core-elements/pdfs/AU-Outpatient-Payer-Toolkit-508.pdf.

[12] https://bit.ly/4e91UbC.

[13] https://Antibiotics.ncqa.org/static/media/NCQAAnalyzingRegionalProductToolkit.263a075403976db1e22e.pdf.

[14] https://antibiotics.ncqa.org/health-equity.

[15] https://www.federalregister.gov/d/2024-06469.

[16] https://Antibiotics.ncqa.org/static/media/NCQAAnalyzingRegionalProductToolkit.263a075403976db1e22e.pdf.

[17] https://Bit.ly/4ejkTQb.

[18] Doi.org/10.1093%2Fofid%2Fofaa587.

[19] Doi.org/10.1017/ice.2021.177.
[20] https://doi.org/10.15585/mmwr.rr6506a1.
[21] https://www.cdc.gov/antibiotic-use/core-elements/pdfs/AU-Outpatient-Payer-Toolkit-508.pdf.
[22] Doi.org/10.1093/cid/ciz910.
[23] https://bit.ly/3ZE4lya.
[24] https://pubmed.ncbi.nlm.nih.gov/34075872/.
[25] Doi.org/10.1001/jama.2016.4151.
[26] Doi.org/10.3390/pharmacy12020046.
[27] https://Bit.ly/4ejkTQb.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2027 CORE SETS

Measure Information	
Measure name	**Evaluation of Hepatitis B and C**
Description	The number and percentage of adult, non-dual eligible Medicaid beneficiaries who were tested for hepatitis B (HBV), tested for hepatitis C (HCV), and treated for HCV. Nine rates are reported: **Overall Population** **1.** The percentage of adults who are tested for HBV in the Intake Period. **2.** The percentage of adults who are tested for HCV in the Intake Period. **3.** The percentage of adults receiving direct-acting antiviral treatment for HCV within six months of being tested for and diagnosed with HCV. **Beneficiaries Diagnosed with Opioid Use Disorder (OUD)** **4.** The percentage of adults diagnosed with OUD who are tested for HBV in the Intake Period. **5.** The percentage of adults diagnosed with OUD who are tested for HCV in the Intake Period. **6.** The percentage of adults diagnosed with OUD receiving direct-acting antiviral treatment for HCV within six months of being tested for and diagnosed with HCV. **Pregnant Women** **7.** The percentage of pregnant women who are tested for HBV during pregnancy. **8.** The percentage of pregnant women who are tested for HCV during pregnancy. **9.** The percentage of women receiving direct-acting antiviral treatment for HCV during the six-month postpartum period among those who were tested for and diagnosed with HCV during the Pregnancy Period.
Measure steward	Medicaid Outcomes Distributed Research Network (MODRN) Data Coordinating Center at the University of Pittsburgh
Meaningful Measures area(s)	Wellness and Prevention
Measure type(s)	Intermediate outcome, population health, and process
Suggested to replace current measure?	No

Technical Specifications	
Ages	The reported age range varies by measure rate: • For **rates 1-6**: Ages 18 to 64 as of June 30 of the Intake Period. • For **rates 7-9**: Ages 18 to 44 as of Date of Delivery.
Data collection method(s)	Administrative.
Denominator	The measure includes denominators for nine rates: **Overall Population** • **HBV/HCV Testing (rates 1 and 2).** Beneficiaries ages 18 to 64 as of June 30 of the Intake Period.* • **HCV Treatment (rate 3).** Beneficiaries included in the denominator for rates 1 and 2 who had an HCV test during the Intake Period and a diagnosis of chronic HCV within six months from Index HCV testing date. Exclude beneficiaries who filled any HCV treatment medication within six months before their index HCV testing. **Beneficiaries Diagnosed with OUD** • **HBV/HCV Testing among Beneficiaries Diagnosed with OUD (rates 4 and 5).** Beneficiaries ages 18 to 64 as of June 30 of the Intake Period who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission at any time during the Intake Period. • **HCV Treatment among Beneficiaries Diagnosed with OUD (rate 6).** Beneficiaries included in the denominator for rates 4 and 5 who had an HCV test during the Intake Period and a diagnosis of chronic HCV within six months from Index HCV testing date. Exclude beneficiaries who filled any HCV treatment medication within six months before their index HCV testing. **Pregnant Women** • **HBV/HCV Testing among Pregnant Women (rates 7 and 8).** Beneficiaries ages 18 to 44 as of Date of Delivery who had a delivery during the Intake Period. • **HCV Treatment within Six-month Postpartum among Pregnant Women (rate 9).** Beneficiaries included in the denominator for rates 7 and 8 who had any HCV testing during the Pregnancy Period and a chronic HCV diagnosis during the Pregnancy Period. * The Intake Period spans from July 1 of the year prior to the measurement year through June 30 of the measurement year.

Technical Specifications	
Numerator	The measure includes numerators for nine rates: **Overall Population** 1. **HBV Testing.** Beneficiaries who had at least one HBV test during the Intake Period. 2. **HCV Testing.** Beneficiaries who had at least one HCV test during the Intake Period. 3. **HCV Treatment.** Beneficiaries who initiated Chronic HCV treatment within 6 months (180 days) of index HCV testing among those with an HCV diagnosis. **Beneficiaries Diagnosed with OUD** 4. **HBV Testing among Beneficiaries Diagnosed with OUD.** Beneficiaries who had at least one HBV test during the Intake Period. 5. **HCV Testing among Beneficiaries Diagnosed with OUD.** Beneficiaries who had at least one HCV test during the Intake Period. 6. **HCV Treatment among Beneficiaries Diagnosed with OUD.** Beneficiaries who initiated Chronic HCV treatment within 6 months (180 days) of index HCV testing among those with a HCV diagnosis. **Pregnant Women** 7. **HBV Testing among Pregnant Women.** Beneficiaries who had at least one HBV test during the Pregnancy Period. 8. **HCV Testing among Pregnant Women.** Beneficiaries who had at least one HCV test during the Pregnancy Period. 9. **HCV Treatment within Six-month Postpartum among Pregnant Women.** Beneficiaries receiving direct-acting antiviral treatment for HCV during the six-months postpartum period among those who were tested and diagnosed with HCV during the Pregnancy Period.
Exclusions	Exclude individuals dually eligible for Medicare and Medicaid. Additional exclusions vary by measure rate: • For **rates 1, 2, 4, and 5**: No additional exclusions. • For **rates 3 and 6**: Exclude beneficiaries who filled any HCV treatment medication within six months before their index HCV testing. • For **rates 7, 8, and 9**: Exclude deliveries that meet any of the following criteria: - Ages 17 and younger, or 45 and older, as of Date of Delivery. - Calculated Pregnancy Period is greater than 43 weeks (301 days).

Technical Specifications	
Continuous enrollment period	The continuous enrollment period varies by measure rate: • For **rates 1, 2, 4, and 5**: The beneficiary must be continuously enrolled during the Intake Period, with no more than one gap in enrollment of up to 45 days during the Intake Period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a one-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). • For **rates 3 and 6**: The beneficiary must be continuously enrolled during the Intake Period and 6 months (180 days) before index HCV testing date through 6 months (180 days) after index HCV testing date (361 total days). - During the Intake Period, no more than 1 gap in enrollment of up to 45 days is allowed. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). - During the 6 months before and after index HCV testing, no more than one gap in enrollment of up to 45 days is allowed. For a beneficiary for whom enrollment is verified monthly, the same rule applies as the above. • For **rates 7, 8, and 9:** The beneficiary must have 4 months (120 days) of cumulative enrollment during pregnancy and 6 months (180 days) of continuous enrollment starting from Delivery Date. For the 6 months postpartum period, no gap in enrollment is allowed. During the Pregnancy Period, gaps in enrollment are allowed as long as the beneficiary has cumulative 4 months (120 days) of enrollment during pregnancy.
Type(s) of codes needed to calculate the measure	Code sets for calculating this measure include: • Current Procedural Terminology (CPT) Category I. • CPT Category II. • International Classification of Diseases (ICD). • Healthcare Common Procedure Coding System (HCPCS) Level II. • National Drug Code (NDC) Directory.
Level of reporting for which specifications are available	State-level, plan-level, and population-level (community, county, city, or regional).

Minimum Technical Feasibility and Appropriateness	
Link to current technical specifications	Specifications for the measure are not publicly available.
Information on testing or use at state Medicaid/CHIP level	The measure was tested among adults (ages 18 to 64), non-dually eligible, full-benefit Medicaid beneficiaries in Delaware, Maryland, Maine, Michigan, Ohio, Pennsylvania, and Virginia. The measure was also tested in subpopulations (pregnancy and opioid use disorder) and demographic subgroups based on race, ethnicity, gender, and geography. According to the individual who suggested the measure and the measure steward, the measure is not currently in use by any state Medicaid programs.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The individual who suggested the measure noted that Medicaid eligibility category and benefits could vary for the pregnancy sub-group across states depending on state coverage policy. In particular, not all states provide postpartum coverage up to 180 days as required in the hepatitis C postpartum treatment rate. Measurement of HCV treatment rates may be affected in those states. As of August 2024, the Kaiser Foundation reported 47 states have extended postpartum coverage for 12 months after delivery, two states are planning to implement a 12-month extension, and one state is considering a limited coverage extension of up to 90 days.[1]
Evidence that measure could lead to improvement in quality of health care delivery and outcomes for Medicaid and CHIP beneficiaries	Since 2020, both the United States Preventive Services Taskforce (USPSTF) and the Centers for Disease Control and Prevention (CDC) have recommended universal one-time HCV screening for all adults and periodic testing for those with ongoing risk factors.[2,3] CDC also recommends HCV screening for all pregnant women during each pregnancy.[4] The American Association for the Study of Liver Disease (AASLD) and the Infectious Diseases Society of America treatment guidelines recommend universal treatment of people diagnosed with HCV except in those with a short life expectancy not remediated by HCV treatment or liver transplantation.[5] HCV diagnosis and treatment has the triple benefit of reducing liver and all-cause mortality, reducing HCV transmission, and reducing health care expenditures associated with HCV complications.[6,7,8] USPSTF recommends screening for HBV for all pregnant women during each pregnancy and among adolescents and adults at increased risk for infection.[9,10] In 2023, CDC recommended universal HBV screening for all adults.[11] Current AASLD guidelines on HBV treatment recommend treatment in a subset of individuals with liver inflammation and damage that may progress to cirrhosis or hepatocellular cancer.[12] HBV treatment reduces the risk of developing HBV-related complications.

