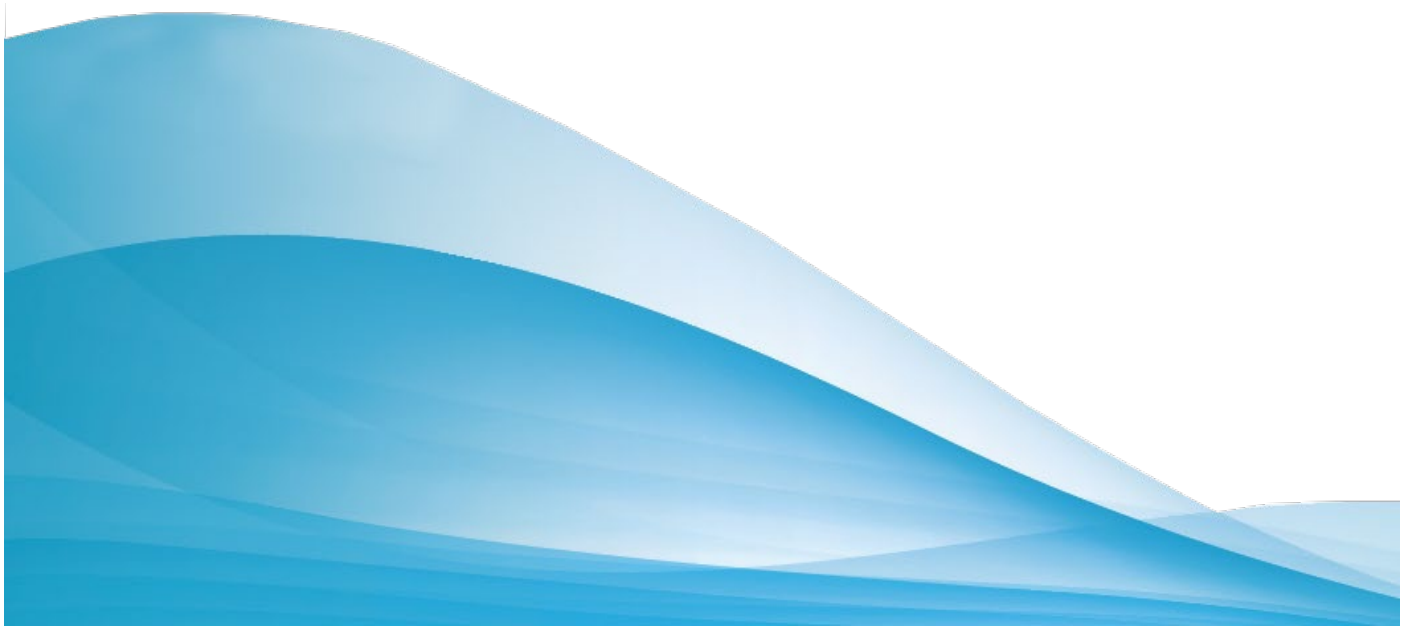
Mathematica
Progress Together

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

Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets

Final Report

August 2021



2022 CHILD AND ADULT CORE SET ANNUAL REVIEW STAKEHOLDER WORKGROUP MEMBERS

Voting Members (Affiliation as of May 2021)

Shevaun Harris, MBA, MSW, Co-Chair
Florida Department of Children and Families

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

Richard Antonelli, MD, MS
Boston Children's Hospital

Lowell Arye, MS
Aging and Disability Policy and LeadershipConsulting, LLC

Tricia Brooks, MBA
Georgetown University Center for Children and Families

Laura Chaise, MBA
Centene Corporation

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

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

Anne Edwards, MD
American Academy of Pediatrics

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

Tricia Elliott, MBA, CPHQ
The Joint Commission

Karen George, MD, MPH, FACOG
George Washington School of Medicine and Heath Sciences

Lisa Glenn, MD
Texas Health and Human Services Commission

Steve Groff
Delaware Department of Health and Social Services

Tracy Johnson, PhD, MA
Colorado Department of Health Care Policy and Financing

Diana Jolles, PhD, CNM, FACNM
Frontier Nursing University

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

Carolyn Langer, MD, JD, MPH
Fallon Health

Jill Morrow-Gorton, MD, MBA
University of Pittsburgh Medical Center (UPMC) Health Plan

