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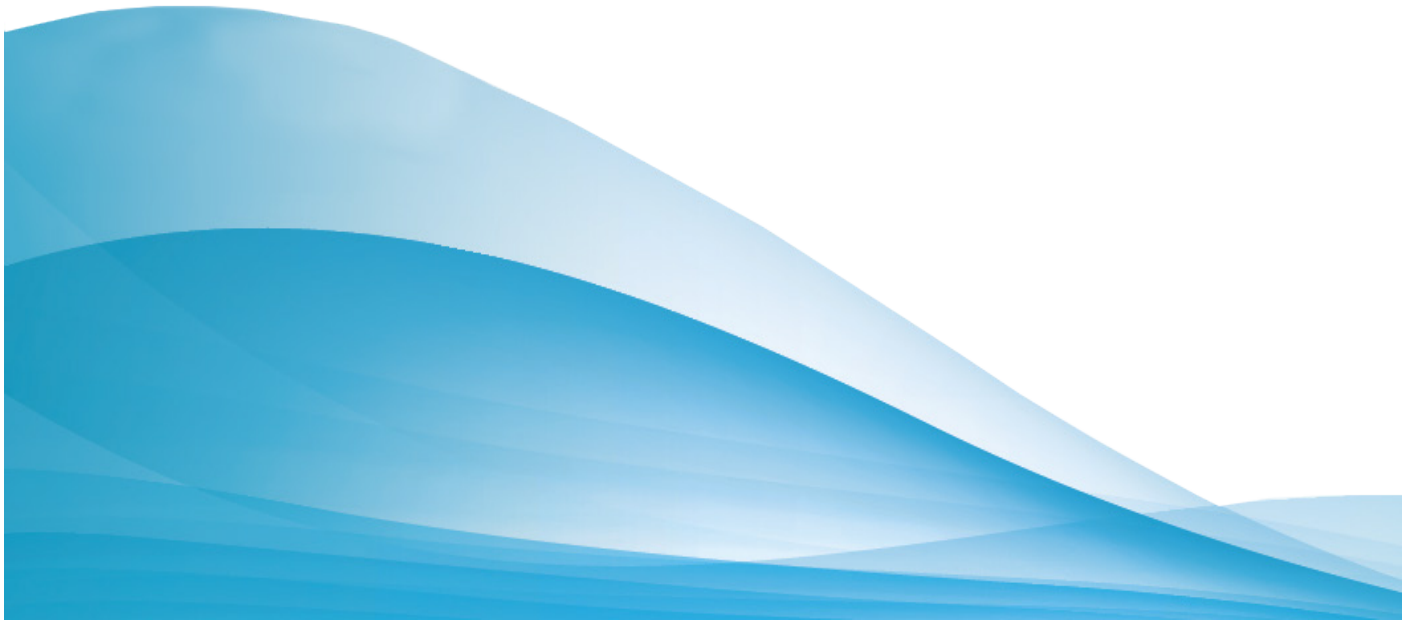
Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

Summary of a Multistakeholder Review of the 2020 Child and Adult Core Sets

Draft Report for Public Comment

July 2019



2020 CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP MEMBERS

Voting Members

Gretchen Hammer, MPH, Co-chair
Public Leadership Consulting Group

David Kelley, MD, MPA, Co-chair
Pennsylvania Department of Human Services

Richard Antonelli, MD, MS
Boston Children's Hospital

Jill Arnold
Maternal Safety Foundation

Lowell Arye, MS
Aging and Disability Policy and Leadership Consulting, LLC

Tricia Brooks, MBA
Georgetown University Center for Children and Families

Laura Chaise, MBA
Centene Corporation

Lindsay Cogan, PhD, MS
New York State Department of Health

James Crall, DDS, ScD, MS
UCLA School of Dentistry

Steve Groff
Delaware Department of Health and Social Services

Kim Elliott, PhD, MA, CPHQ, CHCA
Health Services Advisory Group

Tricia Elliott, MBA, CPHQ
The Joint Commission

Shevaun Harris, MBA, MSW
Florida Agency for Health Care Administration

Diana Jolles, PhD, CNM, FACNM
Frontier Nursing University

David Kroll, MD
Department of Psychiatry, Brigham Health, Harvard Medical School

Carolyn Langer, MD, JD, MPH
Fallon Health

Lauren Lemieux
American College of Obstetricians and Gynecologists

Jill Morrow-Gorton, MD, MBA
University of Massachusetts Medical School

Amy Mullins, MD, CPE, FAAFP
American Academy of Family Physicians

Fred Oraene, MBA
Oklahoma Health Care Authority

Lisa Patton, PhD
IBM Watson Health

Jeff Schiff, MD, MBA
Minnesota Department of Human Services

Marissa Schlaifer, MS
OptumRx

Linette Scott, MD, MPH
California Department of Health Care Services

Jami Snyder, MA
Arizona Health Care Cost Containment System

Jennifer Tracey, MHA
Zero to Three

Sally Turbyville, DRPH, MS, MA
Children's Hospital Association

Bonnie Zima, MD, MPH
UCLA-Semel Institute for Neuroscience and Human Behavior

Federal Liaisons (Non-voting)

Agency for Healthcare Research and Quality, HHS
Center for Clinical Standards & Quality, CMS, HHS
Centers for Disease Control and Prevention, HHS
Health Resources and Services Administration, HHS
National Vaccine Program Office, HHS
Office of the Assistant Secretary for Planning and Evaluation, HHS
Substance Abuse and Mental Health Services Administration, HHS
U.S. Department of Veterans Affairs

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Project director: Margo Rosenbach

Task lead: Bailey Orshan

Senior researchers: Rosemary Borck and Michaela Vine

Analysts: Allison Steiner, Chrissy Fiorentini, Ruth Hsu, and Steve Bruns

Task manager: Dayna Gallagher

Communications and administration: Christal Stone Valenzano, Brice Overcash, Brian Willis, Fiona Shapiro, Derek Mitchell, Anthony Zampelli, Liah Caravalho, Autumn Parker, Alyssa Smith, Shantal Alston James, and Jess Coldren

Technical writers: Megan Thomas and Tanya Schwartz, Harbage Consulting

Mathematica would also like to acknowledge the contributions of the Workgroup members; each member brought an invaluable perspective that informed the recommendations for the 2020 Child and Adult Core Sets. In particular, we thank the Workgroup co-chairs, Gretchen Hammer and David Kelley, for their insightful facilitation and leadership.

In addition, we express our gratitude to the measure stewards contacted throughout the review process. We appreciate the information they provided on the measures under consideration, and for responding to questions from the Workgroup during the in-person meeting.

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

CONTENTS

ACRONYMS

ABA-AD	Adult Body Mass Index Assessment
APC-CH	Use of Multiple Concurrent Antipsychotics in Children and Adolescents
ACA	Affordable Care Act
ACE	Angiotensin Converting Enzyme
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP-CH	Child and Adolescents' Access to Primary Care Practitioners
CCP-AD	Contraceptive Care – Postpartum Women Ages 21–44
CCP-CH	Contraceptive Care – Postpartum Women Ages 15–20
CCW	Contraceptive Care – All Women
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CLABSI-CH	Pediatric Central Line–Associated Bloodstream Infections
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CV	Curriculum Vitae
ECDS	Electronic Clinical Data Systems
EHR	Electronic Health Record
FFY	Federal Fiscal Year
FVA-AD	Flu Vaccinations for Adults Ages 18 to 64
HA1C-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
HCBS	Home- and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HPC-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0 percent)

ACRONYMS *(continued)*

HRSA	Health Resources and Services Administration
HSRI	Human Services Research Institute
HVL-AD	HIV Viral Load Suppression
ICU	Intensive Care Units
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MLTSS	Managed Long-Term Services and Supports
MPM-AD	Annual Monitoring for Patients on Persistent Medications
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
NCI	National Core Indicators
NCI-AD	National Core Indicators for Aging and Disabilities Adult Consumer Survey
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OB/GYN	Obstetrician/Gynecologist
OUD	Opioid Use Disorder
PC01-AD	PC-01: Elective Delivery
PC02-CH	PC-02: Cesarean Birth
PCP	Primary Care Practitioner
PDMP	Prescription Drug Monitoring Program
QMETRIC	Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium
SUD	Substance Use Disorder
TA/AS	Technical Assistance and Analytic Support Program
USPSTF	U.S. Preventive Services Task Force
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents

EXECUTIVE SUMMARY

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to approximately 73 million people, including eligible children, pregnant women, low-income adults, and individuals with disabilities.[1] The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to ensure that Medicaid and CHIP beneficiaries receive health care coverage that promotes high quality care. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures (Core Sets) are key components of this effort.

The Core Sets are used to assess the quality of care provided by states to Medicaid and CHIP beneficiaries. The Core Sets are the mechanism for state reporting on a uniform set of measures to facilitate state and national analyses, track performance over time, and use the results to drive quality improvement in Medicaid and CHIP. Currently, state reporting on the Core Sets is voluntary.

The Secretary of the U.S. Department of Health and Human Services is required to review and update the Child and Adult Core Sets annually.[2] The annual Core Set review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from numerous stakeholders, such as states, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2020 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup). The Workgroup included 28 members, who represented a diverse set of stakeholders based on affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover).

The Workgroup was charged with reviewing the 2019 Core Sets and recommending changes to strengthen and improve the Core Sets for 2020. Workgroup members were asked to suggest measures for removal from or addition to the Core Sets based on characteristics that support the use of the Core Set measures for improving the quality of care for Medicaid and CHIP beneficiaries. See Exhibit ES.1 for the characteristics Workgroup members considered during the 2020 Core Set review.

[1] March 2019 Medicaid and CHIP Enrollment Data Highlights are available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Numbers reflect Medicaid and CHIP enrollment data as of March 2019, as reported by 50 states and the District of Columbia.

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

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

Characteristics Considered for Removal of Existing Measures
Actionability. Does the measure provide few useful or actionable results for state Medicaid and CHIP programs?
Clinical relevance. Does the measure no longer adhere to clinical evidence or guidelines?
Feasibility. Have states reported significant challenges to reporting the measure (such as barriers to accessing or using data needed to report the measure)?
New or alternate measure. Is another measure being recommended to replace an existing Core Set measure?
Performance. Have states consistently reported a high level of performance on the measure, indicating little room for improvement?
Characteristics Considered for Addition of New Measures
Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?
Alignment. Is the measure used in other reporting programs?
Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?
Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?
Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

Workgroup members convened in person from May 7 to 9, 2019, to review 14 existing Core Set measures suggested for removal from the 2020 Core Sets and 42 measures suggested for addition. The 56 measures were presented, discussed, and voted on by domain.[3] To be recommended for removal from or addition to the Core Sets, at least two-thirds of the eligible Workgroup members were required to vote in favor of removal or addition. In summary, the Workgroup recommended:

- **Removal of 4 measures from the Child Core Set** out of a total of 5 measures suggested for removal
- **Removal of 3 measures from the Adult Core Set** out of a total of 9 measures suggested for removal
- **Addition of 5 measures to the Child and Adult Core Sets** out of a total of 42 measures suggested for addition

Exhibits ES.2 and ES.3 show the measures recommended for removal or addition, respectively.

[3] The measures were organized by the following domains: Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, Dental and Oral Health Services, Experience of Care: Patient-Reported Outcomes, Long-Term Services and Supports, and Other Measures.

Exhibit ES.2. Summary of Workgroup Recommendations of Measures to Remove from the 2020 Core Sets

Measure Name	Measure Steward	NQF # (if endorsed)
Recommended for Removal from the Child Core Set		
Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)	National Committee for Quality Assurance (NCQA)	Not endorsed
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents (WCC-CH)	NCQA	0024
Pediatric Central Line–Associated Bloodstream Infections (CLABSI-CH)	Centers for Disease Control and Prevention	0139
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[a]	NCQA	Not endorsed
Recommended for Removal from the Adult Core Set		
Adult Body Mass Index Assessment (ABA-AD)	NCQA	Not endorsed
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	NCQA	0057
Annual Monitoring for Patients on Persistent Medications (MPM-AD)	NCQA	2371[b]

[a]The Workgroup recommended that the APC-CH measure be replaced by another measure: Metabolic Monitoring for Children and Adolescents on Antipsychotics.

[b]This measure is no longer endorsed.

NQF = National Quality Forum.

Exhibit ES.3. Summary of Workgroup Recommendations of Measures to Add to the 2020 Core Sets

Measure Name	Measure Steward	NQF # (if endorsed)
Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia	QMETRIC—University of Michigan	3166
Metabolic Monitoring for Children and Adolescents on Antipsychotics[a]	NCQA	2800
Use of Pharmacotherapy for Opioid Use Disorder	CMS	3400
National Core Indicators (NCI)	Human Services Research Institute (HSRI) and National Association of State Directors of Developmental Disabilities Services	Not endorsed
National Core Indicators for Aging and Disabilities Adult Consumer Survey (NCI-AD)	HSRI and National Association of States United for Aging and Disabilities	Not endorsed

[a]The Workgroup recommended that this measure replace the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) measure in the Child Core Set.

NQF = National Quality Forum.

This report, which is being made available for public comment, summarizes the Workgroup's review process and recommendations. CMCS will use the Workgroup's recommendations, as well as public comments received on this report, to inform decisions about how and whether to modify the 2020 Core Sets. CMCS will release the 2020 Core Sets through a CMCS Informational Bulletin by December 31, 2019. Please submit public comments via email to MACCoreSetReview@mathematica-mpr.com by 8 PM ET on Monday, August 5, 2019, and include "2020 Core Set Review Public Comment" in the subject line.