Minimum Technical Feasibility and Appropriateness	
	According to the individual who suggested the measure, screening, diagnosing, and treating people with HBV and HCV are critical for ensuring national elimination targets by 2030.[13]

Actionability and Strategic Priority	
How measure addresses the most pressing needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	This measure evaluates testing for hepatitis B and C as well as treatment of those recently diagnosed with viral hepatitis C. The measure focuses on adults 18 and older, pregnant individuals, and those living with OUD. According to the individual who suggested the measure, the measure helps Medicaid programs understand disease burden and treatment opportunities to eliminate hepatitis B and C. They indicated that: • Calculating the annual rate of testing is helpful in evaluating the extent of adherence to current guidelines for hepatitis B and C screening. • Calculating the rate of those tested who have a diagnosis of hepatitis C in administrative claims is helpful in estimating disease burden within the Medicaid population tested in that performance period. • Calculating the rate of those initiating treatment for hepatitis C is helpful in determining the gaps in treatment and the missed opportunity to treat and eliminate hepatitis C. The individual who suggested the measure noted that in their multi-state analyses of Medicaid beneficiaries, they found that only 10 to 30 percent of newly diagnosed adults over 18 and those living with OUD were treated for hepatitis C within 180 days of diagnosis. Only 2 to 12 percent of postpartum individuals who were tested for and diagnosed with hepatitis C during the prenatal period were treated within 180 days postpartum, demonstrating the need to track postpartum individuals to initiate treatment when clinically safe and appropriate. They indicated that stratification of the measure by race, ethnicity, sex, and geography would help to identify quality improvement opportunities.
Whether the data source allows for stratification by race, ethnicity, sex, and geography	The individual who suggested the measure noted that since the measure relies on administrative data (Medicaid enrollment and claims) and HBV and HCV is prevalent in all demographic groups, the measure can be stratified by race, ethnicity, sex, and geography. Subpopulations include individuals living with OUD or who are pregnant. The measure steward indicated that they have assessed that it is feasible to stratify the measure by race, ethnicity, sex, and geography within each state.

Actionability and Strategic Priority	
Whether there is evidence of a performance gap for Medicaid and/or CHIP beneficiaries on the measure	The individual who suggested the measure provided pooled testing results from Delaware, Maryland, Maine, Michigan, Ohio, Pennsylvania, and Virginia that indicate that only 7.4 to 9.7 percent of non-dually eligible adults ages 18 to 64 were tested for HBV between 2018 and 2022. The percentage of adults tested for HCV during that period was similarly low (9.8 to 11.0 percent). Testing rates among individuals with OUD were higher than the overall adult population but—according to the individual who suggested the measure—remained sub-optimal for a population at high risk of viral hepatitis. Depending on the year, 20.9 to 24.0 percent of adults diagnosed with OUD were tested for HBV and 26.3 to 29.7 percent were tested for HCV. Just over half of pregnant women, in whom universal prenatal screening is recommended, were tested for HBV (54.1 to 57.6 percent depending on year) and HCV (46.2 to 59.2 percent depending on year). The pooled testing results also show that HBV and HCV testing rates varied by race, ethnicity, geography, and gender. According to the individual who suggested the measure, testing rates could inform quality improvement initiatives to identify the populations eligible for hepatitis treatment and disease prevention. In the pooled testing results, the percentage of Medicaid beneficiaries receiving treatment for HCV within 6 months of being tested and diagnosed was low among adults overall (14.1 and 23.5 percent in 2018 and 2022, respectively), as well as in adults diagnosed with OUD (10.9 and 23.3 percent in 2018 and 2022, respectively), and in postpartum women (3.7 and 6.3 percent in 2018 and 2022, respectively) between 2018 and 2022.
How the measure can be used to monitor improvement	The individual who suggested the measure indicated that Medicaid programs and managed care organizations (MCOs) can cumulatively examine multiple annual testing rates and develop strategies to target adults with ongoing enrollment who meet eligibility to be screened. They can also target specific populations, such as pregnant individuals and those living with OUD for more intensive screening efforts. They noted that Medicaid programs and MCOs can cumulatively track individuals who test positive but remain untreated with the goal of improving access to treatment. Lastly, the individual who suggested the measure indicated that Medicaid programs and MCOs can also track individuals who initiate treatment to assure the completion of treatment and cure.

Actionability and Strategic Priority	
Whether the measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets	According to the individual who suggested the measure, the measure would address existing gap areas in the Core Sets related to health equity and social drivers of health, maternal and perinatal health, and behavioral health care. They indicated that the measure would also fill an identified gap in the Adult Core Set by evaluating the testing for HBV and HCV as well as treatment of those recently diagnosed with HCV.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The individual who suggested the measure was not aware of any national measurements of the prevalence of hepatitis B or hepatitis C in the Medicaid and CHIP population. In the general population, CDC estimates that during 2017–2020, there were approximately 2.2 million non-institutionalized U.S. adults with hepatitis C, corresponding to an overall prevalence of 0.9 percent.[14] Additional modeling accounting for under-sampling of groups at increased risk for hepatitis C estimated that as many as 4.0 million adults have hepatitis C, which corresponds to a prevalence of 1.6 percent.[15] CDC estimates the national prevalence of hepatitis B among people 6 years and older during 2017–2020 was 0.2 percent, corresponding to 660,000 people.[16] According to the individual who suggested the measure, the prevalence of hepatitis B and hepatitis C among Medicaid and CHIP beneficiaries is likely higher than the general population given the social determinants of health and disadvantages disproportionately experienced by Medicaid and CHIP beneficiaries. They cited a study using Pennsylvania Medicaid claims data that estimated the cumulative adult prevalence of hepatitis C to be approximately 46,700 adults as of 2015.[17]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Whether provider workflows will have to be modified to collect additional data needed to report the measure	Not applicable. The individual who suggested the measure indicated that the measure imposes no data entry burden on providers, either because the measure uses data that are routinely generated (i.e. administrative data and claims), the data are collected by someone other than the provider, or the measure repurposes existing data sets to calculate the measure.

Additional Information for Consideration	
Potential barriers states could face in calculating measure and recommended technical assistance resources	The individual who suggested the measure indicated that one potential barrier is that not all states can report the pregnancy subpopulation for the HCV treatment measure since they may not provide coverage six months postpartum. As noted above, as of August 2024, only 3 states do not provide extended postpartum coverage for at least 12 months.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	The individual who suggested the measure noted that the Office of the Assistant Secretary for Health/Office of Infectious Disease and HIV/AIDS Policy (OIDP) supports inclusion of this quality measure in the Adult Core Set. OIDP hosted a technical consultation meeting in March 2024 and public comment period from May to June 2024. The technical consultation and public comment provided an opportunity to build consensus for development of a feasible and meaningful viral hepatitis measure. Through the consensus-building process, the Workgroup (consisting of OIDP, CDC, MODRN Data Coordinating Center at the University of Pittsburgh and six state Medicaid agencies and their university partners) focused on a measure that encompasses hepatitis B screening, hepatitis C screening, and hepatitis C treatment initiation. The individual noted that through both these opportunities input was received from state Medicaid programs, state public health departments, providers, and national or professional organizations representing provider groups, viral hepatitis patients, Medicaid agencies, health plans, and public health departments.

Citations

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2027 CORE SETS

Measure Information	
Measure name	**Depression Remission or Response for Adolescents and Adults**
Description	The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9[a] score, who had evidence of response or remission within 120-240 days (4–8 months) of the elevated score. The following rates are reported: 1. **Follow-Up PHQ-9**.The percentage of members who have a follow-up PHQ-9 score documented within 120−240 days (4–8 months) after the initial elevated PHQ-9 score. 2. **Depression Remission**. The percentage of members who achieved remission within 120−240 days (4–8 months) after the initial elevated PHQ-9 score. 3. **Depression Response**. The percentage of members who showed response within 120−240 days (4–8 months) after the initial elevated PHQ-9 score.
Measure steward	National Committee for Quality Assurance (NCQA)
Meaningful Measures area(s)	Behavioral Health
Measure type(s)	Outcome
Suggested to replace current measure?	No. The individual who suggested this measure noted that there are behavioral health measures in the Core Sets, such as *Screening for Depression and Follow-Up Plan: Ages 12 to 17* (CDF-CH) and *Screening for Depression and Follow-Up Plan: Age 18 and Older* (CDF-AD), that indicate whether or not a depression screening has occurred and if there was follow-up. This measure differs from those other measures since it is an outcome measure that would indicate results of depression screenings, as well as the efficacy of the follow-up on positive screening results.

[a] The Patient Health Questionnaire (PHQ) is a three-page questionnaire that assesses several different mental health disorders. The PHQ-9 is the nine-item depression module from the full PHQ. More information and the full list of questions is available at https://pmc.ncbi.nlm.nih.gov/articles/PMC1495268/.

Technical Specifications	
Ages	Individuals ages 12 and older as of May 1 of the year prior to the measurement period. Report four age stratifications and a total rate: • Ages 12 to 17. • Ages 18 to 44. • Ages 45 to 64. • Age 65 and older. • Total (age 12 and older).
Data collection method(s)	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	Members ages 12 and older as of the start of the intake period (May 1 of the year prior to the measurement period through April 30 of the measurement period) who meet **both** of the following criteria: • Meet requirements for participation.* • Meet the depression encounter and PHQ-9 total score requirements as described by the index episode start date (IESD). The IESD is the earliest date during the intake period when a member has a PHQ-9 total score greater than 9 documented within a 31-day period, including and around (15 days before and 15 days after) an interactive outpatient encounter** with a diagnosis of major depression or dysthymia. The measure's denominator is the same for all three rates within each age group. * Participation is defined as the identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Participation includes both allocation and continuous enrollment criteria. • Allocation criteria: The member was enrolled with a medical benefit from May 1 of the year prior to the measurement period through December 31 of the measurement period. • Continuous enrollment criteria: See below. **An interactive outpatient encounter is a bidirectional communication that is face-to-face, phone based, an e-visit or virtual check-in, or via secure electronic messaging. This does not include communications for scheduling appointments.