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

Fred Oraene, MBA
Oklahoma Health Care Authority

Lisa Patton, PhD
IBM Watson Health

Sara Salek, MD
Arizona Healthcare Cost Containment System

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

Jennifer Tracey, MHA
Zero to Three

Michelle Tyra, PharmD
OptumRx

Ann Zerr, MD
Indiana Family and Social Services Administration

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

Federal Liaisons (Nonvoting)

Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services (HHS)
Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services, HHS
Centers for Disease Control and Prevention, HHS
Health Resources and Services Administration, HHS
Office of Disease Prevention and Health Promotion, HHS
Office of the Assistant Secretary for Planning and Evaluation, HHS
Substance Abuse and Mental Health Services Administration, HHS
U.S. Department of Veterans Affairs

Acknowledgments

This report was developed by Mathematica as part 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 2022 Core Set Annual Review Stakeholder Workgroup process and subsequent development of this report benefitted from the contributions of the entire team:

Project director: Margo Rosenbach, Ph.D., Mathematica

Research, analytics, and logistics team: Chrissy Fiorentini, Dayna Gallagher, Patricia Rowan, Alli Steiner, Jessica Rosenblum, Emily Peterson, and Aditya Acharya, Mathematica

Communications and editorial support: Christal Stone Valenzano, Derek Mitchell, Sheryl Friedlander, Margaret Hallisey, Amy Kasman, Maria Myers, Amanda Bernhardt, Jill Miller, and Matthew Mariani, Mathematica

Technical writers: Megan Thomas and Jenneil Magpantay, Aurrera Health Group

Mathematica would also like to acknowledge the contributions of the Core Set Workgroup members. Each Workgroup member brought an invaluable perspective that informed the recommendations for the 2022 Child and Adult Core Sets. In particular, we thank the Workgroup co-chairs, Shevaun Harris and David Kelley, for their insightful leadership.

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

Mathematica also appreciates the public comments provided by stakeholders during the Workgroup meetings.

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

Contents

Acknowledgments iii

Acronyms vi

Executive Summary ix

Introduction 1

Overview of the Child and Adult Core Sets 3

- The 2021 Child Core Set 3
- The 2021 Adult Core Set 5
- State Challenges with Reporting the Child and Adult Core Set Measures 6
- Use of the Core Sets for Quality Measurement and Improvement 6

Description of the 2022 Core Set Annual Review Process 8

- Workgroup Composition 8
- Workgroup Timeline and Meetings 8

Workgroup Recommendations for Improving the 2022 Core Sets 14

- Criteria Considered for Removal of Existing Measures and Addition of New Measures 14
- Summary of Workgroup Recommendations 17
- Measures Recommended for Removal 18
- Measures Recommended for Addition 22
- Cross-Cutting Themes in Measure Discussions 31
- Discussion of Core Set Measure Gaps 34
- Additional Suggestions for Improving the Core Sets and the Annual Review Process 36

Next Steps 38

Appendix A: Child and Adult Core Set Measures A.1

Appendix B: Measures Suggested for Review at the 2022 Core Set Annual Review, by Domain B.1

Appendix C: Summary of 2022 Child and Adult Core Set Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition C.1

Appendix D: Public Comments on the Draft Report D.1

Exhibits

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

ES.2. Summary of Workgroup Recommendations for Updates to the 2022 Core Sets xii

1. Annual Medicaid and CHIP Expenditures by Service Category, 2018 1

2. Distribution of 2021 Child and Adult Core Set Measures, by Domain 4

3. 2022 Core Set Annual Review Stakeholder Workgroup Timeline 9

4. Framework for Assessing Measures for the 2022 Core Sets 10

5. Criteria Considered for Removal of Existing Measures and Addition of New Measures 14

6. Summary of Workgroup Recommendations for Updates to the 2022 Core Sets 17

7. Synthesis of Workgroup Discussions About Potential Gaps in the Child and Adult Core Sets 35

A.1. 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) A.2

A.2. 2021 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) A.4

A.3. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2012–2021 ..... A.7

A.4. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2013–2021 ..... A.13

B.1. Measures Suggested for Review at the 2022 Child and Adult Core Set Annual Review, by Domain B.2

C.1. Measures Discussed by the 2022 Core Set Annual Review Workgroup and Not Recommended for Removal or Addition, by Domain C.9