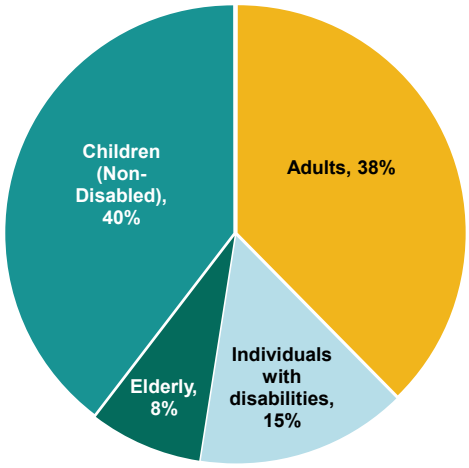
INTRODUCTION

Medicaid and the Children's Health Insurance Program (CHIP) provided health care coverage to approximately 73 million people in March 2019, including eligible children, pregnant women, low-income adults, and individuals with disabilities (Exhibit 1).[4] The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to ensure that Medicaid and CHIP beneficiaries receive health care coverage that promotes high quality care. The Medicaid and CHIP Child and Adult Core Sets (Core Sets) of health care quality measures are key components of this effort.

The goal of the Core Sets is to encourage state reporting on a uniform set of measures to facilitate state and national analyses, track performance over time, and use the results to drive quality improvement in Medicaid and CHIP. Currently, state reporting on the Core Sets is voluntary.

The Secretary of the U.S. Department of Health and Human Services (HHS) is required to review and update the Child and Adult Core Sets annually.[5] The annual Core Set review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The Child Core Set has undergone annual reviews since January 2013 and the Adult Core Set since January 2014.

Exhibit 1. Distribution of Medicaid Population, 2016



Source: 2017 CMS Actuarial Report (2016 data).

CMCS contracted with Mathematica to convene the 2020 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup). The Workgroup included 28 members, who represented a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover). The Workgroup was charged with assessing the 2019 Core Sets and recommending measures that should be removed as well as new measures that should be added, in order to strengthen and improve the Core Sets for 2020. The Workgroup was asked to focus on measures that were feasible for state reporting and that could be used to meaningfully drive quality improvement in Medicaid and CHIP.

This report provides an overview of the Child and Adult Core Sets, describes the 2020 Core Set annual review process, shares state perspectives on Core Set reporting, summarizes the Workgroup recommendations for improving the Core Sets, and specifies next steps for public comment.

4 March 2019 Medicaid and CHIP Enrollment Data Highlights are available at https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html. Numbers reflect Medicaid and CHIP enrollment data as of March 2019, as reported by 50 states and the District of Columbia.

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

OVERVIEW OF THE CHILD AND ADULT CORE SETS

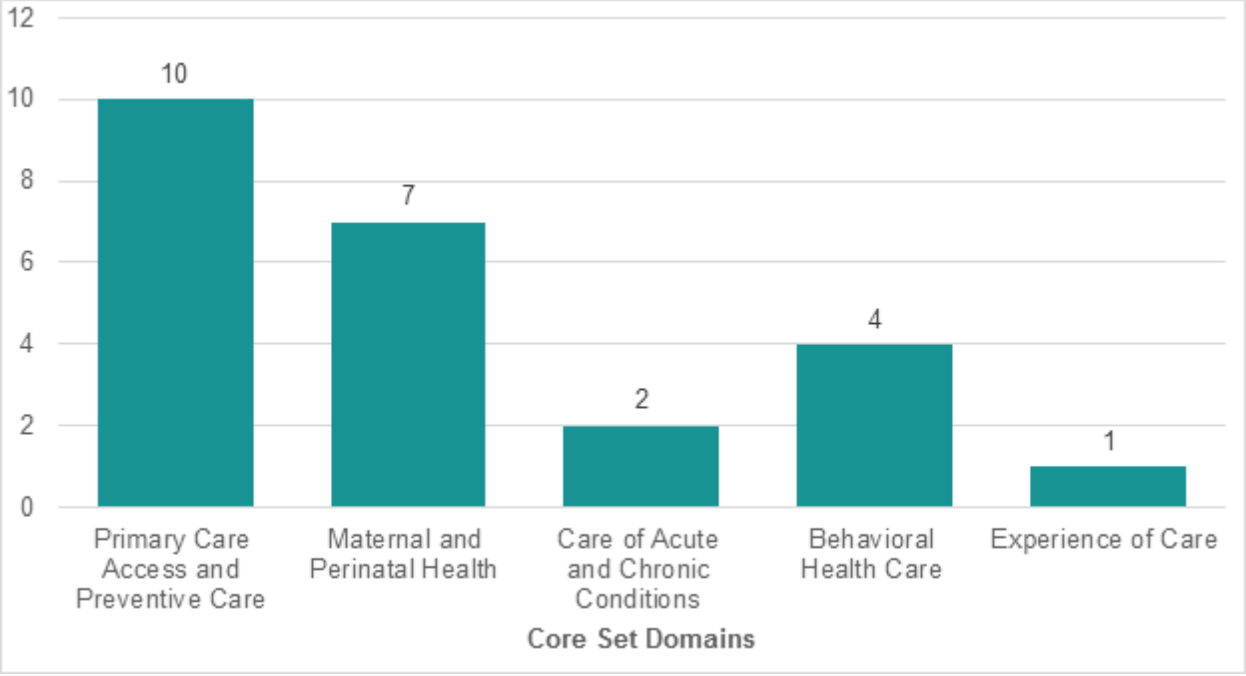
The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions aimed at improving the quality of health care for children in Medicaid and CHIP. CHIPRA required the HHS Secretary to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs (referred to as the Child Core Set). The initial Child Core Set, which was released in December 2009, included 24 measures that covered both physical and mental health. The core set of health care quality measures for adults covered by Medicaid (Adult Core Set) was established in 2010 under the Patient Protection and Affordable Care Act (Affordable Care Act) in the same manner as the Child Core Set. The initial Adult Core Set, which was released in January 2012, included 26 measures.

Appendix A contains tables showing the 2019 Child and Adult Core Set measures and the history of measures included in the Child and Adult Core Sets from 2012 to 2019. Of the 26 measures in the 2019 Child Core Set, two-thirds were part of the initial Child Core Set. Similarly, of the 33 measures in the 2019 Adult Core Set, two-thirds were part of the initial Adult Core Set.

The 2019 Child Core Set

The 2019 Child Core Set includes 26 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Dental and Oral Health Services, and (6) Experience of Care. Nearly two-thirds of the 2019 Child Core Set measures fall into the Primary Care Access and Preventive Care and Maternal and Perinatal Health domains (Exhibit 2). Seventy-three percent are process measures and 85 percent can be calculated using administrative data only.

Exhibit 2. 2019 Child Core Set Measures, by Domain

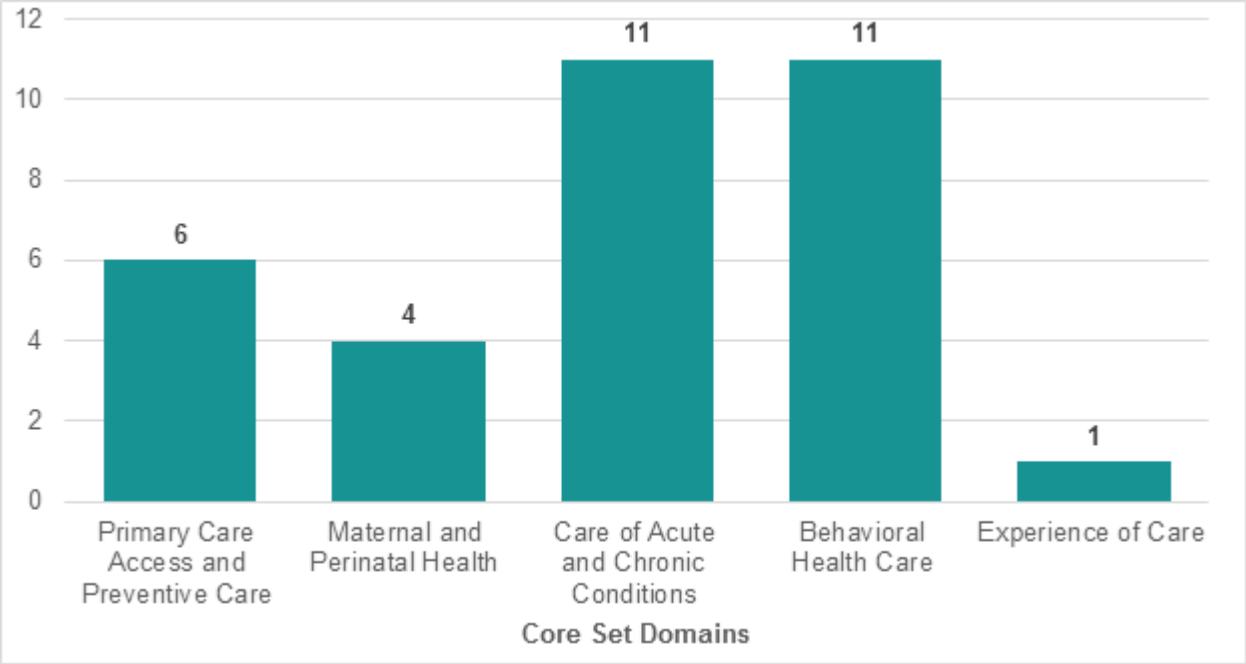


For federal fiscal year (FFY) 2017 reporting, the most recent year for which data are publicly available, all states voluntarily reported on at least one Child Core Set measure and 45 states reported on at least half of the 26 measures in the 2017 Child Core Set. Twenty-one states reported on more measures for FFY 2017 than for FFY 2016, and 47 states reported on both Medicaid and CHIP populations. The median number of measures reported by states was 18. Historically, the Child Core Set measures that are most frequently reported by states are related to preventive dental services and primary care access and preventive care.[6]

The 2019 Adult Core Set

The 2019 Adult Core Set includes 33 health care quality measures across five domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, and (5) Experience of Care. Two-thirds of the measures are related to care of acute and chronic conditions and behavioral health care (Exhibit 3). Seventy percent are process measures, and 88 percent can be calculated using administrative data.

Exhibit 3. 2019 Adult Core Set Measures, by Domain



For FFY 2017 reporting, 45 states voluntarily reported on at least one Adult Core Set measure, while 34 states reported on at least half of the 30 measures in the 2017 Adult Core Set. This included 4 states that reported for the first time. Thirty-three states reported more measures for

[6] More information about the Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

FFY 2017 than for FFY 2016, with states reporting a median of 17 measures. Historically, the Adult Core Set measures most frequently reported by states are spread across the domains.[7]

Use of the Core Set for Quality Measurement and Improvement

CMCS and states use the Child and Adult Core Sets to monitor and improve the quality of care provided to Medicaid and CHIP beneficiaries at the national and state levels and to measure progress over time. CMCS publicly reports information on state performance on the Child and Adult Core Sets annually through chart packs and other resources.[8] In addition, CMCS develops initiatives to drive improvement in quality of care by using the Core Set measures—for example, through its Maternal and Infant Health Initiative and Oral Health Initiative.[9] A subset of Core Set measures is also included in the Medicaid and CHIP Scorecard to increase public transparency in state health system performance.[10]

To support states and their partners in collecting, reporting, and using the Core Set measures to drive improvement in Medicaid and CHIP, CMCS established a Technical Assistance and Analytic Support (TA/AS) Program. The TA/AS program provides one-on-one assistance to address technical issues related to collecting the Core Set measures, offers group trainings and collaborative learning opportunities, prepares issue briefs and analytic reports, and helps states to design and implement quality improvement initiatives that use the Core Set measures.[11]

DESCRIPTION OF THE 2020 CORE SET ANNUAL REVIEW PROCESS

This section describes the 2020 Core Set annual review process, including the call for nominations for Workgroup members, the Workgroup composition, and the Workgroup timeline and meetings.

Call for Nominations

Mathematica issued a call for nominations on December 14, 2019; nomination forms and a resume or CV were due on January 11, 2019. Mathematica distributed the call for nominations electronically to a wide range of state Medicaid and CHIP officials, health care provider

7 More information about the Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

8 Chart packs, measure-specific tables, fact sheets, and other information from annual Core Set reporting are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html and https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

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

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

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

associations, and quality measurement experts. Mathematica received 64 nominations. Nominations were reviewed to address legislative requirements for the Core Set annual review, to ensure geographic distribution, and to represent diverse areas of expertise.[12]

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

Workgroup Composition

The Workgroup included 28 voting members from state Medicaid agencies, professional associations, universities, hospitals, and other organizations from across the country (the Workgroup members are listed on the inside front cover of this report).[13] As a whole, the Workgroup represented expertise in primary care access and preventive care, acute and chronic conditions, maternal and perinatal health, behavioral health and substance use, dental and oral health, long-term services and supports, disability, experience of care, patient safety, and health disparities. Although some Workgroup members were nominated by an organization, all Workgroup members were asked to participate as subject matter experts and consider what measures would be best for improving the quality of care in Medicaid and CHIP overall, and not to advocate on behalf of an organization or a specific interest.

