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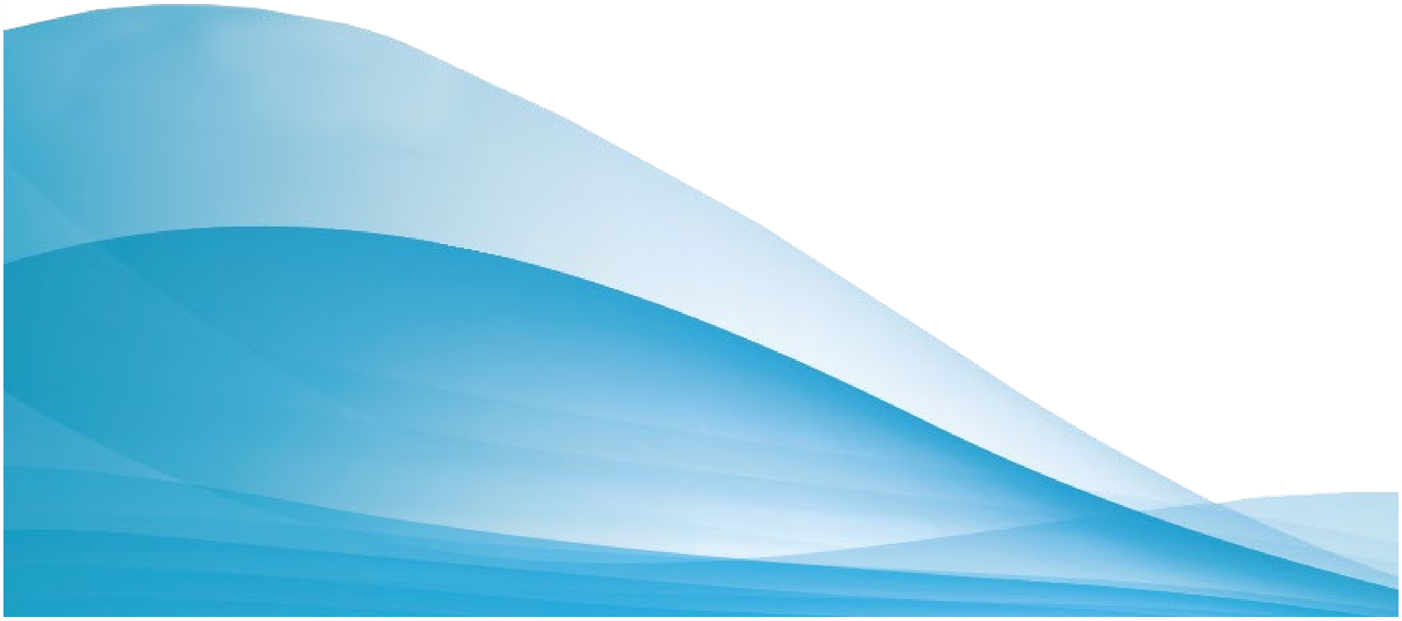
Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

Summary of a Multistakeholder Review of the 2021 Child and Adult Core Sets

Final Report

August 2020



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Mathematica would also like to acknowledge the contributions of the Workgroup members; each member brought an invaluable perspective that informed the recommendations for the 2021 Child and Adult Core Sets. In particular, we thank the Workgroup co-chairs, Gretchen Hammer and David Kelley, for their insightful 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 meeting.

Mathematica also appreciates the public comments provided by stakeholders during the Workgroup meetings and the public comment period for the draft report.

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

Exhibits

Acronyms

ABA-AD	Adult Body Mass Index Assessment
ADA	American Dental Association
AHRQ	Agency for Healthcare Research and Quality
AUD-CH	Audiological Diagnosis No Later than 3 Months of Age
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CDF-AD	Screening for Depression and Follow-Up Plan: Age 18 and Older
CDF-CH	Screening for Depression and Follow-Up Plan: Ages 12–17
CHIP	Children’s Health Insurance Program
CHIPRA	Children’s Health Insurance Program Reauthorization Act
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
CPA-AD	CAHPS Health Plan Survey 5.0H, Adult Version
CPC-CH	CAHPS Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items
CV	Curriculum vitae
DQA	Dental Quality Alliance
ECDS	Electronic Clinical Data Systems
ED	Emergency department
EHDI	Early Hearing Detection and Intervention
EHR	Electronic health record
EPSDT	Early and Periodic, Screening, Diagnostic and Treatment
FFY	Federal fiscal year
FVA-AD	Flu Vaccinations for Adults Ages 18 to 64
HCUP	Healthcare Cost and Utilization Project
HHS	U.S. Department of Health and Human Services
HbA1c	Hemoglobin A1c
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HEDIS	Healthcare Effectiveness Data and Information Set
HIV	Human immunodeficiency virus
HPCMI-AD	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)
HRSA	Health Resources and Services Administration
HSRI	Human Services Research Institute
HVL-AD	HIV Viral Load Suppression

IIS	Immunization information system
LTSS	Long-Term Services and Supports
LBW-CH	Live Births Weighing Less than 2,500 Grams
MLTSS	Managed Long-Term Services and Supports
MLTSS-6	Long-Term Services and Supports Admission to an Institution from the Community
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
NCI-AD	National Core Indicators for Aging and Disabilities Adult Consumer Survey
NCIDDS-AD	National Core Indicators Survey
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer
OHSU	Oregon Health and Science University
OPA	U.S. Office of Population Affairs
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder
PC01-AD	PC-01: Elective Delivery
PC02-CH	PC-02: Cesarean Birth
PCPI	Physician Consortium for Performance Improvement
PDENT-CH	Percentage of Eligibles Who Received Preventive Dental Services
PQA	Pharmacy Quality Alliance
PQI	Prevention Quality Indicators
PQI01-AD	PQI 01: Diabetes Short-Term Complications Admission Rate
Q&A	Question and answer
QTAG	Quality Technical Advisory Group
SEAL-CH	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk
TA/AS	Technical assistance and analytic support
Tdap	Tetanus, diphtheria toxoids, and acellular pertussis
TJC	The Joint Commission
T-MSIS	Transformed Medicaid Statistical Information System
USPSTF	United States Preventive Services Task Force
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
WONDER	Wide-ranging Online Data for Epidemiologic Research

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to approximately 73.5 million people, including eligible children, pregnant women, low-income adults, and individuals with disabilities.[1] To help ensure that individuals enrolled in Medicaid and CHIP receive health care coverage that promotes access to and receipt of high quality and equitable care, the Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care that individuals receive and to drive improvement in Medicaid and CHIP. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort.

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

The Secretary of the U.S. Department of Health and Human Services is required to review and update the Child and Adult Core Sets each year.[3] The Core Set Annual Review 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 2021 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup). The Workgroup included 27 members who represent a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover).

The Workgroup was charged with assessing the 2020 Core Sets and recommending measures for removal or addition in order to strengthen and improve the Core Sets for 2021. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Core Sets based on several criteria that support the use of the Core Set measures to meaningfully drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries. See Exhibit ES.1 for the criteria Workgroup members considered during the 2021 Core Set Review.

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[1] May 2020 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 May 2020, as reported by 50 states and the District of Columbia.

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

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

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

	Criteria Considered for Removal of Existing Measures
Technical Feasibility	
1.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	States report significant challenges in accessing an available data source (including medical records and surveys) that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3.	The available data source does not allow for consistent calculations across states.
Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure does not make a significant contribution to estimating the overall national quality of health care in Medicaid and CHIP.
2.	The measure does not provide useful and actionable results to drive improvement in state Medicaid and CHIP programs.
3.	The measure does not address a strategic priority in monitoring the performance of state Medicaid and CHIP programs.
Other Considerations	
1.	The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3.	Fewer than half of the states will be able to produce the measure for FFY 2021 or FFY 2022 and all states will not be able to produce the measure by FFY 2024, including all their Medicaid and CHIP populations.
	Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)	
1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	The measure must have been tested in state Medicaid and CHIP programs or be in use by one or more state Medicaid and CHIP agencies.
3.	An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4.	The specifications and data source must allow for consistent calculations across states.
Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure must contribute to estimating the overall national quality of health care in Medicaid and CHIP.
2.	The measure must provide useful and actionable results to drive improvement in state Medicaid and CHIP programs.
3.	The measure must address a strategic priority in monitoring the performance of state Medicaid and CHIP programs.

Exhibit ES.1 *(continued)*

Other Considerations	
1.	The prevalence of the condition or outcome being measured should be sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications should be aligned with those used in other CMS programs, where possible.
3.	At least half the states should be able to produce the measure for FFY 2021 or FFY 2022, and all the states should be able to produce the measure by FFY 2024, including all their Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

Workgroup members convened virtually from April 28 to April 30, 2020, to review 13 existing Core Set measures suggested for removal from the 2021 Core Sets and 12 measures suggested for addition. The 25 measures were presented, discussed, and voted on by domain.[4] To be recommended for removal from or addition to the Core Sets, at least two-thirds of the Workgroup members eligible to vote on a measure had to vote in favor of removal or addition.

In summary, the Workgroup recommended the following:

- **Removal of 1 measure from the Adult Core Set** out of a total of 13 measures suggested for removal
- **Addition of 3 measures to the Child and Adult Core Sets** out of a total of 12 measures suggested for addition

Exhibit ES.2 shows the measures the Workgroup recommended for removal from and addition to the 2021 Core Sets.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2021 Core Sets

Measure Name	Measure Steward	NQF # (if endorsed)
Measure Recommended for Removal		
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)	National Committee for Quality Assurance (NCQA)	2607
Measures Recommended for Addition		
Postpartum Depression Screening and Follow-Up	NCQA	Not endorsed
Prenatal Immunization Status	NCQA	Not endorsed
Sealant Receipt on Permanent 1st Molars	American Dental Association (ADA)/Dental Quality Alliance (DQA)	Not endorsed

NQF = National Quality Forum.

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[4] 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, and Long-Term Services and Supports.

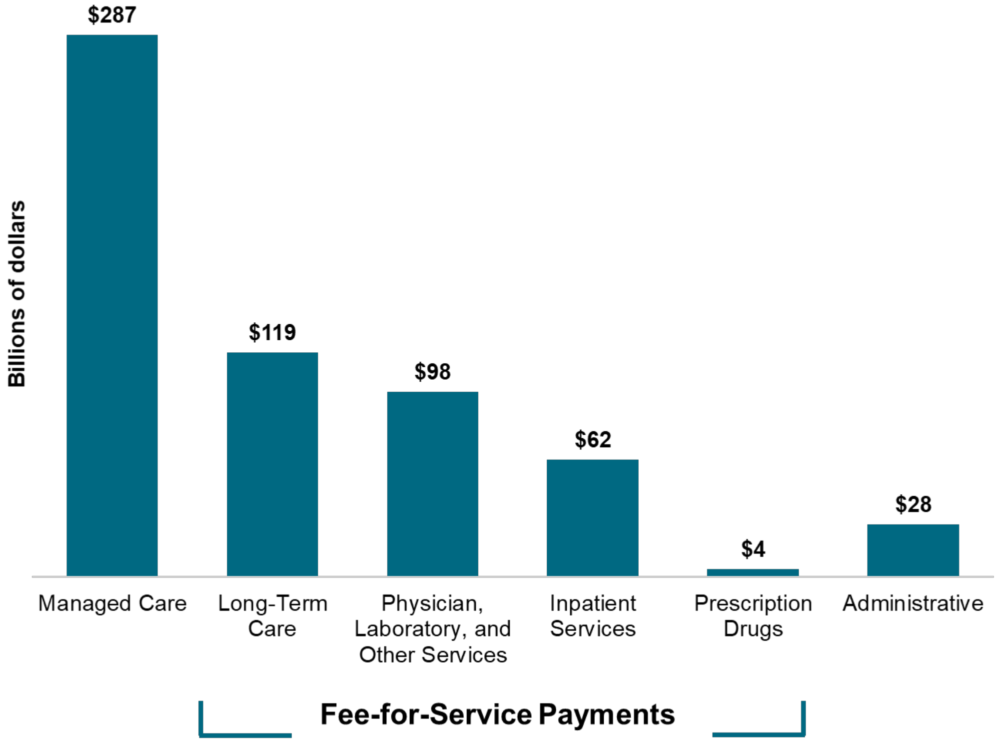
This report provides an overview of the Child and Adult Core Sets, describes the 2021 Core Set Annual Review process, shares state perspectives on Core Set reporting, summarizes the Workgroup’s recommendations for improving the Core Sets, and presents the public comments submitted on the draft report. CMCS will use the Workgroup’s recommendations, public comments received on the draft report, and additional input from CMCS’s state Medicaid and CHIP Quality Technical Advisory Group, internal CMS stakeholder meetings, and interagency federal partners, to inform decisions about updates to the 2021 Core Sets. CMCS will release the 2021 Core Sets through a CMCS Informational Bulletin by December 31, 2020.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to nearly 73.5 million people, including eligible children, pregnant women, low-income adults, and individuals with disabilities.[5] This represents approximately one in five individuals in the United States.[6] Managed care capitation payments are the largest category of Medicaid program expenditures, followed by fee-for-service payments for long-term care (Exhibit 1).

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

Exhibit 1. Annual Medicaid and CHIP Expenditures by Service Category, 2017



Source: CMS Medicaid & CHIP Scorecard National Context. Available at https://www.medicaid.gov/state-overviews/scorecard/national-context/index.html.

Notes: Expenditures by service category do not sum to the total expenditures. Total expenditures also include Medicare payments for some beneficiaries and adjustments to prior year payments. Managed care expenditures cover the same services that are delivered via fee-for-service. Data do not permit allocation of managed care expenditures to the different service categories. Data are for federal fiscal year 2017.

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[5] May 2020 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 May 2020, as reported by 50 states and the District of Columbia.

[6] Center for Medicaid and CHIP Services, Division of Quality and Health Outcomes Medicaid and CHIP Beneficiary Profile. Centers for Medicare & Medicaid Services. Baltimore, MD. February 2020. Available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile.pdf.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries through state reporting on a uniform set of measures. The Core Set measures are intended to cover the continuum of preventive, diagnostic, and treatment services for acute and chronic physical, behavioral, dental, and developmental conditions as well as long-term services and supports. In collaboration with CMCS, state Medicaid and CHIP agencies use these measures to target quality improvement efforts and to assess the effectiveness of these efforts over time. Although state reporting on the Core Sets is currently voluntary, the Child Core Set measures and the behavioral health measures in the Adult Core Set become mandatory for state reporting starting in 2024.[7]

The Secretary of the U.S. Department of Health and Human Services (HHS) is required to review and update the Child and Adult Core Sets each year.[8] The Core Set Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from numerous stakeholders, such as states, health care providers, and quality experts. The Child Core Set has undergone these multistakeholder annual reviews since January 2013 and the Adult Core Set since January 2014.

CMCS contracted with Mathematica to convene the 2021 Child and Adult Core Set Annual Review Stakeholder Workgroup. The Workgroup included 27 members, who represent a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover).

The Workgroup was charged with assessing the 2020 Child and Adult Core Sets[9] and recommending measures for removal or addition in order to strengthen and improve the Core Sets for 2021. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Core Sets based on several criteria that support the use of the Core Set measures to meaningfully drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

This report provides an overview of the Child and Adult Core Sets, describes the 2021 Core Set Annual Review process, shares state perspectives on Core Set reporting, summarizes the Workgroup's recommendations for improving the Core Sets, and presents the public comments submitted on the draft report. CMCS will use the Workgroup's recommendations, public comments received on the draft report, and additional input from CMCS's state Medicaid and CHIP Quality Technical Advisory Group, internal CMS stakeholder meetings, and interagency federal partners, to inform decisions about updates to the 2021 Core Sets. CMCS will release the 2021 Core Sets through a CMCS Informational Bulletin by December 31, 2020.

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

[8] 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.

[9] More information about the annual multistakeholder review of the 2020 Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview. More information about the 2020 updates to the Child and Adult Core Sets is available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib111919.pdf.

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 Secretary of HHS to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs (referred to as the Child Core Set). The initial Child Core Set, which was released in December 2009, included 24 measures that covered both physical and mental health. The core set of health care quality measures for adults covered by Medicaid (Adult Core Set) was established in 2010 under the Patient Protection and Affordable Care Act (Affordable Care Act) in the same manner as the Child Core Set. The initial Adult Core Set, which was released in January 2012, included 26 measures. Currently, state reporting on the Core Set measures is voluntary. In 2024, the Child Core Set measures and the behavioral health measures in the Adult Core Set become mandatory for state reporting.[10]

Please refer to Appendix A for tables showing the 2020 Child and Adult Core Set measures and the history of measures included in the Child and Adult Core Sets. Of the 24 measures in the 2020 Child Core Set, two-thirds were part of the initial Child Core Set. Of the 33 measures in the 2020 Adult Core Set, about three-fifths were part of the initial Adult Core Set.

The 2020 Child Core Set

The 2020 Child Core Set includes 24 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.[11] Nearly two-thirds of the measures in the 2020 Child Core Set fall into the Primary Care Access and Preventive Care and Maternal and Perinatal Health domains (Exhibit 2). Seventy-five percent (18 measures) are process measures and 83 percent (20 measures) can be calculated using an administrative data collection methodology.

Highlights for federal fiscal year (FFY) 2018 Child Core Set reporting,[12] the most recent year for which data are publicly available, include the following:

- All states voluntarily reported at least one Child Core Set measure.
- Forty-three states reported on at least half of the 26 measures in the Child Core Set.
- Twenty-one states reported on more measures for FFY 2018 than for FFY 2017.
- Forty-six states reported data on both the Medicaid and CHIP populations.

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

[11] 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.

[12] More information about FFY 2018 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/ffy-2018-core-set-reporting.pdf. A chart pack summarizing FFY 2018 Child Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-chart-pack.pdf.

- The median number of measures reported by states was 18, which is consistent with the median number of measures reported for FFY 2016 and FFY 2017.
- The most frequently reported measures focus on preventive dental services, child and adolescent well-care visits, emergency department use, and follow-up after hospitalization for mental illness.

Exhibit 2. Distribution of 2020 Child Core Set Measures, by Domain

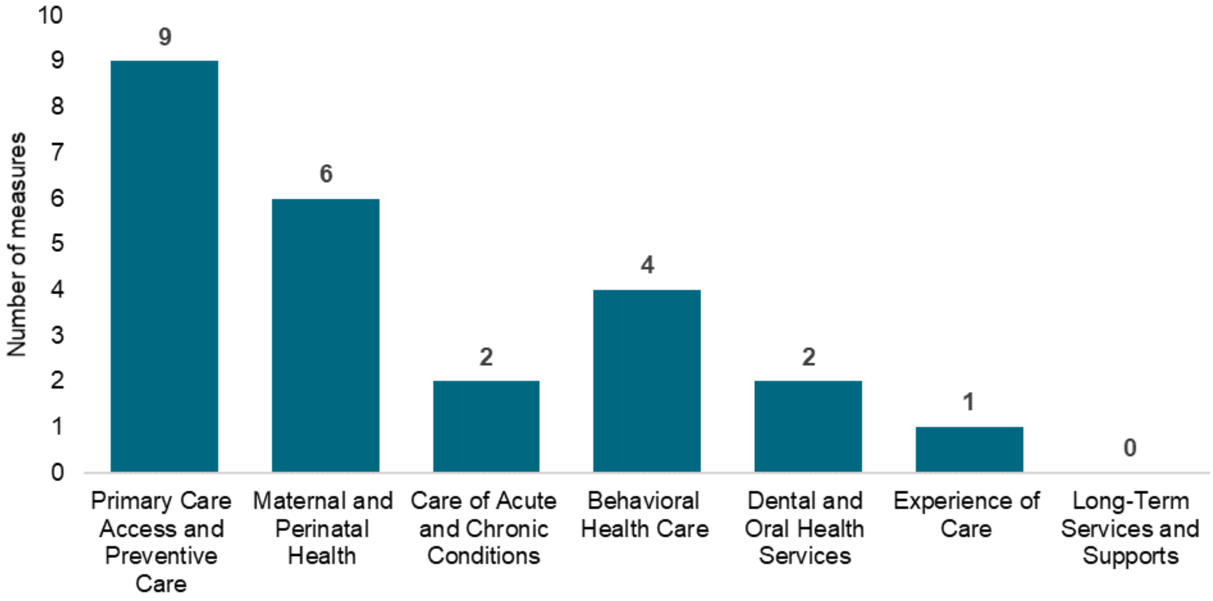
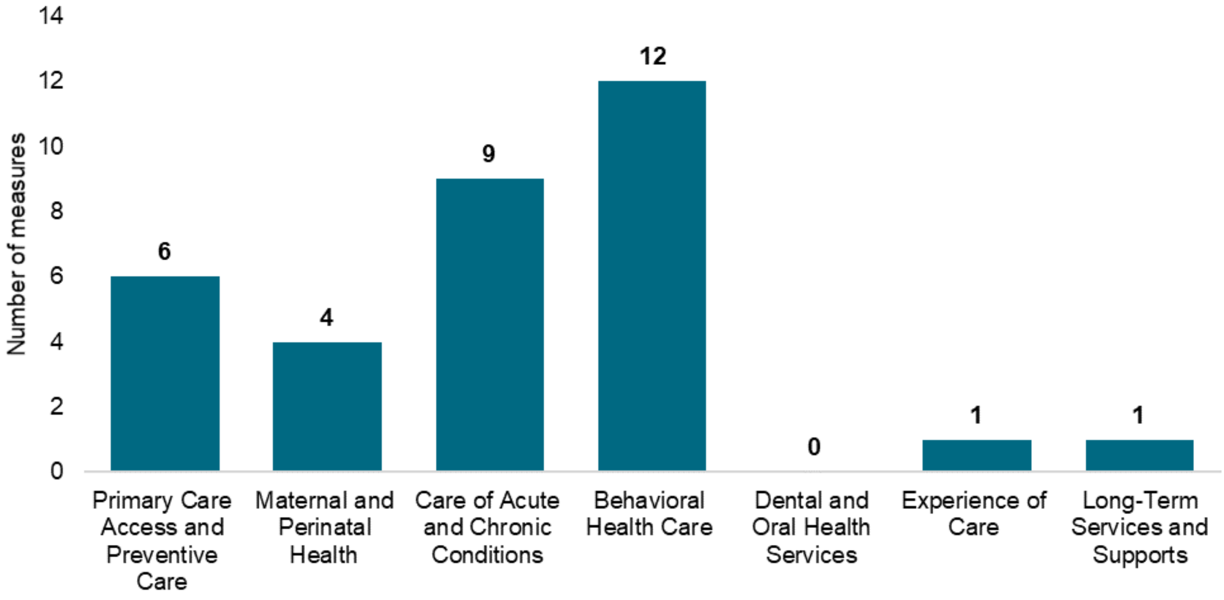


Exhibit 3. Distribution of 2020 Adult Core Set Measures, by Domain



The 2020 Adult Core Set

The 2020 Adult Core Set includes 33 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Experience of Care, and (6) Long-Term Services & Supports.[13] Long-Term Services & Supports (LTSS) is a new domain in the 2020 Adult Core Set. Nearly two-thirds of the 2020 Adult Core Set measures fall into the Care of Acute and Chronic Conditions and Behavioral Health Care domains (Exhibit 3). Behavioral Health Care is the largest domain in the 2020 Adult Core Set and the fastest-growing domain over time, with seven measures added to this domain since 2016. Two-thirds (22 measures) are process measures, and 85 percent (28 measures) can be calculated using an administrative data collection methodology.

Highlights for FFY 2018 Adult Core Set reporting,[14] the most recent year for which data are publicly available, include the following:

- Forty-five states voluntarily reported at least one Adult Core Set measure.
- Thirty-two states reported on at least half of the 33 measures in the Adult Core Set.
- One state reported 32 of the 33 measures.
- Thirty-six states reported more measures for FFY 2018 than for FFY 2017.
- States reported a median of 20 measures, an increase of 3 measures over FFY 2017.
- The most frequently reported measures focus on follow-up after hospitalization for mental illness, breast and cervical cancer screening, chlamydia screening, diabetes management, and postpartum care visits.

State Challenges with Reporting the Child and Adult Core Set Measures

Understanding state challenges with reporting the Child and Adult Core Set measures is key to assessing the feasibility of calculating existing measures as well as those suggested for addition to the Core Sets. The most common reason cited by states for not reporting the Child and Adult Core Set measures for FFY 2018 was lack of access to data to calculate the measure. States' reasons for lack of access to data for Core Set reporting are multifaceted and reflect both the pathways through which data are collected, calculated, and reported (such as through managed care plans or other vendors) and the availability of information from sources other than claims/encounter data. For example, common barriers to data availability include challenges with accessing the required data (such as electronic health records [EHRs], medical records for chart abstraction, and linkage to data sources maintained by other state agencies); concerns about the accuracy and completeness of data used in calculating the measure; and budget and/or staff constraints to program new measures or collect new data.

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[13] 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.

[14] More information about FFY 2018 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/ffy-2018-core-set-reporting.pdf. A chart pack summarizing FFY 2018 Adult Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-chart-pack.pdf.

Please refer to Appendix B for a fact sheet summarizing states' reasons for not reporting the Child and Adult Core Set measures for FFY 2018. These findings informed the Workgroup's discussions of the feasibility of reporting existing measures suggested for removal from the Core Sets and collecting new measures suggested for addition.

Use of the Core Sets for Quality Measurement and Improvement

CMCS and states use the Child and Adult Core Sets to monitor and improve the quality of care provided to Medicaid and CHIP beneficiaries at the national and state levels and to measure progress over time. CMCS publicly reports information on state performance on the Child and Adult Core Sets annually through chart packs and other resources.[15] CMS annually releases Child and Adult Core Set data for measures that were reported by at least 25 states and that met CMS standards for data quality.

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMCS supports states and their partners to collect, report, and use the Core Set measures to drive improvement in Medicaid and CHIP while striving to achieve several goals for state reporting, including: maintaining or increasing the number of states reporting Core Set measures, maintaining or increasing the number of measures reported by each state, and improving the quality and completeness of the data reported.[16] The TA/AS Program offers states various TA opportunities to address technical issues related to collecting and reporting the Core Set measures, including a TA mailbox, one-on-one consultation, issue briefs, fact sheets, analytic reports, and webinars.

CMCS also develops initiatives to drive improvement in quality of care using Core Set measures, for example, through its Maternal and Infant Health Initiative and Oral Health Initiative.[17] The TA/AS Program supports CMCS and states in designing and implementing quality improvement initiatives focused on the Core Set measures through affinity groups, online training opportunities, one-on-one and group coaching, and other approaches. The TA/AS Program also supports the annual CMS Quality Conference by providing states with hands-on information and networking opportunities to support their Medicaid and CHIP quality measurement and improvement efforts. The State Health System Performance pillar of the Medicaid and CHIP Scorecard also uses data for several Child and Adult Core Set measures.[18]

Description of the 2021 Core Set Annual Review Process

This section describes the 2021 Core Set Annual Review process, including the Workgroup composition, timeline, and meetings.

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[15] Chart packs, measure-specific tables, fact sheets, and other Core Set annual reporting resources 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.

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

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

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

Workgroup Composition

The Workgroup for the 2021 Core Set Annual Review included 27 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. The Workgroup was selected through a Call for Nominations issued in December 2018 in conjunction with the 2020 Core Set Annual Review.[19]

As a whole, the Workgroup for the 2021 Core Set Annual Review offered 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 Workgroup members have individual subject matter expertise, and some were nominated by an organization, Workgroup members were asked to participate as stewards of the Medicaid and CHIP programs and not from their individual points of view. They were asked to consider what measures would be best to drive improvement in care delivery and health outcomes in Medicaid and CHIP overall.

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

The Workgroup also included nonvoting federal liaisons who represented eight 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 care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Workgroup Timeline and Meetings

As shown in Exhibit 4, Mathematica held webinars in December 2019 and March 2020 to orient the Workgroup members to the review process and to prepare them for the Workgroup meeting, which was convened virtually in April 2020 because of the COVID-19 pandemic. The two webinars and the Workgroup meeting were open to the public, and public comment was invited at multiple points throughout each meeting.

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[19] Nominations were reviewed to address legislative requirements for the Core Set Annual Review, to ensure geographic distribution, and to represent diverse areas of expertise. 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.

Exhibit 4. 2021 Core Set Annual Review Stakeholder Workgroup Timeline

DEC 2019 13	**Orientation webinar**
JAN 2020 17	**Workgroup call for measures closes**
MAR 2020 19	**Webinar to prepare for Annual Review meeting**
APR 2020 28-30	**Annual Review meeting**

☑ **July 2020:**
Draft report made available for public comment

☑ **August 2020:**
Final report released

☑ **September-December 2020:**
CMCS review of final report and additional stakeholder input

☑ **By December 31st 2020:**
2021 Core Sets released

Orientation Webinar

During the orientation webinar on December 13, 2019, Mathematica outlined the Workgroup charge, introduced the Workgroup members, discussed the Disclosure of Interest process, described the timeline for the 2021 Annual Review, and provided background on the Child and Adult Core Sets.

Mathematica described the additional stakeholder input that would be obtained during the 2021 Annual Review process, including input from federal partners, CMCS's Quality Technical Advisory Group (QTAG), and two workgroups that Mathematica established to provide input on (1) long-term planning for the Core Sets and (2) the feasibility of reporting Core Set measures by states.

Workgroup Charge

The Child and Adult Core Set Stakeholder Workgroup for the 2021 Annual Review is charged with assessing the 2020 Core Sets and recommending measures for removal or addition in order to strengthen and improve the Core Sets for Medicaid and CHIP.

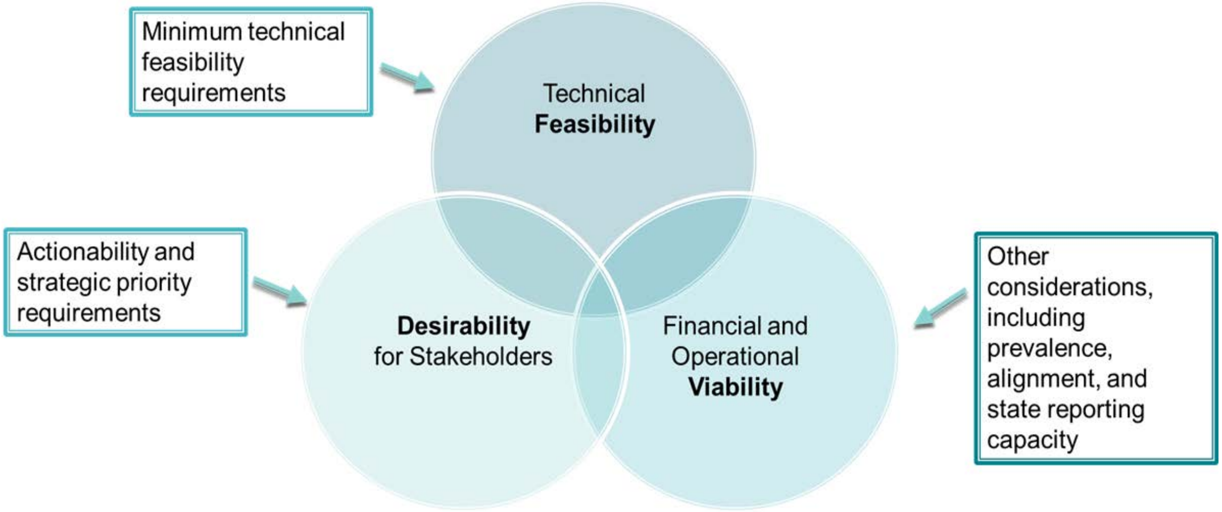
The Workgroup should focus on measures that are actionable, aligned, and appropriate for state-level reporting, to ensure that the measures can meaningfully drive improvement in quality of care and outcomes in Medicaid and CHIP.

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

To operationalize these three components, Mathematica identified a comprehensive set of criteria used to assess measures during all phases of the Workgroup process. As shown in Exhibit 5, the Workgroup was charged with focusing on measures that met the following criteria:

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

Exhibit 5. Framework for Assessing Measures for the 2021 Core Sets



Restating the Workgroup's charge, CMCS directed the Workgroup to consider all criteria when recommending measures to remove from or add to the Core Sets. CMCS encouraged Workgroup members to seek a balance between actionability and strategic priority, while ensuring that feasibility is not the overriding factor in measure recommendations. CMCS also encouraged Workgroup members to reflect on what is important to measure about Medicaid and CHIP program performance.

Call for Measures for Removal from or Addition to the 2021 Core Sets

Following the orientation meeting, Workgroup members and federal liaisons were invited to suggest measures for removal from or addition to the 2021 Core Sets. Workgroup members used an online form to submit their suggestions for removal or addition, including the rationale for the suggestion; information about the technical feasibility, actionability, and strategic priority of measures suggested for removal or addition; whether the removal of a measure would leave a gap in the Core Set; and whether measures suggested for addition were intended to replace current Core Set measures.