D.1. Summary of Public Comments by Topic and Commenter D.3

Acronyms

ACE	Adverse childhood experiences
ACO	Accountable care organization
ADA	American Dental Association
AHRQ	Agency for Healthcare Research and Quality
AMB-CH	Ambulatory Care: Emergency Department (ED) Visits
AOD	Alcohol and other drug
AUD-CH	Audiological Diagnosis No Later than 3 Months of Age
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control and Prevention
CDP-AD	Controlling High Blood Pressure
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
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
FIT	Fecal immunochemical test
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUH	Follow-Up After Hospitalization for Mental Illness
FUM	Follow-Up After Emergency Department Visit for Mental Illness
FVA-AD	Flu Vaccinations for Adults Ages 18 to 64
HbA1c	Hemoglobin A1c
HCBS	Home- and community-based services
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HMO	Health maintenance organization
HPC-AD	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
IET-AD	Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment
LBW-CH	Live Births Weighing Less than 2,500 Grams
LTSS	Long-Term Services and Supports
LRCD-CH	Low-Risk Cesarean Delivery
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
NCI-AD	National Core Indicators for Aging and Disabilities
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder
PC01-AD	PC-01: Elective Delivery

PCMH	Patient-Centered Medical Home
PCPI	Physician Consortium for Performance Improvement
PDC	Proportion of Days Covered
PDENT-CH	Percentage of Eligibles Who Received Preventive Dental Services
PQA	Pharmacy Quality Alliance
Q&A	Question and answer
QTAG	Quality Technical Advisory Group
RAS	Renin angiotensin system
SFM-CH	Sealant Receipt of Permanent First Molars
SUD	Substance use disorder
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support
TAF	T-MSIS Analytic Files
TJC	The Joint Commission
T-MSIS	Transformed Medicaid Statistical Information System
URI	Upper respiratory infection
USPSTF	U.S. Preventive Services Task Force
WONDER	Wide-ranging Online Data for Epidemiologic Research

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to 80.5 million people, including eligible children, pregnant women, low-income adults, the elderly, and individuals with disabilities.[1] To help ensure that Medicaid and CHIP beneficiaries receive 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 beneficiaries 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 will become mandatory for state reporting in 2024.[2]

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.[3] The Core Set Annual Review process is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from numerous stakeholders, including but not limited to state Medicaid and CHIP agency representatives, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2022 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup). The Workgroup included 29 Workgroup members, who represented a diverse set of stakeholders based on their affiliation, subject matter expertise, and quality measurement and improvement experience (see inside front cover for a list of the Workgroup members).

The Workgroup was charged with assessing the 2021 Core Sets and recommending measures for removal or addition, in order to strengthen and improve the Core Sets for 2022. Workgroup members were asked to suggest, discuss, and vote on the measures based on whether they could meaningfully drive improvement in care delivery and health outcomes for Medicaid and CHIP

[1] January 2021 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. The numbers reflect Medicaid and CHIP enrollment data as of January 2021 (last updated as of April 2, 2021), as reported by 50 states and the District of Columbia.

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

[3] Annual updates to the Child Core Set are required under the Children's Health Insurance Program Reauthorization Act of 2009. Annual updates to the Adult Core Set are required under the Affordable Care Act of 2010.

beneficiaries. See Exhibit ES.1 for the criteria that Workgroup members considered during the 2022 Core Set Annual Review.

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 that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3. The specifications and data source do not allow for consistent calculations across states.
4. The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP or does not allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).
2. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3. The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out or improvement is outside the direct influence of Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All states will not be able to produce the measure by FFY 2024.
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.
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.

Exhibit ES.1 *(continued)*

Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP and to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).[4]
2.	The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3.	The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP.
Criteria Considered for Addition of New Measures	
Other Considerations	
1.	The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications are aligned with those used in other CMS programs, where possible.
3.	All states must be able to produce the measure by FFY 2024, including all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

Workgroup members convened virtually from May 4 to May 6, 2021, to review 7 existing Core Set measures suggested for removal from the 2022 Core Sets and 14 measures suggested for addition. The 21 measures were presented, discussed, and voted on by domain.[5] For a measure 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 must vote in favor of removal or addition.

In summary, the Workgroup recommended the following:

- **Removal of 3 measures from the Child Core Set** out of a total of 3 measures suggested for removal
- **Removal of 1 measure from the Adult Core Set** out of a total of 4 measures suggested for removal
- **Addition of 7 measures to the Child and Adult Core Sets** out of a total of 14 measures suggested for addition

Exhibit ES.2 shows the measures the Workgroup recommended for removal from and addition to the 2022 Core Sets.