Technical Specifications	
Numerator	The measure includes numerators for three rates: 1. **Depression Follow-Up**. A PHQ-9 total score in the member's record during the depression follow-up period (120−240 days after the IESD). 2. **Depression Remission:** Members who achieve remission of depression symptoms, as demonstrated by the most recent PHQ-9 total score of less than 5 during the depression follow-up period (120−240 days after the IESD). 3. **Depression Response:** Members who indicate a response to treatment for depression, as demonstrated by the most recent PHQ-9 total score of at least 50 percent lower than the PHQ-9 score associated with the IESD, documented during the depression follow-up period (120−240 days after the IESD).
Exclusions	The denominator for all measure rates excludes the following: • Members with any of the following any time during the member's history through the end of the measurement period. Do not include laboratory claims: - Bipolar disorder. - Personality disorder. - Psychotic disorder. - Pervasive developmental disorder. • Members who use hospice services or elect to use a hospice benefit any time during the measurement period. • Members who die any time during the measurement period.
Continuous enrollment period	The member must be enrolled with a medical benefit May 1 of the year prior to the measurement period through December 31 of the measurement period. A gap in enrollment is allowed only in the measurement period (January 1 to December 31). No gaps in enrollment are allowed from May 1 of the year prior to the measurement period through December 31 of the year prior to the measurement period. The member must be enrolled on the last day of the measurement period.
Type(s) of codes needed to calculate the measure	Logical Observation Identifiers Names and Codes (LOINC) codes are required to determine the result of the PHQ-9 screening, which is required for the denominator and numerators. Code sets for other measure components include: • Current Procedural Terminology (CPT) Category I. • International Classification of Diseases (ICD). • Healthcare Common Procedure Coding System (HCPCS). • Uniform Bill Revenue codes (UBREV).

Technical Specifications	
	The measure steward indicated that the HCPCS and UBREV codes are options for reporting the hospice services exclusion, and for reporting an interactive outpatient encounter for the IESD as part of the denominator.
Level of reporting for which specifications are available	Plan-level.

Minimum Technical Feasibility and Appropriateness	
Link to current technical specifications	See HEDIS MY 2025 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The measure steward indicated that the measure was field-tested in Medicaid in 2014, with the testing dataset including one Medicaid health plan with an integrated delivery system, as well as aggregate data from five Medicaid health plans. They noted that the testing results demonstrated that the measure could be calculated using different data sources and reporting approaches. Performance rates were low across all plans, demonstrating notable room for improvement. The individual who suggested the measure noted that California Medicaid is currently using this measure as part of the state's Medi-Cal Accountability Set, requiring all managed care plans to report on this measure.[1] The measure steward further confirmed that, as of data from 2022, Massachusetts, Pennsylvania, Washington, and Wisconsin also collect data on this measure, with Massachusetts using the measure in value-based purchasing.[2] In addition, the measure steward published a report in November 2024 detailing the performance on this measure from measurement years (MY) 2021-2023 by Medicaid health plans.[3] The report noted that performance results of behavioral health measures reflect the 'total' rate and are not stratified by age. The report showed that 71 Medicaid plans (25.5 percent of Medicaid plans participating in HEDIS) had reportable (non zero) submissions for the *Depression Remission or Response* measure in MY 2023, up from 22 Medicaid plans (8.1 percent) in MY 2021. None of the Medicaid plans with a reportable submission in MY 2023 reported using claims data alone. Mean rates for Medicaid plans that used any non-claims data source in MY 2023 were 7.6 percent (remission), 10.7 percent (response), and 30.0 percent (follow-up PHQ-9). Another, older report published by the measure steward in November 2022 using MY 2021 data included measure performance results from a small number of Medicaid plans that used claims data alone.[4]

Minimum Technical Feasibility and Appropriateness	
	The mean performance rates in MY 2021 for plans that used claims data alone were 0.9 percent (remission) and 5.0 percent (response). The results for the follow-up PHQ-9 rate were not publicly reported.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The individual who suggested this measure noted that states may vary in their ability to implement the PHQ assessment tool(s). The measure steward confirmed their awareness of challenges associated with implementing the PHQ-9 across health care practices in different health plans. They have received requests to consider expanding the specifications to allow additional types of depression assessment tools. However, current consensus and feedback from coding and feasibility experts maintain the recommendation of limiting the measure to the PHQ-9 at this time. The measure steward will continue to monitor the evidence and feedback in this area to ensure appropriate revisions as the data landscape evolves. An additional limitation of the measure is that performance rates vary by data sources used for reporting. As noted in the 2022 report by the measure steward cited above, plans that used administrative claims only reported low (or zero) rates on the measure for MY 2021.[5]
Evidence that measure could lead to improvement in quality of health care delivery and outcomes for Medicaid and CHIP beneficiaries	The measure's technical specifications cite the following clinical recommendations as support for the measure: • The Institute for Clinical Systems Improvement recommends that clinicians establish and maintain follow-up with adult patients who have depression. Appropriate, reliable follow-up is highly correlated with improved response and remission scores.[6] • The American Academy of Pediatrics recommends that adolescents with depression be assessed for treatment response and remission of symptoms using a depression assessment tool such as the PHQ-9 Modified for Teens.[7]

Actionability and Strategic Priority	
How measure addresses the most pressing needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The individual who suggested this measure highlighted that mental health is a priority for the Medicaid population, and that depression and suicide rates for adolescents have continued to rise since the COVID-19 pandemic. A measure that addresses outcomes from depression screening will help determine if treatment that results from screening is lowering depression rates and potentially suicide rates of young people served by Medicaid. The results will provide an opportunity to adjust interventions to improve or continue to improve outcomes from screening for depression.

Actionability and Strategic Priority	
Whether the data source allows for stratification by race, ethnicity, sex, and geography	The individual who suggested this measure indicated that, at present, it does not appear that the measure steward has tested the measure for stratification by race, ethnicity, sex, or geography. The individual notes that stratification by these factors is feasible from a data perspective. The measure steward noted that the measure only reached public reporting status as of MY 2023, so the measure is still gaining traction for reportability by health plans. They also noted that the measure may be considered for stratification by race and ethnicity, along with additional stratification categories, when the number of health plan submissions and average denominator sizes are consistently sufficient to support these changes.
Whether there is evidence of a performance gap for Medicaid and/or CHIP beneficiaries on the measure	The measure steward's 2022 report compared the performance rates on this measure between Medicaid, Medicare, and commercial beneficiary populations for MY 2021.[8] The mean reported rates for depression remission and response among Medicare beneficiaries were all higher than their Medicaid and commercial counterparts, indicating a performance gap in this measure.
How the measure can be used to monitor improvement	The individual who suggested this measure noted that the measure can be trended over time for both the Medicaid and CHIP populations. The Medicaid program, managed care entities, and providers have the ability to directly influence improvement and outcomes. Examples could include providing Medicaid and CHIP beneficiaries with direct access to treatment providers, support in scheduling appointments, and assignment to care management for support and assistance. States and managed care entities could also include appropriate medications on state and managed care entity formularies.
Whether the measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets	The individual who suggested this measure indicated that this measure would address the existing gap area of behavioral health care in the Core Sets.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The individual who suggested this measure cited national, all-payer data on adolescent depression and mental health, while noting that the effectiveness and outcomes of mental health services are mostly unmeasured and unreported. The individual who suggested the measure provided the following statistics:

Additional Information for Consideration	
	• According to the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey, the percentage of high school students feeling sad and hopeless increased significantly over a ten-year period from 2011 (28 percent) to 2021 (42 percent).[9] There is variation within populations, with female students (57 percent) more likely to report persistent feelings of sadness than male students (29 percent). LGBQ+ students (69 percent) were more likely to report persistent feelings of sadness than heterosexual students.[9] • Data from the Substance Abuse and Mental Health Services Administration's 2023 National Survey on Drug Use and Health (NSDUH) show that in the past year 18.1 percent of adolescents (ages 12 to 17) had a major depressive episode; 12.3 percent had serious thoughts of suicide; and 3.3 percent had attempted suicide.[10] The survey found that 31.9 percent of adolescents received mental health treatment (for example, counseling) in the past year.[7] The 2023 NSDUH also includes Medicaid and CHIP-specific results for adolescents and adults on some measures:[11] • Among adolescents ages 12 to 17 with Medicaid or CHIP coverage, 17.1 percent had a major depressive episode in the past year; and 56.8 percent of those with a major depressive episode reported that they received mental health treatment. • Among adults age 18 and older with Medicaid or CHIP coverage, 13.1 percent had a major depressive episode, 7.7 percent had serious thoughts of suicide, and 1.2 percent attempted suicide in the past year.
Use of measure in other CMS programs	The measure's technical specifications state that the measure was developed by the Minnesota Community Measurement (MNCM) organization and adapted by NCQA under a Children's Health Insurance Program Reauthorization Act (CHIPRA) Pediatric Quality Measures Program Centers of Excellence grant. The NCQA version of the measure is not currently in use in other CMS programs. The MNCM version of the measure is currently in use in the following programs: • Kidney Care Choices Model • Merit-Based Incentive Payment System Program (MIPS) • Medicare Shared Savings Program
Whether provider workflows will have to be modified to collect additional data needed to report the measure	No. The individual who suggested this measure indicated that workflow modifications would impose no or limited additional data entry burden on a clinician or other provider to collect the data elements to report the measure because data are routinely collected during the clinical care, AND the data are collected using structured EHR fields.

Additional Information for Consideration	
Potential barriers states could face in calculating measure and recommended technical assistance resources	The individual who suggested this measure highlighted that providers would likely expect payment for administering the PHQ-9, if not currently covered or reimbursed. During previous Workgroup discussions, states have noted challenges using LOINC codes, which are required to calculate this measure. The measure steward noted that they are aware that some plans face feasibility challenges with LOINC because these codes require access to clinical data. The measure steward maintains discussion with coding experts regarding these challenges, and their current recommendations are to maintain the PHQ-9 and inclusion of LOINC until additional options that are both valid and reliable for reporting the data required in this measure become available.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

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[11] Substance Abuse and Mental Health Services Administration. 2023 NSDUH Detailed Tables. Tables 6.40B, 6.73B, 7.2B, and 7.7B. Available at: https://www.samhsa.gov/data/report/2023-nsduh-detailed-tables.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2027 CORE SETS

Measure Information	
Measure name	**Initial Opioid Prescribing for Long Duration**
Description	The percentage of individuals age 18 years and older with at least one initial opioid prescription for more than seven cumulative days' supply. A lower rate indicates better performance.
Measure steward	Pharmacy Quality Alliance (PQA)
Meaningful Measures area(s)	Behavioral Health
Measure type(s)	Process
Suggested to replace current measure?	Yes, *Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)*. Note that the 2026 Child and Adult Core Sets Annual Review Workgroup recommended that CMS remove OHD-AD from the Adult Core Set. In December 2024, CMS confirmed that they have removed the measure from the 2026 Adult Core Set.[1]

Technical Specifications	
Ages	Age 18 and older as of the first day of the measurement year (January 1 through December 31).
Data collection method(s)	Administrative.
Denominator	Individuals who meet all the following criteria: • One or more prescription claims for an opioid during the measurement year. • A negative medication history for any opioid medication during a lookback period of 90 days prior to each opioid prescription claim. Notes: • The prescription claims can be for the same or different opioids. • For multiple opioid claims with the same date of service, calculate the number of days covered by an opioid using the prescription claims with the longest days' supply. • For multiple opioid claims with different dates of service, sum the days' supply for all the prescription claims regardless of overlapping days' supply. • Count the unique individuals (i.e., if an individual has multiple lookback periods, count the individual only once in the denominator).