The Workgroup members and federal liaisons suggested 16 measures for removal and 16 measures for addition. Mathematica conducted a preliminary assessment of the measures and determined that 3 of the 16 measures suggested for removal would not be discussed because they were already retired by CMS from the 2020 Core Set, being retired by the measure steward for 2021, or withdrawn by the Workgroup member because of a change to the measure that addressed their concern. Mathematica also determined that 4 of the 16 measures suggested for addition would not be discussed because they did not meet minimum technical feasibility requirements: 3 had not been field tested in Medicaid and CHIP, and 1 did not have detailed technical specifications that would enable production of the measure at the state level.

The Workgroup considered 25 measures during the April meeting:

- **Thirteen measures for removal**, including 4 of the 24 measures from the 2020 Child Core Set and 9 of the 33 measures in the 2020 Adult Core Set.
- **Twelve measures for addition** across five Core Set domains. Note that the measures suggested for addition were not assigned to the Child or Adult Core Set because CMCS determines the Core Set assignment for measures added during the annual update.

Please refer to Appendix C for the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the 2021 Core Sets.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on March 19, 2020. To help Workgroup members prepare for the discussion at the 2021 Annual Review meeting, Mathematica shared a list of the 13 measures to be considered for removal and the 12 measures to be considered for addition. Mathematica provided guidance on how to prepare for the discussion of the measures at the Workgroup meeting, including the criteria that Workgroup members should consider for recommending measures for removal from or addition to the Core Sets and the resources available to facilitate their review. These resources included detailed measure information sheets for each measure being reviewed, 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; completing the measure worksheet; and coming to the Annual Review meeting prepared with notes, questions, and planned votes on each measure proposed for removal or addition.

Annual Review Meeting

The 2021 Annual Review meeting took place from April 28 to April 30, 2020. The meeting was conducted as a webinar rather than in person because of the COVID-19 pandemic. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

The discussion of measures was organized according to the seven current Core Set domains.[20] For each domain, Mathematica described the 2020 Core Set measures in the domain, highlighted the measures suggested for removal first followed by the measures suggested for addition, noted the key technical specifications of each measure proposed for removal or addition, and summarized the rationale that Workgroup members provided for suggesting the measures for removal or addition.

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

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

Within each domain, the Workgroup voted on measures suggested for removal first, followed by measures suggested for addition, with one exception. During voting on the measures in the Primary Care Access and Preventive Care domain, a Workgroup member requested to vote on the addition of the *Adult Immunization Status* measure before voting on removal of the *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD) measure; the rationale was that the *Adult Immunization Status* measure was suggested to replace FVA-AD and knowing whether *Adult Immunization Status* was added to the Core Sets would inform whether removing FVA-AD would leave a gap. The Workgroup co-chairs agreed to the request to reorder this vote.

For each measure suggested for removal, Workgroup members could select either “Yes, I recommend removing this measure from the Core Set” or “No, I do not recommend removing this measure from the Core Set.” For each measure suggested for addition, Workgroup members could select either “Yes, I recommend adding this measure to the Core Set” or “No, I do not recommend adding this measure to the Core Set.” Measures were recommended for removal or addition if two-thirds of the eligible Workgroup members voted yes. Because of recusals,[21] as well as the unavailability of a few Workgroup members during each day of the three-day Workgroup meeting, some members did not participate in all voting periods.[22] As a result, the

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[20] The Core Set domains are Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, Dental and Oral Health Services, Experience of Care, and Long-Term Services and Supports.

[21] 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.

[22] Because of the COVID-19 pandemic, one Medicaid Director was unable to attend the meeting and two Medicaid Medical Directors were unable to attend for part of the meeting.

two-thirds voting threshold was adjusted based on the number of eligible Workgroup members present for each measure vote.

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

Workgroup Recommendations for Improving the 2021 Core Sets

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

Building on the lessons learned during the Annual Review of the 2020 Core Sets and incorporating stakeholder input, Mathematica refined the criteria the Workgroup used to assess measures for removal from or addition to the 2021 Core Sets. Mathematica specified detailed criteria related to (1) minimum technical feasibility requirements, (2) actionability and strategic priority, and (3) other considerations (Exhibit 6). The intent was to provide greater transparency and guidance to Workgroup members, federal liaisons, and the public about the types of measures that would be a good fit for the Core Sets. As noted earlier, Mathematica instituted a preliminary screening process to assure that measures discussed by the Workgroup adhered to a set of minimum technical feasibility criteria, including that detailed technical specifications were available for calculating the measures and that the measures had been tested or used by state Medicaid and CHIP programs.

Exhibit 6. Criteria Considered for Removal of Existing Measures and Addition of New Measures

Criteria Considered for Removal of Existing Measures	
Technical Feasibility	
1.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	States report significant challenges in accessing an available data source (including medical records and surveys) that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3.	The available data source does not allow for consistent calculations across states.
Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure does not make a significant contribution to estimating the overall national quality of health care in Medicaid and CHIP.
2.	The measure does not provide useful and actionable results to drive improvement in state Medicaid and CHIP programs.
3.	The measure does not address a strategic priority in monitoring the performance of state Medicaid and CHIP programs.

Exhibit 6 *(continued)*

Criteria Considered for Removal of Existing Measures	
Other Considerations	
1.	The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3.	Fewer than half of the states will be able to produce the measure for FFY 2021 or FFY 2022 and all states will not be able to produce the measure by FFY 2024, including all their Medicaid and CHIP populations.
Criteria Considered for Addition of New Measures	
Minimum Technical Feasibility Requirements (all requirements must be met)	
1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	The measure must have been tested in state Medicaid and CHIP programs or be in use by one or more state Medicaid and CHIP agencies.
3.	An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4.	The specifications and data source must allow for consistent calculations across states.
Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure must contribute to estimating the overall national quality of health care in Medicaid and CHIP (as specified in the Statute).
2.	The measure must provide useful and actionable results to drive improvement in state Medicaid and CHIP programs.
3.	The measure must address a strategic priority in monitoring the performance of state Medicaid and CHIP programs.
Other Considerations	
1.	The prevalence of the condition or outcome being measured should be sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications should be aligned with those used in other CMS programs, where possible.
3.	At least half the states should be able to produce the measure for FFY 2021 or FFY 2022, and all the states should be able to produce the measure by FFY 2024, including all their Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

In addition to the criteria considered for removal or addition, Mathematica also noted other factors that the Workgroup should consider, especially with the increasing emphasis on preparing for mandatory reporting of the Child Core Set measures and behavioral health measures in the Adult Core Set beginning in 2024. For example:

- The use of alternative data sources to calculate current Core Set measures. The goals are to (1) reduce state burden, (2) standardize reporting across states, and (3) improve the completeness and transparency of measures. Current efforts focus on the following:
  - Calculating the *Live Births Weighing Less Than 2,500 Grams* (LBW-CH) and *PC-02: Cesarean Birth* (PC02-CH) measures using data from the Centers for Disease Control

  - and Prevention (CDC) Wide-ranging Online Data for Epidemiologic Research (WONDER) databases[23]
  - Promoting state-level reporting of the Child and Adult Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey using data submitted to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Health Plan Survey Database[24]
  - Using CMS's Transformed Medicaid Statistical Information System (T-MSIS) to calculate such Core Set measures as preventive dental services and prevention quality indicators[25]

- The use of digital measures and electronic data sources, such as Electronic Clinical Data Systems (ECDS).[26]
- The implications of the COVID-19 pandemic on quality measurement and particularly the feasibility of measures requiring medical chart reviews as part of the hybrid methodology or for validation of administrative data.

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

Summary of Workgroup Recommendations

The Workgroup recommended the removal of one measure from the Adult Core Set and the addition of three measures to the Core Sets (Exhibit 7). This section summarizes the discussion and rationale for these recommendations. Please refer to Appendix D for information on the measures discussed and not recommended for removal from or addition to the Core Sets. Measure information sheets about each measure discussed by the Workgroup are available on the Mathematica Core Set Review website.[27]

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

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

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

[26] More information about ECDS is available at https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/. Public comments submitted on the reporting of ECDS measures can be found in Appendix E.

[27] The Measure Information Sheets for measures suggested for removal are available at https://www.mathematica.org/-/media/internet/features/2020/coreset/coresetreview_2021removals.pdf?la=en. The Measure Information Sheets for measures suggested for addition are available at https://www.mathematica.org/-/media/internet/features/2020/coreset/core-set-review_2021-additions.pdf?la=en.

Exhibit 7. Summary of Workgroup Recommendations for Updates to the 2021 Core Sets

Measure Name	Measure Steward	NQF # (if endorsed)
Measure Recommended for Removal		
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)	National Committee for Quality Assurance (NCQA)	2607
Measures Recommended for Addition		
Postpartum Depression Screening and Follow-Up	NCQA	Not endorsed
Prenatal Immunization Status	NCQA	Not endorsed
Sealant Receipt on Permanent 1st Molars	American Dental Association (ADA)/Dental Quality Alliance (DQA)	Not endorsed

NQF = National Quality Forum.

Measure Recommended for Removal

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (HPCMI-AD)

The HPCMI-AD measure assesses the percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (types 1 and 2) whose most recent hemoglobin A1c (HbA1c) level during the measurement year is greater than 9.0 percent. Two Workgroup members suggested this measure for removal from the Adult Core Set primarily due to feasibility concerns, noting that only four states reported this measure for FFY 2018. (During FFY 2018 Core Set reporting, many states indicated they had challenges obtaining the medical chart data required to calculate the measure reliably.) One of the Workgroup members suggested that states should prioritize reporting another related measure on the Core Set, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* (SSD-AD), because of the limited real estate on the Core Set and the fact that care provision is more challenging to measure than screening.

During the discussion, Workgroup members suggested that HPCMI-AD and SSD-AD are not interchangeable because they focus on slightly different populations and individuals with schizophrenia and other serious mental illnesses are at high risk for diabetes regardless of whether they are using antipsychotic medications. One Workgroup member mentioned that the HPCMI-AD measure was created to address access issues, social determinants of health, and health disparities among those with a serious mental illness and diabetes.

One of the Workgroup members who proposed the measure for removal said that this measure was a subset of the other diabetes poor control measure in the Adult Core Set, *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%)* (HPC-AD). The member suggested that removing the measure would not result in a gap in the Core Set because states could continue to track HbA1c control among the seriously mentally ill population by stratifying the HPC-AD measure. (Thirty-two states reported the HPC-AD measure for FFY 2018.) The Workgroup member added that stratification could reduce state reporting burden by eliminating the need for states to pull two samples and report both measures while also freeing up valuable real estate in the Core Set. The Workgroup member, who is from a large state Medicaid program, indicated that their state had been able to stratify the HPC-AD measure without encountering sample size issues. Another Workgroup member suggested that states could consider stratifying the HPC-AD measure outside the Core Set measure environment. The measure steward noted, however, that stratification of the HPC-AD measure may be challenging for many health plans and states because the HPCMI-AD measure requires a denominator of 411 beneficiaries with serious mental illness.

Another Workgroup member noted that many states do not currently have ready access to the data needed to calculate this measure. The member added that although the measure can be calculated using only administrative data, not all states have an integrated data warehouse that provides access to the behavioral health claims necessary to identify the population with serious mental illness and would thus need to perform medical record reviews to calculate the measure.

During the public comment period, a representative from a state Medicaid program commented on the feasibility of using the administrative specifications for the measure, noting that providers are not billing using the procedure code that indicates lab results related to diabetes control. They are exploring a couple of other options for obtaining the data, including (1) having their managed care plans stratify the HPC-AD measure by members with serious mental illness and (2) developing a data sharing agreement with a laboratory to get the lab results directly, noting that would give the results only for the subset of the population whose lab results are sent to that laboratory. They concluded that this measure has historically been very difficult, and they are still not reporting it despite these efforts.

Throughout the conversation, various Workgroup members expressed concern over the feasibility of HPCMI-AD in the context of mandatory reporting in 2024 when states will be required to report the behavioral health measures in the Adult Core Set.[28]

Measures Recommended for Addition

Postpartum Depression Screening and Follow-Up

The *Postpartum Depression Screening and Follow-Up* measure assesses the 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 for this measure: (1) the percentage of deliveries in which women were screened for clinical depression using a standardized tool within 84 days post-delivery and (2) the percentage of deliveries in which women received follow-up care within 30 days of screening positive for depression. The measure is specified for the ECDS data collection method.

The Workgroup member who proposed this measure for addition to the Core Sets indicated that the measure should drive improvement in maternal and child health and add focus to the need for health care systems to be responsive to positive depression screens. In addition, the measure would address effective care delivery because it is focused on a period when women often have disruption in care following the birth of a child and when the focus is on the needs of the child. The Workgroup member also noted that depression has been linked to life stressors, such as

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[28] Public comments submitted on the *Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)* (HPCMI-AD) measure can be found in Appendix E.

poverty and the stress of adding a new baby to a family, and that women enrolled in Medicaid often face these and other stressors that can increase their experience of depression.

The Workgroup member highlighted that the measure uses the ECDS methodology, which would avoid the constraints around on-site chart reviews. The measure has been tested by health plans in two states and by provider organizations in another two states. The measures will be reported by commercial and Medicaid health plans as part of the Healthcare Effectiveness Data and Information Set (HEDIS) for the first time in June 2020, and the National Committee for Quality Assurance (NCQA) will then analyze first-year performance data.

During the discussion, several Workgroup members spoke to the importance of the measure, noting the impact that postpartum depression has on mothers and the early outcomes of children. One Workgroup member indicated that the measure is aligned with the social and emotional needs of children and addresses a gap in the Core Sets around dyadic services for mothers and young children. Workgroup members highlighted that the measure includes both a screening component and documentation of follow-up if there is a positive screen, thereby enabling support for better self-care in the postpartum period.

Workgroup members commented that the measure could help Medicaid programs drive accountability in the form of delivery system change and clinical improvements to support women who have a positive screen. Another member added that this measure was aligned with the federal government's push to address maternal morbidity and mortality rates.

The Workgroup and the measure steward also discussed the measure technical specifications, noting that the measure accounts for differences in pregnancy coverage across state Medicaid programs and aligns with clinical guidelines for care. One Workgroup member suggested harmonizing the *Postpartum Depression Screening and Follow-Up* measure and the *Screening for Depression and Follow-up Plan* measure in both the Child and Adult Core Sets (CDF-CH and CDF-AD). Doing so would avoid measuring similar constructs in slightly different ways.

Several Workgroup members also noted that some states allow for postpartum depression screenings to be conducted by pediatricians using the child's Medicaid number, which provides additional opportunities for screenings but may pose challenges in terms of a state's ability to track screening results and follow-up. One Workgroup member emphasized the importance of the "hand off" for follow-up if the screen occurs in the pediatric office. The member noted that it will be important for states to recognize that the follow-up could occur with a behavioral health provider, obstetric provider, or other type of providers or programs and to assure that there is an accountable entity. Another Workgroup member expressed the hope that this measure will drive delivery system improvement so that women with positive screens have a better path to obtain care.

Another Workgroup member questioned whether states would be able to identify whether follow-up occurred using diagnosis or related codes. A Workgroup member from a state Medicaid program that uses a similar state-developed measure noted that they have been able to identify depression screenings and follow-up using administrative claims supplemented with chart review. The Workgroup member further noted that over the decade that the state has been measuring this, they have seen marked improvement in both screening and follow-up.[29]

Prenatal Immunization Status

The *Prenatal Immunization Status* measure assesses the percentage of deliveries in the measurement period in which women had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations. The measure has two individual vaccine rates and a combination rate. One of the two Workgroup members who suggested this measure for addition indicated that Medicaid programs in two states have been testing the measure as specified and another three states have calculated a similar measure using data from immunization information systems (IISs) and claims data. The measure is specified for the ECDS data collection method. In September 2019, NCQA (the measure steward) announced that the measure will be publicly reported using the ECDS data collection method.

This measure was suggested for addition to encourage states, plans, and providers to meet the recommendations by the CDC Advisory Committee on Immunization Practices and the American College of Obstetricians and Gynecologists that all pregnant women should receive the influenza vaccine as well as a dose of Tdap. Another Workgroup member noted that Medicaid pays for nearly half of all births and only a small proportion of women enrolled in Medicaid receive Tdap during pregnancy. They indicated that pregnant women are more likely to have severe illness from the flu, whooping cough (known as pertussis) can be life-threatening for a newborn, and the receipt of recommended vaccinations is a critical strategy to improve the health of pregnant women and their infants. One Workgroup member commented on the critical nature of immunizations and the importance of understanding how immunizations influence the health of individuals in Medicaid and CHIP.

During the discussion, Workgroup members discussed states' access to the data source for the measure. A Workgroup member noted that according to the Association of Immunization Managers and the American Immunization Registry Association, 37 states share data between their Medicaid program and their state IIS, suggesting that the majority of states should be able to report this measure. In addition, the Workgroup member noted that the future availability of a COVID-19 vaccine may result in increased data sharing between Medicaid programs and state IISs, further enhancing states' ability to report on adult immunization measures.

During the public comment period, several immunization program representatives spoke in favor of adding the measure to the Core Set. They commented that the measure would fill a critical public health gap and that IISs are a widely used and trusted resource for vaccination data. They indicated that they are seeing significant progress in expanding the number of adults in IISs and suggested that adding the prenatal immunization measure will further support collaboration between state Medicaid agencies and IISs. They also proposed that including the measure could position states for protecting pregnant women and newborn babies against COVID-19.[30]

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[29] Public comments submitted on the *Postpartum Depression Screening and Follow-Up* measure can be found in Appendix E.

[30] Public comments submitted on the *Prenatal Immunization Status* measure can be found in Appendix E.

Sealant Receipt on Permanent 1st Molars

The *Sealant Receipt on Permanent 1st Molars* measure assesses the percentage of children who have ever received sealants on permanent first molar teeth by their 10th birthdate and includes two rates: (1) at least one sealant, and (2) all four molars sealed by the 10th birthdate. This measure was suggested to replace the *Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk* (SEAL-CH) measure in the Child Core Set, which was retired by the measure steward and will be removed by CMCS from the 2021 Core Set.

The Workgroup member who suggested this measure for addition noted that tooth decay is the most common chronic disease among children in the United States, affecting almost half of all children, and that sealants are an effective intervention for reducing the incidence of cavities on permanent molars, the teeth most likely to get them. The measure was described as an improvement over the SEAL-CH measure because it promotes sealing all molars by age 10 rather than evaluating sealant placement only during the measurement year. The Workgroup member also noted that this measure was developed to address stakeholder feedback on the limitations of the existing SEAL-CH measure.

Workgroup discussion on the measure focused primarily on the measure specifications and data collection methods. One Workgroup member asked if data are available to determine previous sealant placement. The Workgroup member who suggested this measure for addition noted that these data are available in claims and that the measure includes a longer lookback period than the current SEAL-CH measure to be able to exclude previously sealed molars. The Workgroup member also noted that there is the potential for T-MSIS to be used to calculate this measure in the future.

Other Workgroup members sought clarification about the relationship among various pediatric dental measures, including the *Percentage of Eligibles Who Received Preventive Dental Services* (PDENT-CH) measure, the *Annual Dental Visit* measure proposed for replacement of the PDENT-CH measure, and the *Sealant Receipt on Permanent 1st Molars* measure. The Workgroup member suggesting the measure for addition explained that the PDENT-CH measure includes a broad range of preventive services, whereas the proposed sealant measure includes more specificity that the preventive service is a sealant. The *Annual Dental Visit* measure can include any service, including X-rays and emergency visits. One member indicated a preference for including both preventive type performance measures (such as the PDENT-CH measure) as well as interventional measures (such as the sealant measure).

Cross-Cutting Themes in Measure Discussions

Several cross-cutting themes emerged from the Workgroup's review of the 13 existing measures suggested for removal from the Core Sets and the 12 new measures suggested for addition as well as the Workgroup's reflections about gaps in the Core Sets. The discussions revealed an effort to balance the feasibility of state reporting with the strategic priority for driving improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Strategic Priority for Driving Improvement in Care Delivery and Health Outcomes

Workgroup members consistently underscored the importance of driving improvement in Medicaid and CHIP through the Core Sets, particularly in support of CMCS's initiatives related to improving the quality of maternal and perinatal health and of dental and oral health services. Workgroup members were hesitant to remove measures just because they were difficult for states to report or would require data that states may not currently have. Despite state representatives' reports of feasibility concerns and low rates of reporting of various measures suggested for removal (including during the public comment period), members frequently emphasized the desirability of measures or measure concepts over feasibility.

Workgroup members were reluctant to remove a measure without a suitable replacement, even if a measure suggested for removal from the Core Sets proved difficult for states to report. For example, as summarized in Appendix D, the *HIV Viral Load Suppression* (HVL-AD) measure was referred to as the "ultimate outcome measure" and Workgroup members commented that the measure suggested for replacement, *Proportion of Days Covered: Antiretroviral Medications*, was not comparable in measuring care delivery and health outcomes for Medicaid and CHIP beneficiaries with HIV. The Workgroup encouraged efforts to create partnerships among federal agencies (CMS, CDC, and Health Resources and Services Administration [HRSA]), state Medicaid and public health agencies, and managed care plans to help states gain access to the laboratory data required to measure viral load suppression. They suggested sharing lessons across states and providing technical assistance to states as necessary.

Similarly, the Workgroup encouraged moving toward the use of electronic data collection systems for quality measurement in Medicaid and CHIP. For example, in discussing the *Prenatal Immunization Status* measure, they emphasized the strategic importance of vaccinating pregnant women against influenza and pertussis during pregnancy and noted that building state Medicaid and CHIP program capacity to link to IISs would have both short- and longer-term benefits. Although the Workgroup did not recommend the *Adult Immunization Status* measure for addition to the 2021 Core Sets, several members commented that a measure of flu vaccination using electronic data from the IIS (described as a more population-based approach) would be preferred to the current measure based on the CAHPS survey; they suggested that more evidence is needed about state readiness for the transition to the electronic measure in the future. Several Workgroup members also acknowledged the increasing importance of electronic data systems in light of the COVID-19 pandemic and the barriers to conducting on-site chart reviews during the pandemic.

Throughout discussions, Workgroup members frequently reflected on the importance of ensuring that Core Set measures produce data that CMCS and states can use to inform program operations and ultimately improve care delivery and health outcomes for Medicaid and CHIP beneficiaries. Workgroup members often sought to ensure that the intent of what was being assessed by a measure was clear, that measures aligned with the purpose of the Core Sets, and that measure results would be useful to state Medicaid and CHIP programs.

Feasibility for State Reporting

The Workgroup engaged in considerable discussion about states' ability to collect and report the Core Set measures suggested for removal and addition. State reporting capability in the context of public reporting and mandatory reporting in 2024 were common themes during Workgroup discussions and during the public comment period.

Workgroup members expressed a strong preference for measures that could be calculated using administrative data, including through electronic data collection methodologies. Several members spoke to the resources required for measures requiring medical chart review, which must often be collected in-person in a hospital or office setting. In addition, in the context of the COVID-19 pandemic, the challenges of chart review measures took on more salience because the pandemic exacerbated the barriers to conducting a manual chart abstraction process.

Workgroup members also commented on the feasibility of measures with a survey data collection methodology, specifically the high cost and low response rates on the CAHPS survey, and concerns about the validity and consistency of results across states and demographic groups. They were reluctant to remove the *Flu Vaccinations for Adults Ages 18 to 64* measure (FVA-AD) and the *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD) measure, both based on CAHPS, until suitable replacements are available. They also expressed concern with removing the Child and Adult *CAHPS Health Plan Surveys* (CPC-CH and CPA-AD) because of the importance of measuring beneficiary experience as part of the Child and Adult Core Sets. They suggested seeking alternative measures and/or exploring alternative survey methodologies to address these issues.

As noted earlier, the Workgroup often emphasized the strategic priority of measures over their feasibility, particularly in discussions about removing measures from the Core Sets. In several cases, they offered suggestions about how to make the measures more feasible for states to report using administrative data. For example, some measures, such as the *Screening for Depression and Follow-up Plan* measure in both the Child and Adult Core Sets (CDF-CH and CDF-AD), rely on codes not typically included by providers on claims and encounters because states do not reimburse providers based on the codes. The Workgroup discussed strategies, such as value-based payment programs, to incentivize providers to perform the services and record the codes. As discussed below, the Workgroup suggested offering technical assistance to states to address barriers to reporting.

Discussion of Core Set Measure Gaps

During the 2021 Core Set Review, the Workgroup discussed Core Set measure gaps by domain. Mathematica charged the Workgroup with identifying what types of measures or measure concepts are missing in the Core Sets, whether there are any existing measures that could fill the gaps, or whether new measures would need to be developed. In addition, on the third day after the Workgroup had completed domain-specific discussions, the Workgroup had a cross-cutting discussion of measure gaps, with a final round of public comment.

Exhibit 8 synthesizes the gaps mentioned during Workgroup discussions and the public comment period. The gaps are organized first by Core Set domain and then by cross-cutting themes. The discussions about gaps were robust, thoughtful, and detailed. The exhibit does not attempt to prioritize the suggested gaps or assess their feasibility or fit for the Child and Adult Core Sets.

Several Workgroup members indicated that the two domains with the largest gaps are LTSS, with only one measure, and Dental and Oral Health Services, with two pediatric measures and no adult measures. The Behavioral Health Care domain in the Adult Core Set currently has 12 measures and is the largest domain. Workgroup members discussed the need to consider gaps in a different way, by stepping back and reconsidering what is important to measure, what drives the most improvement, and whether some measures overlap or need to be modified because they may not tie back to clinical care recommendations.

In addition to domain-specific gaps, Workgroup members identified cross-cutting gaps related to integrating care across settings and population-specific gaps. They also identified new topic areas related to the impact of COVID-19, social determinants of health and health equity, and global measures of Medicaid and CHIP program performance. Workgroup members frequently discussed the desire to stratify Core Set measures by population subgroups across Core Set domains as an approach to better understand health disparities and progress toward the achievement of health equity.[31]

The Workgroup's reflections about gaps in the Child and Adult Core Sets provides a strong starting point for discussions about updates to the 2022 Core Sets as well as longer-term planning for the future of the Core Sets.[32]

Exhibit 8. Synthesis of Workgroup Discussions About Potential Gaps in the Child and Adult Core Sets

Domain-Specific Gap Areas
Primary Care Access and Preventive Care
Screening • Screening for social-emotional development of children (complement to existing developmental screening and well-child visit measures) • Colorectal cancer screening   – Note that this measure is not currently specified for use in the Medicaid population • Cholesterol screening • Suicide screening *Follow-up care* • Identify if a referral was made based on screening results and whether the beneficiary was ultimately connected to follow-up care • Enhance depression screening and follow-up measures: include depression outcomes, for example, by using screening tools that can also measure performance and outcomes (such as the PHQ-9 tool) • Enhance adult BMI assessment measure by including counseling and follow-up (similar to the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure)

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[31] Health equity resources for beneficiaries, providers, and health care organizations are available from the CMS Office of Minority Health (CMS OMH) Resource Center at https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center.

[32] Public comments submitted on gap areas in the Core Sets can be found in Appendix E.

Exhibit 8 *(continued)*

Maternal and Perinatal Health

Specific gap areas

- Access to oral health services for pregnant women
- Participation in a quality improvement program at the hospital level (such as a Perinatal Quality Collaborative) to improve outcomes in maternity care, including implementation of an evidence-based intervention, data collection, and reporting (for example, patient safety bundles from the Alliance for Innovation on Maternal Health)
- Maternal mortality, including racial disparities in mortality rates

Methodological considerations

- Explore alternative methodologies or data sources for calculating existing measures that are important but not currently feasible for most states, specifically PC01: Elective Delivery (PC01-AD) and Audiological Evaluation No Later than 3 Months of Age (AUD-CH)
- Stratify measures by race, ethnicity, rural/urban, and other categories to address disparities in health outcomes
  - Although some measures, such as Elective Delivery (PC-01), may be topped out for the population as a whole, it is important to look within the Medicaid program and by subgroup stratified by race, socioeconomic status, and geography

Care of Acute and Chronic Conditions

- Measure impact of adverse childhood events on physical and behavioral health outcomes
- Stratify by subgroup–such as serious mental illness, disability, or pregnancy–to look at quality of health care for specific populations using the same measures as for the general population
- Consider measurement approach that focuses on risk factors such as poverty and race

Behavioral Health Care

Overarching gap analysis

- Think about gaps holistically given the large number of measures added to this domain over the past few years. Suggestions included:
  - Pare down the existing list of measures to eliminate overlap, particularly in the area of substance use
  - Assess what matters most in driving improvement
  - Assess whether the current measures tie back to clinical care recommendations (for example, the Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication [ADD-CH] measure)
  - Seek opportunities to harmonize measures across measure stewards
  - Consider stratification of measures in other domains for the behavioral health population (such as people with serious mental illness)

Specific gap areas

- Measures that are feasible for reporting on tobacco use, treatment for tobacco use, and ultimate cessation rates
- Management of depression, beyond screening and follow-up
- Trauma-informed care delivery: impact of toxic stress and adverse childhood events on a developing child
- Anxiety diagnosis, treatment, and follow-up

Dental and Oral Health Services

- Receipt of an age-appropriate preventive pediatric dental care bundle (for example, sealants, fluoride varnish, and oral examination) allowing flexibility in providers and settings for fluoride application
- Link between use of preventive dental care and diagnostic outcomes
- Use of dental care by adults
  - Note that not all states offer comprehensive dental benefits, and the measure should be feasible to report in states with limited dental benefits

Exhibit 8 *(continued)*

Long-Term Services and Supports

Specific gap areas

- Care management and person-centered planning (potential use of the four LTSS measures included in HEDIS after further testing and experience)
- Beneficiary experience for those receiving LTSS services and assessing patient-centeredness in providing services that enrollees want (potential use of the NCI-AD survey or other tools)
- Access to primary care for LTSS beneficiaries
- Intersection of LTSS and chronic disease, especially in the context of the COVID-19 pandemic, where people with diabetes, hypertension, and lung disease are at higher risk of more severe illness
- Process measures to understand states' benefit mix and system differences before measuring outcomes
- Benefits and outcomes of services offered by state Medicaid LTSS programs
- Clinical and quality of life outcomes for individuals receiving LTSS and ability to assess health disparities

Methodological considerations

- Clarification of the goals and outcomes to be measured and how to account for variations in state Medicaid programs (for example, the balance between institutional versus home-based care)
- Measures that correspond across both managed care and fee-for-service LTSS programs and that have been tested in both systems
- Measures that stratify by age group, particularly for dual eligible beneficiaries, where Medicare may be the primary payer for medical care, and Medicaid pays for LTSS

Experience of Care

Population focus

- Experience of care for those receiving pediatric dental care
- Experience of care for individuals with disabilities and chronic conditions

Methodological considerations

- Use of alternate data collection modalities and methodologies to improve response rates
- Results need to represent the consumer voice with culturally sensitive options to reduce the potential for cultural variation in responses
- Collaboration with measure stewards and other survey data collectors to improve measures
- Potential need to re-assess what is important to measure about experience of care
- Potential use of item response theory to shorten surveys and reduce burden on respondents

Cross-Cutting Gap Areas

Integration of Care

- Coordination and integration of care across settings (such as primary care, specialty care, behavioral health) to promote children's social and emotional development, kindergarten readiness, and longitudinal care for children and youth with complex care needs
- Effectiveness of alternative payment models and integrated care delivery systems in serving the physical health, behavioral health, and LTSS needs of beneficiaries with complex needs
- Experiences navigating institutional placements and transitions of care across settings
- Integration of care between Medicare and Medicaid from a service and reimbursement perspective as well as a data perspective

Population-Specific Measure Gaps

- Measures for children between ages 5 and 13
- Measures for adults age 65 and older (may require linkage to Medicare data)
  - Depression and social isolation
  - Immunizations
- Measures for beneficiaries who are dually eligible for Medicare and Medicaid (may require linkage to Medicare data)
- Measures of care delivery and health outcomes for male beneficiaries

Exhibit 8 *(continued)*

New Topic Areas

Social Determinants of Health and Health Equity

- Screening for social determinants of health using standardized tools
- Poverty and race as health equity issues
- Stratification of existing measures with an equity lens to measure progress toward increasing health equity in Medicaid and CHIP

Impact of the COVID-19 Pandemic

- Importance of understanding the immunization status of Medicaid enrollees overall and with a potential vaccine for COVID-19, including the use of immunization information systems to address the feasibility of collecting population-based immunization data
- Inclusion of telehealth and other new modalities in the specifications for all applicable measures
    - Concerns about a possible technology gap for Medicaid beneficiaries
    - Questions about what access to care might look like in the future
- Medicaid's role in testing, diagnosing, and treating COVID-19 given the disproportionate impact of the virus on low-income populations
- Measures of integration between physical health and behavioral health care delivery in order to promote a no-wrong-door approach that addresses behavioral health care needs in light of COVID-19
- Implications of the increases in social determinants of health needs that individuals and families are facing

Global Measures of Medicaid and CHIP Performance

- Continuity of Medicaid and CHIP coverage – discontinuity impedes measuring and improving quality
- Composite measures of performance (such as treatment outcomes overall and not just by individual disease condition)
- Composite measures that suggest the global effectiveness of Medicaid programs for the entire covered population
- Inclusion of measures that balance the services that beneficiaries need, such as immunizations or adult dental services, with the benefits that states cover

Cross-Cutting Methodological Considerations

- Appropriateness of measures for use in both fee-for-service and managed care delivery systems
- Assurance that all information is available for states to understand, calculate, and report measures
    - Note that this applies to both proprietary and public domain measures and includes information on measure content and value sets
- Implications of the new interoperability rules on using electronic health records and health information exchanges to support calculation of Core Set measures, including focused guidance and assistance for states Medicaid and CHIP agencies
- Linkage of Medicaid and Medicare data for measuring quality of care for dually eligible beneficiaries

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

In addition to making recommendations for specific measures to remove from or add to the Core Sets, the Workgroup members were asked to provide input about technical assistance opportunities to support state reporting of the Core Sets as well as suggestions for improving the Core Set Annual Review process.[33]

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[33] Public comments submitted on additional considerations for improving the Core Sets can be found in Appendix E.