[4] https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

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

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2022 Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Removal from the Child Core Set		
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Centers for Medicare & Medicaid Services (CMS)	Not endorsed
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	National Committee for Quality Assurance (NCQA)	Not endorsed
Audiological Diagnosis No Later than 3 Months of Age (AUD-CH)	Centers for Disease Control and Prevention (CDC)	1360
Measure Recommended for Removal from the Adult Core Set		
PC-01: Elective Delivery (PC01-AD)	The Joint Commission (TJC)	0469/0469e
Measures Recommended for Addition		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17[a]	NCQA	3488
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17[a]	NCQA	3489
Oral Evaluation, Dental Services	American Dental Association (ADA)/Dental Quality Alliance (DQA)	2517
Prevention: Topical Fluoride for Children[b]	ADA/DQA	2528
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058
Long-Term Services and Supports: Comprehensive Care Plan and Update	NCQA	Not endorsed
Colorectal Cancer Screening	NCQA	0034

[a] These measures are currently included in the Adult Core Set (FUA-AD and FUM-AD) for the adult age ranges. The Workgroup recommended these measures for addition to the Child Core Set for the child age ranges.

[b] A Workgroup member suggested a version of this measure that focused on children at elevated caries risk (*Prevention: Topical Fluoride for Children at Elevated Caries Risk)*. In spring 2021, the measure steward modified this measure to include *all* children (not just those at elevated caries risk). Because this change applies to calendar year 2021 reporting, which corresponds to the 2022 Child Core Set, the Workgroup discussed and voted on the modified version of the measure.

This report describes the 2022 Core Set Annual Review Workgroup's review process, summarizes the Workgroup's recommendations for improving the Core Sets, and presents the public comments submitted on the draft report. CMCS will review the final report to inform

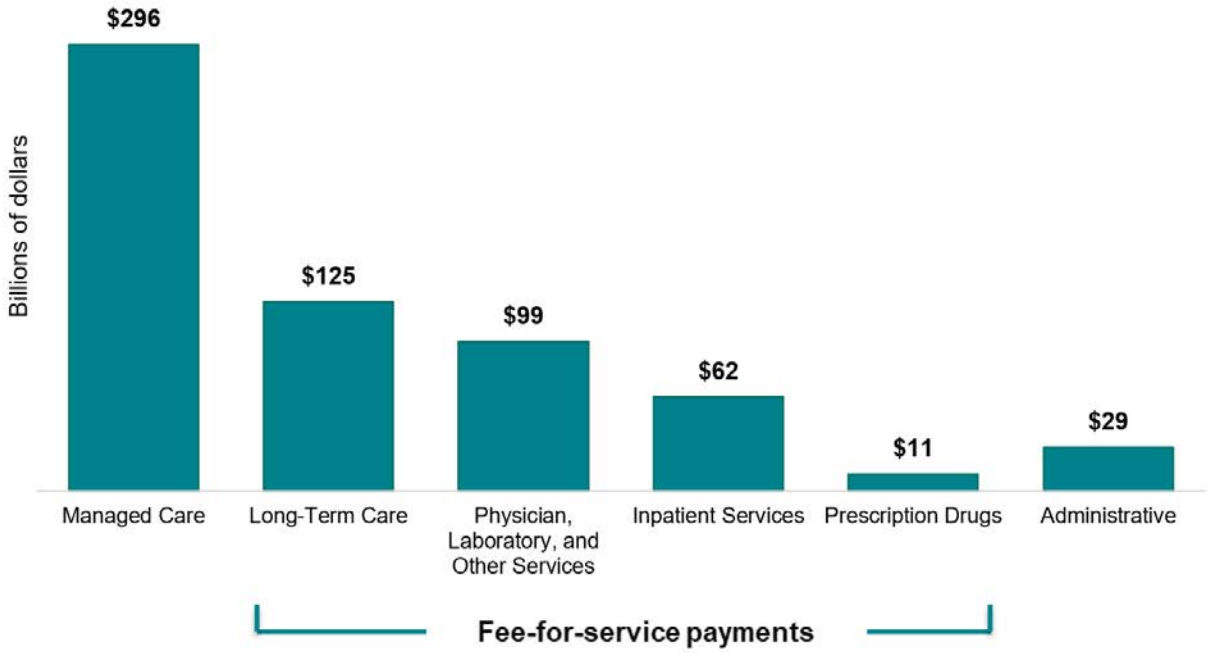
decisions about whether and how to modify the 2022 Child and Adult Core Sets. Additionally, CMCS will obtain stakeholder input from federal agencies and from state Medicaid and CHIP quality leaders to ensure that the Core Set measures are evidence-based and promote measure alignment within CMS and across the federal government.[6] CMCS will release the 2022 Child and Adult Core Sets through a CMCS Informational Bulletin by December 31, 2021.