Technical Specifications	
Numerator	Individuals from the denominator population with over seven cumulative days' supply for all opioid prescription claims within any opioid initiation period.* *Defined as the three-day time period when the numerator is assessed and includes the date of the initial opioid prescription plus two days. Since individuals may have multiple initial opioid prescriptions, there may be multiple opioid initiation periods (meaning that an individual may have multiple opportunities to fall into the numerator multiple times). If the opioid initiation period extends beyond the end of the measurement year, the opioid initiation period is truncated to the last day of the measurement year (i.e., December 31).
Exclusions	Exclude individuals who met at least one of the following during the measurement year or the 90 days prior to the index prescription start date (IPSD)*: • Hospice. • Cancer diagnosis. • Palliative care. • Sickle Cell Disease. *Defined as the earliest date of service for an opioid medication during the measurement year.
Continuous enrollment period	Individuals must be continuously enrolled during the measurement year and the 90 days prior to the IPSD with no allowable gaps.
Type(s) of codes needed to calculate the measure	Code sets used to calculate the measure include: • Current Procedural Terminology (CPT) Category I. • International Classification of Diseases (ICD). • SNOMED CT. • Healthcare Common Procedure Coding System (HCPCS) Level II. • Uniform Billing Codes (UB). • National Drug Code (NDC) Directory. The measure steward indicated that any codes not typically present in claims (e.g., SNOMED CT codes) are only provided as a reporting option within the hospice value set for comprehensiveness.
Level of reporting for which specifications are available	State-level and plan-level. The measure steward noted that while PQA measures are developed and specified at the health plan level, specifications can be (and have been) successfully applied to the state level.

Minimum Technical Feasibility and Appropriateness	
Link to current technical specifications	Specifications for the measure are not publicly available.
Information on testing or use at state Medicaid/CHIP level	The measure steward indicated the measure was tested using Medicaid administrative claims data (i.e., prescription claims and medical claims) and enrollment data from four states. The testing data set consisted of a 100 percent sample of Utah Medicaid beneficiaries (in both managed care and fee-for-service delivery systems) and a convenience sample of Medicaid beneficiaries (in managed care) provided by a data aggregator. The data aggregator's sample included managed care organization (MCO) data across three states: Tennessee, Pennsylvania, and West Virginia. All Medicaid testing data were from calendar year 2017 (January 1, 2017, to December 31, 2017). Data were retrospectively collected for testing, which took place in 2018. The combined testing dataset consisted of data from nine different health plans across the four states. After applying the measure criteria, the final eligible population included in the data set was 84,616. Eligible population sizes across states ranged from 405 to 44,259, with a mean size of 9,402 and a median of 2,297. During measure testing, the measure rates ranged from 9.49 percent to 33.50 percent across the nine health plans, with a mean rate of 23.68 percent, a median rate of 25.93 percent, and a standard deviation of 8.14 percent. Measure rates were also calculated and stratified by age and gender to understand potential disparities among these subpopulations. The measure steward also calculated reliability statistics to evaluate whether differences in performance across entities were due to real differences in quality rather than chance or measurement error. The reliability statistics were calculated based on the methodology published by Adam, et. al., using the measure rates for all nine Medicaid health plans.[2] The mean reliability was 0.98 with a median of 0.99 and a standard deviation of 0.02, indicating a high level of reliability. The measure steward was not aware of any state Medicaid and/or CHIP programs that are currently using the measure. Mathematica found evidence that Washington state had calculated the measure across all payers, including Medicaid, and stratified by payer, as part of a study on multiple opioid prescribing measures using 2015 to 2019 data.[3]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The measure steward noted that all data required for the measure are captured through administrative claims (i.e., prescription and medical claims) and beneficiary enrollment data, which are available across all states. They indicated that state-specific factors such as Medicaid program implementation, data reporting, and data quality may affect the consistency of calculation across states.

Minimum Technical Feasibility and Appropriateness	
	They further noted that state Medicaid programs only report data on covered services; therefore, variations in coverage between state Medicaid programs can also impact the consistency of the measure calculations when compared across states. However, in their opinion, these challenges are intrinsic to quality reporting within the Medicaid program and are not expected to impact this measure any differently than they would other measures that rely on administrative claims data. The measure steward provides technical assistance to mitigate variations in the interpretation of the measure specifications. They noted that states reporting the measure for the Adult Core Set and seeking clarification on PQA measure specifications, interpretation, coding, or any other aspect of their measures can contact them through their website.[4]
Evidence that measure could lead to improvement in quality of health care delivery and outcomes for Medicaid and CHIP beneficiaries	The measure steward highlighted that the measure was developed in alignment with the clinical guidance from the *2016 CDC Clinical Practice Guideline for Prescribing Opioids for Pain*,[5] which recommended that when opioids are used for acute pain, no greater quantity should be prescribed than is needed for the expected duration of pain severe enough to require opioids; a supply of three days or less will often be sufficient and more than seven days' supply will rarely be needed. *The 2022 Clinical Practice Guideline for Prescribing Opioids for Pain*[6] continues to recommend durations of a few days or less for opioids when used in the acute pain setting, while noting that duration should be individualized to a patient's circumstances. The measure does not penalize subsequent fills of greater duration, but, according to the measure steward, ensures appropriate follow-up and evaluation instead of potentially dangerous initial prescriptions. The measure steward also emphasized that the measure was designed for retrospective population-level evaluation and is not intended to guide care for individual patients. In addition, the measure steward noted that this measure is consensus-based entity (CBE) endorsed (#3558) and received unanimous passing votes on the evidence criterion from the National Quality Forum (NQF) standing committee. Finally, the measure steward cited evidence demonstrating that greater duration of initial opioid exposure is associated with a higher likelihood for high-risk and long-term opioid use, misuse, overdose, and other negative outcomes. A selection of this evidence includes: • Tehrani AB, Henke RM, Ali MM, Mutter R, Mark TL. Trends in average days' supply of opioid medications in Medicaid and commercial insurance. *Addict Behav*. Jan 2018;76:218-222. doi:10.1016/j.addbeh.2017.08.005.

Minimum Technical Feasibility and Appropriateness	
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Actionability and Strategic Priority	
How measure addresses the most pressing needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The individual who suggested the measure highlighted that in 2017, the Medicaid and CHIP Payment and Access Commission issued a Report to Congress stating that the nationwide opioid public health crisis disproportionally affects Medicaid beneficiaries.[7] Since 2017, the Department of Health and Human Services (HHS) has continued to employ a comprehensive evidence-based Opioid Strategy to address opioid misuse and abuse by leveraging resources across HHS agencies.[8] With Medicaid beneficiaries accounting for almost 40 percent of the approximately two million non-elderly adults with opioid use disorder in the nation as of 2017, the individual who suggested the measure noted that state Medicaid programs have a responsibility to address the opioid public health crisis.[9,10] According to the individual who suggested the measure, this measure provides an opportunity to monitor Medicaid performance by providing information on early-stage health care processes of opioid prescribing that are associated with high-risk and long-term opioid use, misuse, and overdose. The measure is expected to fill a gap in quality measurement that addresses opioid overdose risk particularly if CMS removes the *Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)* measure from the 2026 Child and Adult Core Sets.[b] The individual who suggested the measure also noted that the measure responds to stated Core Set Workgroup desires for a more upstream measure focused on opioid-related quality.
Whether the data source allows for stratification by race, ethnicity, sex, and geography	The measure steward indicated that this measure allows for stratification by the following factors: • Race and ethnicity, • Sex, and • Geography. They noted that the measure is specified using administrative claims and enrollment data. Stratification is therefore enabled (and limited) by the data captured in a standard manner by each state, consistent with all other claims-based measures used in the Core Sets. They cited estimates from calendar year 2022 of the availability and quality of beneficiary-level data from the Medicaid Data Quality Atlas,[11] including: • Gender: Low Concern (53 states/territories); • Geography (ZIP Code): Low Concern (50 states/territories), Medium Concern (2 states/territories), High Concern (1 state/territory); and

[b] CMS announced that OHD-AD would be removed from the 2026 Adult Core Set in December 2024, several months after Mathematica received this measure suggestion.

Actionability and Strategic Priority	
	• Race and Ethnicity: Low Concern (15 states/territories), Medium Concern (22 states/territories), High Concern (14 states/territories), Unusable (1 state/territory), Unclassified (1 state/territory). The measure steward does not anticipate issues related to stratified population size that would hinder the feasibility of stratified reporting by state, nor do they anticipate that the feasibility of stratifying this measure would be different than for any other measure in the Adult Core Set. The measure steward confirmed that they currently stratify their measures by age and sex during their standard measure testing process, but not by race, ethnicity, and geography. PQA piloted optional collection of race and ethnicity data in its most recent testing plans.
Whether there is evidence of a performance gap for Medicaid and/or CHIP beneficiaries on the measure	The measure steward reported that the measure testing results (not publicly available) showed gaps in performance and substantial room for improvement across Medicaid populations, with rates ranging from 9.5 to 33.5 percent, with lower rates representing better performance. Measure rates between better performing managed care and fee-for-service programs (17.59 percent) were statistically significantly different when compared to measure rates of lower performing health plans (29.53 percent). The measure steward also indicated that the measure has been tested and is currently in use in other populations including Medicare Part D beneficiaries. According to the measure steward, the Medicare Part D Patient Safety Reports show the following mean performance rates: • 21.6 percent (standard deviation=16.1 percent) in 2020, • 19.1 percent (standard deviation=15.7 percent) in 2021, and • 18.6 percent (standard deviation=15.3 percent) in 2022. The Medicare Part C and D Display page shows mean performance rates of 16.9 percent (standard deviation=11.2 percent) in 2021 and 16.7 percent (standard deviation=11.4 percent) in 2022.[12] The measure steward noted that differences in performance between Medicaid and Medicare beneficiaries may imply differences in quality of care across populations, in addition to reflecting different characteristics of each population.
How the measure can be used to monitor improvement	The measure steward indicated that the measure can be trended over time to assess Medicaid and CHIP program performance and progress, as demonstrated through trending in Medicare provided via the Medicare Part D Patient Safety Reports and the Medicare Part C and D Display page.[13] Additionally, they noted that state Medicaid and CHIP programs can influence improvement on this measure through a variety of tools, such as provider education and use of state Medicaid Drug Utilization Review policies.