Technical Assistance to Support State Reporting of the Core Sets

Workgroup members identified several TA opportunities to support states in reporting the Core Set measures, with a focus on preparing for mandatory reporting of the Child Core Set measures and behavioral health measures in the Adult Core Set beginning in 2024. The opportunities focused on building a data infrastructure to address the current gaps in data availability and completeness and any variation in capacity across states.

Workgroup members encouraged CMS to continue pursuing opportunities to support states in Core Set reporting by calculating the measures on their behalf using alternative data sources (such as T-MSIS) or by offering standardized code that states can use to calculate the measures themselves. One measure with a potential alternative data source is the *Audiological Evaluation No Later than 3 Months of Age* (AUD-CH) measure. The measure is currently specified to use EHR data; only three states reported the measure for FFY 2018 and two of the three did not use Core Set specifications. As an alternative, the CDC Early Hearing Detection and Intervention (EHDI) Program maintains records on newborn hearing screening and follow-up but does not stratify by payer. The Workgroup encouraged collaborating and partnering with CDC and state public health agencies to facilitate Core Set reporting of the measure (for example, through a data linkage between Medicaid/CHIP and EHDI data or by adding a payer indicator to the EHDI data system).

Workgroup members also encouraged helping states obtain data collected by state public health agencies for the *HIV Viral Load Suppression* (HVL-AD) measure. During the discussions, Workgroup members encouraged CMS, CDC, and HRSA to convene states to share lessons learned about partnering with state public health agencies. The Workgroup voted not to recommend removing the measure from the Core Sets because of the measure's importance and suggested undertaking additional technical assistance efforts to help states overcome challenges in establishing data-sharing agreements and facilitating the information sharing necessary to collect and report the measure.

Another promising opportunity, albeit longer term, is to leverage EHRs for clinical quality measurement in place of on-site medical chart reviews for hybrid method measures. With the publication of the interoperability final rule,[34] the Workgroup suggested that CMS provide focused guidance to states about how the rule coincides with building the data infrastructure for reporting Core Set measures that cannot be calculated reliably using claims and encounter data alone. Examples of measures specified for reporting using EHRs include the *Screening for Depression and Follow-Up* Plan (CDF-CH and CDF-AD) measures and the *PC-01: Elective Delivery* (PC01-AD) measure. The Workgroup voted not to recommend removing these measures from the Core Sets and suggested that CMS explore opportunities to leverage EHRs and Health Information Exchanges for Core Set reporting.

Finally, Workgroup members urged addressing the low and decreasing survey response rates on the CAHPS surveys. They generally agreed that experience of care measures have an important place on the Core Sets but have concerns about the validity of responses based on response rates that are trending toward single digits. A Workgroup member suggested leveraging existing

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[34] More information about the CMS Interoperability and Patient Access final rule is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index.

efforts by the National Center for Health Statistics and the California Health Interview Survey to explore alternative modalities for data collection. Another Workgroup member commented that an overhaul of CAHPS could be in order to think strategically about what should be collected and how to gather the information. Workgroup members suggested engaging NCQA and AHRQ in these discussions.[35]

Improving the Core Set Annual Review Process

In the spirit of continuous quality improvement, Workgroup members suggested enhancements to the Core Set Annual Review process. In particular, they asked to be kept apprised of progress between Annual Review cycles. They recognize that technical assistance on Core Set reporting, development of alternative data sources, and methodological improvements are ongoing, and regular updates could inform their measure recommendations. Enhancements suggested by Workgroup members focused on the following:

- Creating a structured approach to help Workgroup members track state reporting challenges and efforts and progress to overcome the challenges, with a focus on assessing whether measures are feasible for mandatory reporting of the Child Core Set measures and behavioral health measures in the Adult Core Set beginning in 2024.
- Offering background informational webinars to help Workgroup members prepare for domain-specific discussions about Core Set measures and reporting.
- Establishing one or more subgroups to follow up on noted gaps and/or measure-related methodological issues raised by the Workgroup in such areas as LTSS or experience of care.
- Providing informal input to Workgroup members before the formal submission process about available, feasible, and tested measures that may address gaps identified during the 2021 Core Set Annual Review.
- Obtaining feedback from CMS about any Workgroup recommendations that were not accepted, to inform Workgroup deliberations in the future.

Next Steps

The 2021 Core Set Annual Review Workgroup considered 13 measures for removal from the Core Sets and 12 measures for addition. Workgroup members recommended removing one measure and adding three measures to the 2021 Core Sets. The Workgroup considered such factors as the feasibility for state reporting and opportunities to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries. The measures recommended for addition focus on strategic priorities related to maternal and infant health and children’s oral health.

In recognition of the diverse populations covered by the Medicaid and CHIP programs, and the populations’ varying needs, Workgroup members frequently expressed a desire to use the Core Set measures to better understand the experiences of population subgroups through measure

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[35] The Child and Adult Core Sets include the NCQA version of CAHPS, which is adapted from the AHRQ measure (NQF #0006).

stratification, focus on social determinants of health, and address health disparities in the pursuit of health equity.

The backdrop of the upcoming mandatory reporting of the Child Core Set measures and the behavioral health measures in the Adult Core Set was a consistent thread throughout Workgroup discussions. Despite recognizing states' challenges associated with reporting the measures suggested for removal from the Core Sets, the Workgroup expressed a preference for retaining most of the measures and suggested providing technical assistance and other efforts to support state reporting of Core Set measures and reduce reporting burden. In light of the COVID-19 pandemic, Workgroup members discussed a preference for measures using administrative (claims and encounter) data and other electronic data sources that do not require in-person data collection methods.

The draft report was available for public comment from July 10, 2020 through August 10, 2020. Forty-seven public comments were submitted. These comments are included in Appendix E. CMCS will use the Workgroup's recommendations, public comments received on the draft report, and additional input from CMCS's state Medicaid and CHIP Quality Technical Advisory Group, internal CMS stakeholder meetings, and interagency federal partners to inform decisions about updates to the 2021 Core Sets. CMCS will release the 2021 Core Sets through a CMCS Informational Bulletin by December 31, 2020.

Appendix A:
Child and Adult Core Set Measures

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Exhibit A.1. 2020 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)*	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)^	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 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
Maternal and Perinatal Health			
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 to 20 (CCP-CH)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5 to 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 to 17 (FUH-CH)^	Administrative
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)***^	Administrative
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)^	Administrative

Exhibit A.1 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
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

* This measure was modified for the 2020 Core Set. The Counseling for Nutrition and Counseling for Physical Activity indicators were added to this measure for the 2020 Child Core Set. Prior Core Sets included only the Body Mass Index (BMI) Percentile Documentation indicator.

** This measure is no longer endorsed by NQF.

*** This measure was added to the 2020 Child Core Set. More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

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

^ This measure is part of the Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set). The complete list of 2020 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf.

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

Exhibit A.2. 2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR
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 to 44 (CCP-AD)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW- AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)^	Administrative or EHR
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)^	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)^	Administrative or EHR

Exhibit A.2 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)^	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)^	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)^	Administrative or hybrid
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)^	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB- AD)^	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)**^	Administrative
3488***	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA- AD)^	Administrative
3489***	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)^	Administrative
Not endorsed****	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-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
Long-Term Services & Supports			
Not endorsed	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)**	Survey

* This measure is no longer endorsed by NQF.

** This measure was added to the 2020 Adult Core Set. More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

*** The NQF number for the FUA-AD and FUM-AD measures was previously listed as 2605. These measures now have separate NQF numbers but are the same measures included in the FFY 2019 Adult Core Set.

**** 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).

^ This measure is part of the Core Set of Behavioral Health Measures for Medicaid and CHIP (Behavioral Health Core Set). The complete list of 2020 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-bh-core-set.pdf.

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

Exhibit A.3 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2010–2020

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Primary Care Access and Preventive Care													
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)[a]	X	X	X	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	X	X	X	X	X	X	X	X	X	X	X
0038	NCQA	Childhood Immunization Status (CIS-CH)	X	X	X	X	X	X	X	X	X	X	X
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)[b]	--	--	--	--	--	--	--	--	X	X	X
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	X	X	X	X	X	X	X	X	X	X	X
1407	NCQA	Immunizations for Adolescents (IMA-CH)	X	X	X	X	X	X	X	X	X	X	X
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	X	X	X	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	X	X	X
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV-CH)[c]	--	--	--	X	X	X	X	--	--	--	--
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)	X	X	X	X	X	X	X	X	X	X	X
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)[d]	X	X	X	X	X	X	X	X	X	X	--
Maternal and Perinatal Health													
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)[e]	X	X	X	X	X	X	X	X	X	X	--
0471	TJC	PC-02: Cesarean Birth (PC02-CH)[f]	X	X	X	X	X	X	X	X	X	X	X
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)[g]	--	--	--	--	--	--	X	X	X	X	X
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	X	X	X	X	X	X	X	X	X	X	X
1391*	NCQA	Frequency of Ongoing Prenatal Care (FPC-CH)[h]	X	X	X	X	X	X	X	X	--	--	--
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	X	X	X	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)[i]	--	--	--	--	--	--	--	X	X	X	X
2903/2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)[j]	--	--	--	--	--	--	--	--	X	X	X

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
NA	No current measure steward	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)[k]	--	--	--	X	X	X	X	X	--	--	--
Care of Acute and Chronic Conditions													
0002*	NCQA	Appropriate Testing for Children with Pharyngitis (CWP-CH)[l]	X	X	X	X	--	--	--	--	--	--	--
0060*	NCQA	Annual Pediatric Hemoglobin A1C Testing (PA1C-CH)[m]	X	X	X	X	--	--	--	--	--	--	--
0657	AAOH-HNSF	Otitis Media with Effusion –Avoidance of Inappropriate Systemic Antimicrobials in Children: Ages 2 to 12 (OME-CH)[n]	X	X	X	--	--	--	--	--	--	--	--
1381*	Alabama Medicaid	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One of More Asthma-Related Emergency Room Visits (ASMER-CH)[o]	X	X	X	X	--	--	--	--	--	--	--
1799*	NCQA	Medication Management for People with Asthma (MMA-CH)[p]	--	--	--	X	X	X	X	X	--	--	--
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)[p]	--	--	--	--	--	--	--	--	X	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	X	X	X	X	X	X	X	X	X	X	X
Behavioral Health Care													
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	X	X	X	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)[q]	X	X	X	X	X	X	X	X	X	X	X
1365	PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)[r]	--	--	--	--	--	X	X	X	--	--	--
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)[s]	--	--	--	--	--	--	--	--	--	--	X
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[t]	--	--	--	--	--	--	--	X	X	X	X
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[s]	--	--	--	--	--	--	X	X	X	X	--

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Dental and Oral Health Services													
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)[u]	--	--	--	--	--	X	X	X	X	X	X
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	X	X	X	X	X	X	X	X	X	X	X
NA	CMS	Percentage of Eligibles That Received Dental Treatment Services (TDENT-CH)[v]	X	X	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)[w]	X	X	X	X	X	X	X	X	X	X	X

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

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

More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

*This measure is no longer endorsed by NQF.

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

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

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

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

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

[f] 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.

[g] 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.

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

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

Exhibit A.3 *(continued)*

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[j] The Contraceptive Care – All Women Ages 15 to 20 measure was added to the 2018 Child Core Set to assess access to contraceptive care, which has an important role in promoting health equity.
[k] The Behavioral Health Risk Assessment (for Pregnant Women) measure was removed from the 2018 Child Core Set due to implementation and data collection challenges. AMA-PCPI was the measure steward for the 2013-2016 Child Core Sets; the measure had no steward for the 2017 Child Core Set.
[l] The Appropriate Testing for Children with Pharyngitis measure was retired from the 2014 Child Core Set because the clinical evidence for the measure was obsolete.
[m] The Annual Pediatric Hemoglobin A1C Testing measure was retired from the 2014 Child Core Set because it affects a small number of children, has a weak evidence base, and was approaching the improvement ceiling.
[n] The Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2 to 12) measure was retired from the 2013 Child Core Set because of significant state reporting challenges. The measure was not collected by CMS for the 2012 Child Core Set. AMA-PCPI was the measure steward for the 2010-2012 Child Core Sets.
[o] The Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits measure was retired from the 2014 Child Core Set due to data quality concerns and lack of an active measure steward.
[p] Beginning with the 2018 Child Core Set, the Asthma Medication Ratio: Ages 5 to 18 measure replaces the Medication Management for People with Asthma measure, which was included in the 2013-2017 Child Core Sets.
[q] 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.
[r] The Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure was added to the 2015 Child Core Set to target a high prevalence mental health condition that has severe consequences without appropriate treatment. The measure was removed from the 2018 Child Core Set because of the need for a broader measure of behavioral health.
[s] The Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure was added to the 2016 Child Core Set to target inappropriate prescribing of antipsychotic medications, which may have adverse health effects. The measure was retired from the 2020 Child Core Set because it was retired by the measure steward. It was replaced by the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure, which was added to the 2020 Child Core Set to monitor medication safety for children on psychotropic medications by identifying any gaps in their metabolic follow-up.
[t] 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.
[u] 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.
[v] The Percentage of Eligibles That Received Dental Treatment Services measure was retired from the 2015 Child Core Set because it is not an effective tool for quality improvement; it is unclear if an increase or a decrease in the rate is desirable, and therefore the results are not actionable.
[w] The Child Core Set includes the NCQA version of the CAHPS® Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items measure, which is adapted from the AHRQ measure (NQF #0006).

Exhibit A.4 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2013–2020

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020
Primary Care Access and Preventive Care										
0032	NCQA	Cervical Cancer Screening (CCS-AD)	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	X	X	X	X	X	X	X	X
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	X	X	X	X	X	X	X	X
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	X	X	X	X	X	X	X	X
2372	NCQA	Breast Cancer Screening (BCS-AD)	X	X	X	X	X	X	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)	X	X	X	X	X	X	X	X
Maternal and Perinatal Health										
0469/0469e	TJC	PC-01: Elective Delivery (PC01-AD)	X	X	X	X	X	X	X	X
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	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)[b]	--	--	--	--	X	X	X	X
2903/2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)[c]	--	--	--	--	--	X	X	X
Care of Acute and Chronic Conditions										
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	X	X	X	X	X	X	X	X
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)[d]	X	X	X	X	X	X	X	--
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)[e]	--	--	X	X	X	X	X	X
0063*	NCQA	Comprehensive Diabetes Care: LDL-C Screening (LDL-AD)[e]	X	X	--	--	--	--	--	--
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	X	X	X	X	X	X	X	X
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	X	X	X	X	X	X	X	X
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	X	X	X	X	X	X	X	X
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	X	X	X	X	X	X	X	X
0403*	NCQA	Annual HIV/AIDS Medical Visit (HMV-AD)[f]	X	--	--	--	--	--	--	--
1768	NCQA	Plan All-Cause Readmissions (PCR-AD)	X	X	X	X	X	X	X	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)[g]	--	--	--	--	--	X	X	X
2082/3210e	HRSA	HIV Viral Load Suppression (HVL-AD)[f]	--	X	X	X	X	X	X	X
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)[h]	X	X	X	X	X	X	X	--
Behavioral Health Care										
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	X	X	X	X	X	X	X	X
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	X	X	X	X	X	X	X	X
0105	NCQA	Antidepressant Medication Management (AMM-AD)	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[i]	X	X	X	X	X	X	X	X
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)[j]	--	--	--	X	X	X	X	X
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[k]	--	--	--	--	X	X	X	X
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[j]	--	--	--	X	X	X	X	X
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)[l]	--	--	--	--	--	X	X	X
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)[m]	--	--	--	--	--	--	--	X
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)[n]	--	--	--	--	X	X	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)[n]	--	--	--	--	X	X	X	X
NA	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)[o]	X	X	X	X	X	X	X	X
Care Coordination										
0648*	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR-AD)[p]	X	X	X	X	--	--	--	--

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020
Experience of Care										
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)[q]	X	X	X	X	X	X	X	X
Long-Term Services and Supports										
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)[r]	--	--	--	--	--	--	--	X

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

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

More information on 2020 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf.

*This measure is no longer endorsed by NQF.

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

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

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

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

[e] 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.

[f] 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.

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

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

[i] 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.

[j] 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.

[k] 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.

[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 Use of Pharmacotherapy for Opioid Use Disorder measure was added to the 2020 Adult Core Set to fill a gap in the Core Sets by tracking the appropriate treatment of opioid use

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disorders and improving the understanding of the quality of care for substance use disorders.

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

[o] 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).

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

[q] 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).

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

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Appendix B:
Overview of States' Reasons for Not Reporting the FFY 2018 Child and Adult Core Set Measures

Centers for Medicare & Medicaid Services
Medicaid & CHIP
Health Care Quality Measures

FACT SHEET

June 2020

Quality Measurement in Medicaid and CHIP: Overview of States' Reasons for Not Reporting the FFY 2018 Child and Adult Core Set Measures

Background

The Child and Adult Core Sets of health care quality measures are designed to provide a national and state-level snapshot of the quality of care provided to adults and children in Medicaid and the Children's Health Insurance Program (CHIP). Reporting of the measures in the Child and Adult Core Sets is voluntary and states vary in the number of measures they report each year.

When states choose not to report a Core Set measure, they are asked to provide at least one reason for not reporting in the web-based reporting system for Core Set measures (known as MACPro). The options in the Reasons for Not Reporting section in MACPro include: (1) service not covered, (2) population not covered, (3) data not available, (4) small sample size, and (5) other. Within each of these categories, states can provide additional details using standardized subcategories and open text fields. The information that states provide in MACPro about their challenges with collecting and reporting the Core Set measures offers important insights about the feasibility of the measures and informs technical assistance offerings.

The purpose of this fact sheet is to summarize the reasons states provided in MACPro for not reporting FFY 2018 Child and Adult Core Set measures. Tables 1 and 2, at the end of this fact sheet, present measure-specific information about the number of states reporting the Child and Adult Core Set measures for FFY 2018 and, among those not reporting the measures, their reasons for not reporting. These findings should be interpreted in the context of the technical specifications for each measure, especially the required data sources.[1,2] States could (and often did) select more than one reason for not reporting, so the number of individual reasons does not sum to the number of states not reporting each measure.

Commonly Cited Reasons for Not Reporting

The most commonly selected reason for not reporting was lack of data to calculate the measure (see Tables 1 and 2 at the end of the fact sheet). States identified several common barriers to data availability, such as challenges with accessing the data needed to report the measure (including medical records and linkage to other data sources), concerns about the accuracy and completeness of the data used in calculating the measure, and staff and/or resource constraints within the state agencies responsible for Core Set reporting. The next most common barriers were a wide variety of "other reasons," which states were asked to specify using a text field. States rarely reported that "service not covered," "population not covered," and "small sample size" were factors in their reasons for not reporting.

In the following sections, we highlight the most common reasons states cited for not reporting Child and Adult Core Set measures for FFY 2018 and list the measures that states indicated were not reported because of these challenges. The information was provided by states in MACPro and may not be exhaustive.

Lack of Access to Data

States' reasons for lack of access to data for Core Set reporting are multifaceted and reflect both the pathways

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[1] The technical specifications for the 2020 Child Core Set are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf.

[2] The technical specifications for the 2020 Adult Core Set are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf.

This fact sheet is a product of the Technical Assistance and Analytic Support for the Medicaid and CHIP Quality Measurement and Improvement Program, sponsored by the Center for Medicaid and CHIP Services. The technical assistance team is led by Mathematica in collaboration with the National Committee for Quality Assurance, Center for Health Care Strategies, AcademyHealth, and Aurrera Health Group.

through which data are collected, calculated, and reported (such as through managed care plans or other vendors) as well as the availability of information from sources other than claims/encounter data. The reasons that information may not be available include:

1. Many states rely on managed care plans to collect the data required to calculate Core Set measures. States include calculation of specific Core Set measures in their contracts with managed care plans and they may not be able to report a measure if it is not specified in a health plan contract.

2. The measure is new and not yet programmed for state reporting; states noted that they require lead time to incorporate Core Set updates into their reporting plans both internally and with vendors (such as managed care plans, external quality review organizations, or data analytics contractors). Similarly, measures with substantial changes to technical specifications may be a challenge to states.

3. The measure requires data not available from administrative claims or encounter records, such as medical chart abstractions, electronic health records (EHRs), or survey data collection.

4. The measure requires data from other agencies, such as vital records, immunization registries, laboratory data, and behavioral health data. Some measures may also require linkage between Medicaid and other data, adding another layer of complexity.

We highlight specific measures that were affected by these challenges for FFY 2018 because they were new, required data not readily available from administrative claims/encounters, or required data from other agencies.

Lack of capacity to report new measures. Four measures were new to the Child and Adult Core Sets for FFY 2018 (Box A). Among the factors cited for not reporting are that the state did not require managed care plans to report the measures, there was not enough time to calculate the new measures, and the measures were not a priority for the state. Nevertheless, several of these measures were publicly reported in their first year because the measures were already in use in states before they were added to the Child or Adult Core Sets.

Box A. FFY 2018 Challenge: Lack of Capacity to Report New 2018 Core Set Measures

- Asthma Medication Ratio: Ages 5-18 (AMR-CH) and Ages 19-64 (AMR-AD)
- Contraceptive Care – All Women Ages 15-20 (CCW-CH) and All Women Ages 21-44 (CCW-AD)
- Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)*
- Concurrent Use of Opioids and Benzodiazepines (COB-AD)

*Measure has been in the Adult Core Set for an older age range since 2012.

Lack of capacity to report measures involving medical chart abstraction. States indicated that measures requiring medical chart abstraction were more time- and resource-intensive to report than measures that could be calculated using administrative data only. Five measures in the 2018 Core Sets required medical chart abstraction (Box B, next page).

Two of these measures, Controlling High Blood Pressure (CBP-AD) and Screening for Depression and Follow-up Plan (CDF-CH/ -AD), were specified for the administrative method beginning with FFY 2019 reporting. However, the CPT-II procedure codes and HCPCS G-Codes used in the administrative specifications for these measures may not be available in some states. Furthermore, to calculate the CDF measure states may need to use medical records to validate the administrative codes used in the administrative specifications.

Other measures include a hybrid option, particularly where claims/encounter data may underestimate performance.[3] However, some states did not report any measures using the hybrid method for FFY 2018 because of the additional staff time and cost of conducting

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[3] The hybrid method uses a combination of administrative data and medical records data to identify services included in the numerator or to determine exclusions from the denominator based on diagnoses or other criteria. The hybrid method is used in situations where administrative data alone may be incomplete or may not capture all of the information needed to calculate the measure. In these situations, the hybrid method may yield more accurate rates than administrative data alone.

medical record abstractions. See the bottom panel of Box B for examples.

Box B. FFY 2018 Challenge: Lack of Resources for Medical Chart Abstraction

- Measures requiring medical chart abstraction:
    - PC-01: Elective Delivery (PC01-AD)**
    - PC-02: Cesarean Section (PC02-CH)
    - PC-03: Antenatal Steroids (PC03-AD)*
    - Controlling High Blood Pressure (CBP-AD)** ^
    - Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH) and Ages 18 and Older (CDF-AD)** ^
- Selected measures with option to conduct medical chart abstraction using a hybrid methodology to compensate for incomplete data in claims/encounters:
    - Adult Body Mass Index Assessment (ABA-AD)
    - Body Mass Index Assessment for Children/Adolescents (WCC-CH)**
    - Developmental Screening in the First Three Years of Life (DEV-CH)
    - Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (HPC-AD)**
    - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (HPCMI-AD)
    - Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)
    - Prenatal and Postpartum Care: Postpartum Care (PPC-AD)

* Measure was retired for FFY 2019 Core Set reporting.

** Measure is also specified for the EHR data collection method.

^ Measure was specified for administrative data collection beginning with FFY 2019 reporting. States may need to validate the G codes used in the CDF measure specifications through medical record review.

Lack of access to electronic health record (EHR) data. One measure in the 2018 Child Core Set required use of EHR data (Box C). This measure was among the least frequently reported measures in the 2018 Child Core Set. Two other measures requiring EHR data in the 2017 Core Set also had very low levels of reporting and were retired for FFY 2018 Core Set reporting. Few states have indicated capacity and readiness to use EHR data for Core Set reporting.

Box C. FFY 2018 Challenge: Lack of Access to EHR Data

- Measure requiring use of EHR data:
    - Audiological Evaluation No Later than 3 Months of Age (AUD-CH)

Challenges obtaining Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey data. The 2018 Child and Adult Core Sets included four measures based on the CAHPS Health Plan Survey 5.0H (Box D, next page). Currently, states do not report raw data or state-level rates for the CAHPS survey ratings or composites in MACPro, and instead, are encouraged to submit data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database (or to have their managed care plans or vendors submit).[4] The two measures related to flu vaccination and smoking/tobacco use cessation are directly reported by states into MACPro but have not yet reached the 25-state threshold for public reporting.

States noted several challenges related to CAHPS data collection and reporting. In some cases, states indicated they conduct CAHPS surveys every other year and they are not able to report for the alternate years. In other cases, they indicated they did not have access to data collected by managed care plans to calculate a state-level rate. Some states indicated that the cost of data collection was a barrier. Even among states that collected CAHPS data during a reporting year, some did not report the flu vaccination and smoking cessation measures in the Adult Core Set. (Note that the flu vaccination and smoking cessation questions are included only in CAHPS Health Plan Survey Version 5.0H and not in Version 5.0.)

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[4] More information on CAHPS data reported to the AHRQ CAHPS Database for the Medicaid and CHIP populations is available at https://cahpsdatabase.ahrq.gov/files/2019CAHPSHealthPlanChartbook.pdf.

Box D. FFY 2018 Challenge: CAHPS Health Plan 5.0H Survey Data Not Available for State-level Reporting

- Measures requiring CAHPS 5.0H data:
  - CAHPS Health Plan Survey 5.0H, Child Version (Medicaid) (CPA-CH)
  - CAHPS Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)
  - Flu Vaccinations for Adults (FVA-AD)
  - Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)

Box E. FFY 2018 Challenge: Lack of Access to Data from Another State Agency

- Vital records data:
  - Live Births Weighing Less than 2,500 Grams (LBW-CH)
  - PC-01: Elective Delivery (PC01-AD),
  - PC-02: Cesarean Section (PC02-CH)
  - PC-03: Antenatal Steroids (PC03-AD)*
- Immunization registry data:
  - Childhood Immunization Status (CIS-CH)
  - Immunizations for Adolescents (IMA-CH)
- Laboratory data:
  - HIV Viral Load Suppression (HVL-AD)

* Measure was retired for FFY 2019 Core Set reporting.

Lack of access to data from another state agency. States also identified challenges with reporting measures that use data collected by other state agencies (Box E). For example, the Live Births Weighing Less than 2,500 Grams measure requires vital records and some states reported challenges with accessing these data from other state agencies. Similarly, a few states indicated that they did not report immunization measures in the Child Core Set because they could not access the immunization registry to augment claims/encounter data or could not rely on the completeness of data in the immunization registry. In the case of the HIV Viral Load Suppression measure in the Adult Core Set, some states reported that they could not access HIV viral load data from state laboratories (or other sources) due to restrictions related to privacy concerns.

Concerns about Data Quality and Completeness

Even when states have access to data, some indicated that they did not report a measure if their claims/encounter data did not capture the codes required to calculate the numerator and/or denominator for the measure (Box F). For example, states that use bundled payments for maternity care frequently reported that they were unable to calculate accurate prenatal and postpartum care rates using claims/encounter data because the measures require specific dates of services associated with the prenatal and postpartum visits. Similarly, states reported challenges with calculating measures that use service or procedure codes not collected in state claims/encounter data sources or not consistently and completely recorded by providers in their claims/encounters. This concern suppressed reporting for measures that required provider documentation of specific developmental screening codes and tools, body mass index assessment, and hemoglobin A1c values, among others.

Box F. FFY 2018 Challenge: Concerns about Data Quality and Completeness

1. Measures of prenatal and postpartum care (administrative data may not include dates of service due to bundled payments for maternity care)
   - Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)
   - Prenatal and Postpartum Care: Postpartum Care (PPC-AD)
2. Measures requiring codes frequently not reported in claims/encounter data
   - Adult Body Mass Index Assessment (ABA-AD)
   - Body Mass Index Assessment for Children/Adolescents (WCC-CH)
   - Developmental Screening in the First Three Years of Life (DEV-CH)
   - HIV Viral Load Suppression (HVL-AD)
   - Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (HPC-AD)
   - Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)

Budget and/or Staff Constraints

For almost all Child and Adult Core Set measures, at least one state did not report a measure due to budget or staff constraints. We noted three characteristics of measures that were particularly resource-intensive for states to calculate: (1) measures that require new programming or data collection; (2) measures that involve medical chart abstraction, access to data from EHRs or CAHPS, or use of data collected by other agencies (see Boxes B, C, D, and E); or (3) measures that are not already being collected for other purposes, such as managed care oversight or accreditation. The first category includes both new Core Set measures (see Box A) and existing measures where the measure steward made substantial changes to the measure specifications. For example, several states noted staff and/or resource constraints associated with implementing new risk adjustment specifications for the Plan All Cause Readmissions measure. The third category includes non-HEDIS measures used to measure state performance (see Box G for example measures). Non-HEDIS measures are generally more resource-intensive for states to report, as they are not usually included in states' reporting requirements for their managed care plans. Examples of non-HEDIS measures that were less frequently reported include the Prevention Quality Indicators (PQIs) in the Adult Core Set, the Developmental Screening and Dental Sealant measures in the Child Core Set, and the Contraceptive Care measures in both Core Sets. Availability of programming code for the Dental Sealant and Contraceptive Care measures, among other measures, has reduced the burden on some states to calculate and report these measures.

State Priorities for Core Set Reporting

Because Core Set reporting is currently voluntary and states frequently face budget and/or staff constraints in their quality reporting programs, some states noted that one or more measures was not reported because they were lower priority. For example, some states indicated in "other reasons" that they prioritized reporting for measures that were aligned with the state's quality strategy. One state noted that it did not report several measures focused on process rather than outcomes. These examples illustrate factors that contributed to states' prioritization for Core Set reporting.

Box G. FFY 2018 Challenge: Resources Required to Program and Calculate Selected Non-HEDIS Measures

3. Contraceptive Care – All Women Ages 15-20 (CCW-CH) and All Women Ages 21-44 (CCW-AD)
4. Contraceptive Care – Postpartum Women Ages 15-20 (CCP-CH) and Postpartum Women Ages 21-44 (CCP-AD)
5. Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk (SEAL-CH)
6. Developmental Screening in the First Three Years of Life (DEV-CH)
7. PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)
8. PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)
9. PQI 08: Heart Failure Admission Rate (PQI08-AD)

Implications for Assessing the Feasibility of State Reporting of Child and Adult Core Set Measures

This analysis identified states' challenges with FFY 2018 Child and Adult Core Set data collection, calculation, and reporting. These findings can inform discussions of the feasibility of collecting new measures under consideration for addition to the Core Sets during the annual update process, and guide decisions about removal of existing measures from the Core Set.

This analysis may also help the Center for Medicaid and CHIP Services (CMCS) and its stakeholders understand the implications of changes to existing measures instituted by measure stewards (such as changes in data collection methods or codes). Finally, this analysis may inform technical assistance activities to improve the quality and completeness of state reporting of Child and Adult Core Set measures in the future.

For More Information

More information on quality measurement and improvement in Medicaid and CHIP is available at https://www.medicaid.gov/medicaid/quality-of-care/index.html. Information on Child and Adult Core Set reporting can be accessed from this link.