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

Workgroup Timeline and Meetings

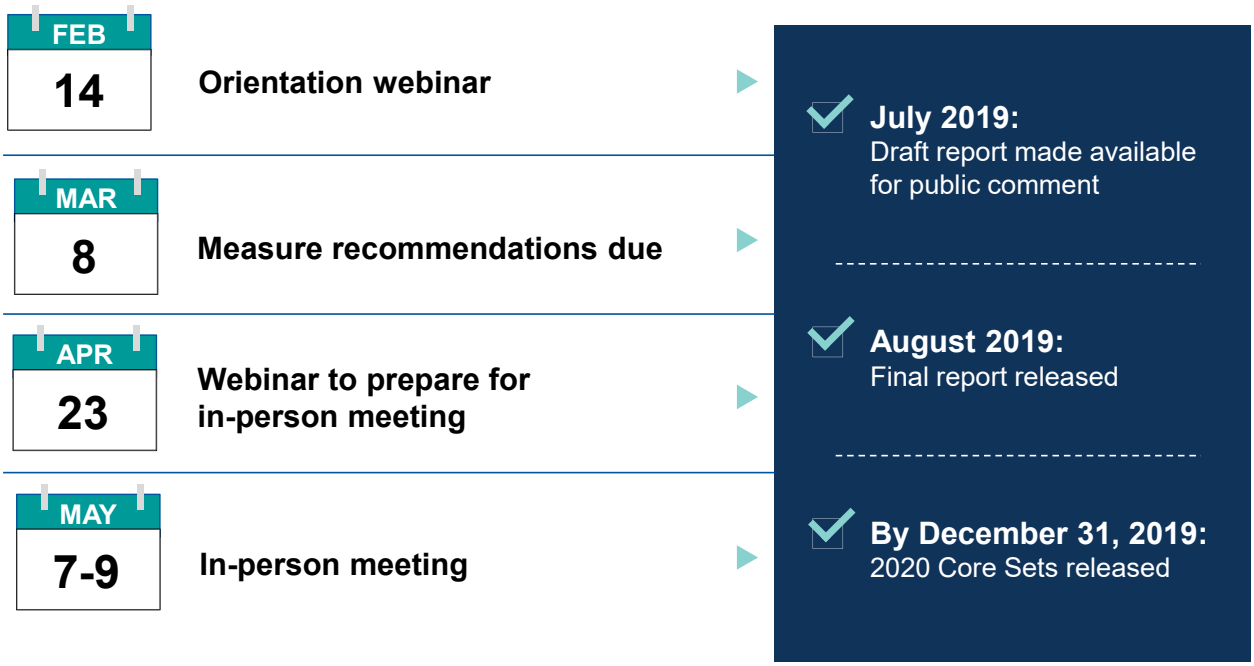
As shown in Exhibit 4, Mathematica held two webinars in February and April 2019 to orient the Workgroup members and to prepare for the in-person Workgroup meeting, which was convened in May 2019. The two webinars and the in-person meeting were open to the public and public comment was invited at multiple points.

This draft report is being made available for public comment in July. The final report will be released in August. CMCS will release the 2020 Core Sets by December 31, 2019, after taking into account Workgroup recommendations and public comments.

[12] The statute requires representation from states, medical and dental professionals (including members of allied health professions), providers caring for children and families who live in medically underserved urban and rural communities, national organizations serving children and those with chronic conditions, consumers and purchasers of health care, and experts in quality measures, as well as voluntary consensus standards-setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

[13] Three additional members were selected but were unable to participate due to conflicts with their schedules.

Exhibit 4. 2020 Core Set Annual Review Stakeholder Workgroup Timeline



Orientation Webinar

During the orientation webinar on February 14, 2019, Mathematica stated the Workgroup charge, introduced the Workgroup members and disclosure of interest process, described the timeline for the 2020 annual review, and provided background on the Core Sets. In addition, CMCS outlined its goals for state reporting of the Core Sets:

Workgroup Charge

The Child and Adult Core Set Stakeholder Workgroup for the 2020 Annual Review is charged with assessing the 2019 Core Sets and recommending measures for removal or addition, in order to strengthen and improve the Core Sets for 2020.

The Workgroup should focus on measures that are actionable, aligned, and appropriate for state-level reporting to ensure that the measures can meaningfully drive improvement in quality of care and outcomes in Medicaid and CHIP.

1. Increase the number of states reporting the measures
2. Increase the number of measures reported by each state
3. Improve the quality of the data reported by states
4. Streamline the Core Set data collection and reporting processes
5. Use the data to drive improvements in health care quality and outcomes

Mathematica explained the process for Workgroup members to suggest measures for removal from or addition to the Child and Adult Core Sets. The Workgroup was charged with focusing on measures that met the following criteria:

- **Actionable.** Results can be used to improve care delivery and health outcomes.

- **Aligned.** Measures are aligned with those used in other programs to minimize burden on states, health plans, and providers where possible.
- **Appropriate.** The technical specifications, data collection methods, and data sources are validated for state use or can be easily adapted by states.

Following the orientation meeting, Workgroup members were invited to suggest measures for removal from or addition to the 2020 Core Sets. Workgroup members used an online tool to provide their suggestions for removal or addition, including the rationale and whether measures suggested for addition were intended to substitute for a current Core Set measure. Workgroup members suggested the following:

- **Fourteen measures for removal**, including 5 of the 26 measures in the 2019 Child Core Set and 9 of the 33 measures in the 2019 Adult Core Set
- **Forty-two measures for addition** across the six current Core Set domains,[14] as well as two new domains related to Long-Term Services and Supports (LTSS) and Other Measures

Webinar to Prepare for the In-Person Meeting

The second webinar took place on April 23, 2019. To help Workgroup members prepare for the discussion at the in-person meeting, Mathematica shared a list of the 14 measures suggested for removal and the 42 measures suggested for addition. Mathematica provided guidance on how to prepare for the measures discussion at the in-person meeting, including the criteria that Workgroup members should consider for recommending measures for removal from or addition to the Core Sets and the resources available to facilitate their review. These resources included detailed measure information sheets, a worksheet to facilitate the review and record notes, and a Medicaid and CHIP beneficiary profile. Workgroup members were responsible for reviewing all materials related to the measures and coming to the meeting prepared to ask questions and discuss the merits of each measure.

In-Person Meeting

The in-person meeting took place in Washington, D.C., May 7-9, 2019. Workgroup members, federal liaisons, measure stewards, and members of the public attended the meeting. Measure stewards and members of the public were also able to participate virtually via webinar.

Before discussing individual measures for removal from or addition to the Core Sets, the state representatives serving on the Workgroup shared their experiences with Core Set reporting. The discussion helped other Workgroup members better understand how states use the Core Set measures and their approach to collecting data and calculating measures.

The discussion of measures was organized into eight domains: the six current Core Set domains plus LTSS and Other Measures. For each domain, Mathematica described the measures

[14] The current domains are Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, Dental and Oral Health Services, and Experience of Care.

suggested for removal or addition, highlighted the key technical specifications, and summarized the rationale Workgroup members provided for suggesting the measures for removal or addition.

The Workgroup co-chairs facilitated the discussion of the measures. They sought technical questions from Workgroup members and asked the measure stewards to clarify measure specifications when needed. The Workgroup then discussed the measures suggested for removal or addition in each domain. The co-chairs accepted motions to vote on the measures in each domain, and there were opportunities for public comment on the measures suggested for removal or addition. Public comments were accepted in person and via telephone.

Mathematica facilitated the voting on the measures. Workgroup members voted by using iClicker devices, with voting results presented in real time. For each measure suggested for removal, Workgroup members could select either "A = Yes, I recommend removing this measure from the Core Set" or "B = No, I do not recommend removing this measure from the Core Set." For each measure recommended for addition, Workgroup members could select either "A = Yes, I recommend adding this measure to the Core Set" or "B = No, I do not recommend adding this measure to the Core Set." Measures were recommended for removal or addition if two-thirds of the eligible Workgroup members voted yes.[15]

STATE PERSPECTIVES ON CORE SET REPORTING

Mathematica invited the Workgroup member from New York's Medicaid agency to present on the state's experience with collecting, reporting, and using the Core Set measures, as well as on its performance measurement priorities. In addition to programming claims and administrative measures internally, the state leverages managed care reporting and collates information from managed care organizations (MCOs) to report almost all of the Core Set measures. Key themes from the presentation included the following:

- **Effort and resources.** New York devotes a high level of effort and resources to implement, report, and maintain Core Set measures, even administrative measures. It can take several years to get new Core Set measures up and running; even small tweaks to existing measures require substantial staff effort.
- **Types of measures.** The state uses Healthcare Effectiveness Data and Information Set (HEDIS®) measures to benchmark internal measure calculations. Measures that are not part of the HEDIS measure set are more difficult to benchmark because they are not audited like HEDIS measures are. The representative also noted that provider-based measures (such as those developed for hospitals) are more difficult for the state to collect and report.
- **Measure alignment.** Aligning measures with other programs is important. The state looks for measures that support its existing initiatives, such as Medicaid Section 1115 demonstrations, as well as measures that can be monitored across all types of health insurance (commercial and public). Alignment helps to drive measure prioritization by the state, health plans, and provider organizations.

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

- **Future priorities.** Moving forward, New York is looking to end medical record review and to more fully integrate electronic data, such as measure results from health information exchanges, into its efforts. Use of electronic data will facilitate the state's focus on population health management and clinical care.

The Workgroup included representatives from eight other state Medicaid/CHIP agencies: Arizona, California, Delaware, Florida, Massachusetts, Minnesota, Oklahoma, and Pennsylvania. They also shared their on-the-ground experiences with reporting the current Core Set measures, monitoring other measures as part of their state quality improvement programs, and using this information to inform programmatic and policy decisions. In this context, the states noted the importance of using data to understand subpopulations, including age groups, racial and ethnic groups, and rural versus urban experiences. State representatives also focused on the feasibility and burden of collecting and reporting measures, particularly when there are substantive changes from year to year.

The state perspectives provided important context for the Workgroup discussion of individual measures. Non-state Workgroup members frequently called on state representatives for insights about their experiences with measures suggested for removal or their assessment of the feasibility and usability of measures suggested for addition.

WORKGROUP RECOMMENDATIONS FOR IMPROVING THE 2020 CORE SETS

Criteria Considered by the Workgroup

The 2020 Core Set Annual Review Workgroup considered 56 measures, including 14 measures suggested for removal and 42 measures suggested for addition. To guide the discussion and voting, Workgroup members were asked to consider the "fit" of each individual measure for the Core Set according to a series of characteristics introduced in the orientation webinar (see Exhibit 5). Additional principles that guided the discussion and voting for measure removal or addition included the following:

- There is no target number, or a minimum or maximum number, of measures that should be included in the Core Sets.
- States should have the capacity and data available to report the measures; otherwise, data will be limited and incomplete if measures cannot be reported by a majority of states.
- The importance of each individual measure should be considered without regard to the relative importance of measures within and across domains.
- The merits of each individual measure should be assessed based on the current technical specifications. Voting was based on the current measure; no suggestions for modifications were allowed.
- The measures should be assessed without regard to whether they will be in the Child Core Set or the Adult Core Set or what domain they will be in, because these decisions will be made by CMCS.

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

Characteristics Considered for Removal of Existing Measures
Actionability. Does the measure provide few useful or actionable results for state Medicaid and CHIP programs?
Clinical relevance. Does the measure no longer adhere to clinical evidence or guidelines?
Feasibility. Have states reported significant challenges to reporting the measure (such as barriers to accessing or using data needed to report the measure)?
New or alternate measure. Is another measure being recommended to replace an existing Core Set measure?
Performance. Have states consistently reported a high level of performance on the measure, indicating little room for improvement?
Characteristics Considered for Addition of New Measures
Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?
Alignment. Is the measure used in other reporting programs?
Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?
Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?
Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

Summary of Workgroup Recommendations

The Workgroup recommended the removal of four measures from the Child Core Set, the removal of three measures from the Adult Core Set (Exhibit 6), and the addition of five measures to the Core Sets (Exhibit 7). This section summarizes the discussion and rationale for the measures recommended for removal from or addition to the 2020 Core Sets. Additional information on the measures not recommended for removal from or addition to the Core Sets is included in Appendix B.

Exhibit 6. Summary of Workgroup Recommendations of Measures to Remove from the 2020 Core Sets

Measure Name	Measure Steward	NQF # (if endorsed)
Recommended for Removal from the Child Core Set		
Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)	National Committee for Quality Assurance (NCQA)	Not endorsed
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents (WCC-CH)	NCQA	0024
Pediatric Central Line–Associated Bloodstream Infections (CLABSI-CH)	Centers for Disease Control and Prevention	0139
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[a]	NCQA	Not endorsed
Recommended for Removal from the Adult Core Set		
Adult Body Mass Index Assessment (ABA-AD)	NCQA	Not endorsed

Measure Name	Measure Steward	NQF # (if endorsed)
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	NCQA	0057
Annual Monitoring for Patients on Persistent Medications (MPM-AD)	NCQA	2371[b]

[a]The Workgroup recommended that the APC-CH measure be replaced by another measure: Metabolic Monitoring for Children and Adolescents on Antipsychotics.

[b]This measure is no longer endorsed.

NQF = National Quality Forum.

Exhibit 7. Summary of Workgroup Recommendations of Measures to Add to the 2020 Core Sets

Measure Name	Measure Steward	NQF # (if endorsed)
Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia	QMETRIC— University of Michigan	3166
Metabolic Monitoring for Children and Adolescents on Antipsychotics[a]	NCQA	2800
Use of Pharmacotherapy for Opioid Use Disorder	CMS	3400
National Core Indicators (NCI)	Human Services Research Institute (HSRI) and National Association of State Directors of Developmental Disabilities Services	Not endorsed
National Core Indicators for Aging and Disabilities Adult Consumer Survey (NCI-AD)	HSRI and National Association of States United for Aging and Disabilities	Not endorsed

[a]The Workgroup recommended that this measure replace the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) measure in the Child Core Set.