Actionability and Strategic Priority	
Whether the measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets	According to the individual who suggested the measure, the measure would address an existing gap area in the Core Sets related to behavioral health care. They specified that the measure is suggested as a replacement for the OHD-AD measure, which the Workgroup recommended for removal from the 2026 Adult Core Set. The measure steward mentioned that, although the suggested measure is related to the *Concurrent Use of Opioids and Benzodiazepines* (COB-AD) measure in its focus on high-risk opioid prescribing, the *Initial Opioid Prescribing for Long Duration* measure adds value to the Core Sets by addressing a broad population. The measure is intended to discern between good and poor performance in the process of care related to initial opioid prescribing indicated for acute pain, in individuals who are not currently taking opioids. They noted that this measure explicitly responds to stated Core Set Workgroup desires for a more upstream measure focused on opioid-related quality. It is also responsive to stated priorities from other stakeholders, such as the cited recommendation for initial prescribing measures offered in the NQF Opioid and Opioid Use Disorder Technical Expert Panel.[14]

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	Data from 2017 demonstrated that Medicaid beneficiaries account for almost 40 percent of the approximately two million non-elderly adults with opioid use disorder in the nation, while an additional study suggests Medicaid beneficiaries are disproportionately at risk of opioid-related adverse events like overdose.[15, 16] According to more recent CMS data on opioid prescribing rates, there were more than 20 million opioid prescriptions among Medicaid beneficiaries in 2022.[17] The individual who suggested the measure indicated that these data demonstrate ample opportunity for state Medicaid programs to address high-risk initial opioid prescribing.
Use of measure in other CMS programs	The measure is currently used in the following CMS programs: • 2024 Medicare Part C and D Display Page (CBE ID #3558) • Medicare Part D Patient Safety Reports The individual who suggested the measure noted that a key part of the CMS National Quality Strategy Goal is aligning quality measures across programs.[18] They indicated that adding this measure to the Medicaid Adult Core Set would be a step forward in measure alignment.

Additional Information for Consideration	
Whether provider workflows will have to be modified to collect additional data needed to report the measure	Not applicable. The measure steward indicated that the measure imposes no data entry burden on providers, either because the measure uses data that are routinely generated (i.e. administrative data and claims), the data are collected by someone other than the provider, or the measure repurposes existing data sets to calculate the measure.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The measure steward noted that they have not identified any potential barriers to calculating this measure, which has been successfully implemented in other major quality programs like Medicare Part D. They indicated that PQA regularly collaborates with programs that use PQA measures to support implementation, such as the Medicaid Adult Core Set, Medicare Part D Star Ratings, and the Health Insurance Marketplace Quality Rating System. PQA also provides technical assistance services to individual measured entities, technology or analytics solutions vendors that license PQA measures, quality researchers, and other parties.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	The measure steward indicated that, in response to stakeholder feedback and evolving evidence, the measure specifications have undergone updates since the measure was tested during its initial development. In 2020, exclusions for individuals undergoing palliative care and patients with sickle cell disease were tested and added through PQA's systematic, consensus-based maintenance process to better align with CDC guidelines and avoid unintended consequences for pain management in these populations. The measure steward anticipates adding a cancer-related pain exclusion beginning in February 2025, which is additive to the current cancer diagnosis exclusion and is intended to better align with CDC guidelines and further avoid unintended consequences.

Citations

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/sho24007.pdf.

[2] Adams JL. The reliability of provider profiling: a tutorial. 2009. Accessed September 11, 2024. https://www.rand.org/pubs/technical_reports/TR653.html.

[3] https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief097.pdf.

[4] https://pqa.memberclicks.net/tech-assist-form.

[5] Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. *MMWR Recomm Rep*. 2016;65:1-49. PMID: 26987082.

[6] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. PMID: 36327391. Available at: https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm#B2_down.

[7] https://www.macpac.gov/publication/june-2017-report-to-congress-on-medicaid-and-chip/.

[8] https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/combatting-opioid-misuse-and-abuse/index.html.

[9] https://www.kff.org/medicaid/issue-brief/state-approaches-to-addressing-the-opioid-epidemic-findings-from-a-survey-of-state-medicaid-programs/.

[10] https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/.

[11] https://www.medicaid.gov/dq-atlas/landing/topics/info.

[12] https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data.

[13] https://www.cms.gov/medicare/health-drug-plans/part-c-d-performance-data.

[14] https://www.qualityforum.org/Publications/2020/02/Opioids_and_Opioid_Use_Disorder__Quality_Measurement_Priorities.aspx.

[15] https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/.

[16] https://pubmed.ncbi.nlm.nih.gov/35089351/.

[17] https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-opioid-prescribing-rates/medicaid-opioid-prescribing-rates-by-geography/data.

[18] https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2027 CORE SETS

Measure Information	
Measure name	**Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit**
Description	Percentage of enrolled children aged six months through five years who received a comprehensive or periodic oral evaluation with a dental provider within six months following a medical preventive service visit.
Measure steward	American Dental Association on behalf of the Dental Quality Alliance (DQA)
Meaningful Measures area(s)	Wellness and Prevention
Measure type(s)	Process
Suggested to replace current measure?	No

Technical Specifications	
Ages	Children aged six months through five years. Report three age stratifications and a total rate:[c] • Ages 6 months to <1 year. • Ages 1 through 2. • Ages 3 through 5. • Total (ages 6 months through 5 years).
Data collection method(s)	Administrative.
Denominator	Unduplicated number of enrolled children aged six months through five years with a medical preventive service visit between July 1 of the year prior to the reporting year and June 30 of the reporting year.
Numerator	Unduplicated number of enrolled children aged six months through five years who received a comprehensive or periodic oral evaluation as a dental service within six months following a medical preventive service.

[c] The measure steward has identified applicable age stratification brackets to identify disparities for quality improvement. If added to the Child Core Set, CMS will determine which age stratifications are required for the purposes of Core Sets reporting.

Technical Specifications	
Exclusions	The denominator excludes children who had a comprehensive or periodic oral evaluation as a dental service during the 180 days before the index medical preventive service visit.
Continuous enrollment period	The beneficiary is continuously enrolled on the date of the index medical preventive service visit through at least 180 days following the index medical preventive service visit. Note: For programs/plans that verify enrollment on a monthly basis, the continuous enrollment criteria should include the month in which the index medical preventive service visit occurred AND six months after the index medical preventive service visit.
Type(s) of codes needed to calculate the measure	The following codes are needed to calculate the measure: • Current Procedural Terminology (CPT) Category I. • International Classification of Diseases (ICD). • Code on Dental Procedures and Nomenclature (CDT). • National Uniform Claim Committee (NUCC) provider taxonomy codes. • Healthcare Common Procedure Coding System (HCPCS) Level II.
Level of reporting for which specifications are available	Plan-level, program-level.

Minimum Technical Feasibility and Appropriateness	
Link to current technical specifications	Specifications for the measure are available at: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2025/2025_early_childhood_oral_eval_following_medical_preventive_visit_final.pdf
Information on testing or use at state Medicaid/CHIP level	The measure steward indicated that this measure has been tested in state Medicaid and CHIP programs, but is not currently in use by any states. Testing was conducted using Medicaid and CHIP enrollment and claims data contained within the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) from the Centers for Medicare & Medicaid Services (CMS) using data for the following states: Alaska, Delaware, Michigan, New Mexico, North Carolina, and Washington. Measure testing included all Medicaid and CHIP populations represented in TAF in these states.[1] This measure was approved at DQA's June 2024 membership meeting; consequently the measure has not yet been implemented by state programs.

Minimum Technical Feasibility and Appropriateness	
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The measure steward stated this measure does not rely on any data sources, data elements, or linkages that are not already required for other Core Set measures. The measure steward noted that, as with all quality measures, incomplete or missing data for any critical data element threatens measure reliability.
Evidence that measure could lead to improvement in quality of health care delivery and outcomes for Medicaid and CHIP beneficiaries	The individual who suggested the measure explained that dental caries is the most common chronic disease of childhood which can result in pain and infections that may lead to emergency department (ED) visits and hospitalizations. Additional adverse impacts include difficulty eating, speaking, playing and learning.[2] The American Academy of Pediatrics (AAP), American Public Health Association, American Academy of Pediatric Dentistry, and American Dental Association recommend that children visit a dentist by age one for timely prevention and identification of dental disease and to enable less invasive approaches to early childhood caries management.[3] Delays in the first dental visit are associated with an increase in dental caries, treatment needs, and number of dental procedures with a consequent increase in the likelihood of using general anesthesia for treatment and caries-related ED visits.[4,5] A study using Medicaid claims data for children ages six months to six years found a significant increase in dental caries when: (1) the first oral health exam occurred at age four compared with age (hazard ratio: 5.4) and (2) the oral exam was with a physician compared with a general dentist (hazard ratio: 2.6).[6]

Actionability and Strategic Priority	
How measure addresses the most pressing needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The individual who suggested the measure noted that delays in the first dental visit increase the likelihood of early childhood caries and consequent adverse effects on child health and quality of life. Yet, most Medicaid beneficiaries do not have a visit with a dental provider. Among Medicaid-enrolled children, 79 percent of 1 to 2-year-olds had a medical visit in federal fiscal year 2021 compared with 26 percent who had a dental visit. Among 3 to 5-year-olds, 63 percent had a medical visit and 49 percent had a dental visit.[7] The high rates of medical visits in early childhood represent an opportunity to connect children accessing the medical system to dental care. The AAP notes the importance of establishing care with a dental provider in early childhood through medical-dental coordination in addition to conducting oral health screenings and providing basic preventive services and anticipatory guidance within medical settings.