Table 1. State Reasons for Not Reporting the Child Core Set Measures, FFY 2018

Reason for Not Reporting	Screening for Depression and Follow-Up Plan: Ages 12–17	Children and Adolescents' Access to Primary Care Practitioners	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Childhood Immunization Status	Immunizations for Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening in Women Ages 16–20	Body Mass Index Assessment for Children and Adolescents	Audiological Diagnosis No Later than 3 Months of Age	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Live Births Weighing Less Than 2,500 Grams	PC-02: Cesarean Birth	Contraceptive Care: Postpartum Women Ages 15-20	Contraceptive Care: All Women Ages 15–20	Asthma Medication Ratio: Ages 5–18	Ambulatory Care: Emergency Department (ED) Visits	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Follow-Up After Hospitalization for Mental Illness: Ages 6–20	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Follow-Up Care for Children Newly Prescribed ADHD Medication	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk	CAHPS Health Plan Survey 5.0H, Child Version (Medicaid)
Number of states reporting the measure	3	45	47	48	47	43	44	25	44	38	3	39	28	16	31	26	32	45	39	45	28	40	33	39
Number of states not reporting the measure	46	4	2	1	2	6	5	24	5	11	46	10	21	33	18	23	17	4	10	4	21	9	16	10
Service not covered	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0
Population not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Entire population not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Partial population not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Data not available	33	0	1	0	1	2	1	16	2	7	34	4	15	23	10	14	10	1	5	2	10	4	7	6
Budget constraints	5	0	1	0	1	0	0	3	2	1	2	0	1	2	1	2	3	1	2	1	4	1	1	2
Staff constraints	5	0	0	0	0	0	0	4	1	2	4	1	2	2	2	3	4	1	3	1	3	1	1	1
Data inconsistencies/ accuracy/other	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Data source not easily accessible	17	0	1	0	1	1	1	2	0	2	12	2	4	9	2	1	1	0	0	0	1	1	0	0
Requires medical record review	15	0	1	0	1	1	1	2	0	2	7	1	0	6	0	0	0	0	0	0	0	0	0	0
Requires data linkage which does not currently exist	4	0	0	0	0	0	0	1	0	0	5	0	3	3	1	0	1	0	0	0	1	1	0	0
Other	2	0	0	0	0	0	0	0	0	0	4	1	2	1	1	1	0	0	0	0	0	0	0	0
Information not collected	11	0	0	0	0	1	1	9	0	3	16	1	8	10	5	7	4	0	2	1	3	2	6	4
Not collected by provider (hospital/ health plan)	5	0	0	0	0	0	0	5	0	1	9	0	4	5	4	5	3	0	2	1	3	1	3	1
Other	7	0	0	0	0	1	1	5	0	2	8	1	5	6	2	3	2	0	1	0	1	1	4	4
Other	2	0	0	0	0	1	0	3	0	0	3	0	2	2	1	3	0	0	0	0	0	0	0	0

Reason for Not Reporting	Screening for Depression and Follow-Up Plan: Ages 12–17	Children and Adolescents' Access to Primary Care Practitioners	Well-Child Visits in the First 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Adolescent Well-Care Visits	Childhood Immunization Status	Immunizations for Adolescents	Developmental Screening in the First Three Years of Life	Chlamydia Screening in Women Ages 16–20	Body Mass Index Assessment for Children and Adolescents	Audiological Diagnosis No Later than 3 Months of Age	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Live Births Weighing Less Than 2,500 Grams	PC-02: Cesarean Birth	Contraceptive Care: Postpartum Women Ages 15-20	Contraceptive Care: All Women Ages 15–20	Asthma Medication Ratio: Ages 5–18	Ambulatory Care: Emergency Department (ED) Visits	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Follow-Up After Hospitalization for Mental Illness: Ages 6–20	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Follow-Up Care for Children Newly Prescribed ADHD Medication	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk	CAHPS Health Plan Survey 5.0H, Child Version (Medicaid)
Sample size too small (less than 30)	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	0	0	0	0	0	1	0	0	0
Other	12	3	0	0	0	4	4	8	2	3	11	4	4	8	7	10	7	2	4	1	11	4	8	3
Reason not provided in MACPro	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	1

Source: Mathematica analysis of MACPro reports for the FFY 2018 reporting cycle.

Notes: The term “states” includes the 50 states and the District of Columbia.

States can specify multiple reasons for not reporting a measure.

The 2018 Child Core Set includes 26 measures. This table excludes the Central Line-Associated Bloodstream Infection (CLABSI) measure and the Percentage of Eligibles Who Received Preventive Dental Services (PDENT) measure. Beginning in FFY 2012, data for the CLABSI measure were obtained from the CDC National Healthcare Safety Network. Beginning in FFY 2012, to minimize state burden, CMS began calculating the PDENT measure on behalf of states using data reported on Form CMS-416.

This table includes the 49 states that reported at least one Child Core Set measure in MACPro for FFY 2018 reporting. Idaho and North Dakota did not submit an FFY 2018 MACPro report.

States that submitted separate data for their Medicaid and CHIP populations were counted as reporting the measure if either report included data for that measure.

ADHD = Attention-deficit/hyperactivity disorder; CAHPS = Consumer Assessment of Healthcare Providers and Systems.

Table 2. State Reasons for Not Reporting the Adult Core Set Measures, FFY 2018

Reason for Not Reporting	Flu Vaccinations for Adults	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women Ages 21–24	Adult Body Mass Index Assessment	Screening for Depression and Follow-Up Plan: Age 18 and Older	Prenatal and Postpartum Care: Postpartum Care	PC-01: Elective Delivery	PC-03: Antenatal Steroids	Contraceptive Care: Postpartum Women Ages 21–44	Contraceptive Care: All Women Ages 21–44	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	PQI 01: Diabetes Short-Term Complications Admission Rate	PQI 05: COPD or Asthma in Older Adults Admission Rate	PQI 08: Heart Failure Admission Rate	PQI 15: Asthma in Younger Adults Admission Rate	Plan All-Cause Readmissions	Asthma Medication Ratio: Ages 19–64	Annual Monitoring for Patients on Persistent Medications	Controlling High Blood Pressure	HIV Viral Load Suppression	Antidepressant Medication Management	Concurrent Use of Opioids and Benzodiazepines	Use of Opioids at High Dosage in Persons Without Cancer	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Adherence to Antipsychotics for Individuals with Schizophrenia	Follow-Up After Hospitalization for Mental Illness: Age 21 and Older	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	Medical Assistance With Smoking and Tobacco Use Cessation	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotics	CAHPS Health Plan Survey, Version 5.0H(Medicaid)
Number of states reporting the measure	22	41	40	38	35	6	37	8	2	29	24	38	28	28	25	25	26	30	29	36	29	6	33	15	27	4	34	33	43	32	20	32	32
Number of states not reporting the measure	23	4	5	7	10	39	8	37	43	16	21	7	17	17	20	20	19	15	16	9	16	39	12	30	18	41	11	12	2	13	25	13	13
Service not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Population not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Entire population not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Partial population not covered	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Data not available	14	0	3	3	8	29	4	28	34	7	10	2	11	10	12	12	12	10	9	3	12	29	6	18	12	30	4	5	1	7	16	4	10
Budget constraints	3	0	2	2	1	5	1	5	5	1	1	0	3	2	2	2	2	4	3	2	2	4	0	4	2	5	0	1	0	2	3	1	2
Staff constraints	3	0	2	2	1	3	0	3	3	1	1	1	4	1	1	1	1	4	4	2	1	4	1	3	2	3	1	2	0	3	2	2	2
Data inconsistencies/ accuracy/other	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0	0	0	0	1	0	0	0	0	0	0
Data source not easily accessible	2	0	0	0	4	16	3	13	17	1	1	0	2	0	0	0	0	0	0	0	11	8	0	1	0	8	0	0	0	0	2	0	0
Requires medical record review	1	0	0	0	4	16	1	10	13	0	0	0	2	0	0	0	0	0	0	0	11	4	0	0	0	7	0	0	0	0	1	0	0
Requires data linkage which does not currently exist	0	0	0	0	0	4	0	5	5	0	0	0	1	0	0	0	0	0	0	0	4	3	0	0	0	2	0	0	0	0	1	0	0
Other	1	0	0	0	0	2	2	2	2	1	1	0	0	0	0	0	0	0	0	0	0	2	0	1	0	1	0	0	0	0	0	0	0

Reason for Not Reporting	Flu Vaccinations for Adults	Breast Cancer Screening	Cervical Cancer Screening	Chlamydia Screening in Women Ages 21–24	Adult Body Mass Index Assessment	Screening for Depression and Follow-Up Plan: Age 18 and Older	Prenatal and Postpartum Care: Postpartum Care	PC-01: Elective Delivery	PC-03: Antenatal Steroids	Contraceptive Care: Postpartum Women Ages 21-44	Contraceptive Care: All Women Ages 21–44	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	PQI 01: Diabetes Short-Term Complications Admission Rate	PQI 05: COPD or Asthma in Older Adults Admission Rate	PQI 08: Heart Failure Admission Rate	PQI 15: Asthma in Younger Adults Admission Rate	Plan All-Cause Readmissions	Asthma Medication Ratio: Ages 19–64	Annual Monitoring for Patients on Persistent Medications	Controlling High Blood Pressure	HIV Viral Load Suppression	Antidepressant Medication Management	Concurrent Use of Opioids and Benzodiazepines	Use of Opioids at High Dosage in Persons Without Cancer	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Adherence to Antipsychotics for Individuals with Schizophrenia	Follow-Up After Hospitalization for Mental Illness: Age 21 and Older	Follow-up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence	Medical Assistance With Smoking and Tobacco Use Cessation	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotics	CAHPS Health Plan Survey, Version 5.0H(Medicaid)
Information not collected	9	0	0	0	4	11	1	13	15	5	7	1	3	7	9	8	9	2	3	0	2	14	3	10	8	15	1	2	0	2	8	2	6
Not collected by provider (hospital/health plan)	5	0	0	0	1	6	0	8	9	4	5	0	0	5	6	6	6	2	2	0	1	5	2	5	6	9	1	1	0	2	4	1	3
Other	6	0	0	0	3	6	1	6	7	2	3	1	3	3	4	3	4	0	1	0	1	10	1	6	3	8	0	1	0	0	6	1	4
Other	1	0	0	0	0	1	0	1	2	0	1	0	2	1	1	2	1	4	1	0	0	3	2	3	2	4	2	1	1	2	3	0	2
Sample size too small (less than 30)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	7	3	1	3	2	10	4	8	8	9	11	4	5	6	7	7	6	5	6	5	3	9	5	11	5	10	6	6	0	5	8	7	2
Reason not provided in MACPro	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	2	1

Source: Mathematica analysis of MACPro reports for the FFY 2018 reporting cycle.

Notes: The term “states” includes the 50 states and the District of Columbia.

States can specify multiple reasons for not reporting a measure.

The 2018 Adult Core Set includes 33 measures.

This table includes the 45 states that reported at least one Adult Core Set measure in MACPro for FFY 2018 reporting. The following 6 states did not submit an FFY 2018 Adult Core Set MACPro report: Alaska, Idaho, Indiana, Maine, Montana, and North Dakota.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; COPD = Chronic Obstructive Pulmonary Disease; HIV = Human Immunodeficiency Virus.

Appendix C:

Measures Suggested for Review at the 2021 Core Set Annual Review, by Domain

Exhibit C.1. Measures Suggested for Review at the 2021 Child and Adult Core Set Annual Review, by Domain

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Primary Care Access and Preventive Care				
Removal: Suggestion was withdrawn due to changes made for 2020 Core Set	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	NCQA	0024	Administrative, Hybrid, or EHR[a]
Removal	Adult Body Mass Index Assessment (ABA-AD) (Note: NCQA has proposed this measure for retirement for Measurement Year 2020)	NCQA	NA	Administrative or Hybrid[a]
Removal	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	CMS	0418/ 0418e	Administrative or EHR
Removal	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	CMS	0418/ 0418e	Administrative or EHR
Removal	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	NCQA	0039	Survey
Addition	Adult Immunization Status (Suggested as a replacement for FVA-AD)	NCQA	NA	ECDS[b]
Addition	Prenatal Immunization Status	NCQA	NA	ECDS[b]
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	HIV Screening	CDC	NA	EHR
Maternal and Perinatal Health				
Removal	Audiological Evaluation No Later than 3 Months of Age (AUD-CH)	CDC	1360	EHR
Removal	PC-01: Elective Delivery (PC01-AD)	TJC	0469/ 0469e	Hybrid or EHR
Addition	Prenatal Depression Screening and Follow-Up	NCQA	NA	ECDS[b]
Addition	Postpartum Depression Screening and Follow-Up	NCQA	NA	ECDS[b]
Care of Acute and Chronic Conditions				
Removal	HIV Viral Load Suppression (HVL-AD)	HRSA	2082/ 3210e	Administrative or EHR
Addition	Proportion of Days Covered: Antiretroviral Medications (Suggested as a replacement for HVL-AD)	PQA	NA	Administrative
Addition	Prevention Quality Indicators (PQI) 92: Prevention Quality Chronic Composite	AHRQ	NA	Administrative

Exhibit C.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Global Assessment of Pediatric Patient Safety (GAPPS) Trigger Tool	CEPQM	3136 (rate #3 only)	EHR or medical record review
Behavioral Health Care				
Removal: Measure will not be discussed because it has been retired from the 2020 Core Set	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	NCQA	NA	Administrative
Removal	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	NCQA	0027	Survey
Removal	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (HPCMI-AD)	NCQA	2607	Administrative or hybrid
Removal	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	PQA	2940	Administrative
Dental and Oral Health Services				
Removal: Measure retired by the measure steward; will be retired from the 2021 Core Set	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH)	ADA/DQA	2508 (No longer endorsed)	Administrative
Removal	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	CMS	NA	Administrative (Form CMS-416)
Addition	Annual Dental Visit (Suggested as a replacement for PDENT-CH) (Note: NCQA has proposed this measure for retirement for Measurement Year 2022)	NCQA	1388 (No longer endorsed)	Administrative
Addition	Sealant Receipt on Permanent 1st Molars (Suggested as a replacement for SEAL-CH)	ADA/DQA	NA	Administrative
Addition	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	ADA/DQA	NA	Administrative
Addition	Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	ADA/DQA	NA	Administrative

Exhibit C.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Long-Term Services and Supports				
Addition[0]	Long-Term Services and Supports (LTSS) Admission to an Institution from the Community (MLTSS-6)	CMS	NA	Administrative
Addition	National Core Indicators for Aging and Disabilities Adult Consumer Survey	ADvancing States, HSRI	NA	Survey
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP[0]	Admission to an Institution from the Community Among Medicaid Fee-for-Service (FFS) Home and Community-based Service (HCBS) Users (HCBS-1)	CMS	NA	Administrative
Experience of Care				
Removal	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)	NCQA	NA	Survey
Removal	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA-AD)	NCQA	NA	Survey
Other Measure				
Addition: Measure will not be reviewed because it has not been fully specified0	Safe Environment for Every Kid (SEEK) Parent Questionnaire-R	University of Maryland	NA	Screening tool

Notes: Data collection methods for each measure are current as of February 2020. The methods may change as measures undergo specification updates and maintenance.

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

[a] There was a change to the ICD-10 coding guidelines, effective October 1, 2018, related to the codes for reporting body mass index (BMI). The change allows providers to bill for BMI codes only if the beneficiary has a clinically relevant condition, such as obesity. As a result, beneficiaries without a relevant condition will no longer be captured in the numerator using administrative claims.

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

ADA = American Dental Association; AHRQ = Agency for Healthcare Research and Quality; CDC = Centers for Disease Control and Prevention; CEPQM = Center of Excellence for Pediatric Quality Measurement; CHIP = Children's Health Insurance Program;
CMCS = Centers for Medicaid and CHIP Services; CMS = Centers for Medicare & Medicaid Services; DQA = Dental Quality Alliance; ECDS = Electronic Clinical Data System; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

Appendix D:

Summary of 2021 Child and Adult Core Set Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

This appendix summarizes the discussion of measures considered by the Workgroup and not recommended for removal from or addition to the 2021 Child and Adult Core Sets. The discussion took place during the Workgroup meeting from April 28 to April 30, 2020. The summary is organized by domain. For more information about the measures discussed and not recommended for removal or addition, please refer to Exhibit D.1 at the end of this appendix, which includes the measure name, measure steward, NQF # (if endorsed), measure description, data collection method, and key points of discussion about each measure.

Primary Care Access and Preventive Care

The *Adult Body Mass Index Assessment* (ABA-AD) measure was suggested for removal from the Adult Core Set. This measure assesses the percentage of beneficiaries ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year. A Workgroup member suggested the measure for removal due to changes in the United States Preventive Services Task Force (USPSTF) recommendations for adult BMI screening. As of 2018, the USPSTF no longer recommends BMI screening for all adults, instead recommending that clinicians offer referrals or behavioral health interventions to individuals with a BMI of 30 or higher. In addition, the measure steward proposed the measure for retirement from Healthcare Effectiveness Data and Information Set (HEDIS) Measurement Year 2020.[1]

The Workgroup discussed whether the ABA-AD measure effectively achieves its intended goals, with Workgroup members commenting that the measure is topped out, describing the measure as a checkbox in the electronic health record (EHR), and suggesting it may not advance quality improvement because it is focused on assessment and not BMI counseling or follow-up. Some Workgroup members advocated for retaining the measure, given the prevalence of obesity among adults and the use of the measure in other federal programs. They also noted that weight assessment is a primary prevention clinical activity and that screening remains suboptimal.[36]

The Workgroup discussed *Screening for Depression and Follow-Up Plan: Ages 12 to 17* (CDF-CH), suggested for removal from the Child Core Set, and *Screening for Depression and Follow-Up Plan: Age 18 and Older* (CDF-AD), suggested for removal from the Adult Core Set. These measures assess the percentage of beneficiaries ages 12 to 17 and 18 and older who are screened for depression on the date of the encounter using a standardized screening tool and, if positive, have a follow-up plan documented on the date of the positive screen. Both measures were suggested for removal because of concerns about the feasibility of collecting the data, as reflected by the low numbers of states reporting the measures. Three states reported the CDF-CH measure for federal fiscal year (FFY) 2018 and six states reported the CDF-AD measure (one of the six did not use Core Set specifications). Workgroup members acknowledged challenges using claims or encounter data to verify that the screening had been completed, a valid tool had been used, and a follow-up plan had been documented. Because of these limitations, states noted

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[1] The measure steward, National Committee for Quality Assurance, announced on July 1, 2020 that the *Adult Body Mass Index Assessment* measure will be retired from HEDIS for Measurement Year 2020.

[36] Public comments submitted on the *Adult Body Mass Index Assessment* (ABA-AD) measure can be found in Appendix E.

that rates using administrative data only are very low and need to be supplemented with medical record reviews.

Workgroup members expressed hesitation about removing the CDF-CH and CDF-AD measures from the Core Sets, noting that depression is a highly prevalent condition for both adults and adolescents, one that significantly impacts functioning. The Workgroup also discussed increasing efforts to integrate behavioral services, such as depression care, into primary care. Workgroup members noted that the ongoing impact of the COVID-19 pandemic has increased the need for mental health services, and screening for depression will be very important to track. Several Workgroup members shared that their states have incorporated the measures into state-level quality initiatives or value-based payment programs, which may incentivize providers' use of the depression screening encounter codes and improve the completeness of the administrative data used to calculate the measure.

During the public comment period, some state representatives shared their challenges with calculating the measures. They noted that providers are not billing the correct codes to reflect the services included in the measure, in part because there is no payment associated with the codes. Thus, obtaining an accurate assessment of screening and follow-up is not possible.

Workgroup members also discussed two "paired" immunization measures: *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD), which was suggested for removal from the Adult Core Set by two Workgroup members, and *Adult Immunization Status*, which was suggested as a replacement for the FVA-AD measure. The FVA-AD measure is based on self-reported data collected through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. It is defined as the percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS survey was completed. It was suggested for removal because of the high cost of collecting the CAHPS data, low survey response rates, and wide variation in response rates across demographic groups. Workgroup members indicated that the measure may not be calculated consistently across states. They noted that these limitations prevent the FVA-AD measure from contributing to an overall estimate of the quality of health care in the Medicaid population.

The *Adult Immunization Status* measure is defined as the percentage of beneficiaries 19 years and older who are up to date on the recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal. This measure was suggested to replace the FVA-AD measure because it includes more vaccines than the existing FVA-AD measure and would help states reduce immunization rate disparities within their Medicaid populations. The Workgroup discussed variability in state Medicaid programs' coverage of the vaccines included in the measure specifications. Workgroup members expressed concern about measuring a service that states do not cover, providers cannot get reimbursed for, and beneficiaries do not have access to because they cannot pay. Workgroup members also expressed concern over states' ability to collect immunization information for the adult population; they noted that whereas all states have immunization registries, those registries vary considerably in their completeness for adult populations. One Workgroup member who questioned the feasibility of identifying the eligible population, as each vaccine in the measure has different population and exclusion criteria, suggested allowing more time for this measure to be operationalized by states before bringing it into the Core Set.

During the public comment period, several commenters expressed their support for adding the *Adult Immunization Status* measure to the Adult Core Set. They noted that the composite measure will allow for a full assessment of immunization status. They also noted that the measure is being used by various health plans, demonstrating its feasibility. Commenters said that many Medicaid agencies and immunization registries are already sharing data, and they also suggested that use of this measure would continue to build the infrastructure of state immunization registries. They noted that immunization registries have helped to improve child vaccination rates, and they would expect a similar outcome for adults. They pointed out that all states are now able to capture lifespan vaccinations.[37]

Maternal and Perinatal Health

Audiological Diagnosis No Later than 3 Months of Age (AUD-CH) assesses the percentage of newborns who did not pass hearing screening and have an audiological diagnosis no later than 3 months of age. This measure was suggested for removal by two Workgroup members because of feasibility concerns: the measure requires the use of EHR data, which are not currently available in most states. Three states reported on the measure for FFY 2018, and two of the three did not use Core Set specifications to calculate the measure. One Workgroup member who suggested the measure for removal also questioned the actionability and strategic priority of the measure, noting that public health Early Hearing Detection and Intervention programs have a follow-up system in place for newborns who do not pass a hearing screening. They commented that it is not known whether adding the Medicaid program into this process leads to better outcomes.

Several Workgroup members expressed concern about removing the measure, noting the importance of early intervention for children with hearing impairment on early childhood development and outcomes, even if the incidence of audiological diagnoses is relatively low. A Workgroup member noted significant geographic and demographic variation in hearing screening follow-up. Another Workgroup member stated that just because the measure is difficult to report does not mean it should not be included. One Workgroup member clarified that although neither the importance of the measure nor the need to improve performance on the measure was in question, the measure is not feasible for states, as evidenced by the relatively low number of states reporting after years of the measure's inclusion in the Core Set. Another Workgroup member from a state Medicaid program identified concerns about the accuracy of the follow-up data and noted that the measure has not been helpful for doing quality improvement work within the state and with its managed care plans. The Workgroup and the measure steward discussed the potential for state Medicaid programs to partner with public health Early Hearing Detection and Intervention programs to improve reporting and performance on the measure if it is retained in the 2021 Core Set.

The *PC-01: Elective Delivery* (PC01-AD) measure assesses the percentage of women with elective vaginal deliveries or elective cesarean sections at 37 weeks or more and less than 39 weeks of gestation completed. A Workgroup member suggested the measure for removal from the Adult Core Set because of feasibility concerns: the measure requires EHR data or medical chart review, and many states do not have the resources to either access EHR data or conduct chart reviews. The Workgroup member who suggested the measure for removal noted that only

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[37] Public comments submitted on the *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD) and *Adult Immunization Status* measures can be found in Appendix E.

eight states reported the measure for FFY 2018, and five of the eight did not use Core Set specifications to calculate the measure. This Workgroup member also felt that elective deliveries were no longer a strategic priority, as rates have decreased and there is little room for additional improvement.

During the discussion, some Workgroup members challenged the assertion that there was little room for improvement on the measure, questioning whether rates in Medicaid are higher than those in the general population and whether there are disparities within the Medicaid program, for example, among women of different racial and ethnic groups. A Workgroup member shared data reported by hospitals to The Joint Commission, the measure steward, noting that elective delivery rates are higher in the race categories of White, African American, and Pacific Islander. The Workgroup member also noted differences in elective delivery rates by maternal age. (The Workgroup member is employed by The Joint Commission and was eligible to discuss the measure but recused from voting on the measure.) Another Workgroup member noted that the rates are quite a bit higher in their Medicaid program, with substantial variation across managed care plans, signaling that the measure is not topped out in the state. Another Workgroup member indicated that there is geographic variation on the measure and cautioned against potential slippage in performance if the measure is removed from the Adult Core Set.

A Workgroup member acknowledged that although a lot of measures in the Core Sets focus on maternal and perinatal health, this is reasonable given the role that Medicaid and CHIP play in financing births in the United States. The Workgroup member also said this is one of two measures focused on the birth experience (the other being the *PC-02: Cesarean Birth* measure). There was some discussion about whether state-level reporting in the Core Set to measure elective deliveries is as actionable as reporting at the hospital level, where opportunities to drive improvement might be greater. Other Workgroup members questioned the feasibility of the measure, noting that the measure requires medical record review, which is difficult for many states, especially in light of the COVID-19 pandemic. However, for many Workgroup members, the feasibility concerns were outweighed by the desirability of retaining the measure on the Core Set because of its importance as a measure of the birth experience.

The *Prenatal Depression Screening and Follow-Up* measure is defined as the percentage of deliveries in which women were screened for clinical depression using a standardized tool during pregnancy while pregnant and if screened positive, received follow-up care within 30 days of the positive screen. A Workgroup member suggested the measure for addition to the Core Sets, indicating that the health care system has struggled with depression screening and access to appropriate care following a positive screen, and that this measure may drive improvement in maternal and child health. This measure was discussed in conjunction with the *Postpartum Depression Screening and Follow-Up* measure, which the Workgroup recommended for addition to the 2021 Core Sets.

Workgroup members appreciated that the measures include both a screening and follow-up component, and therefore are connected to an action. They also commented that the measures look at the impact of dyadic care on the family unit. One Workgroup member indicated, however, that prenatal depression is a problem distinct from postpartum depression. Much of the discussion about the measures focused on the postpartum measure, with several Workgroup members emphasizing the relationship between postpartum depression and infants' social and emotional development. However, several Workgroup members did note the importance of, and expressed support for, the prenatal measure as well.[38]

Care of Acute and Chronic Conditions

The Workgroup considered two measures related to HIV: the *HIV Viral Load Suppression* (HVL-AD) measure suggested for removal from the Adult Core Set, and the *Proportion of Days Covered: Antiretroviral Medications* measure suggested as a replacement. The *HIV Viral Load Suppression* measure is defined as the percentage of beneficiaries age 18 and older with a diagnosis of HIV who had a HIV viral load less than 200 copies per milliliter at last HIV viral load test during the measurement year. A Workgroup member suggested the HVL-AD measure for removal because of barriers that states experience in reporting the measure, specifically confidentiality and privacy laws around sharing data on individuals with HIV. The member suggested the *Proportion of Days Covered: Antiretroviral Medications* measure to replace HVL-AD because it serves as a proxy for viral load suppression and does not present the same barriers to reporting as the current measure does. It measures the percentage of individuals 18 years and older who met the proportion of days covered threshold of 90 percent for 3 or more antiretroviral medications during the measurement year.

Several Workgroup members discussed the challenges in creating data-sharing agreements between Medicaid and public health departments, which are needed to obtain laboratory data on viral load suppression for the HVL-AD measure. They noted the difficulties of coordinating and collaborating with another agency. In addition, confidentiality and privacy laws have often been a barrier to obtaining the data on viral load suppression. They questioned the value in keeping the measure on the Core Set with so few states reporting.

One Workgroup member strongly advocated keeping the measure on the Core Set, describing how their state created a partnership with the state public health agency to match Medicaid IDs to the viral load registry; Medicaid receives aggregate information from the public health agency to calculate the measure. The managed care plans have separate data-sharing agreements with the public health agency and receive information on non-suppressed individuals so they can engage them in care. This Workgroup member, who described the HVL-AD measure as “the ultimate outcome measure,” cautioned against removing it simply because it is hard to report. The member suggested sharing lessons learned across states and having the Centers for Disease Control and Prevention (CDC) help facilitate cooperative agreements between Medicaid and public health agencies to gain access to aggregate data from the viral load registry. Another Workgroup member discussed the strong stakeholder interest in this topic area, which helped support the data-sharing activities needed to have the state public health agency perform the data linkage between Medicaid IDs and the HIV/AIDS registry and provide summarized data for reporting. The Workgroup member noted that data-sharing can be done, but it takes time.

The Workgroup discussed whether there were opportunities for the CDC, the Health Resources and Services Administration (HRSA), and the Centers for Medicare & Medicaid Services (CMS) to help facilitate the partnership building, data linkages, and information sharing necessary for states to report the HVL measure. A representative from HRSA indicated that there may be

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[38] Public comments submitted on the *Prenatal Depression Screening and Follow-Up* measure can be found in Appendix E.

additional funding to support states in building their data infrastructure as part of the Ending the Epidemic initiative.

Workgroup members noted that the data for *Proportion of Days Covered: Antiretroviral Medications* measure can be collected much more readily than that for HVL-AD because the data source for the measure is prescription claims data. The CDC representative noted that the *Proportion of Days Covered: Antiretroviral Medications* measure is an imperfect replacement for HVL-AD, because an individual may pick up a prescription but not take it as prescribed; thus, the measure may overestimate viral load suppression. The Workgroup member who suggested the measure for addition indicated that there are evidence-based behavioral interventions that states can implement to improve medication adherence and address this concern. The Workgroup member considers the measure actionable and gives states and managed care plans ways to intervene with individuals or clinical sites. Additionally, the measure steward shared during the public comment period that other Proportion of Days Covered measures are included in other CMS quality reporting programs, such as the Medicare Advantage Quality Rating System, suggesting that the methodology for calculating proportion of days covered is robust and accurate.[39]

The *Prevention Quality Indicators (PQI) 92: Prevention Quality Chronic Composite* measure was suggested for addition to the Adult Core Set to identify hospitalizations that might be prevented with more timely or appropriate outpatient care. PQI 92 measures the number of inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 population age 18 years and older. The Workgroup member who proposed the measure for addition indicated that the measure could be used to improve access to appropriate care for a set of common conditions that are prevalent in the adult Medicaid population, including hypertension, diabetes, and asthma. The measure is included in the Health Home Core Set and was reported by 23 Health Home programs for FFY 2018.

A Workgroup member commented on the disproportionate occurrence of these conditions among the 65 and older population and expressed interest in alternate measures that may stratify by age, if this measure did not do so. Another member added that the PQI measures are sometimes difficult to report for the 65 and older population because Medicare is generally the primary payer for individuals age 65 and older, and Medicaid may not have access to Medicare data.

One Workgroup member noted that the conditions included in the PQI 92 measure are often captured through other data sources, such as HCUP (Healthcare Cost and Utilization Project) and asked whether CMS may have opportunities to calculate the measure at the state level using this data source. Mathematica noted that while HCUP data are not available for all states, CMS has begun an effort to use T-MSIS (Transformed Medicaid Statistical Information System) to calculate the PQI measures. A Workgroup member cautioned that a limitation of T-MSIS is the lack of Medicare data to capture hospitalizations for those age 65 and older.

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[39] Public comments submitted on the *HIV Viral Load Suppression* (HVL-AD) and *Proportion of Days Covered: Antiretroviral Medications* measures can be found in Appendix E.

Behavioral Health Care

The *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD) measure assesses different facets of providing medical assistance with smoking and tobacco use cessation. There are three measure components: (1) advising smokers and tobacco users to quit, (2) discussing cessation medications, and (3) discussing cessation strategies. A Workgroup member suggested removal of this measure from the Adult Core Set because of the high cost of the CAHPS survey used to collect the measure, low response rates, and cultural variations in response, which present challenges for consistent calculation of the measure across states.

Workgroup members expressed concern about removing this measure without a replacement, particularly in light of growing rates of vaping and the COVID-19 pandemic, which has resulted in more severe illness among smokers. In addition, a Workgroup member commented that smoking cessation is one of the most important ways to promote health in the Medicaid population. Another Workgroup member speculated that the increasing use of telehealth could possibly improve some of the scores. Workgroup members discussed potential alternative strategies for collecting information on smoking cessation. One Workgroup member suggested incentivizing providers to use G-codes so that an administrative measure can be calculated using claims data; two Workgroup members cautioned against expecting providers to use codes that they are not getting paid for. Another suggested exploring an alternative measure used in other programs.

The *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD) measure assesses the percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more. A Workgroup member suggested this measure for removal because, according to the Workgroup member, it measures how chronic pain is treated and does not reflect behavioral health system performance. The Workgroup member indicated that behavioral health system performance is better reflected in another measure in the Adult Core Set, *Use of Pharmacotherapy for Opioid Use Disorder* (OUD-AD). The Workgroup member who suggested the measure for removal clarified that the suggestion was to move the measure to the Care of Acute and Chronic Conditions domain, not remove it from the Core Set. Mathematica reminded the Workgroup that CMCS is responsible for assigning measures to domains, and that the Workgroup would proceed with voting on the measure for removal from the Core Set as initially proposed.