NQF = National Quality Forum.

Measures Recommended for Removal from the Child Core Set

Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)

The CAP-CH measure assesses the percentage of children and adolescents who had a visit with a primary care practitioner (PCP). Four rates are reported: children ages 12 to 24 months and 25 months to age 6 who had a visit with a PCP during the measurement year; and children ages 7 to 11 and adolescents ages 12 to 19 who had a visit with a PCP during the measurement year or the year prior to the measurement year. Forty-eight states reported this measure for FFY 2017.

The Workgroup member who suggested the measure for removal indicated that the measure does not provide useful or actionable results for state Medicaid and CHIP agencies; the measure uses a very broad definition of primary care visits, which makes it more a utilization measure than a quality measure. The member stated that true access to primary care involves a well-care visit, which is already covered by three Child Core Set well-care measures.

Another Workgroup member noted that relatively high performance on the access to care measure does not necessarily correlate with children actually receiving the recommended well-child care. It was suggested that the three well-child visit measures in the 2019 Child Core Set

could serve as substitutes for this measure. Finally, the measure steward, the National Committee for Quality Assurance (NCQA), proposed retiring the measure in 2020, which raised concerns for the Workgroup about whether the measure would be maintained and updated if it remained in the Core Set.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents (WCC-CH)

The WCC-CH measure assesses the percentage of children ages 3 to 17 who had a visit with a PCP or OB/GYN practitioner and evidence of body mass index (BMI) percentile documentation in the medical record. This measure documents evidence of BMI measurement only, and does not include a counseling component. Thirty-seven states reported this measure for FFY 2017.

The Workgroup members who suggested the measure for removal described it as a documentation measure that does not provide useful or actionable results for state Medicaid and CHIP agencies. They further asserted that this measure does not reflect evidence-based practices for interventions for children with or at risk of obesity. One Workgroup member also noted that the data collection burden for this measure does not support its use, particularly because the measure does not support an evidence-based practice.[16]

Workgroup members also noted that, although state focus on childhood obesity is critical, the clinical evidence to support the measure is lacking. One Workgroup member asserted that more integrated and effective models to address obesity than screening alone, such as referrals to care, should be prioritized in the Core Set. It was also noted that this measure is reported under the Promoting Interoperability Program (formerly the Electronic Health Record [EHR] Incentive Program), so removal of the measure from the Child Core Set would not disincentivize physicians from conducting a BMI assessment.

One federal liaison voiced support for the child and adult BMI screening measures, noting there is evidence to support BMI screening in the primary care setting and that BMI screening is part of the U.S. Preventive Services Task Force (USPSTF) recommendations for both children and adults. The commenter also cautioned about sending a signal about the low priority of this topic if the WCC-CH measure is removed from the Child Core Set without a replacement.

Pediatric Central Line–Associated Bloodstream Infections (CLABSI-CH)

The CLABSI-CH measure assesses the number of CLABSIs in neonatal intensive care units (ICUs) reported by acute care hospitals. The standardized infection ratios reported for each state compare the observed number of infections reported during the measurement period to the predicted number of infections for that period. Data for the measure are reported by hospitals to the Centers for Disease Control and Prevention (CDC) in the National Health Care Safety Network. Data reported to CDC are for all payers and not limited to Medicaid and CHIP. Although the Core Set specifications include both neonatal and pediatric ICUs, CDC only reports

[16] Due to limitations of claims data to calculate this measure, the hybrid data collection method, which uses a combination of administrative and medical records, is typically required to produce accurate results.

data for neonatal ICUs, so the Core Set data available for this measure include only neonatal ICUs. CMCS obtains data for this measure directly from CDC each year.

The Workgroup member who suggested the CLABSI-CH measure for removal noted that the measure does not provide useful or actionable results for state Medicaid and CHIP agencies.

Workgroup members discussed the value of measuring and tracking CLABSIs. One noted that states have successfully worked across state agencies and with other states to use the data to achieve reductions in pediatric CLABSIs. At the same time, Workgroup members questioned whether the statewide data reported for the CLABSI measure were more actionable for state departments of public health, which typically have regulatory authority over hospitals and hospital-focused metrics, than for Medicaid agencies. Furthermore, this measure is not limited to populations covered by Medicaid and CHIP. A Workgroup member from one state explained that because the Medicaid agency does not have the raw data to focus on Medicaid beneficiaries or review rates at the county or managed care plan level, it is challenging to use the measure to drive quality improvement in the Medicaid or CHIP program. Workgroup members also discussed how removing the measure from the Core Set would not necessarily undermine or terminate the existing focus in states and departments of public health to continue to use CLABSI data to improve hospital safety and quality and provide accountability at the state level.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)

The APC-CH measure assesses the number of beneficiaries on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. Thirty-seven states reported this measure for FFY 2017. This measure has been proposed for retirement from HEDIS for 2020. The measure is currently included on the Medicaid and CHIP Scorecard.

The Workgroup member who suggested the measure for removal noted that state efforts have led to high performance on this measure with little room for improvement. In 2017, the median rate for this measure was 2.7 percent (lower rates are better). Moreover, the number of children in the denominator has decreased over time, suggesting that the overall number of children on two or more concurrent antipsychotic medications has decreased. Another measure of appropriate antipsychotic treatment with a larger denominator, Metabolic Monitoring for Children and Adolescents on Antipsychotics, was recommended as a replacement for this measure.

Workgroup members suggested that high performance on this measure may indicate that states have achieved the appropriate level of utilization. Moreover, it was noted that there may be a clinical justification for a small number of children to be prescribed these medications. Workgroup members representing states commented that they would continue to track similar measures, particularly for children in foster care, if this measure is removed from the Core Set.

Measures Recommended for Removal from the Adult Core Set

Adult Body Mass Index Assessment (ABA-AD)

The ABA-AD measure assesses the percentage of beneficiaries ages 18 to 74 who had an outpatient visit and whose BMI was documented in the medical record. Thirty-two states reported this measure for FFY 2017.

The rationale Workgroup members provided for suggesting removal of this measure was similar to the rationale for removing the WCC-CH measure from the Child Core Set. As a measure of documentation, rather than outcomes or evidence-based practices for combatting obesity, ABA-AD does not assess whether a high BMI value resulted in follow-up services.

During the discussion, Workgroup members noted that this measure was routinely reported under the Promoting Interoperability Program (formerly the EHR Incentive Program), as BMI is often collected in EHRs. The Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan measure was discussed as a replacement for this measure, which would move the measure in the direction of treatment rather than documentation. However, this measure was not ultimately recommended for addition because of concerns about states' access to data to calculate the measure, among other factors. One Workgroup member also noted that combatting obesity may require a broader societal response than other health conditions, which makes it more challenging for the health care system to address.

As mentioned earlier, one federal liaison voiced support for the child and adult BMI screening measures, noting that there is evidence to support BMI screening in the primary care setting and that BMI screening is part of American Academy of Pediatrics and USPSTF recommendations for both children and adults. The commenter also cautioned about sending a signal about the low priority of this topic if the ABA-AD measure were removed from the Adult Core Set without a replacement.

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)

The HA1C-AD measure assesses the percentage of beneficiaries ages 18 to 75 with diabetes (types 1 and 2) who had a hemoglobin A1c (HbA1c) test. Thirty-eight states reported this measure for FFY 2017.

The Workgroup members who suggested it for removal commented that the high performance on the measure indicated that there was little room for improvement. They also noted that a measure currently on the Core Set—Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0 percent) (HPC-AD)—is an outcome measure that also assesses whether testing is being conducted. Removing the HA1C-AD measure would reduce state reporting burden without losing the value of measuring diabetes control.

Two Workgroup members representing states noted that they no longer use this measure because the HPC-AD measure includes a testing component; further, they want to hold plans accountable for improved outcomes, rather than just testing. A Workgroup member also noted that the HA1C-AD and HPC-AD measures are on the Core Set concurrently because not all states were equipped to report on the HPC-AD measure when it was added. One member expressed concern about removing this measure without knowing the screening rates in the 12 states that are not reporting the measure.

Annual Monitoring for Patients on Persistent Medications (MPM-AD)

The MPM-AD measure assesses the percentage of beneficiaries age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. The therapeutics agents include angiotensin converting enzyme (ACE)

inhibitors or angiotensin receptor blockers (ARB) and diuretics. Thirty-six states reported on this measure for FFY 2017.

One Workgroup member recommended this measure for removal because states report high performance rates on the measure, which indicates that there is little room for improvement. It was also noted that the measure lost NQF endorsement in 2018.

During the Workgroup discussion, a Workgroup member representing a state noted that the high performance rates have led them to remove this measure from their pay-for-performance program. Another member described MPM-AD as a process measure that does not get to outcomes. NCQA, the measure steward, also noted that the measure was proposed for retirement from HEDIS in 2020.

Measures Recommended for Addition to the 2020 Core Sets

Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia

This measure assesses the percentage of children ages 3 months to 5 years who were identified as having sickle cell anemia and who received appropriate antibiotic prophylaxis during the measurement year.

One Workgroup member suggested this measure for addition because individuals with sickle cell anemia, particularly infants and young children, are susceptible to life-threatening infections. Antibiotic prophylaxis is a relatively easy and inexpensive care pathway that is underutilized. During the discussion, the Workgroup compared this measure to another sickle cell measure suggested for addition, Transcranial Doppler Ultrasonography Screening for Children with Sickle Cell Anemia.

During the discussion, the Workgroup generally favored the antibiotic prophylaxis measure from a clinical perspective, with members characterizing it as a measure of continuity of chronic disease care that should be universally performed in all situations—compared to a transcranial Doppler ultrasonography, which is a one-time screening that has to be linked to further downstream processes. Workgroup members noted the disparities in the use of antibiotic prophylaxis treatment and the opportunity for improvement. One Workgroup member also noted that this was an administrative claims-based measure, so it was feasible for states to collect and report. Finally, one Workgroup member noted that, because sickle cell anemia is a genetic disease, the prevalence varies by state; therefore, this measure may or may not be a high priority for states based on the size of their affected population.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure assesses the percentage of children and adolescents age 1 to 17 who had at least two antipsychotic medication dispensing events of the same or different medication and had monitoring for the development of abnormal cholesterol and blood sugar levels, which are known side effects of these medications. An updated version of the measure is currently under consideration that would combine the 1- to 5-year-old and 6- to 11-year-old age groups and add separate rates for blood glucose and cholesterol. This measure was recommended to replace the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) measure, which was recommended for removal from the Child Core Set.

The Workgroup member who suggested this measure noted that it would help states monitor children on multiple concurrent antipsychotics (children previously identified by the APC-CH measure) by identifying any gaps in their metabolic follow-up. The Workgroup member noted that the Medicaid HEDIS national average for appropriate monitoring for children on these medications was 34 percent in 2017, which suggests a gap in the quality of care provided to these children.

One Workgroup member commented that this is one of the few measures that monitors medication safety for children on psychotropic medications. In addition, the denominator for this measure is larger than the denominator for APC-CH, which this measure was recommended to replace.

Use of Pharmacotherapy for Opioid Use Disorder

This measure assesses the percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for, or were administered or ordered, a Food and Drug Administration–approved medication for the disorder during the measure year.

The Workgroup member who suggested this measure noted that it would fill a current gap in the Core Sets by tracking the appropriate treatment of OUDs, which is a critical step in curbing the national OUD epidemic.

One Workgroup member noted that while this measure does not assess treatment adherence, it does provide information about the number of people initiating medication assistance treatment, which is a good first step. Other members expressed that continuity of treatment is equally important.

National Core Indicators (NCI) and National Core Indicators for Aging and Disabilities Adult Consumer Survey (NCI-AD)

The NCI and NCI-AD measures assess the experience and outcomes of individuals with intellectual and developmental disabilities and their families and individuals with physical disabilities and their families, respectively.

- NCI survey measures are standardized indicators used across states to assess the outcomes of services provided to individuals age 18 and older with intellectual and developmental disabilities and their families. The surveys include in-person surveys, family surveys, and a staff suitability survey. Indicators address key areas of concern in five domains: (1) individual outcomes; (2) health, welfare, and rights; (3) system performance; (4) staff stability; and (5) family outcomes. Forty-six states and the District of Columbia participate in the NCI program.
- NCI-AD is a voluntary effort by state Medicaid aging and disability agencies to measure and track their performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals age 18 and older with physical disabilities and their families. Indicators address seven key areas of concern including (1) service planning, (2) rights, (3) community inclusion, (4) choice, (5) health and care coordination, (6) safety, and (7) relationships. Seventeen states collected NCI-AD data in 2018 and 2019.

The Workgroup member who suggested the measures noted that they would fill a gap in the Core Sets related to LTSS for people with intellectual and developmental disabilities or for those who use home- and community-based services (HCBS). Workgroup members acknowledged that LTSS accounts for a substantial portion of Medicaid expenditures and that a large portion of Medicaid beneficiaries use these services.