Actionability and Strategic Priority	
	The report states that "although pediatricians have the opportunity to provide early assessment of risk for dental caries and anticipatory guidance to prevent disease, it is also important that children establish a dental home" and, "with early referral to a dental provider, there is an opportunity to maintain good oral health, prevent disease, treat disease early, and potentially decrease cost."[8] This measure is designed to promote the medical-dental coordination recommended by the AAP.
Whether the data source allows for stratification by race, ethnicity, sex, and geography	The measure steward explained that the data source allows for stratification by race, ethnicity, sex, and geography. This is a claims-based measure. The measure steward stated that stratification feasibility is demonstrated by the DQA oral health dashboard, which reports all measures stratified by age, race/ethnicity, sex, and geography, among other characteristics for which there is sufficient data completeness. They indicated that the primary challenges with stratification using claims data are common to all Medicaid/CHIP claims-based measures, such as data completeness (for example, race and ethnicity data fields are less likely to be complete than age and sex).
Whether there is evidence of a performance gap for Medicaid and/or CHIP beneficiaries on the measure	The measure steward indicated that measure scores ranged from 19 percent to 34 percent among the 6 testing states with statistically significant differences in performance scores between states. Even in the highest performing state, 66 percent of children younger than 6 years old did not have a periodic or comprehensive oral evaluation with a dental provider following the index medical preventive service visit, after excluding those who had an oral evaluation within the 6 months before the medical visit. Thus, the measure demonstrates an overall performance gap as well as variation in performance between programs.
How the measure can be used to monitor improvement	The individual who suggested the measure explained that the measure can be trended over time to assess Medicaid and CHIP program performance and progress. Medicaid and CHIP programs and their participating providers can directly influence improvement on this measure. Examples of improvement strategies include: • A federally qualified health center (FQHC) in Rhode Island implemented a program where pediatricians refer children at age one or first tooth eruption to a dentist. Children are subsequently scheduled for dental appointments every six months. FQHCs are important care providers for Medicaid, providing care for 20 percent of beneficiaries.[9] • The same FQHC also has a dental clinic coordinator that regularly reviews medical records to identify families that recently had babies in the past year and invite the parent to bring the child into the dental clinic for screening at age one.

Actionability and Strategic Priority	
	• A potential barrier to improvement is identifying dental providers for referral. However, the Washington state Access to Baby and Child Dentistry (ABCD) program demonstrates the ability to expand dental provider networks and access for pre-school aged children, increasing the percentage of Medicaid-enrolled children under age 6 with a dental visit from 20 percent in the early 2000s to more than 54 percent in 2018.[10] Thus, they noted that a multi-pronged improvement strategy that engages and connects the medical and dental systems of care can effectively realize meaningful and significant improvement.
Whether the measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets	The individual who suggested the measure asserted that there are currently no measures on the Core Sets that support improvement in the integration and coordination of care between medical and dental care systems that are critical to support whole child health. This measure focuses on early childhood where the impact on oral health can be the greatest by preventing early childhood caries, establishing children with a dental provider, and laying the foundation for ongoing dental care, thereby promoting improved oral and overall health outcomes. Stratification of this measure by patient characteristics additionally supports health equity goals. The individual who suggested this measure also noted that this measure supports the recommendations set forth by the CMS-established Medicaid and CHIP Oral Health Initiative Workgroup, which recommended an increased emphasis on preventive, minimally invasive oral health care that "focuses on the early prevention of caries and timely interception of disease." The report also noted that children should have an oral evaluation at the eruption of the first tooth and by age one year with ongoing dental visits at least every six months.[11]

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	Dental caries is the most common chronic disease in children in the United States.[12] Almost one-fourth of children ages two to five years and about one-third of children ages two to five years living in poverty in the United States have dental caries.[13]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.

Additional Information for Consideration	
Whether provider workflows will have to be modified to collect additional data needed to report the measure	Not applicable. The measure steward indicated that the measure imposes no data entry burden on providers, either because the measure uses data that are routinely generated (i.e. administrative data and claims), the data are collected by someone other than the provider, or the measure repurposes existing data sets to calculate the measure.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The measure steward indicated that there are no data sources, data elements, or linkages that are not already required for other Core Set measures. The measure does require access to and the ability to link medical claims with dental claims; this is also required to calculate the *Oral Evaluation During Pregnancy* measure, which was added to the Child and Adult Core Sets and is voluntary for 2025 reporting. Should there be questions, DQA offers technical assistance to all measure users. Additionally, this measure is included in DQA's online, interactive oral health dashboard for reporting dental quality measures using T-MSIS data for all 50 states plus the District of Columbia. The DQA dashboard is available at: https://www.ada.org/resources/research/dental-quality-alliance/dqa-improvement-initiatives.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.

Citations

[1] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dqa_interimreport_oralevaluationfollowingmedi.pdf?rev=17a637491c604cc68a61c1b93d4d3582&hash=3C874F7CDF239CE9BBC5F82D6E915967.
[2] https://www.cdc.gov/oral-health/prevention/oral-health-tips-for-children.html.
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[8] https://pubmed.ncbi.nlm.nih.gov/36530159/.
[9] https://ppc.uiowa.edu/sites/default/files/ced_environmental_scan.pdf.
[10] https://abcd-dental.org/about-abcd/providers/.
[11] https://www.medicaid.gov/media/176321.
[12] https://www.cdc.gov/oral-health/prevention/oral-health-tips-for-children.html.
[13] https://www.cdc.gov/oral-health/media/pdfs/Oral-Health-Surveillance-Report-2019-h.pdf.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2027 CORE SETS

Measure Information	
Measure name	**Adults With Diabetes – Oral Evaluation**
Description	Percentage of enrolled adults aged 18 years and older with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year.
Measure steward	American Dental Association on behalf of the Dental Quality Alliance (DQA)
Meaningful Measures area(s)	Chronic Conditions
Measure type(s)	Process
Suggested to replace current measure?	No

Technical Specifications	
Ages	Adults aged 18 years and older on the last day of the reporting year. Report ten age stratifications and a total rate:[d] • Age 18. • Ages 19 through 20. • Ages 21 through 24. • Ages 25 through 34. • Ages 35 through 44. • Ages 45 through 54. • Ages 55 through 64. • Ages 65 through 74. • Ages 75 through 84. • Ages 85+. • Total (Ages 18 and older).
Data collection method(s)	Administrative.
Denominator	Unduplicated number of enrolled adults aged 18 years and older with diabetes.

[d] The measure steward has identified applicable age stratification brackets to identify disparities for quality improvement. If added to the Adult Core Set, CMS will determine which age stratifications are required for the purposes of Core Sets reporting.

Technical Specifications	
Numerator	Unduplicated number of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation.
Exclusions	Exclude adults if any of the following conditions are met: • Age criterion is not met or there are missing or invalid field codes (e.g., date of birth). • Subject does not meet continuous enrollment criterion (see below). • Subject is dually eligible for Medicaid and Medicare during the reporting year (if linked Medicaid-Medicare claims are not available). • Subject received care at a hospice facility in the reporting year. • Subject died during the reporting year. • Subject received palliative care in the reporting year. • Subject is age 66 and older as of December 31 of the reporting year with frailty and advanced illness. • Subject does not have a diagnosis from the NCQA Diabetes Value Set (type I or type II Diabetes) in any setting and is in the NCQA Diabetes Exclusion Value Set (e.g., has a diagnosis of polycystic ovarian syndrome, gestational diabetes, or steroid/drug induced diabetes) in the reporting year or the year prior to the reporting year.
Continuous enrollment period	Continuously enrolled for the reporting year (12 months) with a single gap of no more than 45 days (one-month gap for programs that determine eligibility on a monthly basis).
Type(s) of codes needed to calculate the measure	Code sets needed for this measure include: • Current Procedural Terminology (CPT) Category I. • International Classification of Diseases (ICD). • Code on Dental Procedures and Nomenclature (CDT). • Healthcare Common Procedure Coding System (HCPCS) Level II. • National Drug Code (NDC) Directory. • Uniform Billing Codes (UB).
Level of reporting for which specifications are available	State-level (e.g., state Medicaid program).

Minimum Technical Feasibility and Appropriateness	
Link to current technical specifications	Specifications are available at: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2025/2025_adult_diabetes_oral_evaluation_final.pdf
Information on testing or use at state Medicaid/CHIP level	The measure steward reported that measure testing was conducted using data from the Iowa and Oregon Medicaid programs. Measure testing in Oregon included all Medicaid-eligible adults (age 18 and older) enrolled in Oregon Medicaid. Measure testing in Iowa Medicaid included adults ages 19 to 64 enrolled in the Dental Wellness Plan, the Family Medical Assistance Program and the Supplemental Security Income population. Moreover, the Oregon Health Authority has included the finalized measure as a metric in its Coordinated Care Organization (CCO) Quality Incentive Program for several years.[1] Results from state Medicaid testing and use were included with the measure submission: • OHA Internal Measure Steward Information and • DQA Final Report - Adult Oral Health Performance Measures.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The data required include dental, medical and pharmacy administrative enrollment and claims data from the single reporting year (prior year needed for diabetes identification). When using claims data to determine service receipt, include both paid and unpaid claims (including pending, suspended, and denied claims). The measure specifications suggest that use of this measure for stand-alone dental benefit plans may result in feasibility issues due to lack of access to necessary data. Use by health plans that provide both medical and dental benefits may be considered after assessment of data element feasibility within the plans' databases. The measure steward stated there are no special considerations for this measure. As with all quality measures, incomplete or missing data for any critical data element threatens measure reliability. They indicated that there are no data sources, data elements, or linkages that are not already required for other Core Set measures. The denominator is consistent with diabetes identification in other Adult Core Set measures. The numerator is consistent with identifying oral evaluation in other Child and Adult Core Set measures.
Evidence that measure could lead to improvement in quality of health care delivery and outcomes for Medicaid and CHIP beneficiaries	The measure steward shared that *2024 Standards of Medical Care in Diabetes* call for initial care management to include referral to a dentist.[2] The measure steward also noted that diabetes is associated with xerostomia, dental caries, periodontal disease, and tooth loss with significant research examining the relationship between diabetes and periodontal disease and demonstrating a bi-directional relationship.[3,4,5]

Minimum Technical Feasibility and Appropriateness	
	Diabetes is associated with increased prevalence and severity of periodontal disease. Periodontal disease is associated with poor glycemic control. A Cochrane Database systematic review found that periodontal treatment improves glycemic control in individuals with both periodontitis and diabetes.[6] Oral evaluations are an important entry point into the dental care system. Diagnosis and treatment planning for the prevention and treatment of periodontal and other oral disease at these visits have the potential to improve diabetes outcomes. The following sources were provided by the measure steward as evidence and guidelines supporting a relationship between diabetes and periodontitis: • https://pubmed.ncbi.nlm.nih.gov/32652980/, • https://pubmed.ncbi.nlm.nih.gov/37654263/, • https://pubmed.ncbi.nlm.nih.gov/23631572/, • https://pubmed.ncbi.nlm.nih.gov/25342350/, and • https://pubmed.ncbi.nlm.nih.gov/29280174/. The following sources were provided as evidence supporting a relationship between dental care for diabetics and improved outcomes: • https://pubmed.ncbi.nlm.nih.gov/35420698/ and • https://pubmed.ncbi.nlm.nih.gov/38642823/.