During the discussion, other Workgroup members agreed that the measure is not strictly a behavioral health measure but emphasized the critical importance of measuring opioid prescribing and misuse in responding to the opioid epidemic. One member noted that this is the only Core Set measure that makes prescribers and pharmacies accountable for overprescribing, overdispensing, and overuse of opioids. Another Workgroup member noted that high-dose opioid prescribing is associated not just with addiction but also with a number of adverse medical outcomes, such as mortality related to respiratory suppression.

Dental and Oral Health Services

The Workgroup first discussed the removal of the *Percentage of Eligibles Who Received Preventive Dental Services* (PDENT-CH) measure from the Child Core Set. This measure assesses the percentage of children ages 1 to 20 who received at least one preventive dental service during the reporting period. CMS calculates this measure using data that states submit as part of annual Early and Periodic, Screening, Diagnostic and Treatment reporting (Form CMS-416). Two Workgroup members suggested removing the PDENT-CH measure. One member noted concerns with the measure's methodology, specifically that the measure requires only 90 days of eligibility but assesses services throughout the full calendar year. The other member noted that the measure might lead to duplication of efforts by health plans that are reporting the HEDIS *Annual Dental Visit* measure, which was suggested as a replacement for PDENT-CH. The *Annual Dental Visit* measure assesses the percentage of patients ages 2 to 20 who had at least one dental visit during the measurement year.

During the discussion, one Workgroup member acknowledged concerns about the PDENT-CH measure, including the appropriateness of some of the Current Dental Technology codes included in the measure, and the use of a 90-day continuous enrollment period. Despite concerns with the PDENT-CH measure, the Workgroup member strongly preferred the focus of the measure on children's preventive services, whereas the *Annual Dental Visit* measure assesses the receipt of any dental services. Specifically, the Workgroup member expressed concern about counting emergency care, X-rays, and treatment services in a dental quality measure. The member also noted that an analysis of the *Annual Dental Visit* 11-month continuous enrollment criterion, when applied to the PDENT-CH measure, significantly reduced the denominator and increased rates, without changing the underlying quality of care. The member commented that the denominator loses reporting on a significant number of children by imposing a requirement for 11 months of continuous eligibility. The member added that state and national data show there is still substantial room for improvement on the measure.

Another Workgroup member commented that their state uses both measures and increasingly is pushing toward the PDENT-CH measure to focus on preventive services. The state shares quarterly performance on the PDENT-CH measure with managed care plans (calculated on a rolling annual basis) and has implemented interventions around improving the PDENT-CH measure. This member commented that the 90-day eligibility for the measure is an advantage because it includes more children and, from a Medicaid and public health standpoint, holds plans and providers accountable for care from the day the child enrolls.

Other Workgroup members expressed reservations about the PDENT-CH measure. Two members objected to the 90-day eligibility requirement because the data may not be available to hold plans accountable for providing recommended preventive services. For example, if a child was enrolled for three months and had a preventive dental visit in the three months before enrolling in Medicaid, the state and the plan would have no record of the service although the child actually did receive the needed service. The Workgroup members further explained that the measure could drive states and plans to provide unnecessary services. Another Workgroup member noted that 90 days may not be enough time to find an appointment with a dental provider, given the shortage of dental providers that serve Medicaid populations. That

Workgroup member also mentioned placing responsibility on the delivery systems for getting Medicaid-eligible providers.

Additionally, Workgroup members expressed concern about adding the *Annual Dental Visit* measure to the Core Set, as the National Committee for Quality Assurance (NCQA) plans to retire the measure. One Workgroup member noted that CMS, NCQA, and DQA have begun discussions about a replacement for the *Annual Dental Visit* measure. Mathematica also noted that CMS is currently testing production of the PDENT-CH measure using T-MSIS data to reduce state burden, standardize calculation across states, and explore refinements to the measure.

Two dental and oral health measures focused on adults were suggested for addition to the Core Sets: (1) *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* and (2) *Follow-Up After Emergency Department Visits for Non-Traumatic Dental Conditions in Adults*. The first measure is defined as the number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions, per 100,000 beneficiary months. The second measure assesses the percentage of ambulatory care sensitive non-traumatic dental condition ED visits that resulted in a follow-up with a dentist within 7 and 30 days of the ED visit.

Both measures were suggested to address a gap in the Core Sets around oral health care for adults. Additionally, both measures promote diverting dental care out of the ED through increased preventive care, treatment of acute dental issues, and appropriate follow-up after ED use. Discussion on these measures focused primarily on whether the measures are appropriate for the Core Sets, as not all state Medicaid programs have an adult dental benefit. The Workgroup member who suggested the measures for addition to the Core Sets indicated that 35 states provide some level of dental benefits for adults in Medicaid, with 19 providing limited benefits and 16 providing more extensive benefits. Another 11 states cover emergency services only. Some Workgroup members expressed concerns over including measures that would not be comparable across states, suggesting that the Core Set should focus on consistent benefits and requirements. One member commented that focusing on at least the basic set of services would help people address acute infection and pain.

Workgroup members generally agreed that the *Ambulatory Care Sensitive ED Visit* measure would be more comparable and feasible across states than the *Follow-Up after ED Visits* measure. Some Workgroup members believed that the *Ambulatory Care Sensitive ED Visit* measure could be feasible for states to report even if they provide limited, emergency dental coverage for adults in Medicaid, and would highlight access to care. Workgroup members noted that there are effective interventions for ED diversion, and that the measure could help states quantify the extent of ED utilization and the savings they could potentially realize from reduced ED care, which could be spent on routine dental care for adults. There was some discussion about whether including this measure in the Core Set might spur states to expand adult dental coverage. However, some Workgroup members questioned whether this was consistent with the purpose of the Core Sets.[40]

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[40] Public comments submitted on the *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* and *Follow-Up After Emergency Department Visits for Non-Traumatic Dental*

Experience of Care

A Workgroup member suggested removing both CAHPS measures from the Core Sets *(CAHPS Health Plan Survey 5.0H Child Version Including Medicaid and Children and Chronic Conditions Supplemental Items* [CPC-CH] and *CAHPS Health Plan Survey 5.0H, Adult Version* [CPA-AD]). The Child CAHPS Survey 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. Similarly, the Adult CAHPS Survey provides information on the experience of adult Medicaid beneficiaries with their health care and gives a general indication of how well the health care meets their expectations. Both surveys include global ratings of all health care, the health plan, the personal doctor, and the specialist seen most often. In addition, four composite measures summarize experiences with customer service, getting care quickly, getting needed care, and how well doctors communicate.

The Workgroup member provided the same reasons for removal for both measures, saying that the surveys are expensive to field and response rates are low and decreasing. The Workgroup member raised concerns about the ability to trend CAHPS results over time because of falling response rates. The Workgroup member also said that as survey responses vary widely across cultures, age groups, and other demographics, the surveys do not allow for consistent calculations across states, and they do not accurately portray the views of health care experiences across beneficiary demographics.

During Workgroup discussion, some Workgroup members indicated that CAHPS response rates are nearing single digits, despite efforts to explore alternative data collection modalities, including mailed surveys and a one-time text to link to a survey online. One Workgroup member discussed their state's use of a consumer advocacy group and statewide consumer subcommittee to encourage managed care plans' use of the CAHPS survey instruments and to evaluate their performance. Another Workgroup member and a representative from NCQA agreed that low survey response rates are problematic for many large surveys. The NCQA representative noted that mail and phone modalities are the most prominent for survey data collection. The Workgroup largely acknowledged and appreciated the concerns expressed about low response rates and the resulting validity of the data. However, many Workgroup members did not support removing the measures because the surveys provide valuable information about beneficiaries' experience. They noted that removal of the measures would leave a gap in the Core Sets.

Another Workgroup member noted that these concerns about CAHPS have been raised in previous Annual Review discussions. Workgroup members strongly urged NCQA and AHRQ to explore options for addressing the methodological issues raised by Workgroup members in a timely manner, especially in the context of mandatory reporting of the Child Core Set in 2024.[41]

During the public comment period, a commenter acknowledged the concerns and added that their team was actively pursuing different forms of testing to address the low response rates. The commenter also highlighted the importance of measuring patient and family experience in the

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Conditions in Adults measures can be found in Appendix E.

[41] The Child and Adult Core Sets include the NCQA version of CAHPS, which is adapted from the AHRQ measure (NQF #0006).

current health system to identify disparities in experience, especially socioeconomic differences. The commenter noted that their hospital is using the findings to lead to improvement through interventions. The commenter also noted that the Child CAHPS survey is one of the few tools available at the state level to assess patient and family experience.

Long-Term Services and Supports

Workgroup members discussed two LTSS measures: *Long-Term Services and Supports Admission to an Institution from the Community* (MLTSS-6) and the *National Core Indicators for Aging and Disabilities* (NCI-AD) *Adult Consumer Survey*.[42] Neither of these measures were recommended for addition to the 2021 Core Sets.

MLTSS-6 measures the number of admissions to an institutional facility among Managed LTSS (MLTSS) plan members age 18 and older residing in the community for at least one month. The measure is a ratio of institutional facility admissions per 1,000 enrollee months. The Workgroup member who suggested the measure for addition to the Core Sets indicated that effective LTSS programs ensure that individuals living in the community have access to the care coordination, services, and supports needed to avoid institutional admissions, and that this measure demonstrates a state's ability to provide care coordination and a community-based service infrastructure for enrollees to reside in the setting of their choice. The Workgroup discussed whether the measure potentially disincentivizes transitions to an institutional setting that may reflect appropriate care for some individuals, depending on the severity of their condition. The measure steward clarified that there is risk adjustment for the measure.

One Workgroup member raised a concern that residing in the community is defined as spending at least one day in the community in the last month, which may not reflect whether someone has actually resided in the community. Another Workgroup member commented that the measure is more "process-oriented" than an outcome and is looking at whether people who have been in the community transfer to a nursing home.

Workgroup members discussed that the measure is specified at the health plan level, excluding states that do not have managed care arrangements. In response, the Workgroup member who suggested this measure for addition acknowledged that they had recommended a corresponding measure that could be used in non-managed care settings, but that measure did not meet the technical feasibility requirement that it be tested in state Medicaid programs. Additional concerns were raised that only 24 states operate MLTSS programs, and that the measure may not reach the threshold for public reporting. Workgroup members discussed the use of this measure in plans without an integrated Medicare and Medicaid product line, where Medicaid is the payer of last resort. A Workgroup member confirmed that the eligible population is defined as having both an LTSS and a medical benefit; plans and states are allowed to exclude dually eligible beneficiaries who are not in aligned plans for Medicare and Medicaid.

The NCI-AD survey was proposed for addition to the 2021 Core Set to measure and track the experience and outcomes of older adults and individuals with physical disabilities who receive

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[42] The NCI-AD measure was recommended by the 2020 Child and Adult Core Set Annual Review Workgroup for addition to the 2020 Core Set. CMCS opted not to add the measure to the 2020 Core Set because further consultation with state partners indicated there was not enough support to add the measure.

LTSS, a population that accounted for 23 percent of Medicaid enrollment and 55 percent of Medicaid expenditures in FFY 2016. NCI-AD is a voluntary survey effort by state Medicaid, aging, and disability agencies to measure the performance of LTSS programs. The Workgroup member who suggested the measure for addition noted that 21 states are currently utilizing the measure and another three states are in the technical assistance year. The Workgroup member also noted that this measure would complement the current *National Core Indicators Survey* (NCIDDS-AD) measure that was added to the 2020 Adult Core Set and is focused on the experiences and outcomes of beneficiaries with intellectual and developmental disabilities.

In response to a question from a Workgroup member, the measure steward confirmed that the NCI-AD is an in-person survey that allows for a proxy to answer questions on behalf of the respondent, as needed, and can be adjusted to be administered to nonverbal individuals. In light of the COVID-19 pandemic, the measure steward noted that many states would prefer modalities other than an in-person survey; they are carefully considering options for other modes of data collection. Noting that NCI-AD requires states to sample a minimum of 400 respondents, the measure steward shared that many states oversample to allow them to stratify results by respondent demographics and geographic region.

Several Workgroup members spoke to the value of the NCI-AD survey tool and data, as well as the importance of capturing the experience of a broader population of LTSS beneficiaries, including older adults and those with physical disabilities. One Workgroup member described the NCI-AD as an "absolute treasure trove of information," and noted that measuring beneficiary experience with LTSS is critical.[43]

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[43] Public comments submitted on the *National Core Indicators for Aging and Disabilities* (NCI-AD) *Adult Consumer Survey* can be found in Appendix E.

Exhibit D.1. Measures Discussed by the 2021 Core Set Annual Review Workgroup and Not Recommended for Removal or Addition, by Domain

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Primary Care Access and Preventive Care			
Measures discussed and not recommended for removal from the 2021 Core Set			
Adult Body Mass Index Assessment (ABA-AD) Measure steward: NCQA	Not endorsed	Percentage of beneficiaries ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year. Data collection method: Administrative or hybrid	• Suggested for removal because of changes in the USPSTF recommendations for adult BMI screening. • May not advance quality improvement because: – the measure is topped out – it's a checkbox in the EHR – it's focused on assessment and no BMI counseling or follow-up • Advocacy to retain measure, given the prevalence of obesity among adults and use of the measure in other federal programs. • Proposed for retirement from HEDIS Measurement Year 2020.
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) Measure steward: CMS	0418/0418e	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. Data collection method: Administrative or EHR	• Suggested for removal because of concerns about the feasibility of data collection and low rates of reporting. • Limitations of administrative data to verify that screening was completed, a valid tool was used, and a follow-up plan was documented. Medical record review may be required to supplement administrative data. • Concern about removing this measure, as depression is a highly prevalent condition for adolescents that significantly impacts functioning. Screening for teenagers is also a USPSTF recommendation. • Ongoing impact of the COVID-19 pandemic has increased mental health needs, and depression screening will be important to track. • Several states are incorporating the measure into their value-based payment program, which may incentivize screening and coding in the administrative data.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD) Measure steward: CMS	0418/0418e	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. Data collection method: Administrative or EHR	• Suggested for removal due to concerns about feasibility of data collection and low rates of reporting. • Limitations of administrative data to verify that screening was completed, a valid tool was used, and a follow-up plan was documented. Medical record review may be required to supplement administrative data. • Concern about removing this measure, as depression is a highly prevalent condition for adolescents and significantly impacts functioning. • Ongoing impact of the COVID-19 pandemic has increased mental health needs and depression screening will be important to track. • Several states are incorporating the measure into their value-based payment program, which may incentivize screening and coding in the administrative data.
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD) Measure steward: NCQA	0039	Percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H Adult Medicaid Survey was completed. Data collection method: Survey	• Suggested for removal because of the cost of administering the survey, low survey response rates, and cultural variation in responses. • Because of variation in survey responses across demographic groups, rates may not be consistent across states.
Measures discussed and not recommended for addition to the 2021 Core Set			
Adult Immunization Status Measure steward: NCQA	Not endorsed	The percentage of beneficiaries 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, and pneumococcal. Note: The Medicaid rate includes beneficiaries ages 19-65 and excludes pneumococcal vaccines. Data collection method: ECDS	• Suggested to replace FVA-AD. • Measure includes more vaccines than the FVA-AD measure and would help states reduce disparities in immunization rates among Medicaid beneficiaries. • Concern that some states do not cover all the vaccines specified in the measure. • Concern about states’ ability to collect immunization information for the adult population using electronic data, including immunization registries, although there was a comment that use of this measure could continue to build the data infrastructure.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Maternal and Perinatal Health			
Measures discussed and not recommended for removal from the 2021 Core Set			
Audiological Evaluation No Later Than 3 Months of Age (AUD-CH) Measure steward: CDC	1360	Percentage of newborns who did not pass hearing screening and have an audiological diagnosis no later than 3 months of age (90 days). Data collection method: EHR	• Suggested for removal due to feasibility concerns because the measure requires EHR data. • Questions about the actionability and strategic priority of the measure, given existing protocols for screening and follow-up through public health Early Hearing Detection and Intervention (EHDI) programs. • Concern about accuracy of data maintained by public health for follow-up by managed care plans. • Comment about the importance of early intervention on childhood development and outcomes. • Discussion about potential opportunities to improve reporting and performance by partnering with EHDI programs.
PC-01: Elective Delivery (PC01-AD) Measure steward: The Joint Commission	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. Data collection method: Hybrid or EHR	• Suggested for removal due to feasibility concerns because the measure requires EHR data or medical chart reviews, and the assertion that there was little room for improvement. • Concern about feasibility of medical chart review in light of the COVID-19 pandemic. • Question about whether state-level reporting in the Core Set is the right place to measure elective deliveries rather than driving improvement at the hospital level. • Discussion about variation in elective deliveries by race, ethnicity, maternal age, and geography. • Comment that this is one of two measures in the Core Sets focused on the birth experience. • Concern about potential slippage in performance if the measure is removed from the Core Set.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measures discussed and not recommended for addition to the 2021 Core Set			
Prenatal Depression Screening and Follow-Up Measure steward: 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. Data collection method: ECDS[a]	• Suggested for addition because the health care system has struggled with depression screening and access to appropriate follow-up and this measure may drive improvement in maternal and child health. • Measure was discussed in conjunction with the Postpartum Depression Screening and Follow-up measure, which was recommended for addition. • Both measures are important for looking at the impacts of dyadic care on the family unit. • Both measures include both a screening and a follow-up component and therefore are connected to an action. • Prenatal depression is a distinct problem from postpartum depression
Care of Acute and Chronic Conditions			
Measures discussed and not recommended for removal from the 2021 Core Set			
HIV Viral Load Suppression (HVL-AD) Measure steward: 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. Data collection method: Administrative or EHR	• Suggested for removal because of barriers to obtaining viral load suppression data on Medicaid beneficiaries with HIV, including (1) confidentiality and privacy barriers in developing data-sharing agreements with public health agencies, and (2) challenges coordinating and collaborating with another agency. • Strong advocacy for retaining the measure even though it is hard to report; described as the "ultimate outcome measure." • Examples given of (1) Medicaid partnering with public health to provide Medicaid ID's to public health and obtaining aggregate data on viral load suppression, and (2) managed care plans obtaining lists of non-suppressed individuals from public health so they can engage those individuals in care. • Discussion of opportunities to share lessons learned and help states develop the partnerships, linkages, and information sharing needed to calculate the measure.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measures discussed and not recommended for addition to the 2021 Core Set			
Proportion of Days Covered: Antiretroviral Medications Measure steward: 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. Data collection method: Administrative	• Suggested to replace HVL-AD because it serves as a proxy for viral load suppression and does not present the same barriers to reporting. • Concern that the measure is not a proxy for the HVL-AD measure because it assumes medication adherence and may overestimate viral load suppression. • Discussion of evidence-based behavioral interventions that can address medication adherence, contributing to the actionability of this measure for states and managed care plans. • Included in other CMS quality reporting programs.
Prevention Quality Indicators (PQI) 92: Prevention Quality Chronic Condition Composite Measure steward: AHRQ	Not endorsed	Number of inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 population, age 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure. Data collection method: Administrative	• Suggested for addition to identify hospitalizations that might be prevented with more timely or appropriate outpatient care. • Includes conditions that are prevalent in the adult Medicaid population, such as hypertension, diabetes, and asthma. • Suggestion that data completeness is a challenge for PQI measures, as Medicaid may not have access to Medicare hospitalization data for adults age 65 and older. • Discussion of potential opportunities for collecting this data through alternate data sources, such as HCUP or T-MSIS.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Behavioral Health Care			
Measures discussed and not recommended for removal from the 2021 Core Set			
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) Measure steward: 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. Data collection method: Survey (CAHPS 5.0H Adult Medicaid Survey)	• Suggested for removal because of the cost of administering the survey, low survey response rates, and cultural variation in responses. • Because of variation in survey responses across demographic groups, rates may not be consistent across states. • Concern about removing this measure without a replacement, particularly in light of increasing rates of vaping and the COVID-19 pandemic, which has resulted in more severe illness among smokers. • Discussion about potential alternative strategies for collecting information around tobacco use and cessation.
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) Measure steward: PQA	2940	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. Data collection method: Administrative	• Suggested for removal because it measures how chronic pain is treated and does not reflect behavioral health system performance. • Discussion about how measuring opioid prescribing and misuse is crucial in responding to the opioid epidemic and how over-prescribing is associated with a number of adverse medical outcomes beyond addiction. • Comment that this is the only measure in the Core Set that makes prescribers and pharmacies accountable for overprescribing, overdispensing, and overuse of opioids.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Dental and Oral Health Services			
Measures discussed and not recommended for removal from the 2021 Core Set			
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) Measure steward: CMS	Not endorsed	Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period. Data collection method: Administrative (Form CMS-416)	• Suggested for removal because of concerns with the measure's methodology and possible duplication of effort for managed care plans reporting the Annual Dental Visit measure. • Concern that the measure has a 90-day continuous enrollment requirement and counts services over a 12-month period. Acknowledgment that an 11-month continuous eligibility requirement would increase rates but lose a lot of children in the denominator and not improve the overall quality of care for children. • Discussion about the important focus of the measure on preventive services. • Comment that there is still room for improvement on the measure at the state and national levels.
Measures discussed and not recommended for addition to the 2021 Core Set			
Annual Dental Visit Measure steward: NCQA	1388*	Percentage of patients 2-20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract. Data collection method: Administrative	• Suggested as a replacement for PDENT-CH. • Concern that the measure focuses on children's receipt of any dental service, and counts emergency care, X-rays, and treatment services. • Measure will be retired by the measure steward because of its broad focus on any dental service. • Discussions underway between CMS, NCQA, and DQA about a replacement for the measure.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults Measure steward: ADA/DQA	Not endorsed	Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 beneficiary months for adults. Data collection method: Administrative (enrollment and medical claims)	• Suggested for addition to address a gap area in the Core Sets around oral health care for adults. Would promote diverting dental care out of the emergency department through increased preventive care and treatment of acute dental issues. • Concern about the usefulness and fairness of the measure because not all states provide dental coverage for adults (35 states provide some coverage, of which 16 provide more extensive benefits). • Suggestion that the measure might be feasible for states that provide only limited emergency dental coverage and would highlight access to care. • Discussion about interventions for ED diversion and use of the measure to quantify ED utilization and potential savings that could be spent on routine dental care for adults.
Follow-Up After Emergency Department Visits for Non-Traumatic Dental Conditions in Adults Measure steward: ADA/DQA	Not endorsed	The percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the beneficiary visited a dentist within (a) 7 days and (b) 30 days of the ED visit. Data collection method: Administrative	• Suggested for addition to address a gap area in the Core Sets around oral health care for adults. Would promote diverting dental care out of the emergency department through appropriate follow-up after emergency department use. • Concern about the usefulness and fairness of the measure because not all states provide dental coverage for adults (35 states provide some coverage, of which 16 provide more extensive benefits). • States without an adult dental benefit would not have administrative data to calculate this measure.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Experience of Care			
Measures discussed and not recommended for removal from the 2021 Core Set			
Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan Survey 5.0H – Child Version (Medicaid) (CPC-CH) Measure steward: 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. Data collection method: Survey	• Suggested for removal because of the cost of administering the survey, low survey response rates, and cultural variation in responses. • Because of variation in survey responses across demographic groups, CAHPS scores may not be consistent across states. • Comment that response rates in some states are reaching single digits. May affect trending of results over time due to decreases in response rates. • Concern about leaving a gap in the Core Set related to beneficiary experience if the measure is removed.
Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan Survey 5.0H – Adult Version (Medicaid) (CPA-AD) Measure steward: 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. Data collection method: Survey	• Suggested for removal because of the cost of administering the survey, low survey response rates, and cultural variation in responses. • Because of variation in survey responses across demographic groups, CAHPS scores may not be consistent across states. • Comment that response rates in some states are reaching single digits. May affect trending of results over time due to decreases in response rates. • Concern about leaving a gap in the Core Set related to beneficiary experience if the measure is removed.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Long-Term Services and Supports (LTSS)			
Measures discussed and not recommended for addition to the 2021 Core Set			
Long-Term Services and Supports (LTSS) Admission to an Institution from the Community (MLTSS-6) Measure steward: CMS	Not endorsed	The number of admissions to an institutional facility among Managed Long-Term Services and Supports (MLTSS) plan members age 18 and older residing in the community for at least one month. The number of short-term, medium-term, or long-term admissions is reported per 1,000 enrollee months. Enrollee months reflect the total number of months each beneficiary is enrolled in the program and residing in the community for at least one day of the month. The following three rates are reported across four age groups (ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older): 1. Short-Term Stay. The rate of admissions resulting in a short-term stay (1 to 20 days) per 1,000 MLTSS enrollee months. 2. Medium-Term Stay. The rate of admissions resulting in a medium-term stay (21 to 100 days) per 1,000 MLTSS enrollee months. 3. Long-Term Stay. The rate of admissions resulting in a long-term stay (greater than or equal to 101 days) per 1,000 MLTSS enrollee months. Data collection method: Administrative	• Suggested for addition to demonstrate a state's ability to provide care coordination and a community-based service infrastructure for enrollees to reside in the setting of their choice. • Questions about whether the measure may prevent appropriate care transitions that reflect appropriate clinical treatment. • Concern that the measure’s definition of “residing in the community for at least one day of the month” does not appropriately capture the intended population. • Comment that this is a process-oriented measure rather than an outcome measure and is looking at whether people who have been in the community transfer to a nursing home. • Measure is specified at the plan level and excludes states that do not have managed care arrangements for LTSS. • Concern that only 24 states operate MLTSS programs and that the measure may not meet the threshold for public reporting. Concern also that fee-for-service LTSS programs would be left out of the measure as specified. • Note that another measure applicable to fee-for-service LTSS programs was suggested by a Workgroup member and not discussed by the Workgroup because the measure had not been tested in state Medicaid programs.

Exhibit D.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
National Core Indicators for Aging and Disabilities (NCI-AD) Adult Consumer Survey Measure steward: ADvancing States, HSRI	Not endorsed	NCI-AD is a voluntary effort by state Medicaid, aging, and disability agencies to measure and track the performance of their long-term services and supports programs. The core indicators are standard measures used across states to assess the outcomes of publicly funded services provided to older adults and adults with physical disabilities. Indicators address 18 areas: (1) service coordination, (2) rights and respect, (3) community participation, (4) choice and control, (5) health care, (6) safety, (7) relationships, (8) satisfaction, (9) care coordination, (10) access to community, (11) access to needed equipment, (12) wellness, (13) medications, (14) self-direction, (15) work, (16) everyday living, (17) affordability, and (18) person-centered planning. Data collection method: Survey	• Suggested for addition to measure and track the experience and outcomes of older adults and individuals with physical disabilities who receive LTSS, including those who may be nonverbal. • Comment that measure is focused on the unique and complex needs of older adults and people with disabilities who receive LTSS. This population accounted for 23 percent of Medicaid enrollment and 55 percent of Medicaid expenditures in FFY 2016. • Sixteen states collected data from 2018 to 2019, which is the most recent year for which data collection is complete. A total of 28 states have ever conducted the survey. • Discussion about the in-person mode of data collection, especially in light of the COVID-19 pandemic. States have indicated they would prefer other modalities in addition to in-person surveys; the measure steward is carefully considering other options. • Considered a valuable resource for capturing the experience of a broader population of LTSS beneficiaries, including older adults and those with physical disabilities. Noted that the measure would complement the NCI in-person survey measure added to the 2020 Adult Core Set.

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Appendix E:
Public Comments on the Draft Report

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The draft report was available for public review and comment from July 10, 2020 through August 10, 2020 at 8 p.m. Eastern Time, and stakeholders were invited to submit comments via email. Mathematica received a total of 47 public comments. Commenters included state and federal agencies, professional associations, stakeholder organizations, academic institutions, research firms, health plans, and individuals. Mathematica appreciates the time and effort taken by commenters to prepare and submit their comments on the draft report.

Exhibit E.1 categorizes the public comments received on the draft report by the following topics: general comments, measures recommended for removal from or addition to the Core Sets, measures considered but not recommended for removal or addition, and gap areas. Many comments addressed more than one topic, and commenters are listed under each applicable subject area. The verbatim public comments are included after the exhibit, organized in alphabetical order by commenter name (agency/organization or individual last name).

In summary, public comments were submitted on the one measure the Workgroup recommended for removal and the three measures recommended for addition. Comments were also received on nine measures considered by the Workgroup, but not recommended for removal from or addition to the 2021 Core Sets. The majority of comments received were related to maternal and perinatal health measures.

Exhibit E.1. Summary of Public Comments by Topic and Commenter

Topic	Commenter
General Comments	• American Academy of Pediatrics • Arizona Health Care Cost Containment System • Association for Community Affiliated Plans • Novo Nordisk • Ohio Commission on Minority Health
Measure Recommended for Removal from the Adult Core Set	
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)	• Association for Community Affiliated Plans • Connecticut Department of Social Services
Measures Recommended for Addition to the 2021 Core Sets	
Postpartum Depression Screening and Follow-Up	• 2020 Mom • American Academy of Pediatrics • Arizona Health Care Cost Containment System • Association for Community Affiliated Plans • Colorado Children's Campaign • Connecticut Department of Social Services • District of Columbia Department of Health Care Finance • Elevate Policy Lab, Yale School of Medicine • Heart of Lynchburg Midwifery • Jefferson College of Nursing • Lifeline4Moms Center • Los Angeles County Department of Mental Health • Massachusetts Executive Office of Health and Human Services • Maternal and Child Health Program, Denver Public Health • Maternal Mental Health Leadership Alliance • Melissa L. James • Moms Mental Health Initiative • MomsWell • North American Society for Psychosocial Obstetrics and Gynecology • Pacific Business Group on Health • Perigee Fund • Perinatal Support Washington • Postpartum Resource Center of New York • Texans Care for Children • The Greater Good of Northeast Indiana • The Periscope Project, Medical College of Wisconsin • University of Vermont Medical Center • University of Washington Maternal-Child Mental Health • University of Washington Medicine • University of Washington, School of Social Work • Washington Chapter of the American Academy of Pediatrics • Washington State Health Care Authority

Exhibit E.1 *(continued)*

Topic	Commenter
Measures Recommended for Addition to the 2021 Core Sets	
Prenatal Immunization Status	• Adult Vaccine Access Coalition • American Immunization Registry Association • Arizona Health Care Cost Containment System • Association for Community Affiliated Plans • Association of Immunization Managers • California Immunization Coalition • Connecticut Department of Social Services • District of Columbia Department of Health Care Finance • Massachusetts Executive Office of Health and Human Services
Sealant Receipt on Permanent 1st Molars	• American Academy of Pediatrics • Arcora Foundation • Association for Community Affiliated Plans • Dental Quality Alliance • District of Columbia Department of Health Care Finance
Measures Considered and Not Recommended for Removal by Domain	
Primary Care Access and Preventive Care Domain	• American Immunization Registry Association • Novo Nordisk
Care of Acute and Chronic Conditions Domain	• National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention
Measures Considered and Not Recommended for Addition by Domain	
Primary Care Access and Preventive Care Domain	• Adult Vaccine Access Coalition • American Immunization Registry Association
Maternal and Perinatal Health Domain	• 2020 Mom • Cynthia Battle • Elevate Policy Lab, Yale School of Medicine • Heart of Lynchburg Midwifery • Jefferson College of Nursing • Lifeline4Moms Center • Maternal Mental Health Leadership Alliance • Melissa L. James • Moms Mental Health Initiative • MomsWell • North American Society for Psychosocial Obstetrics and Gynecology • Perigee Fund • Perinatal Support Washington • Postpartum Resource Center of New York • The Greater Good of Northeast Indiana • The Periscope Project, Medical College of Wisconsin • University of Vermont Medical Center • University of Washington Maternal-Child Mental Health • University of Washington, School of Social Work

Exhibit E.1 *(continued)*

Topic	Commenter
Measures Considered and Not Recommended for Addition by Domain	
Care of Acute and Chronic Conditions Domain	• National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention
Dental and Oral Health Services Domain	• Arcora Foundation • Dental Quality Alliance
Long Term Services and Supports Domain	• Lowell Arye • Disability and Aging Collaborative
Gap Areas	• Adult Vaccine Access Coalition • American Academy of Pediatrics • University of Massachusetts Medical School Baystate • Lowell Arye • California Colorectal Cancer Coalition • Dental Quality Alliance • Disability and Aging Collaborative • Novo Nordisk • Ohio Commission on Minority Health

Public Comments Listed Alphabetically by Agency/Organization Name or Individual Commenter's Last Name

2020 Mom (Alice Lu)

The undersigned organizations, which represent the nearly four million women who deliver each year, and the providers who serve them, are writing to support the committee's recommendation to adopt the NCQA Postpartum Depression Screening and Follow-Up measure and also to urge you to adopt the prenatal depression screening measure.

As the committee is aware, maternal depression has significant consequences for women, their infants and families. Postpartum depression hinders infant attachment and bonding and can lead to developmental disorders that last into adolescence and beyond (Field, 2010; Kingston, 2012; Dawson, 1999). During infancy, important caregiving activities such as breastfeeding, sleep, adherence to well child visits and vaccine schedules can be compromised in depressed mothers (Field, 2010; Gregory, 2015; Minkovitz, 2005).