Workgroup members discussed the fact that many states are currently using the NCI and NCI-AD measures; whereas, other proposed measures such as the Consumer Assessment of Healthcare Providers and Systems Home and Community Based Services (HCBS CAHPS) survey are newer. Workgroup members with experience using the NCI and NCI-AD measures in their states articulated several advantages:

- Both sets of indicators have provided actionable results to states on beneficiary outcomes in terms of function and well-being. In addition to calculating state-level rates, some states oversample to assess performance for subpopulations within the state, including performance by managed care plan, provider, region, and county. One Workgroup member reported that her state was able to use the individual-level survey results to implement quality improvement activities that made a difference in people's lives.
- Both sets of indicators are aligned with measures used for other reporting programs and can be used for both managed care and fee-for-service populations.
- Both sets of indicators have been tested and are believed to be valid and reliable, with strong inter-rater reliability. In addition, technical assistance is available to states for implementing the surveys. Multiple years of comparative data are available so that states can benchmark their performance and progress.

Workgroup members acknowledged that adding new survey-based measures to the Core Set would require states to either add requirements for these surveys to managed care contracts or to field them directly. At the same time, measures from other data sources that assess the experience of beneficiaries and their functional status and well-being are not currently available. The NCI surveys are accessible in multiple languages to people with disabilities who are nonverbal, blind, deaf, or have other disabilities.

Cross-Cutting Themes in Measure Discussions

Several cross-cutting themes emerged from the Workgroup discussions about measures suggested for removal or addition:

- **Feasibility.** One of the strongest considerations that Workgroup members expressed was the feasibility for states to collect and report the measures. Throughout the meeting, Workgroup members asked colleagues representing state Medicaid programs for their opinions on the feasibility of measures. It was noted that feasibility varies by state, particularly related to whether states have managed care delivery systems and are able to leverage MCOs to support Core Set reporting. The Workgroup noted that measures that use already available administrative data or measures used for other purposes (such as in pay for performance programs) are more feasible. As part of this discussion, some Workgroup members representing states expressed concern about survey-based measures due to the high level of effort and resources required to administer surveys.

- **Appropriateness.** Workgroup members highlighted that the most appropriate measures for the Core Sets are those in which state-to-state comparisons would be helpful in monitoring the quality of care in Medicaid and CHIP. Given variations in state Medicaid programs and delivery systems, the results of some measures may not be meaningful when compared across states. Other measures may be more appropriate to monitor at the plan or provider levels. Workgroup members repeatedly stressed that nothing about the value of the measure or the importance of the topic area should be inferred from the decision not to recommend it for addition to the Core Sets.
- **Readiness.** Workgroup members discussed whether measures were ready for implementation in the Core Sets and for Medicaid and CHIP. For example, there were concerns about using first-year HEDIS measures and measures that had not been tested for use in state Medicaid programs. Workgroup members commented that the Core Sets are not the place to put new measures or measures untested at the state level.
- **Actionability.** Workgroup members noted the importance of ensuring that Core Set measures are actionable, that is, that CMCS and states can use the data to inform program and policy decisions and to improve the quality of care for Medicaid and CHIP beneficiaries. There was ample discussion in support of working toward moving from process to outcome measures as they become feasible and ready. Outcome measures are necessary to more fully understand the quality of care provided to Medicaid and CHIP beneficiaries.

Discussion of Core Set Measure Gaps

The Workgroup discussed improving the Core Sets by taking a holistic approach to measuring the quality of care provided to diverse populations and subpopulations enrolled in Medicaid and CHIP. Workgroup members frequently cited the need to address issues related to social determinants of health as a gap area in the Core Sets, either as measures themselves or to risk adjust measures for valid comparison. Workgroup members noted that the measures in the Core Set are heavily focused on medical care, whereas Medicaid programs provide wraparound services that are not being captured by the current Core Set measures. Workgroup members acknowledged feasibility challenges for measuring and addressing the social determinants of health; however, they suggested that CMCS, measure stewards, and states work together to promote inclusion of such measures in quality measurement efforts.

Workgroup members expressed their preference for having a gap in the Core Set rather than recommending measures that did not meet the specified criteria, and especially to avoid increasing burden on states. In addition, because measures continue to be tested, the Workgroup noted that many of the measures that were not recommended should be reconsidered in the future. The Workgroup suggested potential gap areas that could be considered for future Core Set measures (Exhibit 8).

Exhibit 8. Potential Gap Areas for Future Core Set Measures

Populations	Health Areas	Health Care Delivery	Other Measure Attributes
• Adolescent and young adults • Children in foster care • Maternal health • Men's health • Individuals with multiple chronic conditions • Elderly individuals, including those who are Medicare-Medicaid dual eligibles • Individuals of all ages with disabilities, including access to services and supports to assist them with living and participating in the community safely	• Immunizations (prenatal, adult) • Obesity • Adverse childhood experiences • Child social and emotional development • LTSS (including rebalancing) • Oral health beyond prevention • Access to oral health care for individuals with special needs • Behavioral health integration in acute medical settings • Depression • Suicide • Trauma-informed care • Rare diseases	• Follow-up on referrals • Care transitions (e.g., from hospital or nursing home to the community) • Appropriateness of care—underutilization and overutilization • Workforce and caregiver supports • Provider accountability • Network adequacy	• Stratification by race and ethnicity • Measures addressing social determinants of health • Measures with life course potential • Measures that cut across Medicaid and Medicare

Additional Workgroup Suggestions for Improving the Core Sets

In addition to making recommendations for specific measures, the Workgroup members discussed improvements for the Core Sets and quality measurement more broadly.

Considering the Various Uses of Quality Measures in Medicaid and CHIP

Workgroup members representing state Medicaid and CHIP agencies noted that they use quality measures for various purposes and indicated that not all measures are appropriate for the Core Sets. Several state representatives, for example, expressed enthusiasm for taking some of the measures back to their state, including some that the Workgroup did not recommend for addition to the Core Set. State representatives noted that there are a lot of good measures that may not be appropriate for the Core Set but that would be useful to states as part of their own quality monitoring activities, such as evaluation of Medicaid Section 1115 and other waivers, managed care oversight, and value-based purchasing.

Integrating Health Information Technology

The Workgroup stressed the importance of integrating health information technology, including EHRs and electronic data extraction, into quality reporting efforts. Like New York, other state representatives noted they were on a path toward integrating electronic data into reporting efforts. One Workgroup member noted that states have made substantial investments in hospitals, health systems, and providers to report electronic measures but that many states are not yet yielding the value of these investments because reporting is difficult. To get to true meaningful use, several members recommended that federal agencies work together to direct resources and attention to electronic initiatives to assist states in collecting electronic quality measures.

Creating Shared Learning and Technical Assistance Opportunities

Several Workgroup members suggested that federal agencies, including CMCS, provide shared learning opportunities for states in the following areas:

- **Racial and ethnic stratification.** Several Workgroup members suggested providing technical assistance to help states better understand the racial and ethnic makeup of their Medicaid and CHIP population and the experiences of different racial and ethnic groups in the health care system. This includes assistance in standardizing the collection of data on race and ethnicity makeup.
- **Data linkages.** Workgroup members noted the need to link data for families in Medicaid to better understand their needs and service patterns. For example, one Workgroup member noted data challenges with pairing mothers and their babies in order to monitor the link between perinatal services and child health outcomes.
- **Medicaid and immunization registry coordination.** A Workgroup member recommended that CMCS consider an affinity group or grant opportunity to help drive state coordination between Medicaid and public health registries, particularly immunization registries.
- **State quality staff connections.** A Workgroup member recommended convening an affinity group for state quality staff to help them understand their work across states. They noted that connecting with other staff working on the same issues could help with staff morale and retention.

NEXT STEPS

The 2020 Core Set Annual Review Workgroup considered 14 measures for removal from the Core Sets and 42 measures for addition. Workgroup members recommended the removal of 7 measures and the addition of 5 measures to the 2020 Core Sets. For the first time, the Workgroup recommended adding 2 measures on LTSS and one measure on the treatment of opioid abuse.

The Workgroup considered such characteristics as the feasibility, appropriateness, readiness, and actionability of measures for the Core Sets. Workgroup members discussed whether measures were ready for implementation in the Core Sets and for Medicaid and CHIP. Workgroup members commented that the Core Sets are not the place to put new or untested measures. Workgroup members also repeatedly stressed that nothing about the value of the measure or the importance of the topic area should be inferred from the decision not to recommend a measure for addition to the Core Sets.

This report summarizing the 2020 annual review Workgroup process and recommendations is being made available for public comment. CMCS will use the public comments, together with the Workgroup's recommendations, to inform decisions about how and whether to modify the Core Sets for 2020. CMCS will release the 2020 Core Sets through a CMCS Informational Bulletin by December 31, 2019.

Please submit public comments via email to MACCoreSetReview@mathematica-mpr.com by 8 PM ET on Monday, August 5, 2019, and include "2020 Core Set Review Public Comment" in the subject line.

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Appendix A
Child and Adult Core Set Measures

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Exhibit A.1. 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure steward	Measure name	Data collection method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	Administrative or hybrid
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH)	Administrative or hybrid
Not endorsed	NCQA	Adolescent Well-Care Visits (AWC-CH)	Administrative or hybrid
Not endorsed	NCQA	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)	Administrative
Maternal and Perinatal Health			
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)	Medical records (CDC's NHSN)
0471	TJC	PC-02: Cesarean Birth (PC02-CH)	Hybrid
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	EHR
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 15–20 (CCW-CH)	Administrative
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5–18 (AMR-CH)	Administrative
Not endorsed	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Administrative

Exhibit A.1. *(continued)*

NQF #	Measure steward	Measure name	Data collection method
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Administrative
Not endorsed	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Administrative
Dental and Oral Health Services			
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	Administrative
Not endorsed	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Administrative (Form CMS-416)
Experience of Care			
Not endorsed	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

*This measure is no longer endorsed by NQF.

CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NCQA = National Committee for Quality Assurance; NHSN = National Healthcare Safety Network; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

Exhibit A.2. 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure steward	Measure name	Data collection method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21–24 (CHL-AD)	Administrative or EHR
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR
Not endorsed	NCQA	Adult Body Mass Index Assessment (ABA-AD)	Administrative or hybrid
Maternal and Perinatal Health			
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	Hybrid or EHR
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 21–44 (CCW-AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	Administrative or hybrid
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19–64 (AMR-AD)	Administrative
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)	Administrative
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Administrative or EHR
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Survey

Exhibit A.2. *(continued)*

NQF #	Measure steward	Measure name	Data collection method
0105	NCQA	Antidepressant Medication Management (AMM-AD)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Administrative
2605	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)[a]	Administrative
2605	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)[a]	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Administrative or hybrid
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Administrative
Not endorsed**	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Administrative
Experience of Care			
Not endorsed***	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)	Survey

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

*This measure is no longer endorsed by NQF.

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

***The Adult Core Set includes the NCQA version of the measure, which is adapted from the AHRQ measure (NQF #0006).

[a]The FUA-AD and FUM-AD measures were previously included in the Adult Core Set as a single measure (FUA/FUM-AD). For the 2019 Adult Core Set, they are included as two separate measures.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

Exhibit A.3. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2012–2019

NQF #	Measure Steward	Measure Name	2012	2013	2014	2015	2016	2017	2018	2019
Primary Care Access and Preventive Care										
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)	X	X	X	X	X	X	X	X
0038	NCQA	Childhood Immunization Status (CIS-CH)	X	X	X	X	X	X	X	X
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)[a]	--	--	--	--	--	--	X	X
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	X	X	X	X	X	X	X	X
1407	NCQA	Immunizations for Adolescents (IMA-CH)	X	X	X	X	X	X	X	X
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	X	X	X	X	X	X	X	X
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	X	X	X	X	X	X	X	X
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV-CH)[b]	--	X	X	X	X	--	--	--
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)	X	X	X	X	X	X	X	X
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)	X	X	X	X	X	X	X	X
Maternal and Perinatal Health										
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)	X	X	X	X	X	X	X	X
0471	TJC	PC-02: Cesarean Birth (PC02-CH)[c]	X	X	X	X	X	X	X	X
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)[d]	--	--	--	--	X	X	X	X

Exhibit A.3. *(continued)*

NQF #	Measure Steward	Measure Name	2012	2013	2014	2015	2016	2017	2018	2019
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	X	X	X	X	X	X	X	X
1391*	NCQA	Frequency of Ongoing Prenatal Care (FPC-CH)[e]	X	X	X	X	X	X	--	--
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)[f]	--	--	--	--	--	X	X	X
2903/2904	OPA	Contraceptive Care – All Women Ages 15–20 (CCW-CH)[g]	--	--	--	--	--	--	X	X
NA	No current measure steward	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)[h]	--	X	X	X	X	X	--	--
Care of Acute and Chronic Conditions										
0002*	NCQA	Appropriate Testing for Children with Pharyngitis (CWP-CH)[i]	X	X	--	--	--	--	--	--
0060*	NCQA	Annual Pediatric Hemoglobin A1C Testing (PA1C-CH)[j]	X	X	--	--	--	--	--	--
0657	AAOH-HNSF	Otitis Media with Effusion –Avoidance of Inappropriate Systemic Antimicrobials in Children: Ages 2-12 (OME-CH)[k]	X	--	--	--	--	--	--	--
1381*	Alabama Medicaid	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One of More Asthma-Related Emergency Room Visits (ASMER-CH)[l]	X	X	--	--	--	--	--	--
1799*	NCQA	Medication Management for People with Asthma (MMA-CH)[m]	--	X	X	X	X	X	--	--
1800	NCQA	Asthma Medication Ratio: Ages 5–18 (AMR-CH)[m]	--	--	--	--	--	--	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	X	X	X	X	X	X	X	X

Exhibit A.3. *(continued)*

NQF #	Measure Steward	Measure Name	2012	2013	2014	2015	2016	2017	2018	2019
Behavioral Health Care										
0108	NCQA	Follow-Up Care for Children Prescribed Attention- Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)[n]	X	X	X	X	X	X	X	X
1365	PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)[o]	--	--	--	X	X	X	--	--
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[p]	--	--	--	--	--	X	X	X
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[q]	--	--	--	--	X	X	X	X
Dental and Oral Health Services										
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)[r]	--	--	--	X	X	X	X	X
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	X	X	X	X	X	X	X	X
NA	CMS	Percentage of Eligibles That Received Dental Treatment Services (TDENT-CH)[s]	X	X	X	--	--	--	--	--
Experience of Care										
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	X	X	X	X	X	X	X	X

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

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

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

*This measure is no longer endorsed by NQF.