Actionability and Strategic Priority	
How measure addresses the most pressing needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The individual who suggested the measure asserted that lack of dental care that includes diagnosis, prevention, and care planning can result in poor oral and overall health outcomes including dental caries, periodontal disease, and tooth loss with consequent pain and adverse impacts on eating and speaking.[7,8] Despite recommendations that adults with diabetes be referred to a dentist, almost 60 percent of adults with diabetes have a medical visit but no dental visit.[9] They indicated that these high rates of medical visits but no dental visits represent an important opportunity to connect adults with diabetes who access the medical system to dental care. This measure is designed to promote medical-dental coordination that could improve both oral health and overall health outcomes and quality of life for Medicaid beneficiaries living with diabetes.
Whether the data source allows for stratification by race, ethnicity, sex, and geography	The measure steward noted that stratification feasibility is demonstrated by the DQA oral health dashboard, which reports all measures stratified by age, race/ethnicity, sex, and geography, among other characteristics for which there is sufficient data completeness.[10]

Actionability and Strategic Priority	
	They indicated that the primary challenges with stratification using claims data are common to all Medicaid/CHIP claims-based measures, such as data completeness (e.g., race and ethnicity are less likely to be completely filled than age and sex).
Whether there is evidence of a performance gap for Medicaid and/or CHIP beneficiaries on the measure	The measure steward stated that there is evidence of a performance gap. The measure scores ranged from 23 percent to 34 percent among the testing programs with statistically significant differences. There were also statistically significant variations by age, sex, and geographic location. Even in the highest performing testing program, only 34 percent of adults with diabetes did have a periodic or comprehensive oral evaluation during the reporting year.[11] In the Oregon CCO program, the statewide score was highest (among years 2018 through 2022) in 2019 at 31 percent, usually ranging from 23 percent to 35 percent across CCOs. Consistent with the rest of the testing data, in the highest performing CCO, about two-thirds of adults with diabetes did not have an oral evaluation.[12] This evidence from testing demonstrates a performance gap in the Medicaid program, as well as variation in performance between reporting entities and by beneficiary characteristics.
How the measure can be used to monitor improvement	The individual who suggested the measure explained the measure can be trended over time to assess program performance and progress. They also indicated that programs and their participating providers can directly influence improvement on this measure and provided the following examples of improvement strategies: • To improve on the DQA measure *Adults with Diabetes - Oral Evaluation*, the Oregon Health Authority has been promoting "Routine diabetes care includes dental care!"[13] CareOregon has an Oral Health Integration Team that develops materials and trainings, including brochures about diabetes and oral health for patients, and trainings for medical professionals to help them identify the oral manifestations of diabetes and encourage referrals to dental exams. There are also resources for medical-to-dental referrals.[14] • The Colorado Oral Health Unit of the Colorado Department of Public Health and Environment has a Diabetes, Cardiovascular Disease, and Oral Health Integration program that includes increasing diabetes disease screening, bidirectional referral and management outcomes in federally qualified health centers. Resources include implementation plans, workflows, and educational materials.[15] • The CMS-established Medicaid and CHIP Oral Health Initiative Workgroup identified methods to integrate oral health into chronic disease management.

Actionability and Strategic Priority	
Whether the measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets	According to the individual who suggested the measure, this measure supports improvement in the integration and coordination of care between medical and dental care systems that are critical to support whole person health. This measure focuses on adults with diabetes who are at increased risk for oral disease and consequent impacts on quality of life. Stratification of this measure by patient characteristics additionally supports health equity goals. The individual also noted that this measure is aligned with the recommendations set forth by the CMS-established Medicaid and CHIP Oral Health Initiative Workgroup. This measure specifically aligns with Strategic priority 1.1: Improve coordination and integration of care to increase utilization of recommended care. The DQA measure *Adults with Diabetes – Oral Evaluation* is included as a potential measure "for the next phase of the Medicaid and Oral Health Initiative."[16]

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	It is estimated that between 7.5 percent and 12.7 percent of Medicaid beneficiaries ages 18 to 64 have diabetes.[17]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Whether provider workflows will have to be modified to collect additional data needed to report the measure	Not applicable. The measure steward indicated that the measure imposes no data entry burden on providers, either because the measure uses data that are routinely generated (i.e. administrative data and claims), the data are collected by someone other than the provider, or the measure repurposes existing data sets to calculate the measure.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The measure steward noted that there are no data sources, data elements, or linkages that are not already required for other Core Set measures. Should there be questions, DQA offers technical assistance to all measure users. Additionally, this measure is included in the DQA's online, interactive oral health dashboard for reporting dental quality measures using T-MSIS data for all 50 states plus the District of Columbia.[18]
Summary of prior Workgroup discussions	This measure was discussed at the 2020 Core Sets Annual Review meeting. At the 2020 meeting, the measure was not recommended for addition to the Core Sets.

Additional Information for Consideration	
	Although the Workgroup noted that the *Adults with Diabetes – Oral Evaluation* measure would fill a gap in the Adult Core Set and is feasible to report (having been implemented in one state's incentive program), some Workgroup members expressed concern that the measure was still undergoing testing and that it might be more related to diabetes (for which there are several other Adult Core Set measures) than oral health care. The specifications were also not finalized at the time of the 2020 meeting. In their submission, the individual that submitted the measure acknowledged the previous Workgroup discussion. They noted that DQA has since completed testing for the measure in Medicaid programs and that the measure now has finalized specifications.

Citations

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[2] https://diabetesjournals.org/care/article/47/Supplement_1/S52/153956/4-Comprehensive-Medical-Evaluation-and-Assessment.
[3] https://pubmed.ncbi.nlm.nih.gov/28642531/.
[4] https://pubmed.ncbi.nlm.nih.gov/10936666/.
[5] https://www.cdc.gov/oral-health/data-research/facts-stats/fast-facts-diabetes-and-oral-health.html.
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[7] https://www.cdc.gov/oral-health/data-research/facts-stats/fast-facts-diabetes-and-oral-health.html.
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[9] https://pubmed.ncbi.nlm.nih.gov/35287941/.
[10] https://www.ada.org/resources/research/dental-quality-alliance/dqa-improvement-initiatives.
[11] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/measure-development/dqa_final_report_testing_adult_oral_health_pe.pdf.
[12] https://visual-data.dhsoha.state.or.us/t/OHA/views/CCOPerformanceMetrics/welcome?%3Aembed=y&%3AisGuestRedirectFromVizportal=y.
[13] https://careoregondental.org/providers/provider-updates/2021/06/11/routine-diabetes-care-includes-dental-care-2021-diabetes-metric-explained.
[14] https://www.careoregondental.org/ohip.
[15] https://coloradooralhealth.org/initiatives/oral-health-integration/dcvdohi/.
[16] https://www.medicaid.gov/media/176321.
[17] https://pubmed.ncbi.nlm.nih.gov/29153115/.
[18] https://www.ada.org/resources/research/dental-quality-alliance/dqa-improvement-initiatives.

Measure That Will Not Be Discussed by the Workgroup

CHILD AND ADULT CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2027 CORE SETS

Measure Information	
Measure name	**HIV Screening**
Description	Percentage of patients ages 15 to 65 at the start of the measurement period who were between 15 and 65 years old when tested for human immunodeficiency virus (HIV).
Measure steward	Centers for Disease Control and Prevention (CDC)
Meaningful Measures area(s)	Wellness and Prevention
Measure type(s)	Process
Suggested to replace current measure?	No

Technical Specifications	
Ages	Patients ages 15 to 65 at the start of the measurement period.
Data collection method(s)	Electronic clinical data and electronic health record (EHR). Note: Electronic clinical data sources include, but are not limited to, member eligibility files, electronic health records, personal health records, clinical registries, health information exchanges, administrative claims systems, electronic laboratory reports, electronic pharmacy systems, immunization information systems, and disease/case management registries.
Denominator	Patients ages 15 to 65 at the start of the measurement period who had at least one outpatient visit during the day of the measurement period.
Numerator	Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday.
Exclusions	Exclude patients diagnosed with HIV prior to the day of the start of the measurement period. Exclude patients who meet the following criterion only if the patients do not meet the criteria for inclusion in the numerator: patients who die on or before the end of the last day of the measurement period.
Continuous enrollment period	Not specified.
Type(s) of codes needed to calculate the measure	Code sets needed for this measure include: • Logical Observation Identifiers Names and Codes (LOINC). • SNOMED CT. • International Classification of Diseases (ICD).

Technical Specifications	
	• Current Procedural Terminology (CPT) Category I. To stratify this measure by race, ethnicity, and sex, the following code sets are also needed: • CDCREC (race and ethnicity). • AdministrativeGender (sex).
Level of reporting for which specifications are available	Clinician: group/practice-level.

Minimum Technical Feasibility and Appropriateness	
Link to current technical specifications	Specifications for the measure are available at: https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS349v7.html
Information on testing or use at state Medicaid/CHIP level	The individual who suggested the measure indicated that the following states use an HIV screening measure in their Medicaid programs: • Maryland (as part of the Maryland Medicaid HealthChoice Program, the state's managed care program),[1] • Louisiana (as part of a performance improvement project for Medicaid managed care plans), and • Michigan (as part of their Medicaid withhold program). Mathematica consulted with these states and determined that none of them use the suggested measure as specified by the technical specifications. Maryland reported that they are measuring HIV screening rates during the calendar year (that is, with no look-back period) using Medicaid eligibility and claims/encounters data. Louisiana reported using several different HIV screening measures that rely on administrative data. Michigan reported that they are measuring pre-exposure prophylaxis (PrEP) and HIV testing during the third trimester for pregnant women. According to the measure steward, this measure has not been tested with Medicaid programs, and they are not aware of any state Medicaid or CHIP programs that are using the measure as specified in the technical specifications.