Further, research has demonstrated up to 17% of women will suffer from prenatal depression (Pearson, 2019). Women with untreated depression during pregnancy are at risk of developing severe postpartum depression and suicidality, and of delivering premature or low birthweight babies (Chan, 2014).

Depression during pregnancy can result in alterations to the DNA of the developing fetus. In this case, the mother transmits the trauma and stress of the psychological condition that she is experiencing into the biology of her offspring. Therefore, decreasing the rates of fetal exposure to prenatal depression or anxiety is essential in protecting the next generation. (Van den Bergh, 2004; Wadhwa, 1993; Field, 2003; Field, 2004)

Because of this compelling research, and because prenatal screening helps raise awareness of maternal depression including postpartum depression, we urge you to adopt both of the maternal depression measures developed by NCQA:

- Prenatal Depression Screening and Follow-Up
- Postpartum Depression Screening and Follow-Up

Sincerely,

2020 Mom

Academy of Lactation Policy and Practice

American Academy of Nursing

American Association for Psychoanalysis in Clinical Social Work

American Association of Birth Centers

American Association of Suicidology
American College of Nurse-Midwives
American Foundation for Suicide Prevention
American Medical Women's Association
Anxiety and Depression Association of America
Aspen Health and Wellness, LLC
Association for Ambulatory Behavioral Healthcare
Association of Women's Health and Neonatal Nursing of California
California Nurse-Midwives Association
Cherished Mom
Clarity Counseling
Commission for the Accreditation of Birth Centers
Didi Hirsch Mental Health Services
Doula At Your Cervix
Every Mother Counts
First 5 Association of CA
Foundation for the Advancement of Midwifery
Global Alliance for Behavioral Health and Social Justice
HealthNet
Healthy Children Project, Inc.
Healthy Mothers, Healthy Babies - the Montana Coalition
International OCD Foundation
International Society of Psychiatric-Mental Health Nurses (ISPN)
Jewish Healthcare Foundation
Johns Hopkins Women's Mood Disorders Center
Lamaze International
Lifeline4Moms Center at the University of Massachusetts Medical School
Mamatoto Village Inc
March of Dimes
Maternal and Child Health Access
Maternal Mental Health Leadership Alliance
MomsRising
National Alliance on Mental Illness

National Association for Rural Mental Health
National Association of Nurse Practitioners in Women's Health
National Association of Social Workers (NASW) California Chapter
National Birth Equity Collaborative
National Center for Youth Law
National Eating Disorders Association
National Federation of Families for Children' Mental Health
National Partnership for Women & Families
North American Society for Psychosocial Obstetrics and Gynecology (NASPOG)
Perinatal Support Washington
Postpartum Health Alliance
Postpartum Resource Center of New York
Postpartum Support International
Preeclampsia Foundation
Return to Zero: HOPE
Run Tell Mom LLC
Society for Maternal-Fetal Medicine
Supporting Mamas
The California Children's Trust
The Children's Partnership
The National Alliance to Advance Adolescent Health
The Tatia Oden French Memorial Foundation
University of Washington Maternal-Child Health Program
Utah Association for Infant Mental Health
Women and Girls Foundation

Adult Vaccine Access Coalition (Abby Bownas)

The Adult Vaccine Access Coalition (AVAC) appreciates the opportunity to comment on Mathematica's Annual Review of the Child and Adult Core Sets of Quality Measures for Medicaid and CHIP. We appreciate the Workgroup's interest in identifying gaps in existing quality measures and strengthening and improving the Core Sets. AVAC recognizes the importance of quality measures to improve the health of individuals and entire communities. As such, we encourage the Workgroup to take a focused, concerted approach to adult immunizations as a means of improving population health as well as the overall health of Medicaid patients. In our below comments, AVAC:

- Commends the workgroup for inclusion of the Prenatal Immunization Status Measure.
- Encourages the workgroup to reconsider inclusion of Adult Immunization Status Measure.

AVAC consists of nearly 60 organizational leaders in health and public health that are committed to addressing the range of barriers to adult immunization and to raising awareness of the importance of adult immunization. AVAC works towards common legislative and regulatory solutions that will strengthen and enhance access to adult immunization across the health care system. Our priorities and objectives are driven by a consensus process with the goal of enabling the range of stakeholders to have a voice in the effort to improve access and utilization of adult immunizations.

Prenatal Immunization Status Measure

AVAC applauds the Workgroup for recommending inclusion of the prenatal immunization status measure, which includes influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations. Maternal and perinatal health has been identified in prior reviews as an area to strengthen in the quality measure sets. The Prenatal Immunization Status measure will help to address substantial disparities in prenatal immunization rates.

Integrating immunization assessment as will occur through adoption of these measures have been found to improve the likelihood of a patient being immunized at provider encounters. Immunizing mothers during their third trimester protects 9 in 10 babies from pertussis infections serious enough to need treatment in a hospital.[1] Currently, prenatal immunization levels are lower among Medicaid members compared to privately insured women. Getting a flu shot reduces a pregnant woman's risk of hospitalization by 40% and helps protect the newborn before he/she is old enough to be vaccinated.

We appreciated that workgroup members discussed states' access to the data source to implement the measure. The National Committee for Quality Assurance (NCQA) tested the prenatal measures in Medicaid and commercial health plans, concluding that they are feasible to implement. State Immunization Information Systems (IIS) are widely used as a trusted source of immunization data for state Medicaid programs. Utilizing IIS data can improve the completeness and accuracy of immunization records in the Medicaid program. According to the 2019 AIM Annual Survey and follow-up calls, at least 37 states (74%) share data between IIS and their state Medicaid agency, and/or the state Medicaid agency uses IIS data for Medicaid reporting. Adding the prenatal immunization measure will further support collaboration between state Medicaid agencies and IIS.

Moreover, adoption of this measure illustrates the recognition of the importance of adult immunization in protecting health and the preventing disease in this medically vulnerable group.[2] It provides useful and actionable results for state Medicaid and CHIP programs, especially if they publicly post results and require reporting by Medicaid managed care plans. Such performance assessment and feedback can drive quality improvement efforts to raise immunization coverage rates among the prenatal population.

Adult Immunization Status Measure

AVAC recommends that the Workgroup reassess their conclusion around the Adult Immunization Status Measure (AIS). The AIS measure is a composite of several age-recommended vaccines for adults, including influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal. The HHS Office of Infectious Disease and HIV/AIDS Policy (OIDP) and the Centers for Disease Control and Prevention (CDC) in collaboration with the National Adult Immunization and Influenza Summit Quality Working group were instrumental in spearheading the development and testing of a the AIS measure. The AIS would provide a sound, reliable and comprehensive means to assess the receipt of routine adult vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP).

Many adult patients are not being assessed and offered important ACIP-recommended vaccines, resulting in poor adult immunization coverage rates nationally.[3] Despite the clear harm from influenza, as witnessed during the 2017-2018 influenza season, immunization coverage rates continue to lag behind Healthy People 2020 goals.[4] While the benefits of pneumococcal vaccination of adults with certain chronic high-risk conditions are well documented, only about 20% of these persons are vaccinated. Adults over the age of 65 are especially vulnerable to complications from vaccine preventable diseases and thus are recommended for vaccinations including influenza, pneumococcal, and zoster. Unfortunately, even in this most vulnerable population, vaccination coverage rates are below national goals.

Adoption of an AIS measure would put vaccination coverage rates into a larger context and encourage a more systematic approach for all vaccines. In the Value and Imperative of Quality Measures for Adult Vaccines, renowned vaccine experts explain how quality measures that capture and create incentives for appropriate adult vaccinations can prevent illness and death, reduce caregiving demands, avoid unnecessary healthcare spending, and set the foundation for healthy aging.[5] There is evidence that a composite measure of the adult immunization schedule, such as those demonstrated by the Northwest Tribal Epidemiology Center and by the National Nursing Home Quality Care Collaborative, can improve patient health outcomes.[6]

We understand that the Workgroup expressed concerns with states' ability to accurately and reliably collect immunization information for the adult population. The measures draw from Electronic Clinical Data Systems (ECDS), which include immunization information systems (IIS), case management registries, claims, and electronic health records (EHRs). We understand that while state Medicaid and CHIP programs can access member claims, encounters, and the corresponding state/local Immunization IIS, it may be more of a challenge for many state Medicaid agencies to capture EHR data. Therefore, states could choose to assess different models of data capture, such as encouraging providers to report to a community, regional or state-based health information exchange, in order to build capacity for measures that rely on electronic clinical information. The National Committee for Quality Assurance (NCQA) tested the AIS in Medicaid and commercial health plans, concluding that while the specifications are new and innovative, they are feasible to implement.

We appreciate the Workgroup noting for future discussion the importance of understanding the immunization status of Medicaid enrollees overall and with a potential vaccine for COVID-19, including the use of immunization information systems to address the feasibility of collecting population-based immunization data. In the past, Workgroup members representing state Medicaid programs expressed their commitment to establishing the infrastructure by which to report these new data sources. With the potential vaccine for COVID-19, it is more important than ever to strengthen data capture through immunization information systems.

Potential Gap Areas for Future Core Set Measures

We appreciate the draft Workgroup report noted gaps in terms of immunization quality measures, particularly with regard to the over 65 population. Significant racial and ethnic disparities currently exist in adult immunization[7] coverage rates across the life course. The failure to improve these rates among the Medicaid population only exacerbates these disparities. Opportunities to assess the immunization status of Medicaid beneficiaries, particularly Medicare age, and medically vulnerable adults with chronic conditions such as diabetes and heart disease, should be done by the range of clinicians who care for them, including primary care and specialty providers. Taking advantage of each and every patient encounter to facilitate counseling and education on vaccines, based on their age and health status, and to offer a strong provider recommendation have been found to improve the likelihood of a patient being immunized.

Published literature indicates that integrating immunization assessment and additional providers offering these critical preventive services will result in greater opportunities for immunization.[8] The National Vaccine Advisory Committee's (NVAC) Adult Immunization Standards call for all providers caring for adult patients to assess, recommend, vaccinate or refer, and document vaccinations. Immunization quality measures are a crucial tool for health care quality improvement and have demonstrated effectiveness in improving immunization coverage across adult populations. Quality measures, such as the adult immunization status measure and the prenatal immunization status measure can help to fill gaps while eliminating disparities around adult immunization moving forward.

Again, thank you for the opportunity to share our perspective on this draft report. AVAC looks forward to working with Mathematica on this important endeavor. Please contact an AVAC Coalition Manager if you wish to further discuss our comments. To learn more about the work of AVAC visit www.adultvaccinesnow.org.

Citations

[1] https://www.cdc.gov/pertussis/pregnant/mom/vacc-effectiveness.html.

[2] https://www.ncqa.org/news/ncqa-updates-quality-measures-for-hedis-2019/.

[3] National Vaccine Advisory Committee. 2014. Public Health Rep. 2014 Mar-Apr; 129(2): 115–123.

[4] https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases/objectives.

[5] https://dev-adultvaccinesnow.pantheonsite.io/wp-content/uploads/2016/07/AVN-White-Paper-FINAL.pdf.

[6] https://www.hhs.gov/sites/default/files/tab_10.05_weiser_adult_iz_composite-measures.pdf.

[7] Williams, W.W. et al. MMWR Surveillance Summary 2017;66(11):1–28.

[8] Quilici et al. "Role of vaccination in economic growth." J Mark Access Health Policy; (2015) 3:10.3402/jmahp.v3.27044.

American Academy of Pediatrics (Sara H. Goza)

The American Academy of Pediatrics (AAP) is pleased to have the opportunity to comment on the draft report of the 2021 Child and Adult Core Set Review Workgroup. The AAP and its over 67,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists applaud the efforts to review and update the Child and Adult Core Sets each year and especially as states prepare for mandatory reporting on the Child Core Set measures in 2024.

The Academy supports the workgroup recommendations related to the Child Core Set measures as outlined in the draft report and would like to provide the following feedback.

Postpartum Depression Screening and Follow-Up

Maternal depression can have a lasting impact on a child's health and well-being if left untreated. When parents are depressed it can negatively impact a child's development, impede their ability to learn, and have effects that can last into adulthood. Professional recommendations from the AAP, the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Family Practitioners (AAFP) endorsed screening. The Fourth Edition of Bright Futures (2017) recommends that pediatricians screen for maternal perinatal depression at four well care visits in the first six months of life, and ACOG now recommends routine antenatal screening for depression. As such, it is important to maintain billing practices that allow for pediatricians to bill appropriately for depression screening of the child's caregiver.

Sealant Receipt on Permanent 1st Molars

The likelihood of developing pit and fissure decay begins early in life, so children and teenagers are clear candidates for dental sealants. In accordance with Bright Futures recommendations, pediatricians are encouraged to refer children to a dentist so that a dental home can be established by one year of age. Children at high risk should be referred as early as six months of age and no later than six months after the first tooth erupts or 12 months of age (whichever comes first). The Academy would like to stress the importance of this measure centering on dentists and the dental community as they are eligible to apply dental sealants.

Additionally, the COVID-19 pandemic continues to highlight the significant health disparities, inclusive of children and adults served by Medicaid and CHIP programs. While the healthcare delivery system and Medicaid/CHIP programs have rapidly adjusted to support access to quality care through innovations such as expanded telehealth, it is likely that some if not all metrics will demonstrate widening disparities.

Metrics which focus on system improvements to improve outcomes, e.g. developmental/mental health screening, referrals and follow-up metrics, will become increasingly important for states to monitor and best support equitable health care delivery. Addressing gaps in health literacy through measures may further support states in addressing health disparities.

Thank you again for the opportunity to comment. Please do not hesitate to contact Cathleen Guch, Senior Manager Quality Improvement and Certification Initiatives, with any questions on these comments.

References

[1] Earls MF; Committee on Psychosocial Aspects of Child and Family Health, American Academy of Pediatrics. Clinical report: Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. Pediatrics 2010;126(5):1032–1039.

[2] American College of Obstetricians and Gynecologists. Screening for perinatal depression. Committee Opinion No. 630. Obstet Gynecol. 2015;125(5):1268–1271.

[3] Lanagan RC and Goodbred AJ. Identification and Management of Peripartum Depression. Am Fam Physician. 2016 May 15;93(10):852-858.

[4] Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017.

American Immunization Registry Association (Rebecca Coyle)

On behalf of the American Immunization Registry Association (AIRA), we thank you for the opportunity to submit comments on the immunization measures included as part of the *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP* draft report.

The American Immunization Registry Association (AIRA) is a national membership organization that promotes the development and implementation of immunization information systems (IIS) as an important tool in preventing and controlling vaccine-preventable diseases. These comments are a compilation of the input of our members, representing a community of almost 700 members and 80 public health organizations.

Immunization information systems (IIS), previously known as immunization registries, are confidential, population-based, computerized databases that record all immunization doses administered by participating providers to persons residing within a given geopolitical area. At the point of clinical care, an IIS can provide consolidated immunization records and a forecast for immunizations due for use by a vaccination provider in determining appropriate client vaccinations. At the population level, an IIS provides aggregate data on vaccinations for use in surveillance, quality improvement and program operations, and in guiding public health action with the goals of improving vaccination rates and reducing vaccine-preventable disease.

Diseases that are vaccine-preventable and are backed by vaccination recommendations from the Advisory Committee for Immunization Practices (ACIP) (e.g. influenza, pneumococcal, Tdap, and zoster) continue to cause preventable and unnecessary morbidity and mortality among adults. Disparities in coverage for individuals on Medicaid compared to those on private insurance continue to demonstrate the need for improvements in vaccination among those with public insurance. COVID-19 has also heighted the awareness of vaccination and the need for assessing vaccination coverage for all ages, particularly adults.

AIRA would like to emphasize the importance of using the IIS to contribute to more complete, quality vaccination data among adults to inform efforts to improve vaccine uptake, access and delivery. Composite measures put in place for childhood immunization status have helped to make great strides in vaccination coverage, and we expect a similar pattern for adults.

Along with partners such as the Association of Immunization Managers and the Adult Vaccine Access Coalition, AIRA strongly supports the April 28, 2020 Workgroup decision to add the Prenatal Immunization Status measure (PRS) to the 2021 Core Set.

Additionally, while the Adult Immunization Status (AIS) was not recommended at this time, AIRA strongly encourages the continued discussion and consideration of the AIS. The vote was very close, some states have already adopted the measure, and workgroup discussion also reflected briefly in the draft report demonstrated a commitment to further exploring states' readiness and advancing progress to support the AIS in the future. AIRA supports the decision to NOT remove the Flu Vaccinations for Adults (FVA-AD) measure for reasons discussed at the Workgroup meeting and reflected in the Mathematica report, including that this would leave a gap in measuring adult vaccination until the AIS is potentially added to the Core Set in the future.

Support for the Prenatal and Adult Immunization measures and the importance of using IIS to contribute to measurement

According to the 2019 Association of Immunization Managers (AIM) Annual Survey and additional state outreach, at least 37 states (74%) indicated they share data between the IIS and their state Medicaid agency and/or the state Medicaid agency uses IIS data for Medicaid reporting.[1] Some states are calculating coverage rates for pregnant women and adults on Medicaid demonstrating the feasibility of utilizing available data to report on the measures.

Opportunities to capture adult vaccination data are increasing with broader adoption of interoperable electronic health record systems, and significant progress has been made related to the numbers of adults represented in IIS. In 2018, 56% of adults were represented in an IIS[2], compared to only 25 percent or less in 2010. At least 18 states and jurisdictions capture between 75% and 95% of adults further demonstrating progress. The percent participation among children improved from 82% in 2010 to 95% in 2018. As states prepare for the rollout of an anticipated COVID-19 vaccination campaign, they are placing greater emphasis on efforts to improve the adult participation in their IIS which should improve its use for all vaccines for adults.

Thanks to recent legislative changes in two states, all IIS are now able to capture lifespan vaccination data. It takes time to capture comprehensive longitudinal data for a full population and taking steps today will help ensure we achieve the progress we've made for children and continue to build upon important immunization infrastructure.

The old adage, "what gets measured gets done", is extremely applicable in efforts to help to reduce the burden of vaccine-preventable diseases among adults. AIRA greatly appreciates your efforts to formalize more accurate measurement of immunization status for adults. Please contact Liz Abbott, AIRA's Adult Program Manager with any questions.

Citations

[1] https://cdn.ymaws.com/www.immunizationmanagers.org/resource/resmgr/publications/Using_IIS_to_Assess_IZ_in_Me.pdf.

[2] 2019 and 2020 data should reflect an increase in this percent when the data is made available by CDC.

Arcora Foundation (Alia Katabi)

I would like to thank the Mathematica Core Set Review Team for the opportunity to provide feedback on the 2021 Child and Adult Core Set Annual Review report. Arcora Foundation would like to express its' support to the revision proposed to the 2021 Child and Adult Core Set dental/oral health service's measures as detailed below:

- Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH): Replacing this measure with Sealant Receipt on Permanent 1st Molars will address the limitations of the exiting SEAL-CH measure and will provide an alternative to better track progress towards sealing all molars by age 10.
- Ambulatory Care Sensitive Emergency Department (ED) Visits for Non-Traumatic Dental Conditions and Follow-Up after ED Visits in Adults: The addition of both measures will close an existing gap in the current Core Sets around oral health care for adults. They will provide support needed to track progress in diverting dental care out of the emergency department through increased preventive care and appropriate follow-up after ED visits.

Finally, I would like to bring to your attention that I noticed an error in one of the exhibits in the report. In Exhibit D.1 on page 90, the measure description and data collection method associated with the PDENT-CH measure does not provide the correct information for this measure. It describes number of emergency department (ED) visits for caries-related reasons instead of preventive dental services.

Thank you for the opportunity to submit our feedback.

Arizona Health Care Cost Containment System (Lindsey Irelan)

Arizona requests that when implementing new measures with new calculation methodology (i.e., Electronic Clinical Data System [ECDS]), CMS will not require mandatory reporting for these measures and that the measures will be voluntary until States are able to implement the ECDS framework.

Lowell Arye

I am writing to express disappointment and opposition to the Workgroup's decision not to recommend inclusion of the National Core Indicators for Aging and Disability (NCI-AD) into the LTSS domain of the Adult Core Set for 2021. It is difficult for me to understand how a measurement could be recommended in one year by the Workgroup (but not approved by CMS for inclusion in the Core Set) and then not be recommended by the Workgroup the following year. The decision this year was made despite articulation by many Workgroup members that there is a clear gap in the LTSS domain; one that the NCI-AD can successfully fill. In the comments below, I will explain why I believe the NCI-AD should be included in the Core Set.

I do wish to acknowledge the fine facilitation of Mathematica staff of the Workgroup. I have worked with and been associated with Mathematica since around 1989, serving as a Project Officer in ASPE, USDHHS for a Mathematica project and have always found them to be most professional and thorough. This year's work continued that tradition. The draft final report acknowledges and provides specificity of the gap areas in the LTSS domain and that is truly appreciated by this author. But the dissent below is also based upon the summarized discussions of the Workgroup. You will find similar words such as "person-centered care" and "measures that correspond across both managed care and the fee-for-service LTSS programs and that have been tested in both systems".

During the 2020 Child and Adult Core Set Annual Review (2019), the Workgroup recommended to CMS for the first time two measurements for the LTSS domain: 1) the National Core Indicators (NCI) which examines outcomes for people with intellectual and developmental disabilities (I/DD), and 2) the National Core Indicators for Aging and Disability (NCI-AD) which examines outcomes for seniors and people with physical disabilities. A decision was made by CMS that only the NCI be included in 2020 Core Set. It was not made clear why CMS made that decision, other than a reference from Mathematica that 25 states needed to use the measurement in order to qualify for inclusion in the Core Set, which the NCI-AD did not meet. It is this author's understanding that there is a 25-state threshold for the Medicaid and CHIP Scorecard. It is interesting to note that in the 2020 Adult Core Set nine other measurements are used by less than 25 states (a few measurements are used by eight or less states) and three measurements in the Child Core Set (two of which are used by three states). Six of the Adult measurements not meeting the 25-state threshold were proposed for removal during the 2021 Workgroup meeting but only one was recommended for removal. In addition, of the three measurements recommended for addition by the Workgroup this year, two of them do not meet the 25-state threshold. Specifically, in the prenatal immunization measurement, Mathematica estimates that at least 10 states used immunization information systems data and a Workgroup member noted that multiple states (citing six states) measure or calculate prenatal immunization levels for Medicaid. In the post partum depression measurement NCQA has tested it in three states at the health plan level and in two states at the provider level. One state is requiring its Medicaid health plans to report the measure beginning in 2020. It would be useful to know why CMS and the Workgroup have decided to set a higher bar for the LTSS domain than for other domains in the Core Set. As an aside, as a Workgroup member, I believe it would be helpful in the future for CMS to open up a dialogue with the Workgroup when it does not approve of the Workgroup's recommendation. This will assist the Workgroup in understanding CMS' decision-making.

In order to express why LTSS is so important to Medicaid and justify the inclusion of LTSS-related measurements in the Core Set, I wish to reiterate what was stated during this year's Workgroup deliberations: Seniors comprise 7% of beneficiaries and approximately 16% of total Medicaid expenditures. People with disabilities comprise 15% of beneficiaries and 39% of total Medicaid expenditures. According to a 2018 ASPE paper written by RTI International, LTSS users represent a substantial proportion of Medicaid benefit spending (41.8%). In sum, more than 30% of all Medicaid expenditures are for LTSS, and seniors and people with physical disabilities comprise 61% of that total cost. In contrast, people with I/DD comprise approximately 28% of LTSS expenditures and people with severe mental illness or serious emotional disturbance and other populations comprise about 11% of LTSS expenditures. Given this, it is interesting to note that more than 18% of total Medicaid expenditures (i.e., LTSS for seniors and people with physical disabilities) have no measurements included in the Core Set. I respectfully suggest that we can and should do better.

All would agree that states need reliable measures to assess the quality of Medicaid home and community-based services (HCBS) settings and identify areas for improvement. Some have suggested that one of the most important outcomes is the extent to which the system is shifting the balance between the share of spending and use of services delivered in HCBS relative to institutional care. To that end, CMS is exploring the potential to test the scientific validity and reliability of the quality measure called the New Medicaid LTSS Beneficiaries Using HCBS First, (November 2019) which examines the percentage of new Medicaid aged or disabled LTSS users first receiving services in the community. Many would argue that rather than such a process-oriented measure a more important and useful indicator to have is a valid outcome measurement which is person-centered, includes examination of choice and decision-making, community participation, and experience of care; all of which are included in the NCI-AD. Furthermore, the New Medicaid LTSS Beneficiary Using HCBS First measure was used in the 2017 AARP LTSS Scorecard, but the data for the measure were from the year 2012. National and state-level HCBS use changed significantly over those five years, meaning that the measure did not provide timely data that can be used by state program managers and decision makers to improve performance. Although understanding the shift of balance from institutional care to HCBS is important, it does not fully explore how well individuals are being served by the HCBS or within institutional services. As a case example, New Jersey quickly shifted the balance in LTSS by moving to Managed LTSS (MLTSS) in July 2014. On that date, 29.4% of services were provided through HCBS (NJ DMAHS data) the remainder in nursing homes. In the fourth year of the program (2018) at least 50% of individuals were receiving HCBS and by October 2019, 55.3% of LTSS population were receiving HCBS. But the 2017 AARP LTSS Scorecard measurement for New Medicaid LTSS Beneficiary Using HCBS First measure for New Jersey reports 48.9% (2012 data year) and Percent of Medicaid and State-funded LTSS spending going to HCBS for seniors and people with disabilities of 18.3% (2014) Despite discrepancies in data between NJ DMAHS and the AARP Scorecard, the Scorecard data was and is not fully useful for State Officials. New Jersey began planning for the NCI-AD in October 2014, (3 months after the move to MLTSS). New Jersey over-sampled so that each managed care organization could be tracked for people being served in HCBS and nursing homes under MLTSS, as well as individuals remaining in fee-for-service nursing homes, and PACE (individual participants selected for NCI-AD survey must have been receiving LTSS services for a minimum of six months and still enrolled in LTSS as of May 2015). A report was issued in November 2016 with valid and reliable person-reported data, about the impact of the move to MLTSS for individuals receiving HCBS as well as how individuals who remained in fee for service nursing homes were fairing on the quality of life and outcomes of seniors and adults with physical disabilities.

During this year's Workgroup's discussion about gaps in the LTSS domain, as well during the later recap and future directions discussion, members expressed that there is a gap in LTSS process and person-centered outcome measurements. Specifically, members expressed that it is important to have LTSS measurements which explore specific individual experiences and determine whether the services are providing quality of life/care for the individual. Members also expressed the need for measurements which explored social determinants of health. In addition, concerns were raised that some measurement could not be used in both Managed Long Term Services and Supports (MLTSS) and Fee-for Service (FFS). One member discussed that there were no measurements with the integration of physical and behavioral health care. Given that 24 states have integrated physical and LTSS through MLTSS (with many also integrating behavioral health), it is unfortunate that there is no measurement being recommended which would explore this issue for LTSS.

As a former Deputy Commissioner for the New Jersey Department of Human Services (2012-2016) with responsibilities that included leading the planning, development, and implementation of MLTSS, I can personally speak to the desire by state officials responsible for aging and disability agencies to have valid, reliable, and quantifiable data on the performance of their publicly funded programs for older adults and individuals with physical disabilities, including those under Medicaid, the Older Americans Act, and PACE. In 2012, in recognition of these needs, ADvancing States (then called NASUAD) joined with HSRI (the measurement steward for the NCI) to begin a two-year planning and development effort, including input from state aging and disability executives, to realign the initial indicator measurements used in the NCI for people with I/DD to aging and disability. This culminated in the official launching of the NCI-AD in mid-2015 with 13 participating states. As discussed earlier with the case example from New Jersey, within 18 months of the technical assistance to begin the survey (and in less than 2 ½ years after MLTSS implementation), the State received important program data from the NCI-AD.

The NCI-AD measures and tracks states' Medicaid, aging, and disability agencies' performance, and can crosswalk/evaluate system-wide compliance across the majority of the new HCBS setting expectations laid out in the HCBS Settings regulation. It provides an important value proposition to the field of aging and disability services through indicators and outcomes that assess quality of life, community integration, and person-centered services. The NCI-AD helps address long-recognized gaps in assessing outcomes in LTSS systems (HCBS and institutional) that go beyond measures of health and safety to address important social, community, and person-centered goals as well as quality of life. Indicators address key areas of concern including service planning, rights, community inclusion, choice, health and care coordination, safety, and relationships. For example, the NCI-AD Survey instrument includes a Background Information section, which gathers demographic and service-related data about the consumer from agency records, and an In-Person Survey, which includes subjective satisfaction-related questions that can only be answered by the consumer as well as objective questions that can be answered by the consumer or, if needed, by their proxy.

Since its initial pilot in 2014, 27 states have used the NCI-AD at some time. This year (2020), 24 states are using the NCI-AD, with three of those states in the technical assistance phase. The NCI-AD is used by states in both MLTSS and FFS environments. Many of the MLTSS states have oversampled to examine and track by managed care organization. Some MLTSS states which still have FFS nursing home services are using the NCI-AD as well to keep track of both MLTSS and FFS. What states have found with the NCI-AD is basically what they and advocates found with the NCI: It is a valid and reliable evidence-based tool for tracking and trending outcomes data for individuals served within the state over a series of years, and for tracking how the state compares to its sister states nationally. This information is used to monitor performance and drive improvements in care delivery and health outcomes. Seeing as the NCI is used in 49 states and the District of Columbia, it is not beyond reach to suggest that the NCI-AD will also reach national scale, given that in just 6 years it is already used by almost half of all states.

As one can see from the discussion above, the NCI-AD accomplishes and fills the role which Workgroup members raised in the LTSS domain. The measurements are outcome based and explore specific individual experiences and determine whether the services are providing quality of life/care for the individual. The NCI-AD measurements examine social determinants of health and are able to be used in both a managed care and fee-for service environment. The NCI-AD assists states in driving improvement in care delivery and outcomes for MLTSS, FFS, providers and beneficiaries.

I respectfully suggest that the decision of the Workgroup to not recommend the addition of the NCI-AD in the Core Set to CMS is misguided and a missed opportunity to fill the gap in the LTSS domain. I also respectfully request that CMS consider inclusion of the NCI-AD as part of the Core Set in 2021.

Association for Community Affiliated Plans (Margaret A. Murray)

The Association for Community Affiliated Plans (ACAP) is grateful for the opportunity to submit comments on the proposed changes to the 2021 Child and Adult Core Sets. ACAP is a national association of 77 not-for profit health plans. Collectively, ACAP health plans provide coverage to 20 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicaid and CHIP as well as other publicly supported programs. Below are our responses to specific measure recommendations.

General Comments and Concerns

ACAP member plans concur with the broad criteria for assessing measures to remove from or add to the Core Measure Sets. Technical feasibility and actionability are critically important factors to our plans as they seek to accurately and reliably calculate and report measure rates and to use that information to drive quality improvement within their plans. ACAP plans also agree with considering the removal of measures that do not align with those used in other CMS programs or that will not be reportable by states in 2024 as mandated (e.g., Child Core Set measures and Adult Behavioral Health Core Set measures). ACAP plans also agree that aligning performance measures allows for more efficient and effective use of resources to support data collection, analysis, and reporting.

While ACAP supports improvements in healthcare delivery and outcomes, member plans underscored the need to develop and establish data sharing partnerships with Federal agencies, state Medicaid agencies, and other local partners prior to adding measures. This ensures completeness of data and a more accurate representation of any improvements as a result. ACAP also notes that such data sharing partnerships may be more likely to occur with the implementation of the CMS Interoperability and Patient Access Final Rule.

Proposed Measures for Removal

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (HPCMI-AD) *Support*.

Proposed Measures for Addition

Postpartum Depression Screening and Follow-Up *Support*.

Prenatal Immunization Status *Do not Support*.

While ACAP plans support, in concept, the desire to more accurately report immunization rates, they are concerned that they are not be able to access comprehensive data needed to compile accurate rates for this measure. Specifically, plans note that, in some states, immunization information systems (IIS) data are incomplete or not accessible by health plans – these data are typically supplemented from other sources beyond plan claims data, such as from schools, pharmacies, and other public health locations. State reporting on adult immunization is particularly uneven. Such incomplete data make it very difficult for some plans to aggregate those data to capture and report the full picture of immunization rates for their members. Since the IISs are a crucial data source, ACAP plans do not support the addition of this measure until such time that immunization data are more complete and more available to them to support the feasibility of producing an accurate rate for this measure.

Sealant Receipt on Permanent 1st Molars *No Comment but Concerned.*

Most ACAP plans are somewhat agnostic about a requirement that states must report this measure to CMS — in most states, dental services are carved out to be managed by the state Medicaid agency directly or through contracted dental managed care organizations. A requirement for states to report this measure would not impact most of our plans. Some of our plans that may need to comply with reporting this measure raised a technical issue: the specifications of the measure require a 48-month look-back period to determine the provision of at least one sealant and for sealants on all four molars. Given the amount of churn that Medicaid health plans experience with their enrollees, our plans voiced concern that the data necessary to produce the rate would not be available to them.