Exhibit A.3. *(continued)*

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

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

[c] The California Maternal Quality Care Collaborative Cesarean Rate for Nulliparous Singleton Vertex measure was replaced by The Joint Commission PC-02: Cesarean Birth measure beginning with the 2014 Child Core Set.

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

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

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

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

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

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

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

[k] The Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2-12) measure was retired from the Child Core Set in 2013 because of significant state reporting challenges. AMA-PCPI was the measure steward for the 2012 Child Core Set.

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

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

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

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

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

[q] The Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure was added to the 2016 Child Core Set to target inappropriate prescribing of antipsychotic medications, which may have adverse health effects.

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

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

Exhibit A.4. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2013–2019

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019
Primary Care Access and Preventive Care									
0032	NCQA	Cervical Cancer Screening (CCS-AD)	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 21–24 (CHL-AD)	X	X	X	X	X	X	X
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	X	X	X	X	X	X	X
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	X	X	X	X	X	X	X
2372	NCQA	Breast Cancer Screening (BCS-AD)	X	X	X	X	X	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)	X	X	X	X	X	X	X
Maternal and Perinatal Health									
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	X	X	X	X	X	X	X
0476	TJC	PC-03: Antenatal Steroids (PC03-AD)[a]	X	X	X	X	X	X	--
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)[b]	--	--	--	--	X	X	X
2903/2904	OPA	Contraceptive Care – All Women Ages 21–44 (CCW-AD)[c]	--	--	--	--	--	X	X
Care of Acute and Chronic Conditions									
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	X	X	X	X	X	X	X
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	X	X	X	X	X	X	X
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)[d]	--	--	X	X	X	X	X

Exhibit A.4. *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019
0063*	NCQA	Comprehensive Diabetes Care: LDL-C Screening (LDL-AD)[d]	X	X	--	--	--	--	--
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	X	X	X	X	X	X	X
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	X	X	X	X	X	X	X
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	X	X	X	X	X	X	X
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	X	X	X	X	X	X	X
0403*	NCQA	Annual HIV/AIDS Medical Visit (HMV-AD)[e]	X	--	--	--	--	--	--
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	X	X	X	X	X	X	X
1800	NCQA	Asthma Medication Ratio: Ages 19–64 (AMR-AD)[f]	--	--	--	--	--	X	X
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	--	X	X	X	X	X	X
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)	X	X	X	X	X	X	X
Behavioral Health Care									
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	X	X	X	X	X	X	X
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	X	X	X	X	X	X	X
0105	NCQA	Antidepressant Medication Management (AMM-AD)	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[g]	X	X	X	X	X	X	X
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)[h]	--	--	--	X	X	X	X

Exhibit A.4. *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019
2605	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA -AD)[i]	--	--	--	--	X	X	X
2605	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)[i]	--	--	--	--	X	X	X
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[j]	--	--	--	--	X	X	X
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[h]	--	--	--	X	X	X	X
NA	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)[k]	X	X	X	X	X	X	X
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)[l]	--	--	--	--	--	X	X
Care Coordination									
0648*	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR-AD)[m]	X	X	X	X	--	--	--
Experience of Care									
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)[n]	X	X	X	X	X	X	X

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

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

More information on 2019 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf.

*This measure is no longer endorsed by NQF.

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

Exhibit A.4. *(continued)*

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

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

[d] The Comprehensive Diabetes Care: LDL-C Screening measure was replaced by the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure beginning with the 2015 Adult Core Set. The Comprehensive Diabetes Care: LDL-C Screening measure was retired from the Adult Core Set because clinical guidelines underpinning this measure were in flux and because NCQA removed it from HEDIS 2015. The Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) measure addresses the prevalent condition of diabetes and facilitates state efforts to drive quality improvement on the risk factor of poor HbA1c control.

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

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

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

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

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

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

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

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

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

[n] The Adult Core Set includes the NCQA version of the CAHPS® Health Plan Survey 5.0H, Adult Version (Medicaid) measure, which is adapted from the AHRQ measure (NQF #0006).

Appendix B
Summary of 2020 Core Set Annual Review Workgroup Discussion of Measures Not Recommended For Removal or Addition

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This appendix summarizes the discussion of measures suggested but not recommended for removal from or addition to the 2020 Child and Adult Core Sets. The discussion took place during the in-person Workgroup meeting May 7-9. The summary is organized by domain. For more information about the measures discussed but not recommended for removal or addition, please refer to Exhibit B.1 at the end of this appendix, including the measure name, measure steward, NQF # (if endorsed), measure description, and data collection method.

Primary Care Access and Preventive Care

In the Primary Care Access and Preventive Care domain, the Workgroup first discussed immunization measures, including the *Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD*) measure suggested for removal from the Adult Core Set and four immunization measures proposed for addition (*Flu Vaccinations for Adults Age 65 and Older; Influenza Immunization; Adult Immunization Status; Prenatal Immunization Status*). The FVA-AD measure was suggested for removal because of the high cost of the CAHPS survey and the fact that it only covers flu vaccinations while other measures include additional immunizations and wider age ranges. The *Influenza Immunization* measure was suggested to replace the FVA-AD measure because it is lower cost and more comparable across diverse populations, according to the Workgroup member who suggested it. The *Adult Immunization Status* measure was suggested for addition because it includes more vaccines than the current immunization measure (FVA-AD) and would help states monitor appropriate adult immunization use beyond influenza. Workgroup members suggested adding the *Prenatal Immunization Status* measure because vaccinations for this population are not currently being measured in the Core Set, and there are substantial disparities in prenatal immunization levels.

The Workgroup discussed the accuracy and reliability of the data needed for the immunization measures, many of which rely on patient recall or administrative data that may be incomplete for people who cycle in and out of Medicaid plans. Furthermore, because influenza vaccines can be administered in a variety of settings, data on them might be incomplete. Workgroup members noted that while all states have immunization registries, there is considerable variability in their completeness. In the case of the *Prenatal Immunization Status* measure, Workgroup members acknowledged its importance and strong connection to improved outcomes, but had concerns about the feasibility of the new data collection method[17] and were reluctant to recommend a first-year HEDIS measure that might not be ready for state reporting.

For the *Lead Screening in Children* and *HIV Screening* measures, Workgroup members deliberated whether these measures were more appropriate for public health surveillance programs rather than for Medicaid quality measurement. Data completeness concerns were also raised for both measures, especially in states where there is no linkage between state public health and Medicaid data. For the *Body Mass Index Screening and Follow-Up Plan* and *Follow-Up with Patient Family After Developmental Screening* measures, Workgroup members acknowledged these are areas of high interest but had concerns whether the proposed measures would promote quality improvement. In addition, there were concerns about the burden of the

[17] The *Prenatal Immunization Status* and *Adult Immunization Status* measures are specified for the Electronic Clinical Data Systems (ECDS) data collection method, which includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.

medical record reviews required to calculate these measures. For the *Colorectal Cancer Screening* measure, Workgroup members acknowledged that such screenings are highly effective and associated with reduced costs. However, they also restated concerns about recommending a HEDIS measure that had not yet been used for the Medicaid population and raised concerns about the measure's extended look-back period.

Maternal and Perinatal Health

A Workgroup member suggested the *PC-01: Elective Delivery (PC01-AD)* measure for removal from the Adult Core Set and suggested an existing Child Core Set measure, *PC-02: Cesarean Birth (PC02-CH)*, as a substitute. The Workgroup acknowledged that early elective induction, in the absence of medical necessity, is a driver of cesarean rates and neonatal intensive care unit utilization. Workgroup members commented that few states are reporting the PC01-AD measure and state representatives noted the challenges with collecting the measure, including that the numerator is not available in claims data, so medical record review or vital records linkage is required (and some have found that vital records linkage does not provide the information needed to calculate the measure). Some Workgroup members questioned whether reporting on the rate of elective deliveries in the Core Set allows for action by states, and furthermore, whether outliers on the measure should be regulated outside a quality measurement program. They also noted that other perinatal measures have demonstrated more unwarranted variation and impact a greater number of beneficiaries. However, several Workgroup members shared a concern of slippage in performance if the PC01-AD measure is removed from the Adult Core Set and noted that because Medicaid pays for such a high percentage of births, measures are an important indicator of priorities for quality of care, and this issue is a high priority.

A Workgroup member suggested removal of the *Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)* measure because another measure in the Core Set, the *Contraceptive Care – All Women Ages 15–20 (CCP-CH)*, addresses the same measure concept. It was noted that only the ages 21–44 portion of the measure was suggested for removal and not the age 15–20 measure, which was concerning to the Workgroup. It was also clarified that the postpartum population cannot be parsed out from the *Contraceptive Care – All Women (CCW-CH/AD)* measure in the Child and Adult Core Sets. The Workgroup felt it important to have a measure for postpartum women, as effective postpartum contraception is a method to increase birth spacing, which is related to low birthweight and other poor outcomes. A Workgroup member also noted that maintaining the measure in the Core Set could drive states to resolve payment issues around insertion of long-acting reversible methods of contraception. A public commenter noted that CMCS, CDC, and the Office of Population Affairs partnered to support states in calculating, reporting, and using the Contraceptive Care measures to track access and drive improvements.

The *PC-05: Exclusive Breast Milk Feeding* measure was suggested for addition to the Core Sets as there is evidence that breast milk feeding improves life course and reduces disparities. The Workgroup member noted that the measure can be used to hold systems accountable with the understanding that the goal is not a rate of 100 percent. Exclusive breastfeeding is a goal of the World Health Organization, U.S. Department of Health and Human Services, American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists. Workgroup members noted that it is a non-medical measure that can be used to address disparities and capture data about intended breastfeeding, allowing states to see where

interventions are needed for certain hospitals and populations. Workgroup members questioned whether there is anything built into the measure to take into account cultural preferences, medications the mother is taking, or breastfeeding attempts, which may limit a mother's ability to breastfeed exclusively or at all in the first few days of life. The Workgroup shared concerns about the title of the measure and the signal it would send if it was added to the Core Set. Finally, one Workgroup member noted that the data collection method is medical record review, which could make it difficult for states to report.

Workgroup members suggested the *Prenatal Depression Screening and Follow-Up* measure for addition to the Core Sets because prenatal depression can be treated successfully if treated early; the measure could be used to assess the content of prenatal care and to improve outcomes for mothers and babies. A Workgroup member suggested addition of the *Postpartum Depression Screening and Follow-Up* measure to capture maternal well-being and newborn development. The measures address a gap area, could address disparities, and might incentivize meeting minimum thresholds for screening. It was noted that these measures are particularly important because (1) access to behavioral health care for the Medicaid population is essential; and (2) women are especially vulnerable for depression in the perinatal period, which can have a large impact on their lives and life of their child. It was also noted that some women do not return for their postpartum appointment, so a Workgroup member noted that the postpartum measure will pick up screens done at newborn appointments, which might be the only opportunity to reach the mother.

The *Prenatal Depression Screening and Follow-Up* and *Postpartum Depression Screening and Follow-Up* measures are proposed for addition to HEDIS 2020 and are specified for the ECDS data collection method. Workgroup members shared concern with the measures being new and untested at the state level as well as using a new data collection method. Although Workgroup members noted the appeal and importance of having a measure that incentivizes documenting postpartum screening in the mother's chart rather than the infant's, there was also concern about being able to capture the infant's date of birth without linking claims or vital records to the mother's record.

Care of Acute and Chronic Conditions

A Workgroup member suggested removal of the *HIV Viral Load Suppression (HVL-AD)* measure from the Adult Core Set given the low uptake by states. Workgroup members acknowledged the feasibility challenges obtaining access to laboratory data on viral load suppression, which one member attributed in part to the stigmatization of HIV. They expressed concerns that dropping the measure might signal that CMCS is deprioritizing HIV and serve only to increase stigmatization. Workgroup members discussed state progress on developing mechanisms to report the measure, including through a learning collaborative jointly sponsored by CDC, HRSA, and CMCS, which may increase the number of states able to report the measure in the future.

The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* and *Appropriate Treatment for Upper Respiratory Infection* measures assess appropriate use of antibiotics for respiratory infections with the goal of improving patient safety. Workgroup members noted the importance of these measures for combating inappropriate antibiotic use, which recently has

been affected by the rise in telemedicine. However, Workgroup members raised concerns about the measure methodologies, including whether these conditions are coded accurately in administrative data, and whether changes in coding practices could be mistaken for quality improvement.

The *Transcranial Doppler Ultrasonography Screening for Children with Sickle Cell Anemia* measure was one of two measures suggested for improving quality of care for children with sickle cell anemia. This measure was suggested because it has the potential to address disparities for a population at early risk for stroke. When comparing the two sickle cell measures, Workgroup members felt that the *Appropriate Antibiotic Prophylaxis* measure was the more actionable of the two and had more opportunities for improvement.