Minimum Technical Feasibility and Appropriateness	
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The individual who suggested the measure noted that technical assistance may be required to ensure HIV screening documentation collected through health system EHRs is consistent with the measure specification requirements. They also acknowledged that insufficient data completeness may create challenges to report the measure, in part due to the variation in HIV screening coverage across states. For example, it is only mandatory for Medicaid programs to cover "medically necessary" diagnostic testing for HIV (where indicated due to high risk), whereas "routine" screening (screening regardless of risk) is an optional benefit in traditional (non-expansion) Medicaid programs.[2] This could lead to variability in how many Medicaid beneficiaries get screened for HIV regardless of their status and create potential inconsistencies in the availability and comprehensiveness of HIV screening data across different states. However, they noted that although not mandatory, most states choose to cover routine HIV screening,[3] highlighting the importance of HIV screening as a standard practice across states. The individual who suggested the measure indicated that, given the disparities in HIV rates among certain regions in the United States,[4] a quality measure for HIV testing would hold states and providers accountable for improving patient identification methods to ensure all eligible groups are receiving appropriate prevention and HIV care linkages.
Evidence that measure could lead to improvement in quality of health care delivery and outcomes for Medicaid and CHIP beneficiaries	The individual who suggested the measure noted that is supported by the U.S. Preventive Services Task Force recommendation (grade "A") stating clinicians should screen for HIV infection in patients ages 15 to 65 years old, including screening for those outside of this age range that are considered at increased risk of infection.[5] They also referenced CDC clinical guidelines, which recommend that all patients between the ages of 13 and 64 get tested for HIV at least once as part of routine health care, and annually for patients with ongoing risk factors.[6] They noted that, as a key strategy under the federal Ending the HIV Epidemic initiative, the CDC is continuing to implement initiatives for state health care facilities that support timely and guideline-concordant HIV screening. This includes through enhanced technology to facilitate routine screenings and targeted quality improvement initiatives to increase testing frequency among patients at high risk.[7] According to the individual who suggested the measure, adding this measure to the Core Sets would present a significant opportunity for Medicaid programs to implement HIV screening performance metrics at the state level to enhance national HIV prevention initiatives and ensure critical care processes are being tracked and assessed among Medicaid beneficiaries.

Actionability and Strategic Priority	
How measure addresses the most pressing needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The individual who suggested the measure commented that, as the largest source of health care coverage for patients with HIV, Medicaid programs play a critical role in improving the quality of care received by their enrollees, particularly for those with or vulnerable to HIV. Although HIV can affect anyone, they noted that racial and ethnic minorities, and gay, bisexual, and other men who have sex with men in the United States are more impacted than others. Populations disproportionately affected by HIV are also often affected by stigma due to their sex, sexual orientation, gender identity, race or ethnicity, drug use, sex work, or other factors.[8] The individual who suggested the measure indicated that there is significant progress to be made on HIV prevention tactics, including through enhancing metrics for HIV screening across states to reduce disparities in care. In their opinion, it is important for CMS to continue to implement and align measures across quality reporting structures where health equity metrics are present to serve as a foundation to address the serious inequities in HIV care and outcomes. They argued that prioritizing HIV screening among Medicaid beneficiaries is crucial to bridging prevention gaps and reducing health disparities in marginalized populations and that the *HIV Screening* measure is a key strategy for states to achieve this goal.
Whether the data source allows for stratification by race, ethnicity, sex, and geography	The *HIV Screening* measure is not currently stratified for the purposes of reporting in the Merit-Based Incentive Payment System (MIPS) Program, although the technical specifications include payer, race, ethnicity, and sex as supplemental data elements to be evaluated at the patient-level. The measure steward confirmed that stratification of the measure by race, ethnicity, and sex is feasible. They indicated that they have not assessed the feasibility of stratifying the measure by geography. According to the individual who suggested the measure, stratification by race, ethnicity and sex would be feasible and beneficial because: • Existing screening measures in CMS programs, such as Breast Cancer and Cervical Cancer Screening, are stratified by demographic factors under NCQA's HEDIS program. • Advances in interoperability and data sharing, such as those proposed by the Office of the National Coordinator for Health Information Technology and the Department of Health and Human Services, enhance the collection of accurate patient data.[9] This includes demographic factors necessary for stratification, aiding in tracking patient populations, informing HIV policies, and capturing comprehensive HIV prevention efforts. The individual who suggested this measure affirmed their support of CMCS's efforts to mandate stratification of key demographic data for select Core Set measures and urges Medicaid to expand this requirement to HIV measures.

Actionability and Strategic Priority	
	They argued that stratifying the *HIV Screening* measure and the *HIV Viral Load Suppression* measure that is already in the Adult Core Set would improve transparency, identify care disparities, and help develop targeted approaches to enhance access to quality HIV care.
Whether there is evidence of a performance gap for Medicaid and/or CHIP beneficiaries on the measure	The individual who suggested the measure did not provide evidence of a performance gap on the measure, but inferred there may be one due to state-level differences in coverage of HIV screenings. They noted that while traditional Medicaid programs must cover medically necessary HIV testing and are incentivized under the Affordable Care Act to cover preventive services like screening and PrEP,[10] there are few mechanisms to hold states accountable or track performance in HIV screening and prevention. They recommended adopting the *HIV Screening* quality measure to enhance the Medicaid Core Sets and advance high-quality HIV care for Medicaid beneficiaries. They also indicated that the measure could also enhance early HIV detection, which is critical for timely treatment and reducing virus transmission.
How the measure can be used to monitor improvement	The individual who suggested this measure applauds the Workgroup and CMCS's commitment to HIV care and treatment as a public health priority, as demonstrated in the inclusion of the *HIV Viral Load Suppression* measure in the Medicaid Adult Core Set. Viral load suppression is the gold standard in HIV quality, as it signifies that a patient has reached the clinical goal of HIV treatment. In addition to improving patient health, inclusion of this measure aligns with the national Ending the HIV Epidemic Initiative's strategies of rapid treatment and HIV transmission prevention.[11] The individual who suggested this measure encourages CMCS to continue this momentum of supporting high quality HIV care for Medicaid beneficiaries by incorporating measures that assess key components of the care delivery process, such as HIV screening and prevention. According to them, enhancing state reporting of HIV screenings will improve public transparency and accountability for state Medicaid programs, aiding in better care for people with HIV. It will also enhance data collection, help states identify key patient populations, inform HIV policy and resource allocation, and provide a comprehensive view of HIV prevention efforts at all levels.
Whether the measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets	According to the individual who suggested the measure, it would address the following gaps in the Core Sets: • Health equity and social drivers of health • Prevention of HIV and other sexually transmitted diseases The measure would also complement the *HIV Viral Load* Suppression measure in the Adult Core Set.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The individual who suggested the measure cited data showing that Medicaid is the largest source of insurance coverage for people living with HIV in the U.S., covering an estimated 40 percent of nonelderly adult beneficiaries with HIV.[12] Medicaid covers HIV preventive services, such as diagnostic HIV testing that is considered "medically necessary;" routine HIV screening in some states, and HIV PrEP. They noted that Medicaid enrollment among people living with HIV continues to grow due to populations living longer and the continued acquisition of disease.[13]
Use of measure in other CMS programs	The individual who suggested the measure noted that CMS tracks this measure through the MIPS program, indicating its importance and feasibility. They also commended the inclusion of "Improving Practice Capacity for HIV Prevention" in the 2024 MIPS Improvement Activity Inventory, reflecting CMS's commitment to HIV prevention. They argued that including the *HIV Screening* measure across CMS programs, such as the Medicaid Core Sets, would further bolster these efforts as well as improve state performance and accountability.
Whether provider workflows will have to be modified to collect additional data needed to report the measure	The individual who suggested the measure indicated that they are unable to determine whether workflow modifications would impose additional data entry burden on providers.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The individual who suggested the measure acknowledged the previous discussion from the 2020 Workgroup Annual Review meeting regarding potential challenges associated with data completeness for states to collect and calculate the *HIV Screening* measure. In response to these challenges, the individual who suggested the measure is encouraged by the recent actions from the CMCS Technical Assistance and Analytic Support (TA/AS) Program to improve state capacity to report high quality data for the Core Set measures by establishing more efficient and streamlined data collection processes. They encourage CMCS to continue to support similar efforts that create partnerships among Medicaid, other federal agencies, and public health entities to help states gain access to claims and EHR data required to measure HIV testing. As one example, they suggested that CMCS implement HIV quality improvement initiatives directly with states as part of their efforts under the TA/AS program, providing states with necessary resources (e.g., data sources needed to calculate HIV testing statewide) and partnerships to allow for public reporting of state-level *HIV Screening* measure performance rates. They noted that this would support greater transparency and accountability for state Medicaid programs in caring for people with HIV.

Additional Information for Consideration	
Summary of prior Workgroup discussions	This measure was discussed at the 2020 Child and Adult Core Sets Annual Review meeting. The measure was not recommended for addition to the Core Sets because of concerns with data completeness, especially in states where there is no linkage between state public health and Medicaid data. The Workgroup also deliberated whether the measure was more appropriate for public health surveillance programs than for Medicaid quality improvement. The measure was also suggested for addition in the 2021 Core Sets Annual Review cycle, but was not discussed by the Workgroup. That is because Mathematica instituted minimum technical feasibility criteria during the 2021 review cycle that require evidence that a measure has been tested in or is currently in use by state Medicaid or CHIP programs in order for the Workgroup to consider the measure. At that time, Mathematica was unable to find evidence that the measure had been tested in or was currently in use in state Medicaid or CHIP programs.
Other	The measure steward indicated that CDC and the U.S. Preventive Services Task Force are in the process of updating their HIV screening guidelines,[14,15] and that the updated guidelines are likely to impact measure specifications for Medicaid populations. CDC recommends that CMS not add this measure to the Core Sets until the updated guidelines have been officially released.

Citations

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[2] KFF. HIV Testing in the United States. May 29, 2024. https://www.kff.org/hivaids/fact-sheet/hiv-testing-in-the-united-states/. Accessed September 17, 2024.

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[6] Centers for Disease Control and Prevention (CDC). Clinical Testing Guidance for HIV. September 10, 2024. https://www.cdc.gov/hivnexus/hcp/diagnosis-testing. Accessed September 17, 2024.

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[14] https://www.federalregister.gov/documents/2024/12/03/2024-28294/draft-cdcs-recommendations-for-hiv-screening-in-clinical-settings.

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