Additional Comments:

ACAP appreciates the consideration the Workgroup took to balance the feasibility of state reporting with the strategic priority for driving improvement in care delivery and health outcomes. However, in some cases, feasibility seemed to matter less that the desirability to have certain measures in the Core Sets and ACAP plans have concerns that those measure rates will not be accurate or reliable. To be clear, ACAP has long supported the mandatory reporting of Child Core Set measures and Adult Behavioral Health Core Set measures. As was referenced in the draft recommendations, any technical assistance support being considered, including building data infrastructure, to help states, and subsequently health plans, address barriers to reporting would be welcome. Such assistance can help overcome the concerning feasibility issues and help achieve desired goals.

Again, we thank you for this opportunity to comment on these important proposed modifications to the Core Set measures. Please feel free to contact me or Enrique Martinez-Vidal, Vice President for Quality and Operations, if you would like to discuss any of these issues in greater depth.

Association of Immunization Managers (Claire Hannan)

The Association of Immunization Managers (AIM) — which represents the 64 federally-funded state, local, and territorial immunization programs — appreciates this opportunity to comment on the draft Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multi-Stakeholder Review of the 2021 Child and Adult Core Sets report. AIM fully supports the 2021 child and adult core set annual review working group's recommendations to include the prenatal immunization status measure to assesses the percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations.

AIM joins other organizations, such as the National Quality Forum, the Adult Vaccine Access Coalition, and the American Immunization Registry Association, in fully endorsing the adoption of the prenatal immunization status measure. Young infants are at greatest risk of hospitalization or death from pertussis, and the Tdap vaccine is highly effective at protecting infants when administered to pregnant women during the third trimester of each pregnancy. Prenatal immunization against influenza reduces the mother's risk of hospitalization by 40% and helps protect infants that are too young to be vaccinated against influenza.[1] Adding this measure will provide Medicaid providers with clarity on why and how to implement quality improvement strategies to best protect mothers and their newborn babies from a number of serious and potentially life-threatening vaccine-preventable diseases.

Adopting the prenatal immunization measure is currently actionable for well over half of states due to their state-level immunization information systems (IIS), which are confidential, population-based, computerized databases that record all vaccine doses administered by participating providers to persons residing within a given geographical area. The immunization community has taken great strides to advance the use of IIS to collect and report quality immunization data. According to the 2019 AIM Annual Survey and follow-up calls, at least 37 states (74%) share data between IIS and their state Medicaid agency, and/or the state Medicaid agency uses IIS data for Medicaid reporting.[2] Three additional states are in the process of implementing data sharing between the IIS and state Medicaid program.

Adoption of the prenatal measure will further support collaboration between state Medicaid agencies and IIS in order to be functionally connected systems. This will become even more vital during the COVID-19 vaccination campaign as we use IIS to identify high-risk populations, track vaccine uptake, and conduct reminder/recall. Since nearly half of all pregnant women are Medicaid recipients, promoting collaboration and data sharing between state Medicaid and immunization programs including a prenatal measure will not only make an impact on routine vaccine-preventable diseases, but could make a difference in how we protect pregnant women and their newborn babies against COVID-19.

AIM supports the working group's recommendations and believes they are critical to improving prenatal influenza and Tdap vaccination rates. We should take action now to protect our most vulnerable: pregnant women and their newborn infants.

Thank you again for this opportunity to offer comments on the working group's draft Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multi-Stakeholder Review of the 2021 Child and Adult Core Sets report.

Citations

[1] https://www.cdc.gov/vitalsigns/maternal-vaccines/.

[2] https://www.immunizationmanagers.org/resource/resmgr/publications/Using_IIS_to_Assess_IZ_in_Me.pdf.

Cynthia Battle

Please consider adding a prenatal depression screen. It is very important. We need screening throughout the perinatal period — during pregnancy and postpartum, and at follow up if there was a positive screen.

Thank you for your consideration.

California Colorectal Cancer Coalition (Daniel S. Anderson)

Please add colorectal cancer screening to the 2022 CMS Medicaid Quality Core Set as you have to the Commercial and Medicare Adult Quality Core Sets. Colorectal cancer is the second leading cause of cancer deaths in the United States and California.[1] Screening is very effective in reducing mortality and it is recommended by the United States Preventive Services Task force.[2,3]

In 2019, California was considering adding colorectal cancer screening to the California Medi-Cal Managed Care Quality Set. That year, California adopted the CMS Adult and Child Quality Core Sets as their Medi-Cal Managed Care Quality Measures. In California, Medicaid screening rates are not measured. As in the rest of the country, they lag behind the Private and Medicare screening rate and are closer to the uninsured screening rate. The National Health Interview Study in 2018, found screening rates of 30% for uninsured, 54% for Medicaid, and 80% for Private and Medicare Insurance.[4] In California the screening rate is likely the same as the uninsured rate as illustrated by nearly identical rates of late stage colorectal cancer diagnosis of 70.7 in Medicaid and 70.6 in the uninsured from 2012 to 2016.

Thank you very much for considering this request to include colorectal cancer screening in your 2022 CMS Medicaid Adult Quality Core Set.

Citations

[1] https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2020/cancer-facts-and-figures-2020.pdf.

[2] Bibbins-Domingo K, Grossman DC, Curry SJ, et al; US Preventive Services Task Force. Screening for colorectal cancer: US PreventiveServices Task Force recommendation statement. JAMA. 2016;315:2564-75. [PMID: 27304597] doi:10.1001/jama.2016.5989.

[3] Lin JS, Piper MA, Perdue LA, et al. Screening for colorectal cancer: updated evidence report and systematic review for the US Preventive Services Task Force. JAMA. 2016;315:2576-94. [PMID:27305422] doi:10.1001/jama.2016.3332.

[4] Siegel RL; Kimberly D. Miller KD; et al. Colorectal Cancer Statistics, 2020. Cacancerjournal.doi: 10.3322/caac.21601.

California Immunization Coalition (Catherine Flores-Martin)

I am writing on behalf of the California Immunization Coalition in support of the inclusion of the prenatal immunization measure into CMS Child Core Set.

Disparities are prevalent

As in the U.S., California has significant disparities, with lower vaccination rates among low-income mothers. Infants born to women with Medi-Cal coverage have more than twice the risk of pertussis than those who are privately-insured. In 2019, 202 infants fell ill with pertussis in California, many required hospitalization, and one infant died.[1]

It is feasible

As an immunization community, we have taken great strides to advance the use of immunization information systems (IIS) to collect and report quality pediatric immunization data. We should take action now to extend this success to our most vulnerable: pregnant women and their newborn infants.

According to the 2019 Association of Immunization Managers (AIM) Annual Survey data and follow-up calls, at least 37 states (74%) share data between IIS and their state Medicaid agency, and/or the state Medicaid agency uses IIS data for Medicaid immunization coverage reporting. Needless to say, the systems needed to report on the prenatal measure are already in place in most states. For the slim minority where this is not the case, reporting of the prenatal measure would only help increase collaboration between state Medicaid agencies and IIS and better prepare us as a nation for what is to come.

It's needed to advance prenatal and all vaccination efforts

Adoption of the Prenatal measure will further support collaboration between state Medicaid agencies and IIS in order to be functionally connected systems. This will become even more vital during the COVID-19 vaccination efforts as we use the IIS to identify high-risk populations, track vaccine uptake and conduct reminder recall.

Since nearly half of all pregnant women are on Medicaid,[2] promoting collaboration and data sharing between state Medicaid and Immunization Programs, including a prenatal measure, will not only make an impact on routinely-recommended immunizations, put could make a difference in how we protect pregnant women and their newborn babies against COVID-19.

We urge adoption of the measure

Our organization joins the Association of Immunization Managers and other organizations like the National Quality Forum, Adult Vaccine Access Coalition, and the American Immunization Registry Association to fully endorse the adoption of the Prenatal Immunization measure. We strongly urge you to adopt the Prenatal Immunization measure in the 2021 CMS Core Set.

Thank you for the opportunity to comment on these measures. Please contact me with any questions.

Citations

[1] Pertussis Report. California Department of Public Health https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/PertussisReport16December19.pdf

[2] Kaiser Family Foundation. https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage

Colorado Children’s Campaign (Erin Miller)

Thank you for the opportunity to submit comments on the draft report of the 2021 Child and Adult Core Set Review Workgroup, “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” We thank the Workgroup for its efforts to review measures included in the 2020 Child and Adult Core Set and to make recommendations for improvements to the Core Sets.

The Colorado Children’s Campaign is a nonprofit, nonpartisan advocacy organization committed since 1985 to realizing every chance for every child in Colorado. We advocate for the development and implementation of data-driven public policies that improve child well-being in health, education and early childhood. We do this by providing Coloradans with trusted data and research on child well-being and organizing an extensive state-wide network of dedicated child advocates. We know that the evidence-based measures in the Child and Adult Core Sets are very valuable for tracking and assessing the quality of health care that Medicaid and CHIP beneficiaries receive in Colorado.

We support the Workgroup’s recommendation to add the “Postpartum Depression Screening and Follow-Up” measure to the 2021 Adult Core Set.

Perinatal mood and anxiety disorders (PMADs) are the most common complication of pregnancy and early motherhood. In recent years, maternal mortality rates in Colorado have sharply increased, and behavioral health issues, including intentional suicide and accidental overdose, are a driving cause of maternal mortality in Colorado.

One in 11 Colorado women experience pregnancy-related depression, and half all women who experience perinatal depression are neither diagnosed nor treated. Untreated maternal depression has significant costs to our economy, health system, and most importantly, the wellbeing of moms and babies. According to a Mathematica study, untreated perinatal mood and anxiety disorders cost Colorado $200 million per year.[1] One study also found that women suffering from maternal depression had health care costs that were 90 percent higher than those of non-depressed women.[2] Untreated maternal depression can also impact child development because the symptoms of depression sometimes get in the way of parents providing the care they would like to provide to their infants. The effects of perinatal depression are linked to reductions in the behavioral, cognitive, and social and emotional functioning of young children.[3] Children raised by mothers with clinical depression experience barriers to mental health, social adjustment and school success later in life.[4]

Screening for postpartum depression is a critical intervention. Infants of depressed caregivers are less likely to be impacted at one year if the caregiver’s depression is resolved or effectively managed by the time the baby is 6 months old. The U.S. Preventive Services Task Force recommends universal screening for depression in pregnant and postpartum women, noting that evidence shows even the effect of screening plus “minimal additional intervention” have shown reductions in postpartum depression at follow-up – saving money and improving the wellbeing of moms and babies.[5]

Because maternal depression screening is critical for the wellbeing of mothers, babies and our economy, Colorado has worked to expand access to maternal depression screening under a child's Medicaid ID at regular intervals, and partner organizations are practices make the necessary transformations to implement this policy.

However, currently, limited data are available in Colorado to understand the proportion of health professionals who screen women for maternal mental health challenges and the rate of referrals or follow-up to care. The standardized Postpartum Depression Screening and Follow-Up measure would help Colorado's Medicaid agency, health professionals, and the public better understand how many new moms are screened and referred for follow-up care.

We appreciate your commitment to identifying key indicators that help Colorado track the quality of health care that Medicaid and CHIP beneficiaries receive. If you have any questions or need more information, please contact Erin Miller, Vice President of Health Initiatives.

Citations

[1] Dara Lee Luca, Nellie Garlow, Colleen Staatz, Caroline Margiotta, Kara Zivin,"Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Colorado" available at: https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-colorado.

[2] Dagher et al., "Postpartum Depression and Healthcare Expenditures among Employed Women" available at: https://pdfs.semanticscholar.org/af2d/e78ef0db1feba22f8d5c95772fcd71bb837e.pdf.

[3] National Center for Children in Poverty. (2008). Reducing Maternal Depression and Its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework.

[4] Center on the Developing Child at Harvard University. (2009). Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8. www.developingchild.harvard.edu.

[5] U.S. Preventive Services Task Force. (2016). Final Recommendation Statement, Depression in Adults: Screening. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1.

Connecticut Department of Social Services (Ifeoma Nwankwo)

Connecticut HUSKY Health (Medicaid) Program has reviewed the proposed recommendations for the 2021 Child and Adult Core Sets:

1. We are in agreement with the addition of Postpartum Depression Screening and Follow-Up; and Prenatal Immunization Status.
2. We are also in agreement with the proposed removal of Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (HPCMI-AD).

We apologize for the last minute response. Its been a most eventful six months. Thank you and best regards.

Dental Quality Alliance

The Dental Quality Alliance (DQA) welcomes the opportunity to comment on the draft report of the Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multi-Stakeholder Review of the 2021 Child and Adult Core Sets.

Comments related to the Workgroup recommendation Measure Addition to the Child Core Set:

The DQA appreciates the Workgroup recommendation to update the dental/oral health measure domain with the proposed addition of the “Sealant Receipt on Permanent 1st Molars” to the 2021 Child Core Set. This proposed addition will replace the Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH) measure in the Child Core Set, which has been retired and will be removed by CMCS from the 2021 Core Set.

The DQA applauds the Workgroup recommendation and notes that the addition of this measure builds upon the foundation of state performance improvement through the use of the retired sealant measure and will promote sealing all four molars by age 10.

Comments related to the Core Set Measure Gaps Identified by the Workgroup:

The DQA appreciates the Workgroup recognition of gaps in dental/oral health measures within the Core Set. Our specific comments are noted below.

1. Receipt of an age-appropriate preventive pediatric dental care bundle (for example, sealants, fluoride varnish, and oral examination) allowing flexibility in providers and settings for fluoride application

The DQA is encouraged by the Workgroup’s emphasis on measures that address receipt of age appropriate preventive services. Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions.

However, we caution that a single measure that assesses a “dental care bundle” is not appropriate as each of these clinical interventions require either different frequencies, are applicable to different age groups, or are performed in different settings. Ultimately, in order to achieve improvement, the measures need to serve as a tool to identify the improvement opportunities. Bundling these clinical interventions simply for the purpose of reducing the number of independent measures will result in a measure that will lack interpretability and validity.

The DQA has developed a set of measures focused on caries prevention and disease management in children. A measure of Oral Evaluation and measures of evidence-based prevention, including topical fluoride and sealant placement (the aforementioned measure), enable programs to assess whether specific recommended services are provided. The DQA also has a measure of Care Continuity that allows for an assessment of whether children are receiving comprehensive or periodic oral evaluations in two consecutive years. Improving the continuity of receipt of diagnostic services is essential to promoting oral and overall health. Each of these measures can be stratified by age to identify improvement opportunities.

In terms of flexibility in provider type, we note that measure specifications for DQA measures, when appropriate, are available to users in 3 versions: (1) “Dental Services” version, (2) “Oral Health Services” version and (3) “Dental OR Oral Health” Services version. For example, the DQA specifically designed its Topical Fluoride measure with separate specifications based on application of fluoride as a dental service or an oral health service or dental/oral health service. The definition of “Dental Service” and “Oral Health Service” aligns with the definition promulgated by CMS. Services performed by independently practicing dental hygienists and pediatricians are classified as oral health services. Services provided by many other providers are included as dental services.

The CMS 416 data demonstrate that the frequency of dental services rendered by providers who are not dentists is very low, with approximately 5% of children in FFY receiving an oral health service (figure).[44] Receipt of oral health services among non-dental providers is highest among children younger than 5 years of age. In 2018, 9.6% of 90-day eligibles had an oral health service. Among those children <5 years of age who had any dental or oral health services, 22% had an oral health service.

In determining which version of the measure is most appropriate, measure implementers must be cognizant of data availability to compute the measure.

2. Link between use of preventive dental care and diagnostic outcomes

The DQA agrees that the linkage between use of preventive dental care and patient outcomes should be the highest priority in moving the system forward. However, the DQA would like to note the difficulty in inferring any significant linkages between preventive dental care and diagnostic outcomes given the limited evidence base as well as the difficulty in identifying diagnostic outcomes due to data limitations in currently available clinical record or administrative claims data.

3. Use of dental care by adults

The DQA appreciates the Workgroup’s emphasis on lack of oral/dental health measures for the adult core set.

Low-income adults suffer a disproportionate share of dental disease and are nearly 40 percent less likely to have a dental visit in the past 12 months compared with higher-income adults.[45] However, adult dental benefit coverage, which low income adults rely on, is varied among state Medicaid programs, further exacerbating disparities in dental access and utilization.

The DQA has developed a set of measures that addresses prevention and disease management in adults. Periodontal Evaluation assesses utilization of dental services, and Non-Surgical Ongoing Periodontal Care measures the continuity of care for those individuals who have been previously treated for periodontal disease. Topical Fluoride for Adults at Elevated Risk tracks at least 2 fluoride applications per year. Oral Evaluation for People with Diabetes represents an important

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[44] The figure submitted with this comment cannot be reproduced and has been omitted. The text summarizes the key findings in the figure.

[45] Centers for Disease Control and Prevention. “Oral and Dental Health: Table 78.” May 2017. Available at: https://www.cdc.gov/nchs/fastats/dental.htm.

entry point into the dental care system where diagnosis and treatment planning for the prevention and treatment of periodontal disease at these visits offer patients appropriate dental care with the potential to improve diabetes outcomes. Furthermore, Ambulatory Care Sensitive (ACS) ED visits for Non-Traumatic Dental Conditions (NTDC) and subsequently Follow-Up After ACS ED Visits for NTDC promote appropriate dental care outside of the ED through increased preventive care, treatment of acute dental issues, and appropriate follow-up after ED use.

Measuring performance is critical to improving quality of care. And that is why, dentistry has been committed to pursuing coordinated, meaningful, and parsimonious measurement from the outset through the DQA, convened by the American Dental Association (ADA), at the request of the CMS. The DQA is the only comprehensive multi-stakeholder organization in dentistry that develops dental quality measures through consensus-based processes. Thirty-eight organizations with oral health experience participate in the DQA along with a public member. The DQA strongly encourages the Workgroup to consider measures into the Core Sets that are appropriately specified to properly reflect current evidence-based clinical guidelines, be more meaningful, and coordinated to address system improvement rather than in silos.

The DQA appreciates the Workgroup’s consideration of these comments. If you have any questions, please contact the DQA.

Disability and Aging Collaborative (Clarke Ross)

Since 2012, the Disability and Aging Collaborative (DAC) and Consortium for Citizens with Disabilities (CCD) Task Force on Long-Term Services and Supports (LTSS) have advocated through the National Quality Forum (NQF), with CMS, and with other appropriate forums and organizations for robust, meaningful, publicly reported home-and-community-based services (HCBS) quality measures.

We have consistently advocated for the use of person-reported HCBS outcome measures, such as the National Core Indicators (NCI); National Core Indicators-Aging and Disability (NCI-AD); Council for Quality and Leadership (CQL) Personal Outcomes Measures (POM); and the CAHPS (Consumer Assessment of Healthcare Providers and Systems) HCBS Experience Survey. While a range of measures are needed, person-reported measures such as these are critical to advancing meaningful, person-centered outcomes within HCBS.

Last year, we were pleased that CMS added for the first time an HCBS quality measure to the adult core set, the National Core Indicators (NCI). NCI is widely used in states to assess a broad range of quality domains for individuals with intellectual and developmental disabilities (IDD) receiving Medicaid HCBS. However, additional HCBS measures must be included to fill gaps. Most notable, the adult core set currently contains no HCBS measures for individuals with physical disabilities and older adults.

The National Core Indicators-Aging/Disability Omission

The Child and Adult Core Set Review Workgroup facilitated and supported by Mathematica through a contract with CMS considered the National Core Indicators -Aging and Disability (NCI-AD) for addition to the 2021 core set. Despite the expressed support of many members of the committee and public comments, it was ultimately not included for recommendation in the draft report. We respectfully request that Mathematica final report explicitly acknowledge LTSS and HCBS advocacy requests that CMS consider the inclusion of NCI-AD in the 2020 core set.

1. In 2020, the Child and Adult Core Set Review Workgroup — facilitated and supported by Mathematica through a contract with CMS — recommended both the NCI and NCI-AD for inclusion in the core measure set. CMS subsequently included NCI but not NCI-AD. The same Mathematica project that recommended NCI-AD in 2020, excluded NCI-AD in 2021. Why? The report needs to clearly and forthrightly explain why NCI-AD was included in 2020 and excluded in the draft 2021 draft report.
2. While CMS desires that measures meet a 25-state threshold for inclusion in the core set, exclusion of NCI-AD solely based on this requirement is a double standard. As Workgroup member, Lowell Arye, pointed out in his dissent, nine of the existing 2020 core measures do not meet this threshold. Since its inception, the number of states using NCI-AD has steadily increased each year. In the most current data collection cycle, 24 states are participating in NCI-AD. Inclusion in the core set would likely contribute to additional states adopting.

Areas Requiring Additional Attention

We further recommend that the Mathematica final report to CMS include highlights from the ACL funded, NQF administered reports — Home-and-Community-Based Services and Person-Centered Planning and Practice.

Our organizations have other interests and views in items raised in the draft report. This collective statement focuses on LTSS, HCBS, and the NCI-A/D circumstance. We agree with the Mathematica identification of LTSS gaps and encourage CMS-AHRQ-ACL-SAMHSA and other federal agencies to proactively address these gaps.

The Mathematica report documents but understates the importance of LTSS and the LTSS quality measurement gaps. Further, Mathematica Workgroup member, Lowell Arye in his dissent, has provided LTSS and HCBS Medicaid enrollment and expenditures data to stress the importance of these areas for Medicaid and quality measurement. 7% of Medicaid beneficiaries are seniors; they consume 16% of Medicaid expenditures. 15% of Medicaid beneficiaries are persons with disabilities; they consume 39% of Medicaid expenditures. 30% of Medicaid expenditures are for LTSS; 61% of these expenditures are for seniors and persons with disabilities. 28% of Medicaid LTSS expenditures are for persons with ID/DD and 11% of Medicaid LTSS expenditures are for persons with serious mental illness (or children with serious emotional expenditures).

Thank you for considering our views.

Further information is available from either Dr. Clarke Ross, American Association on Health and Disability, and Dr. Joe Caldwell, Brandeis University Community Living Policy Center.

Submitting Organizations:

American Association on Health and Disability

American Network of Community Options and Resources (ANCOR)

Autistic Self Advocacy Network

Center for Public Representation

Community Catalyst

Community Living Policy Center, Brandeis University

Human Services Research Institute

Justice in Aging

Lakeshore Foundation

National Council on Aging

National Health Law Program

The Arc

District of Columbia Department of Health Care Finance (Abby Kahn)

The District of Columbia Department of Health Care Finance (DHCF), the District's Medicaid agency, has the following comments on the three measures proposed for addition to the 2021 Core Set:

1. Postpartum Depression Screening and Follow-Up (PDS) – DHCF is not currently able to report this measure. DHCF currently reimburses providers for the CPT code for maternal depression screening. However, the presence of a CPT code does not verify that a "standardized depression screening tool" per the measure specifications, was utilized, which can only be verified when conducting chart audit. Currently, DHCF does not have the capacity to conduct chart audits. Nor are our contracted MCOs reporting this measure via HEDIS.
2. Prenatal Immunization Status (PRS) – DHCF is not currently able to report this measure. DHCF only has access to immunization data via claims. Nor are our contracted MCOs reporting this measure via HEDIS.
3. Sealant Receipt on Permanent 1st Molars – DHCF is not currently able to report this measure. Currently, DHCF does not have the capacity to conduct chart audits and so would run into the same "Measure Limitations due to Limitations of Administrative Data" identified in the specifications.

Elevate Policy Lab, Yale School of Medicine (Caroline Simmons)

Overview of Elevate

Elevate is a policy lab based out of the Yale School of Medicine that works with government partners to advance maternal mental health as a strategy to disrupt intergenerational poverty. One of Elevate's core programs is called the Mental health Outreach for MotherS (MOMS) Partnership®, which has successfully reduced depressive symptoms among over-burdened, under-resourced mothers.

Elevate Supports Adding the Postpartum Depression Screening and Follow-Up Measure to the Medicaid 2021 Core Set of Health Care Quality Measures for Medicaid and CHIP

Elevate supports the Workgroup's recommendation to add the Postpartum Depression Screening and Follow-Up Measure to the Medicaid 2021 Core Set of Health Care Quality Measures for Medicaid and CHIP. Each year, one in seven women experience Perinatal Mood and Anxiety Disorders (PMADs), including postpartum depression.[1] Without adequate screening and treatment, postpartum depression can have devastating effects on mothers and families, especially for low-income mothers and families receiving Medicaid. Medicaid covers nearly half of all births in the U.S., and rates of depressive symptoms for low-income mothers are between 40-60 percent.[2] Adding postpartum depression screening measures to the Medicaid 2021 Core Set is critical to helping identify mothers who are in need of treatment and improving maternal and infant health outcomes for Medicaid recipients.

Elevate Supports Adding the Prenatal Depression Screening and Follow-Up Measure to the Medicaid Core Set

Elevate encourages the Workgroup to add the Prenatal Depression Screening and Follow-Up Measure to the Medicaid Core Set. Depression and other mental health concerns do not only effect women after delivery, but can impact women during pregnancy. Evidence shows that prenatal depression is more common than postpartum depression and is a strong predictor of postpartum depression.[3] As a result, prenatal depression screening is crucial to identifying women in need of treatment early in their pregnancy in order to help prevent detrimental health outcomes for the mother and the baby. A lack of screening and treatment for prenatal depression can lead to mothers receiving less prenatal care and is correlated with higher rates of obstetric complications,[4] low-birth weights, and pre-term deliveries.[5] Children exposed to prenatal depression in utero are also more likely to have learning deficits, behavior disorders, and mental health complications.[6] Prenatal depression screening can help prevent these adverse outcomes.

Elevate is grateful that the Workgroup is advocating for adequate, reliable, and accessible maternal mental health care. We look forward to assisting with this process in any way that we can.

Citations

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[2] https://www.medicaidinnovation.org/_images/content/2018-IMI-Medicaid-Maternal-Depression-Anxiety-Report.pdf

[3] https://doi.org/10.1016/j.infbeh.2010.09.008

[4] https://doi.org/10.1080/14767050701209560

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724170/

[6] https://doi.org/10.1016/j.neubiorev.2008.03.002

Heart of Lynchburg Midwifery (Savannah Fassero)

As perinatal mood and anxiety disorders have been recognized as the #1 complication of the childbearing year, affecting 1 in 5 women, it is vital that postpartum and prenatal mood screening be supported as a means to diagnose women who need additional resources to achieve healthy motherhood. This is a matter of life and death, but also a matter of long-term societal health, as maternal mental health affects infant bonding, breastfeeding, and mothering, which in turn affects the physical and psychological health of future generations. Please support adding the Postpartum Depression Screening and Follow-Up Measure, as well as the Prenatal Depression Screening and Follow-Up Measure, to the 2021 Adult Core Set.

Melissa L. James

Hi, I understand that the Workgroup has recommended against adding a measure to screen and treat women for prenatal depression. I am emailing to first say thank you for recognizing the need for postpartum depression screening and follow-up. That's a huge step forward! But for some women, that will already be too late. Please, please consider also adding prenatal depression screening and follow-up. As I'm sure you know, in anything dealing with pregnancy and babies, the earlier the intervention, the better. The earlier we start, the more problems we can prevent and also the more dollars saved. Thank you.

Jefferson College of Nursing (Aparna Kumar)

Thank you so much for including measures of POSTPARTUM Depression Screening and Follow-Up measures as a performance measure. As a psychiatric mental health nurse practitioner and researcher in the area of prenatal mental health, I strongly recommend that you also include a measure for PRENATAL depression. We know that screening three times in pregnancy is indicated and recommended by ACOG as well as postpartum services international. Should you have additional questions, please do not hesitate to reach out.

Lifeline4Moms Center (Nancy Byatt)

I am writing to thank you for adding the POSTPARTUM screening measure. I also want to encourage you to adding the PRENATAL screening to the measure as soon as possible. Of women that develop PPD, almost two-thirds will develop that depression before the baby is born. Thus, it is imperative that screening begins in pregnancy.

Los Angeles County Department of Mental Health (Emily C. Dossett)

I am writing to support the adding the “Postpartum Depression Screening and Follow-Up” to the Adult Core Set measure. Perinatal mood and anxiety disorders, which include postpartum depression, affect 15% of the population overall, and up to 40% of low-income women, Black women, and Latinx women. As a reproductive psychiatrist for over 15 years, I have worked in the Los Angeles County safety net with many of these women, and I have repeatedly seen how valuable screening and linkage is to identifying and helping high-risk women and their children. I have always been dismayed at how this common, preventable, and treatable illness — that has lifelong impact on the mother-infant dyad — is repeatedly overlooked by almost all health providers.

Hopefully, adding this measure to the Core Set could change this. Setting a clear standard of accountability is the best chance we have of driving practice in the right direction for mothers and infants.

If I can be of any assistance in this process, please let me know. Thank you for your consideration!

Massachusetts Executive Office of Health and Human Services (Amanda Cassel Kraft)

Thank you for the opportunity to review the recommendations. MassHealth is supportive of the proposed changes to the core measure set. We would note, however, that states may have challenges in initially reporting the postpartum and prenatal measures via electronic clinical data systems (ECDS) per the specifications. The states would be dependent on health plan readiness in submitting these data as it becomes part of their NCQA accreditation requirements and where these ECDS measures are currently voluntary or first year measures. We support the measures and this method of data submission as both plans and providers demonstrate the capability to submit ECDS data over time.

Maternal and Child Health Program, Denver Public Health (Kelly Stainback-Tracy)

Thank you for the opportunity to submit comments on the draft report of the 2021 Child and Adult Core Set Review Workgroup, "Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP." We thank the Workgroup for its efforts to review measures included in the 2020 Child and Adult Core Set and to make recommendations for improvements to the Core Sets.

Denver Public Health's Maternal and Child Health program is dedicated to improving the health and well being of families in Denver. For the past five years, we have addressed our state's priority to support maternal mental health through population interventions. One of our major strategies has been to support the implementation of perinatal depression screening at Denver Health, Denver's largest safety net health system, and other Denver-based health systems during prenatal, postpartum, and well-child checks.

We support the Workgroup's recommendation to add the "Postpartum Depression Screening and Follow-Up" measure to the 2021 Adult Core Set.

Perinatal mood and anxiety disorders (PMADs) are the most common complication of pregnancy and the early postpartum period. In recent years, maternal mortality rates in Colorado have sharply increased, and behavioral health issues, including intentional suicide and accidental overdose, are a driving cause of maternal mortality in Colorado. One in 11 Colorado women experience pregnancy-related depression, and half all women who experience perinatal depression are neither diagnosed nor treated. Untreated maternal depression has significant costs to our economy, health system, and most importantly, the wellbeing of moms and babies. According to a Mathematica study, untreated perinatal mood and anxiety disorders cost Colorado $200 million per year.[1] One study also found that women suffering from maternal depression had health care costs that were 90 percent higher than those of non-depressed women.[2] Untreated maternal depression can also impact child development because the symptoms of depression sometimes get in the way of parents providing the care they would like to provide to their infants. The effects of perinatal depression are linked to reductions in the behavioral, cognitive, and social and emotional functioning of young children.[3] Children raised by mothers with clinical depression experience barriers to mental health, social adjustment and school success later in life.[4]

Screening for postpartum depression is a critical intervention. Infants of depressed caregivers are less likely to be impacted at one year if the caregiver's depression is resolved or effectively managed by the time the baby is 6 months old. The U.S. Preventive Services Task Force recommends universal screening for depression in pregnant and postpartum women, noting that evidence shows even the effect of screening plus "minimal additional intervention" have shown reductions in postpartum depression at follow-up — saving money and improving the wellbeing of moms and babies.[5]

Because maternal depression screening is critical for the wellbeing of mothers, babies and our economy, Colorado has worked to expand access to maternal depression screening under a child's Medicaid ID at regular intervals and we have partners working to help practices make the necessary transformations to implement this policy. However, currently, limited data are available in Colorado to understand the proportion of health professionals who screen women for maternal mental health challenges and the rate of referrals or follow-up to care. The standardized Postpartum Depression Screening and Follow-Up measure would help Colorado's Medicaid agency, health professionals, and the public better understand how many new moms are screened and referred for follow-up care.

We appreciate your commitment to identifying key indicators that help us track the quality of health care that Medicaid and CHIP beneficiaries review. If you have any questions or need more information, please contact Kelly Stianback-Tracy, Perinatal Mental Health Program Specialist, Denver Public Health.

Citations

[1] Dara Lee Luca, Nellie Garlow, Colleen Staatz, Caroline Margiotta, Kara Zivin,"Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in Colorado" available at: https://www.mathematica.org/our-publications-and-findings/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-colorado.

[2] Dagher et al., "Postpartum Depression and Healthcare Expenditures among Employed Women" available at: https://pdfs.semanticscholar.org/af2d/e78ef0db1feba22f8d5c95772fcd71bb837e.pdf.