The *Proportion of Days Covered: Antiretroviral Medications* measure was suggested for addition because viral load can be reduced if antiretrovirals are taken regularly, whereas lack of compliance can lead to antiretroviral resistance. Workgroup members raised questions about how the specifications handle pre-exposure prophylaxis and whether an HIV diagnosis is required for an individual to be included in the measure-eligible population. The measure steward clarified that the measure is not intended to capture prophylaxis adherence. Although it was suggested to replace the *HIV Viral Load Suppression* measure, Workgroup members did not recommend it as a replacement measure.

The *Statin Therapy for the Prevention and Treatment of Cardiovascular Disease* measure was suggested for addition given the high prevalence of cardiovascular disease and the relative availability and affordability of statins. Discussion of the measure centered on concerns that the measure assessed whether a statin was ordered, rather than whether it was filled or taken. As with other EHR and registry-based measures, Workgroup members also raised concerns about feasibility due to limited access to the necessary data.

Behavioral Health Care

A Workgroup member suggested removal of the *Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)* measure from the Adult Core Set, because of low state uptake and the high cost of conducting the CAHPS survey. Workgroup members noted that there are other surveys and measures that monitor tobacco use. One concern with the MSC-AD measure is that it does not ask about vaping, but rather leaves the question open for interpretation. The *Tobacco Use: Screening and Cessation Intervention* measure was suggested as a potential replacement for the MSC-AD measure, but Workgroup members raised similar concerns about the absence of vaping from the measure specifications. Other members acknowledged that tobacco use is a large public health issue, and that the Workgroup should not reject these measures solely because they do not currently include vaping. Workgroup members also emphasized that tobacco cessation education or other activities might occur outside the primary care setting, and that the MSC-AD measure might give a broader perspective on those services.

A Workgroup member suggested the addition of the *Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling* measure to address gaps in assessing alcohol screening and brief intervention among non-alcohol-dependent adults. This topic is a high priority for some states, because it addresses gaps in alcohol screening, which is especially

relevant for pregnant women. Workgroup members noted that this measure is important because there is a lack of accountability for alcohol screening among providers. However, Workgroup members cited lack of specificity related to the screening tool as a weakness of the measure. Further, one Workgroup member noted that the field of addiction medicine is moving away from labeling people as having "problematic alcohol use."

The Workgroup discussed, but did not recommend, three measures related to opioid use: (1) Use of Opioids from Multiple Providers in Persons without Cancer, (2) Continuity of Pharmacotherapy for Opioid Use Disorder, and (3) Pharmacotherapy for Opioid Use Disorder. The first measure was suggested because it could be used to assess the effectiveness of state initiatives to address the opioid epidemic. However, Workgroup members raised concerns about underreporting, as individuals might pay out-of-pocket for opioids. One state representative noted that they are currently calculating the measure but not releasing the results because the data are unreliable. The Workgroup member who suggested the Continuity of Pharmacotherapy for OUD measure noted that it was a first step in measuring recovery and health outcomes in a population at high risk for overdose and death. It could be used to address the gap in assessing retention in care, which can serve as a proxy for recovery. Workgroup members noted that measuring continuity of medication assisted treatment is important; however, it was noted that the measure does not incorporate a therapy component. The Pharmacotherapy for OUD measure was suggested because of evidence that pharmacotherapy can improve outcomes for individuals with OUD. This measure looks only at new episodes, which differentiates it from the Continuity of Pharmacotherapy measure. Workgroup members deliberated whether measuring the first appointment versus continuity of care was more valuable for the Core Set, with some Workgroup members saying both are critical to measure. Workgroup members deliberated the merits of each of the measures and called on the measure stewards and technical experts to differentiate the two measures for future consideration.

A Workgroup member suggested the *Query of Prescription Drug Monitoring Program* measure to address gaps in tracking the use of Prescription Drug Monitoring Programs (PDMPs), which can improve prescribing of controlled substances, a key step in controlling the opioid epidemic. According to the Workgroup member, PDMP implementation is associated with decreased opioid-related overdose deaths. Several Workgroup members from state Medicaid agencies raised concerns about state laws preventing health plans from accessing the PDMP data. Another member noted that as part of the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, there will be reporting requirements related to PDMP beginning in 2023.

A Workgroup member suggested addition of the *Follow-Up After High-Intensity Care for Substance Use Disorder* measure to address a gap in tracking receipt of follow-up care for SUD treatment services. The member who suggested this measure noted that nationally, there is greater investment in inpatient services for SUD, and less emphasis on continuity of care after receiving inpatient services. Workgroup members expressed concern that because this measure was proposed for HEDIS 2020, it was not yet ready for the Core Set; however, one member noted that the concept of follow-up care had been tested for other measures.

Dental and Oral Health Services

The Workgroup discussion about the three dental and oral health measures considered for addition to the Core Sets focused on whether the measures were ready for implementation by state Medicaid programs. The Workgroup discussion on the *Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children* and the *Follow-Up After Emergency Department Visits for Dental Caries in Children* focused on the results from states that have tested or implemented the measure, as well as the relationship between the proposed measures and the two existing dental measures in the Child Core Set. The Workgroup also raised questions about the measure technical specifications, the sources of data needed to calculate the measure, and whether this information would be readily available to all state Medicaid programs (especially those with dental carve-outs). Although the Workgroup noted that the *Adults with Diabetes – Oral Evaluation* measure would fill a gap in the Adult Core Set and is feasible (having been implemented in one state's incentive program), some 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. Nevertheless, states expressed considerable interest in the three measures and some indicated they were planning to share the measures with their staff.

Experience of Care

A Workgroup member suggested removing both CAHPS measures (*CAHPS Health Plan Survey 5.0H –Child Version [CPC-CH]* and *CAHPS Health Plan Survey 5.0H – Adult Version [CPA-AD]*), citing poor state response rates, the high cost of administering the surveys, and the fact that results may not be comparable across diverse populations. Many Workgroup members noted that CAHPS is valuable because analysis of the data helps understand how patients experience the care they receive. State representatives commented that they analyze CAHPS data, including by health plan in managed care states, publicly post the findings, and use the results to inform system and health plan performance improvement. Workgroup members were interested in learning more about how CMCS uses the CAHPS data that states report for the Core Sets.

Two measures were considered for addition to the Core Set: *Child Hospital CAHPS Survey* and *Healthy Days Core Module – Health-Related Quality of Life*. The Workgroup member who suggested the *Child Hospital CAHPS Survey* measure noted that it would fill a gap by measuring the experience of health care for children in hospitals. This measure has been considered in the past, and it was recommended for additional testing (which is in process). A Workgroup member noted that states are not actively using the measure. In addition, the survey is currently conducted for all children and would need to be modified to be specific to the Medicaid population. Furthermore, a Workgroup member noted that Medicaid programs have limited oversight over hospital care, which may make it less appropriate for the Child Core Set.

The Workgroup member who suggested the *Healthy Days Core Module – Health-Related Quality of Life* measure noted that although there is robust dialogue on how to measure and improve an individual's or a community's social determinants of health, few measures have been used or tested. This measure, however, has been available in the Behavioral Risk Factor Surveillance System (BRFSS) since 1993 and is on the core module for that surveillance system. Workgroup members noted concerns about the feasibility of reporting this measure specifically

for Medicaid beneficiaries because questions on respondents' insurance status (including Medicaid coverage) are optional in BRFSS and are not asked by all states.

Long-Term Services and Supports

Workgroup members discussed six LTSS measures that were suggested but not recommended for addition to the 2020 Core Sets. All six measures were suggested to fill a gap in the 2019 Core Sets, which contain no LTSS-focused measures. Workgroup members noted the importance of adding LTSS measures, as this population comprises a large and growing share of Medicaid beneficiaries and Medicaid expenditures and existing measures do not capture the unique needs and experiences of this population.

Workgroup members discussed four measures as a group: (1) LTSS: Successful Transition After Long-term Institutional Stay, (2) LTSS: Comprehensive Assessment and Update, (3) LTSS: Comprehensive Care Plan and Update, and (4) LTSS: Reassessment/Care Plan Update After Inpatient Discharge. These measures were developed on behalf of CMS as part of a suite of LTSS measures and were designed specifically for states with managed LTSS delivery systems (currently about 24 states). Measure developers noted that the measures could potentially be adapted for use in states with fee-for-service delivery of LTSS. Workgroup members raised concerns about the feasibility of collecting the data at the state level, especially because three of the four measures require a case management record review. Workgroup members noted that the first measure, LTSS: Successful Transition After Long-Term Institutional Stay, is an outcome measure designed to assess progress in transitioning people to the community. However, the other three measures focus on processes rather than on outcomes, such as completing assessments, care plans, and care plan updates. For the two measures related to care plans, the Workgroup questioned how the care plan elements were selected. Some states and home and community based service (HCBS) waiver programs already have their own approaches to care planning, and Workgroup members suggested that it could be difficult or undesirable to mandate a single federal approach. Other Workgroup members responded that although the measures are not perfect and might not exclusively represent outcomes, LTSS is a noted gap area, and there is value in beginning to assess LTSS across states. They pointed out that states could use these four measures to compare results across LTSS plans and care management entities to identify issues. Additionally, there was discussion about the potential for using these four measures in the Health Home Core Set or in Medicaid MLTSS contracts if they are not appropriate for the Child and Adult Core Sets.

The next LTSS measure suggested but not recommended for addition to the 2020 Core Sets was the *Consumer Assessment of Healthcare Providers and Systems Home and Community Based Services* (HCBS CAHPS) survey, a cross-disability survey of the experience of HCBS beneficiaries receiving LTSS. It is designed to facilitate comparisons across state Medicaid HCBS programs throughout the country and is available for voluntary use as part of quality assurance and improvement activities and public reporting. The survey instrument is designed to be accessible to all populations of beneficiaries with disabilities, including individuals who are nonverbal. The measure steward noted that 17 states have used the survey, including states participating in the Testing Experience & Functional Tools (TEFT) demonstration and MLTSS states. Because this is a new survey and the platform is still under development (scheduled to become available in January 2020), Workgroup members voiced concern about adding it to the

2020 Core Sets. Members noted that data collection would need to be built into requirements for MLTSS plans or fielded and funded by state Medicaid programs, which might be costly. Some members also expressed concern about the survey length and how it could affect response rates, since the survey covers 21 different areas and would likely take 30 minutes to an hour or more to complete.

The final LTSS measure discussed but not recommended by the Workgroup was the *Personal Outcome Measures,* a tool designed to ensure that services and supports are person-centered. During a Personal Outcome Measures interview, 21 indicators are used to understand the presence, importance, and achievement of outcomes involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment, and more. Measure developers noted that people have been trained to use the tool in 45 states, and it is available for public use online. Some states already incorporate the tool into person-centered plans and others use it with a sample of their clients. Workgroup members voiced concerns about the high cost and time intensiveness of collecting this data via in-depth interviews.

As part of the discussion on both the *HCBS CAHPS* survey and the *Personal Outcome Measures* tool*,* Workgroup members agreed that, although collecting in-depth information is challenging at the state level, it is important to find a way to better understand the experiences of people receiving LTSS. Likewise, in light of the significant resources that states invest in LTSS, it is important to provide feedback to the Medicaid program. One member suggested that to accommodate the variety of data collection options states are exploring, CMCS could give states flexibility in choosing which tool to use to assess LTSS. States could explain which tool they used when reporting to CMCS.

Other Measures

Workgroup members suggested two other measures that were discussed but not recommended for addition to the 2020 Core Sets. The Workgroup member who suggested the *Continuity of Insurance: Informed Participation* measure for consideration noted that duration of coverage is a current gap in the Core Sets and that it affects the completeness of other measures in understanding the experience of all Medicaid and CHIP beneficiaries. Workgroup members asked questions about the measure technical specifications, which were answered by the measure steward, and noted that the Core Set may not be the appropriate place for this measure. One Workgroup member noted that this measure has not been used extensively, so it could be beneficial for states to try it and see how it could be used for quality measurement and improvement.

The Workgroup member who suggested the *Health-Related Social Needs Screening* measure noted the growing evidence that addressing health-related social needs can help improve overall health and well-being. The member commented that few measures are being used or tested to enable state Medicaid programs to measure social needs. Many Workgroup members emphasized the importance of measuring social determinants of health. However, it was noted that CMS's Center for Medicare & Medicaid Innovation is currently testing this measure, and as a result, some Workgroup members were concerned that it is not ready for use in the Core Set. There was also a question about whether states would want to use this tool or identify other tools that achieve similar aims.