[3] National Center for Children in Poverty. (2008). Reducing Maternal Depression and Its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework.

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Maternal Mental Health Leadership Alliance (Jamie Zahlaway Belsito)

Thank you for focusing on the health and wellness of our nation's postpartum mothers.

As the founder of the Maternal Mental Health Leadership Alliance (MMHLA) and a postpartum depression survivor, I would strongly recommend that language be added to address PRENATAL depression screening and follow-up measures to the Medicaid Core Set.

I can be reached at the below number if you would like further information.

Many thanks.

Maternal Mental Health Leadership Alliance (Adrienne Griffen)

Maternal Mental Health Leadership Alliance (MMHLA) is a 501(c)3 nonprofit organization focused on advocating for maternal mental health (MMH) conditions. MMHLA's vision is that all childbearing women in the United States will be educated about and screened for anxiety and depression during the perinatal timeframe and have access to resources for recovery.

POSTPARTUM DEPRESSION SCREENING. MMHLA applauds the Workgroup's recommendation to add the Postpartum Depression Screening and Follow-Up Measure to the Medicaid 2021 Core Set of Health Care Quality Measures for Medicaid and CHIP. Mental health conditions — primarily anxiety and depression — are the MOST COMMON complications of pregnancy and childbirth, affecting 1 in 5 women. Left untreated, these illnesses can have long-term negative impact on mother, baby, family, and society.

PRENATAL DEPRESSION SCREENING. MMHLA encourages adding the Prenatal Depression Screening and Follow-up Measure to the Medicaid Core Set as soon as possible. It is essential to identify women who are experiencing depression or other mental health disorder as soon as possible to preserve the mental health and wellbeing of both mother and baby:

- Depression during pregnancy is the strongest predictor of postpartum depression. Massachusetts General Hospital Center for Women's Mental Health.
- Of women experiencing postpartum depression, approximately 1/3 enter pregnancy with symptoms, 1/3 develop symptoms during pregnancy, and the remaining 1/3 develop symptoms in the postpartum timeframe. *Wisner et al, 2012.*
- Women with untreated MMH conditions during pregnancy are more likely to have poor prenatal care and use substances such as alcohol, tobacco, and drugs. *Zhou et al, 2019; Field, 2010.*
- Infants born to mothers with untreated MMH conditions are at increased risk of pre-term labor, small gestational size, and longer stays in the NICU. *Grote et al, 2010; Field, 2010; Fittelson et al, 2017.*
- Women who live in poverty are MORE likely to experience MMH conditions but LESS likely to receive treatment. *Grote et al, 2010; Taylor, 2019.*
- The American College of Obstetricians and Gynecologists, along with the United States Preventive Services Task Force, recommend that women be screened at least once during pregnancy.

MMHLA is grateful that the Workgroup is elevating the issue of maternal mental health and look forward to assisting this process in anyway possible.

Moms Mental Health Initiative (Sarah O. Bloomquist)

Please support adding the POSTPARTUM Depression Screening & Follow-Up Measure to the 2021 Adult Core Set.

Please add the PRENATAL Depression Screening & Follow-Up Measure to the 2021 Adult Core Set.

The cost of untreated pregnancy and postpartum depression/anxiety is $32,000 a year per mother and baby dyad. The risk to the development of the child can have lifetime implications. These illnesses are treatable.

The financial burden of preventative measures such as utilizing screening tools is nothing compared to the huge costs of not screening. PPD is the most common complication of childbirth and is the second leading cause of death among postpartum women. We don't want children to become motherless because the system failed their mother.

Momswell (Maureen Fura)

Please add PRENATAL Depression Screening and Follow-Up measures to the POSTPARTUM Depression Screening and Follow-Up measure. Untreated depression during pregnancy increases a woman's chance for pre-term by six times. Untreated depression during pregnancy also leads to low birth weight. And with suicide being one of the leading causes of death during the perinatal period, leaving this out will cost women and their families too much.

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention (Erica Figueroa)

Please see our comments below on the draft report:

- CDC agrees with the Workgroup's decision to keep the HIV Viral Load Suppression measure, because it is the "ultimate outcome measure" and the measure suggested for replacement, "Proportion of Days Covered: Antiretroviral Medications," is not comparable in measuring care delivery and health outcomes for Medicaid and CHIP beneficiaries with HIV.
- The suggested measure, "Proportion of Days Covered: Antiretroviral Medications," could overestimate viral load suppression because persons prescribed medications may not always take the medication as prescribed.
  - Among PWH in the United States in HIV clinical care (defined as either receiving HIV medical care or having a CD4 or viral load test within the past year), about 80 percent were virally suppressed at their last test, which means up to 20 percent did not achieve viral suppression.
- CDC finds that the solutions proposed by the Workgroup (noted below) will present challenges and require further discussion with CDC and the collaborating agencies in order to identify the best approaches for improving the reporting of viral load data.
- In response to states' need for and challenges creating data sharing and confidentiality agreements between state public health and Medicaid agencies, in 2016 CMS, CDC, and HRSA collaboratively established and led an affinity group to increase state-level interagency collaboration for improved data sharing that would increase reporting of the HIV Viral Load Suppression Adult Core Set measure by state Medicaid programs.
- Among the nineteen states that participated in the HIV affinity group:
  - At the end of the one-year period, 13 states (68%) had established or refined their data sharing agreements between state Medicaid agencies and public health departments
  - Of the 12 states that successfully matched the data or streamlined the data matching process, 67% (n=8) generated an HIV care continuum for state Medicaid beneficiaries, including estimating viral suppression rates, and identified targets for performance improvement.
- Due to the timing of the Adult Core set reporting and the conclusion of the affinity group, it may be too soon to determine the effect of the technical assistance on reporting of HIV viral suppression. Nonetheless, CDC and HRSA are committed to assisting states to report the HIV Viral Load Suppression measure.

Issues with measure (noted in page 77 of draft report):

HIV Viral Load Suppression suppression measure suggested for removal because of barriers to obtaining viral load suppression data on Medicaid beneficiaries with HIV, including (1) confidentiality and privacy barriers in developing data-sharing agreements with public health agencies, and (2) challenges coordinating and collaborating with another agency.

Some proposed solutions (noted in page 77 of the draft report) :

Sharing lessons learned across states and having CDC help facilitate cooperative agreements between Medicaid and public health agencies to gain access to aggregate data from the viral load registry. Undertaking additional technical assistance efforts to help states overcome challenges in establishing data-sharing agreements and facilitating the information sharing necessary to collect and report the measure.

The Workgroup discussed whether there were opportunities for the CDC, HRSA, and CMS to help facilitate the partnership building, data linkages, and information sharing necessary for states to report the HVL measure. A representative from HRSA indicated that there may be additional funding to support states in building their data infrastructure as part of the Ending the Epidemic initiative.

Please let me know if you have any questions!

North American Society for Psychosocial Obstetrics and Gynecology (Colleen Hughes)

I applaud you for recommending the adoption of the postpartum depression measure. I urge you to also consider adoption of the prenatal depression measure.

Women with untreated depression during pregnancy are at risk of developing severe postpartum depression and suicidality, and delivering premature or low birthweight babies (Chan, 2014). Depression during pregnancy can also result in alterations to the DNA of the developing fetus — the mother transmits the trauma and stress of the psychological condition that she is experiencing into the biology of her offspring. Therefore, decreasing the rates of fetal exposure to prenatal depression or anxiety is essential in protecting the next generation. (Van den Bergh, 2004; Wadhwa, 1993; Field, 2003; Field, 2004.)

Thank you for the opportunity to make public comment on measures.

Novo Nordisk (Stephanie B. Kutler)

Novo Nordisk is pleased to provide the following comments on the draft report of the 2021 Child and Adult Core Set Review Workgroup: Recommendations for Improving the Core Set of Health Care Quality Measures for Medicaid and CHIP.

Novo Nordisk is a global healthcare company with 95 years of innovation and leadership in diabetes care. This heritage has given us experience and capabilities that also enable us to help people defeat other serious chronic conditions: rare bleeding disorders, growth hormone-related disorders, and obesity. As an organization, we are also committed to ensuring patients have access to high-quality, affordable health care. We support the Centers for Medicare and Medicaid Services' (CMS) continued efforts to transform the health care delivery system through competition and innovation to provide patients with better value and outcomes.

BMI Assessment

The United States is facing an epidemic of obesity. Given the burden of this disease on our health care system, patients, and on our society, we believe it is vital that CMS continue to focus on measuring and improving care for patients with obesity. As such, we thank CMS for considering our comments on the 2020 Core Measure Set and for maintaining the following measures:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessmen for Children/Adolescents (WCC-CH)
- Adult Body Mass Index Assessment (ABA-AD)

In addition to retaining the weight assessment measure in the Child Core Set, CMS added counseling for nutrition and counseling for physical activity to WCC-CH. The addition of the two counseling items will shift the measure from being a purely administrative measure that documents whether a child's BMI was recorded to a more meaningful process measure that assesses the extent to which health care providers take action on those BMI results to address obesity. While measurement of BMI is the first step in preventing and/or treating obesity, simply knowing a patient's BMI has no impact unless it is followed by intensive behavioral counseling and/or treatment. Novo Nordisk supports efforts to raise awareness of the importance of addressing obesity through measurement, and treatment with behavioral therapy, bariatric surgery and/or anti-obesity medications.

The 2021 report also highlights the need to enhance the Adult BMI Assessment measurement beyond BMI measurement alone, recommending that the measure be expanded as WCC-CH was expanded last year. Novo Nordisk supports adding counseling and treatment components and we urge CMS to include the expanded measure in the 2022 Adult Core Measure Set.

Racial and socioeconomic disparities

The Workgroup also identified a need to incorporate measurement approaches that consider the impact of race and poverty on health outcomes. This is an important recommendation, as race and socioeconomic status influence the likelihood of developing diabetes and obesity. Black and Hispanic Americans are more likely than White Americans to experience obesity,[1] with obesity being 1.3 times more common in Black Americans and 1.2x more common in Hispanic Americans. Four out of five Hispanic American women are overweight or obese. Minority Medicare beneficiaries with diabetes are more likely to receive lower quality care[2] and have diabetes-related complications, such as end-stage renal disease, chronic kidney disease, and amputations.[3,4] The need to address racial and socioeconomic disparities is highlighted by the COVID-19 pandemic. Black and Hispanic Americans represent a disproportionate share of COVID-19 hospitalizations and deaths. Though only 10% of the Medicare population, Black Medicare beneficiaries represent 22% of COVID-19 cases and 28% of hospitalizations.[5] Though only 13% of the U.S. population, 36% of those who hospitalized with COVID-19 are Black.[6]

Potential New Measures

It is clear there is a need to measure processes and outcomes so that we can drive towards improvements in care for patients with obesity and diabetes – two of the costliest and prevalent chronic conditions in the U.S. Given that future quality measure work will largely focus on outcome measures such as BMI reduction or maintenance, a process measure such as BMI screening, which is currently in the Medicaid/CHIP Core Quality Set, is the first step before an outcome measure can be developed. Novo Nordisk believes in the importance of outcomes measurement and is supporting pipeline obesity measure development efforts that are intended to build upon the work already done by AMGA, Discern Health, and the National Quality Forum (NQF).[7] We would welcome the opportunity to share information on these efforts with CMS.

In 2016, the National Quality Forum (NQF), in collaboration with the STOP Obesity Alliance and with funding from Novo Nordisk, convened a roundtable discussion on system-level accountability in treating individuals with obesity. Following this meeting, an NQF Measure Incubator® strategy session was held in early 2017 to further refine the measure concepts proposed in the initial discussion. Participants included experts in obesity care, population health, and measure development and implementation, along with patients and patient advocates. Key recommendations included a greater focus on the clinical treatment of obesity, coupled with population- and community-based approaches to address the obesity epidemic. The Expert Panel prioritized two measure concepts for further development: 1) an outcome measure focused on serial body mass index (BMI) reduction or maintenance; and, 2) a shared decision-making (SDM) measure that focuses on patient-centered communication and clinician action to guide obesity care.

Initial development and testing of these measures began in 2018 as part of a broader subset of obesity measures used in the AMGA Obesity Care Model Collaborative, a 3- year collaborative to define, pilot, and evaluate a framework and necessary components to address obesity in multi-specialty medical groups and integrated health systems. Discern Health was the lead developer for four obesity quality measures for the adult population:

- Documentation of obesity diagnosis;
- Weight change over time;*
- Evidence-based treatment for obesity; and,
- Obesity quality of life patient-reported outcome performance measure (PROPM).*,#

- *Modified version of prioritized measure concept from the NQF-convened 2017 strategy session.
- # Initial measure testing focused on early feasibility assessment only

The AMGA, Discern, and NQF partnership specified and tested the documentation measure and weight change over time measure. Additional work on these and other obesity-related measure concepts will be undertaken beginning in 2020. We would welcome the opportunity to discuss with CMS the use of any or all of these measures in the Medicaid Adult or Child Core Set.

Summary

Obesity is among the most important health management challenges facing the U.S. It is vital that CMS continue to send a strong signal to providers that they should screen for and manage obesity so that patients get the best care and achieve the best outcomes. Encouraging health care providers to not only screen for obesity but also provide counseling and/or treatment will signal CMS' dedication to addressing the obesity epidemic.

Thank you for this opportunity to comment on the draft report of the 2021 Child and Adult Core Set Review Workgroup. Novo Nordisk will continue to work towards improving care. If you have any questions about our comments, please do not hesitate to reach out to me.

Citations

[1] Office of Minority Health, HHS. Obesity and African Americans [Internet]. 26 Mar 2020 [cited 24 Apr 2020]. Available from: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25

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[5] CMS Preliminary Medicare COVID-19 Data Snapshot. June 22, 2020. https://www.cms.gov/files/document/medicare-covid-19-data-snapshot-fact-sheet.pdf

[6] US CDC. COVID-19 laboratory-confirmed hospitalizations [Internet]. 2020 May 9 [cited 2020 May 15]. Available from: https://gis.cdc.gov/grasp/COVIDNet/COVID19_5.html

[7] This work is supported by Novo Nordisk Inc.

Ohio Commission on Minority Health (Angela Cornelius Dawson)

In order to impact pervasive health disparities experienced by racial and ethnic populations there would need to a significant shift in the current lens to focus on health equity as a primary view in the development of the core set of measures.

1. This would include an expansion of the existing measures/metrics to include data that is stratified by race, ethnicity and language.
2. Consideration of the metrics used by the Agency for Health Care Research and Quality
3. A deep dive into Maternal Mortality and the unacceptable racial disparities.
4. All pre-natal, peri-natal and post natal measures should be examined by race and ethnicity as well as socioeconomic status and housing security/density.
5. The unjust distribution of essential resources known as social determinants of health only perpetuate the persistence of racial and ethnic health disparities. A lens on poverty and race risk factors would drive solutions.
6. Why are poverty, incarceration and housing insecurity prevalent societal problems that are inequitably distributed in the population.
7. Identify metrics that would drive solutions beyond the downstream focus on program implementation but also identify system barriers in the upstream and midstream level.
8. Focus on metrics that reveal system racism and healthcare disparities by examining poverty, race, incarceration rates, housing insecurity and high school graduation rates.
   This approach would ask the question why do whites have lower rates of poverty, incarceration and housing insecurity?
9. Stratify HEDIS measures by race, ethnicity, language, geographic area and provider for patterns and opportunities for training (cultural competency and implicit bias training).

Pacific Business Group on Health (Blair Barrett Dudley)

The Pacific Business Group on Health (PBGH) strongly recommends the addition of the Postpartum Depression Screening and Follow-Up measure to the national Medicaid and CHIP Core Set.

Postpartum depression creates an environment that is not conducive to the personal development of mothers or the optimal development of a child. It is critical to screen women for depression to detect and treat the illness during the postnatal period as early as possible to avoid harmful consequences. Mothers with perinatal depression experience feelings of extreme sadness, anxiety, and fatigue that may make it difficult for them to carry out daily tasks, including caring for themselves or others. When a woman is suffering from postpartum depression, she may have difficulty reacting to her child in appropriate ways, including engaging in healthy feeding and sleep practices with the infant. The lack of appropriate interaction can impact a child's cognitive, behavioral, and physical development. Treatment for perinatal depression is important for the health of both the mother and the baby, as perinatal depression can have serious health effects on both. Treatment may include therapy or medication or a combination of the two. With proper treatment, most women feel better and their symptoms improve.

This measure and its inclusion of both the screening rate and follow up rate will encourage care coordination amongst maternity, pediatric, primary care, and behavioral health providers. Adding this measure to the Core Set will accelerate transparency and accountability and will ultimately drive delivery system improvement so that women with positive screens have a better path to obtain care.

Thank you for your consideration.

Perigee Fund (Elizabeth M.S. Krause)

Thank you for the opportunity to submit comments on the draft report of the 2021 Child and Adult Core Set Review Workgroup, “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.”

Perigee Fund is a Seattle-based national philanthropic funder focused on mental health during pregnancy and the postpartum period and then during infancy and early childhood. We prioritize families affected by poverty, racism, and trauma. We are part of a small cohort of national funders that explicitly includes maternal mental health in our funding priorities.

As such, Perigee supports the Workgroup’s recommendation to add the “Postpartum Depression Screening and Follow-Up” measure to the 2021 Adult Core Set.

Perinatal mood and anxiety disorders, including depression, are the most common pregnancy complication. In 2019, with California Health Care Foundation and Zoma Foundation, Perigee co-founded a Mathematica study on the cost of untreated maternal depression that estimated the five-year economic cost for babies born in 2017 to be $14.2 billion.

Postpartum depression is highly treatable, but is too often missed by the health care system despite multiple opportunities to screen for it in maternity, pediatric, and primary care settings. Improving screening and critical follow-up with the support of the quality measure is fundamental to ensuring that birthing parents receive treatment and support – both in the health system and in the community.

As the Workgroup is keenly aware, in 2018, Medicaid financed slightly less than half of all births in the US. One in seven of all birthing people experiences postpartum depression, but risk and prevalence are higher in the population eligible for Medicaid. Each year, several hundred thousand birthing people and their infants stand to benefit from improvements in the quality of postpartum depression screening and follow-through. The measure sits at the cross section of maternal and child health, maternity care, pediatric care, maternal morbidity and mortality, health equity, behavioral health, and child health and development.

Perigee is grateful to the Workgroup for identifying measures that improve the quality of care and quality of life for Medicaid and CHIP beneficiaries. Again, we urge CMS to adopt the Postpartum Depression Screening and Follow-Up measure into the adult Core Set. While the workgroup did not prioritize the prenatal depression screening measure, we encourage CMS to consider future adoption.

If you have any questions, please do not hesitate to contact Elizabeth Krause, director.

Perinatal Support Washington (Mia Edidin)

I am writing to commend the inclusion of Postpartum Depression Screening and Follow-Up measure. Screening is the first step to accessing care.

I also would like to encourage adding a Prenatal Depression Screening and Follow-Up measure. 60% of what we diagnose as postpartum depression is depression that started before birth or even before pregnancy. Depression during pregnancy is correlated with pregnancy complications, preterm birth, and low rates of breastfeeding initiation and duration. These impacts are significant. Screening in pregnancy can reduce these negative pregnancy and birth outcomes and help ensure healthy bonding and attachment for every mother-baby dyad. Why wait to screen?

Postpartum Resource Center of New York, Inc. (Sonia Murdock)

The Postpartum Resource Center of New York commends the Workgroup’s recommendation to add the Postpartum Depression Screening and Follow-up Measure to the Medicaid 2021 Core Set of Health Care Quality Measures for Medicaid and CHIP. Mental health conditions — primarily anxiety and depression — are the MOST COMMON complications of pregnancy and childbirth, affecting 1 in 5 women. Left untreated, these illnesses can have long-term negative impact on mother, baby, family, and society.

The Postpartum Resource Center of New York encourages adding the Prenatal Depression Screening and Follow-up Measure to the Medicaid Core Set as soon as possible. It is essential to identify women who are experiencing depression or other mental health disorder as soon as possible to preserve the mental health and well-being of both mother and baby.

The Postpartum Resource Center of New York, Inc. is the 501(c)(3) IRS recognized non profit organization that since 1998 has worked to improve awareness and access to care by providing non-judgmental education, emotional support, resource referrals and trainings for thousands of New York women and families suffering from perinatal mood and anxiety disorders, including postpartum depression and postpartum psychosis. The Postpartum Resource Center of New York has been recognized by Postpartum Support International as a model program.

Thank you to the Workgroup for addressing maternal mental health in these important ways so lives will be saved and healthy families will be created now and for future generations.

Texans Care for Children (Adriana D. Kohler)

Thank you for the opportunity to submit comments on the draft report of the 2021 Child and Adult Core Set Review Workgroup, "Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP." We thank the Workgroup for its efforts to review measures included in the 2020 Child and Adult Core Set and its work to make recommendations for improvements to the Core Sets. Texans Care for Children works statewide to improve the health of Texas children and families. We know that the evidence-based measures in the Child and Adult Core Sets are very valuable for tracking and assessing the quality of health care that Medicaid and CHIP beneficiaries receive in Texas.

We support the Workgroup's recommendation to add the "Postpartum Depression Screening and Follow-Up" measure to the 2021 Adult Core Set.

Maternal mental health challenges — sometimes called postpartum depression or maternal depression — are among the most common complications of pregnancy, affecting 1 in 7 Texas women. Early screening and treatment of maternal mental health challenges are critical for a mother's health and a child's health, brain development, and ability to succeed in school.

In Texas, as more state leaders and our Texas Medicaid agency (HHSC) recognize that a child's health is inextricably linked to the health of his or her mother, there has been growing interest in maternal health, including maternal mental health. Addressing maternal mental health is becoming even more urgent as moms face the added social isolation and stress of the COVID-19 pandemic and rising unemployment. Isolation and lack of available help from friends and family due to social distancing leave many new parents on an island like never before, increasing risks of postpartum depression among new mothers.

Currently, limited data are available in Texas to understand the proportion of health professionals who screen women for maternal mental health challenges and the rate of referrals or follow-up to care.

Texas uses a piecemeal approach that fails to capture the full picture of postpartum depression screenings. Currently, a provision in Texas law requires HHSC to analyze screening and treatment of postpartum depression among women in Medicaid. The state analyzes various procedure codes indicating a depression screening was done and procedure codes indicating an office visit for pregnancy-related depression occurred. This analysis also includes information on medication utilization and office visits to state-funded community mental health centers for pregnancy-related depression. But this does not capture postpartum depression screenings done by pediatric providers at well-child visits. And there is no standard screening or follow-up rate that could be compared or used to show progress across years.

The standardized Postpartum Depression Screening and Follow-Up measure would help Texas' Medicaid agency, Texas Medicaid and CHIP plans, health professionals, and the public better understand how many new moms are screened and referred for follow-up care.

Texas and HHSC have a vested interest in quality improvement and value-based payment reforms in Medicaid. Quality measures are a critical way for the state, health plans, and health providers to move towards more value-based or alternative payment arrangements. By using the new NCQA Postpartum Depression Screening and Follow-Up measure: (1) the state, health plans, and providers would have a standard metric to track and compare progress on maternal mental health screening and follow-up; and (2) Texas can make progress towards its goal of more alternative payment arrangements in future years.

Tracking postpartum depression screening and follow-up is one small step towards assessing and tackling racial health inequities in our state.

While all women are at risk of maternal mental health challenges, Black moms in Texas are more likely to experience them, and research shows Black moms are less likely to receive treatment compared to other moms.[1] In Texas, 18.5% of Black moms reported symptoms of postpartum depression within six months of delivery compared to 12.9% of White moms and 14.4% statewide.[2] Having a standardized Postpartum Depression Screening and Follow-up measure — especially if this measure can be disaggregated by race/ethnicity at the state level — would help show where the gaps are in screenings and follow-up. This data would help health professionals and health plans develop targeted strategies for improving screenings and follow-up.

We appreciate your commitment to identifying key indicators that help Texas track the quality of health care that Medicaid and CHIP beneficiaries review. If you have any questions or need more information, please contact Adriana Kohler, Policy Director or Stephanie Rubin, CEO of Texans Care for Children.

Citations

[1] https://khn.org/news/black-mothers-get-less-treatment-for-postpartum-depression-than-other-moms/. See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3733216/.

[2] DSHS Maternal & Child Health Epidemiology Regional Reports. Prepared by Maternal & Child Health Epidemiology, DSHS, based on Pregnancy Risk Assessment Monitoring System (PRAMS) combined CY 2012 - 2015 data.

The Greater Good of Northeast Indiana (Jennifer Norris-Hale)

I am writing in support of adding the POSTPARTUM Depression Screening & Follow-Up Measure to the 2021 Adult Core Set and encourage you to add PRENATAL Depression Screening & Follow-Up Measure to the 2021 Adult Core Set as well.

The Periscope Project, Medical College of Wisconsin (Christina L. Wichman)

The Periscope Project is a program of the Medical College of Wisconsin (MCW) Department of Psychiatry and Behavioral Medicine. MCW is a 501(c)3 nonprofit organization with the vision to pioneer pathways to a healthier world. The Periscope Project is perinatal psychiatric consultation program in Wisconsin aimed at building capacity in frontline health care providers to diagnosis and treat mental health conditions in perinatal patients.

POSTPARTUM DEPRESSION SCREENING. The Periscope Project applauds the Workgroup's recommendation to add the Postpartum Depression Screening and Follow-up Measure to the Medicaid 2021 Core Set of Health Care Quality Measures for Medicaid and CHIP. Mental health conditions — primarily anxiety and depression — are the MOST COMMON complications of pregnancy and childbirth, affecting 1 in 5 women. Left untreated, these illnesses can have long-term negative impact on mother, baby, family, and society.

PRENATAL DEPRESSION SCREENING. The Periscope Project encourages adding the Prenatal Depression Screening and Follow-up Measure to the Medicaid Core Set as soon as possible. It is essential to identify women who are experiencing depression or other mental health disorder as soon as possible to preserve the mental health and wellbeing of both mother and baby:

- Depression during pregnancy is the strongest predictor of postpartum depression. Massachusetts General Hospital Center for Women's Mental Health.
- Of women experiencing postpartum depression, approximately 1/3 enter pregnancy with symptoms, 1/3 develop symptoms during pregnancy, and the remaining 1/3 develop symptoms in the postpartum timeframe. *Wisner et al, 2012.*
- Women with untreated MMH conditions during pregnancy are more likely to have poor prenatal care and use substances such as alcohol, tobacco, and drugs. *Zhou et al, 2019; Field, 2010.*
- Infants born to mothers with untreated MMH conditions are at increased risk of pre-term labor, small gestational size, and longer stays in the NICU. *Grote et al, 2010; Field, 2010; Fittelson et al, 2017.*
- Women who live in poverty are MORE likely to experience MMH conditions but LESS likely to receive treatment. *Grote et al, 2010; Taylor, 2019.*
- The American College of Obstetricians and Gynecologists, along with the United States Preventive Services Task Force, recommend that women be screened at least once during pregnancy.

The Periscope Project is grateful that the Workgroup is elevating the issue of maternal mental health and look forward to assisting this process in anyway possible.

University of Massachusetts Medical School Baystate (Matthew Sadof)

Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)

It is important to remember that this measurement reflects the EPR 3 guidelines published in 2007 that promoted continual inhaled corticosteroids. The science around this is changing and the EPR4 may reflect that. See link for evidence being used for this revision. https://effectivehealthcare.ahrq.gov/sites/default/files/cer-194-evidence-summary-corticosteroids-asthma_2.pdf

University of Vermont Medical Center (Sandra G. Wood)

I am a Psychiatric Mental Health Nurse Practitioner embedded in an Obstetrical Outpatient clinic. I support adding the POSTPARTUM Depression Screening and Follow-Up Measure to the 2021 Adult Core Set. Additionally I strongly encourage the addition of the PRENATAL Depression Screening and Follow-Up Measure. Up to 2/3 of women who experience postpartum depression were depressed during or prior to pregnancy. Screening and addressing depression in the prenatal period can provide additional time to offer treatment and help birthing women get on the path to wellbeing sooner. Routine Prenatal Care offers the perfect opportunity to offer screening and follow up!

University of Washington Medicine (Sarah Prager)

I am an OBGYN in Seattle and it is critical that the Center for Medicare and Medicaid Services adds the Postpartum Depression Screening and Follow-Up measure to the 2021 Medicaid Core Set of measures. I am expressly hoping you will support this and add them to the core services.

University of Washington Maternal-Child Mental Health (Amritha Bhat and Deborah Cowley)

The University of Washington (UW) Maternal-Child Mental Health program believes that all perinatal people deserve access to equitable, timely, and high quality behavioral healthcare. We aim to improve maternal-child mental health care through evidence-based interventions that promote the behavioral health of pregnant and parenting people and their families.

Postpartum Depression Screening: We highly recommend that you add the "Postpartum Depression Screening and Follow-Up" Measure to the Medicaid 2021 Core Set of Health Care Quality Measures for Medicaid and CHIP. Perinatal mood and anxiety disorders affect 1 in 7 perinatal women in the U.S.[1] 50% are detected, 15% receive any treatment, 7% receive adequate treatment, and only 4% are treated to remission.[2]

Prenatal Depression Screening: We highly recommend that you add the "Prenatal Depression Screening and Follow-Up" measure as well. Depression during pregnancy is the strongest predictor of postpartum depression. More than half of women with postpartum depression have the onset of symptoms during pregnancy.[3,4] Prevalence rates for depression during pregnancy are 7.4%, 12.8%, and 12.0% for the first, second, and third trimesters, respectively, making depression in pregnancy more common than gestational diabetes. Screening for depression in pregnancy provides an opportunity to intervene early before the critical postpartum period.

Furthermore, women with untreated depression during pregnancy are more likely to have poor prenatal care and use substances such as alcohol, tobacco, and drugs.[5,6] Infants born to mothers with untreated depression are at increased risk of low birth weight, and longer stays in the Neonatal Intensive Care Unit.[7,6]

Women who live in poverty or are insured by Medicaid are MORE likely to experience depression but LESS likely to receive treatment.[7] The American College of Obstetricians and Gynecologists, along with the United States Preventive Services Task Force, recommend that women be screened at least once during pregnancy.

We are incredibly grateful for the efforts of the workgroup in elevating the issue of perinatal mental health, and looking forward to assisting this process in any way possible.

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University of Washington, School of Social Work (Nancy K. Grote)

I support adding the POSTPARTUM Depression Screening & Follow-Up Measure to the 2021 Adult Core Set.

I strongly encourage adding the PRENATAL Depression Screening & Follow-Up Measure to the 2021 Adult Core Set. Most postpartum depressions begin during pregnancy or even before pregnancy! It is better to pick up depression during pregnancy and treat it before it becomes postpartum!

Washington Chapter of the American Academy of Pediatrics (Diane Liebe)

The Washington Chapter of the American Academy of Pediatrics represents nearly 1200 pediatric health care providers in the state of Washington. We strongly support adding the Postpartum Depression Screening and Follow-Up measure to the 2021 Medicaid Core Set of measures.

The first months of secure attachment between parent and baby set the groundwork for healthy social, emotional and physical development. Without it, negative outcomes can affect lifelong health. The science is clear: the well-being of the two-generation child-family dyad impacts lifelong health yet care for children and families remains siloed. Health equity begins at birth; factors impacting health equity and early relational health begin prenatally and continue throughout a child's life. It is critical to support the parent/child dyad early to reduce the potential for negative outcomes.

Beginning in a baby's earliest days, secure parent-baby attachment is essential for healthy child development, supports breastfeeding, sleeping and infant/parent behavioral health. Unfortunately, post-partum mood disorders (PPMD) in the mother are common and inhibit strong parent-baby attachment. One in five moms experiences PPMD, and 40-60% are living at low incomes. Although PPMD affects roughly 12% of all white mothers, it affects at least 3 times as many mothers of color (38%). The problem is only about 16% of women experiencing PPMD receive any treatment, and only 6% of women receive adequate treatment. Timely identification is vital — just 30% of women are identified in a clinic setting — and we know accessing behavioral health care can be very challenging.

The good news is when mom receives treatment for PPMD a child is more likely to be ready for school, with improved behavioral health. Babies have multiple pediatric primary care visits in their first 6 months while new moms typically only have one post-partum visit with their own doctors. Pediatric visits are an opportune time to screen new moms and connect them to services if needed. Bright Futures standard of care, the gold-standard of screening in pediatric primary care, advises screening for PPMD at all well-baby visits in the first six months of life.

However, from our work with Washington State clinics, we know this is the exception, not the norm. Furthermore, clinics are unclear of their role in helping moms get care and have concerns about documentation and their ability to be effective. This is not a problem without a solution. Consistent and family-centered PPMD screening and referral in the pediatric setting helps mitigate care inequities in identification. Forging reliable relationships between pediatric medical homes and behavioral health helps overcome inequities and delays in treatment.

Washington State Health Care Authority (Beth Tinker)

I strongly support adding the Postpartum Depression Screening and Follow-Up measure to the 2021 Medicaid Core Set of measures.

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