Exhibit B.1. Measures discussed by the 2020 Core Set Annual Review Workgroup but not recommended for removal or addition, by domain

Measure name	Measure steward	NQF #	Measure description	Data collection method
Primary Care Access and Preventive Care				
Discussed but not recommended for removal from the 2020 Core Set				
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	NCQA	0039	Percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Adult Medicaid Survey was completed.	Survey (CAHPS 5.0H Adult Medicaid Survey)
Discussed but not recommended for addition to the 2020 Core Set				
Lead Screening in Children	NCQA	Not endorsed	Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	Administrative or hybrid
Follow-Up with Patient Family After Developmental Screening	AHRQ, PMCoE	Not endorsed	Percentage of patients aged 6 months to 36 months whose family received a follow-up discussion of developmental screening results on the same day of the screening visit.	EHR or medical record review
Prenatal Immunization Status	NCQA	Not endorsed	Percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations. Three rates are reported: influenza, Tdap, and a combination rate.	ECDS[a]
Colorectal Cancer Screening	NCQA	0034	Percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	Administrative or hybrid
Flu Vaccinations for Adults Age 65 and Older	NCQA	0039	Percentage of Medicare members 65 years of age and older who received a flu vaccination between July 1 of the measurement year and the date when the Medicare CAHPS survey was completed.	Survey (this measure is derived from the Medicare CAHPS Survey)

Measure name	Measure steward	NQF #	Measure description	Data collection method
Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan	CMS	0421/0421e	Percentage of patients age 18 years and older with a body mass index (BMI) documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m^2.	Administrative or EHR
Adult Immunization Status	NCQA	Not endorsed	Percentage of adults 19 years and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); herpes zoster; and pneumococcal.	ECDS[a]
HIV Screening	CDC	Not endorsed	Percentage of patients ages 15–65 who have been tested for HIV within that age range.	EHR
Influenza Immunization	PCPI	0041/0041e	Percentage of patients age 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Administrative or EHR
Maternal and Perinatal Health				
Discussed but not recommended for removal from the 2020 Core Set				
PC-01: Elective Delivery (PC01-AD)	TJC	0469/0469e	Percentage of women with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed. Lower rates are better for this measure.	Hybrid or EHR
Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)	OPA	2902	Among women ages 21–44 who had a live birth, the percentage that: (1) were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery; (2) were provided a long-acting reversible method of contraception within 3 and 60 days of delivery.	Administrative

Measure name	Measure steward	NQF #	Measure description	Data collection method
Discussed but not recommended for addition to the 2020 Core Set				
PC-05: Exclusive Breast Milk Feeding	TJC	0480/0480e	Percentage of newborns that were exclusively fed breast milk during the newborn's entire hospitalization. "Exclusive breast milk feeding" is defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.	EHR or chart review
Prenatal Depression Screening and Follow-Up	NCQA	Not endorsed	Percentage of deliveries in which women were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported: (1) depression screening: the percentage of deliveries in which women were screened for clinical depression using a standardized tool during pregnancy; and (2) follow-up on positive screen: the percentage of deliveries in which pregnant women received follow-up care within 30 days of screening positive for depression.	ECDS[a]
Postpartum Depression Screening and Follow-Up	NCQA	Not endorsed	Percentage of deliveries in which women were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported: (1) depression screening: percentage of deliveries in which women were screened for clinical depression using a standardized tool within 12 weeks (84 days) post-delivery; and (2) follow-up on positive screen: percentage of deliveries in which women received follow-up care within 30 days of screening positive for depression.	ECDS[a]
Care of Acute and Chronic Conditions				
Discussed but not recommended for removal from the 2020 Core Set				
HIV Viral Load Suppression (HVL-AD)	HRSA	2082/3210e	Percentage of beneficiaries age 18 and older with a diagnosis of human immunodeficiency virus (HIV) who had an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.	Administrative or EHR

Measure name	Measure steward	NQF #	Measure description	Data collection method
Discussed but not recommended for addition to the 2020 Core Set				
Transcranial Doppler Ultrasonography Screening for Children with Sickle Cell Anemia	QMETRIC–University of Michigan	2797	Percentage of children ages 2 through 15 years during the measurement year and identified as having sickle cell anemia who received at least one Transcranial Doppler ultrasonography screening within a year.	Administrative
Proportion of Days Covered: Antiretroviral Medications	PQA	Not endorsed	Percentage of individuals 18 years and older who met the Proportion of Days Covered threshold of 90% for ≥ 3 antiretroviral medications during the measurement year.	Administrative
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	Not endorsed	Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: (1) adults age ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease; OR (2) adults age ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR (3) adults ages 40–75 with a diagnosis of diabetes with a fasting or direct LDL-C level of 70–189 mg/dL.	EHR or registry
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058	Percentage of episodes for members age 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.	Administrative or EHR
Appropriate Treatment for Upper Respiratory Infection	NCQA	0069	Percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event.	Administrative or EHR

Measure name	Measure steward	NQF #	Measure description	Data collection method
Behavioral Health Care				
Discussed but not recommended for removal from the 2020 Core Set				
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	NCQA	0027	The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: (1) advising smokers and tobacco users to quit: a rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who received advice to quit during the measurement year; (2) discussing cessation medications: a rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year; and (3) discussing cessation strategies: a rolling average represents the percentage of beneficiaries age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.	Survey (CAHPS 5.0H Adult Medicaid Survey)
Discussed but not recommended for addition to the 2020 Core Set				
Tobacco Use: Screening and Cessation Intervention	PCPI	0028/0028e	Percentage of patients age 18 and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	Administrative or EHR
Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	PCPI	2152	Percentage of patients age 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.	EHR or registry
Use of Opioids from Multiple Providers in Persons Without Cancer	PQA	2950	Percentage of individuals age 18 and older without cancer who received prescriptions for opioids from four or more prescribers AND four or more pharmacies within less than or equal to 180 days. Lower rates are better for this measure.	Administrative

Measure name	Measure steward	NQF #	Measure description	Data collection method
Continuity of Pharmacotherapy for Opioid Use Disorder	USC	3175	Percentage of adults 18–64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	Administrative or EHR
Pharmacotherapy for Opioid Use Disorder	NCQA	Not endorsed	Percentage of new pharmacotherapy treatment episodes that resulted in 180 or more covered treatment days among members 16 years of age and older with a diagnosis of OUD.	Administrative or EHR
Query of Prescription Drug Monitoring Program	CMS	Not endorsed	For at least one Schedule II opioid electronically prescribed using Certified Electronic Health Records Technology (CEHRT) during the performance period, the Merit-based Incentive Payment System eligible clinician uses data from CEHRT to conduct a query of a Prescription Drug Monitoring Program for prescription drug history, except where prohibited and in accordance with applicable law.	Administrative or EHR
Follow-Up After High-Intensity Care for Substance Use Disorder	NCQA	Not endorsed	Percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder that result in a follow-up visit or service for substance use disorder among individuals 13 years of age and older. Two rates are reported: (1) percentage of visits or discharges for which the individual received follow-up for substance use disorder within the 30 days after the visit or discharge, and (2) percentage of visits or discharges for which the individual received follow-up for substance use disorder within the 7 days after the visit or discharge.	Administrative
Dental and Oral Health Services				
Discussed but not recommended for addition to the 2020 Core Set				
Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children	ADA/ DQA	2689	Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children. Rates are stratified by age and by ED visit disposition (visits resulting in an inpatient admission and those not resulting in an inpatient admission). Lower rates are better for this measure.	Administrative

Measure name	Measure steward	NQF #	Measure description	Data collection method
Follow-Up After Emergency Department Visits for Dental Caries in Children	ADA/ DQA	2695	Percentage of caries-related ED visits among children 0 through 20 years in the reporting period for which the member visited a dentist within (1) 7 days and (2) 30 days of the ED visit.	Administrative
Adults with Diabetes – Oral Evaluation	ADA/ DQA	Not endorsed	Percentage of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.	Administrative
Experience of Care				
Discussed but not recommended for removal from the 2020 Core Set				
Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan Survey 5.0H – Child Version (Medicaid) (CPC-CH)	NCQA	Not endorsed	This measure provides information on parents' experiences with their child's health care and gives a general indication of how well the health care meets their expectations. Results summarize children's experiences through ratings, composites, and individual question summary rates. The Child Core Set measure includes the Children with Chronic Conditions Supplemental Items.	Survey
Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan Survey 5.0H – Adult Version (Medicaid) (CPA-AD)	NCQA	Not endorsed	This measure provides information on beneficiaries' experiences with their health care and gives a general indication of how well the health care meets the beneficiaries' expectations. Results summarize beneficiaries' experiences through ratings, composites, and individual question summary rates.	Survey
Discussed but not recommended for addition to the 2020 Core Set				
Child Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	AHRQ	2548	This measure asks parents and guardians of children under 18 years old to report on their and their child's experiences with inpatient hospital care. Results consist of 39 items organized by overarching groups into 18 composite and single-item measures. The domains include: Communication with Parent, Communication with Child, Attention to Safety and Comfort, Hospital Environment, and Global Rating.	Survey

Measure name	Measure steward	NQF #	Measure description	Data collection method
Healthy Days Core Module – Health-Related Quality of Life	CDC	Not endorsed	The four Health-Related Quality of Life Healthy Days Core Module (HRQOL-4) items ask about self-rated general health and the number of days when a person was physically unhealthy, mentally unhealthy, or limited in usual activities within the previous 30 days. A summary measure combines physically and mentally unhealthy days. The module was developed for national and state surveillance surveys, including the state-based Behavioral Risk Factor Surveillance System (BRFSS), the National Health and Nutrition Examination Survey, and the Medicare Health Outcomes Survey.	Survey
Long-Term Services and Supports (LTSS)				
Discussed but not recommended for addition to the 2020 Core Set				
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home and Community Based Services (HCBS) Survey	CMS	2967 (19 HCBS CAHPS measures are endorsed)	The HCBS CAHPS is a cross-disability survey of the experience of HCBS beneficiaries receiving LTSS. It is designed to facilitate comparisons across state Medicaid HCBS programs that target adults with disabilities, including frail elderly, individuals with physical disabilities, persons with developmental or intellectual disabilities, those with acquired brain injury, and persons with severe mental illness. The HCBS CAHPS Survey is available for voluntary use in HCBS programs as part of quality assurance and improvement activities and public reporting.	Survey
LTSS: Successful Transition After Long-Term Institutional Stay	CMS	Not endorsed	Proportion of long-term institutional facility stays among Medicaid Managed LTSS (MLTSS) plan members age 18 and older, which result in successful transitions to the community (community residence for 60 or more days). This measure is reported as an observed rate and a risk-adjusted rate.	Administrative

Measure name	Measure steward	NQF #	Measure description	Data collection method
LTSS: Comprehensive Assessment and Update	CMS	Not endorsed	Percentage of Medicaid MLTSS plan members 18 years of age and older who have documentation of a comprehensive assessment in a specified time frame that includes documentation of core elements. The following rates are reported: (1) assessment of core elements: MLTSS plan members who had a comprehensive LTSS assessment with nine core elements documented within 90 days of enrollment (for new members) or annually; and (2) assessment of supplemental elements: MLTSS plan members who had a comprehensive LTSS assessment with nine core elements and at least 12 supplemental elements documented within 90 days of enrollment (for new members) or annually. In addition, two rates of required exclusions should be reported: (1) member could not be contacted for care planning; and (2) member refused to participate in care planning.	Case management record review
LTSS: Comprehensive Care Plan and Update	CMS	Not endorsed	Percentage of Medicaid MLTSS plan members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified time frame that includes documentation of core elements. The following rates are reported: (1) care plan with core elements documented: MLTSS plan members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or annually; and (2) care plan with supplemental elements documented: MLTSS plan members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or annually.	Case management record review

Measure name	Measure steward	NQF #	Measure description	Data collection method
LTSS: Reassessment/ Care Plan Update After Inpatient Discharge	CMS	Not endorsed	Percentage of discharges from inpatient facilities for Medicaid MLTSS plan members 18 years of age and older for whom a reassessment and care plan update occurred within 30 days of discharge. Two performance rates are reported: (1) reassessment after inpatient discharge: percentage of discharges from inpatient facilities resulting in a LTSS reassessment within 30 days of discharge; and (2) reassessment and care plan update after inpatient discharge: percentage of discharges from inpatient facilities resulting in an LTSS reassessment and care plan update within 30 days of discharge. In addition, two rates of required exclusions should be reported: (1) member could not be contacted for assessment and/or care planning; and (2) member refused to participate in assessment and/or care planning.	Case management record review
Personal Outcome Measures	CQL	Not endorsed	Personal Outcome Measures is a tool designed to ensure that services and supports are person-centered. In a Personal Outcome Measures interview, 21 indicators are used to understand the presence, importance and achievement of outcomes involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment, and more. Measures are organized into five topic areas: human security, community, relationships, choices, and goals.	In-depth interview
Other Measures				
Discussed but not recommended for addition to the 2020 Core Set				
Continuity of Insurance: Informed Participation	CHOP	3154	This measure assesses the continuity of enrollment of children in publicly financed insurance programs (Medicaid and CHIP), as defined by the ratio of enrolled months to eligible months over an 18-month period (called an “observation window”). The measure uses a natural experiment based on the random event of appendicitis to “inform” the estimate of coverage in a given state.	Administrative

Measure name	Measure steward	NQF #	Measure description	Data collection method
Health-Related Social Needs (HRSN) Screening	CMS	Not endorsed	A 10-item screening tool designed to identify patient needs in 5 domains that can be addressed through community services (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety).	Survey

[a] ECDS data collection method includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.

ADA = American Dental Association; AHRQ = Agency for Healthcare Research and Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CHOP = Children's Hospital of Philadelphia; CMCS = Centers for Medicaid and CHIP Services; CMS = Centers for Medicare & Medicaid Services; CQL = Council on Quality and Leadership; DQA = Dental Quality Alliance; ECDS = Electronic Clinical Data System; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = Office of Population Affairs; PCPI = Physician Consortium for Performance Improvement; PMCoE = Pediatric Measurement Center of Excellence; PQA = Pharmacy Quality Alliance; QMETRIC = Quality Measurement, Evaluation, Testing, Review, and Implementation Consortium; TJC = The Joint Commission; USC = University of Southern California.

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