[6] More information is available in the CMCS fact sheet, Medicaid and CHIP Child and Adult Core Sets Annual Review and Selection Process, at https://www.medicaid.gov/medicaid/quality-of-care/downloads/annual-core-set-review.pdf.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to 80.5 million people, including eligible children, pregnant women, low-income adults, the elderly, and individuals with disabilities.[7] Medicaid and CHIP are the largest single source of health coverage in the United States.[8] Managed care capitation payments are the largest category of Medicaid and CHIP program expenditures, followed by fee-for-service payments for long-term care (Exhibit 1).

Exhibit 1. Annual Medicaid and CHIP Expenditures by Service Category, 2018



Source: CMS. 2020 Medicaid & CHIP Scorecard. Analysis of CMS-64 expenditure reports for FFY 2018 from the Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES). Available at https://www.medicaid.gov/state-overviews/scorecard/annual-medicaid-chip-expenditures/index.html.

Notes: Expenditures by service category do not sum to the total expenditures. Total expenditures also include Medicare payments for some beneficiaries and adjustments to prior year payments. Managed care expenditures cover the same services that are delivered via fee-for-service. The data do not permit allocation of managed care expenditures to the different service categories. Data are for FFY 2018.

[7] January 2021 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. The numbers reflect Medicaid and CHIP enrollment data as of January 2021 (last updated as of April 2, 2021), as reported by 50 states and the District of Columbia.

[8] Centers for Medicare & Medicaid Services. "New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 million Americans Enrolled in Coverage During the COVID-19 Public Health Emergency." June 21, 2021. Available at: https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during.

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.

The purpose of the Child and Adult Core Sets is to estimate the 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 monitor the performance of state Medicaid and CHIP programs and identify where improvements in care delivery and outcomes are needed, and target quality improvement efforts and assess their effectiveness over time.

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.[9] 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, including but not limited to state Medicaid and CHIP agency representatives, 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 2022 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup). The Workgroup included 29 Workgroup 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 2021 Child and Adult Core Sets[10] and recommending measures for removal or addition in order to strengthen and improve the Core Sets for 2022. 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 2022 Core Set Annual Review process, summarizes the Workgroup's recommendations for improving the Core Sets, and includes public comments on the Workgroup recommendations.

[9] 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.

[10] More information about the annual multistakeholder review of the 2021 Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview. More information about the 2021 updates to the Child and Adult Core Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.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 enrolled in Medicaid and CHIP. CHIPRA required the Secretary of HHS to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs (referred to as the Child Core Set). The initial Child Core Set, which was released in December 2009, included 24 measures that covered both physical and mental health. The core set of health care quality measures for adults covered by Medicaid (Adult Core Set) was established in 2010 under the Patient Protection and Affordable Care Act (Affordable Care Act) in the same manner as the Child Core Set. The initial Adult Core Set, which was released in January 2012, included 26 measures. Currently, state reporting 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.[11] Each year, CMS publicly reports data for Child and Adult Core Set measures that were reported by at least 25 states and met CMS standards for data quality.

Please refer to Appendix A for tables showing the 2021 Child and Adult Core Set measures and the history of measures included in the Child and Adult Core Sets. Of the 23 measures in the 2021 Child Core Set, about three-fifths were part of the initial Child Core Set. Similarly, of the 32 measures in the 2021 Adult Core Set, about three-fifths were part of the initial Adult Core Set.

The 2021 Child Core Set

The 2021 Child Core Set includes 23 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.[12] Just over 60 percent of the measures in the 2021 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 (19 measures) can be calculated using an administrative data methodology.

Highlights for federal fiscal year (FFY) 2019 Child Core Set reporting,[13] the most recent year of publicly available data, include the following:

---

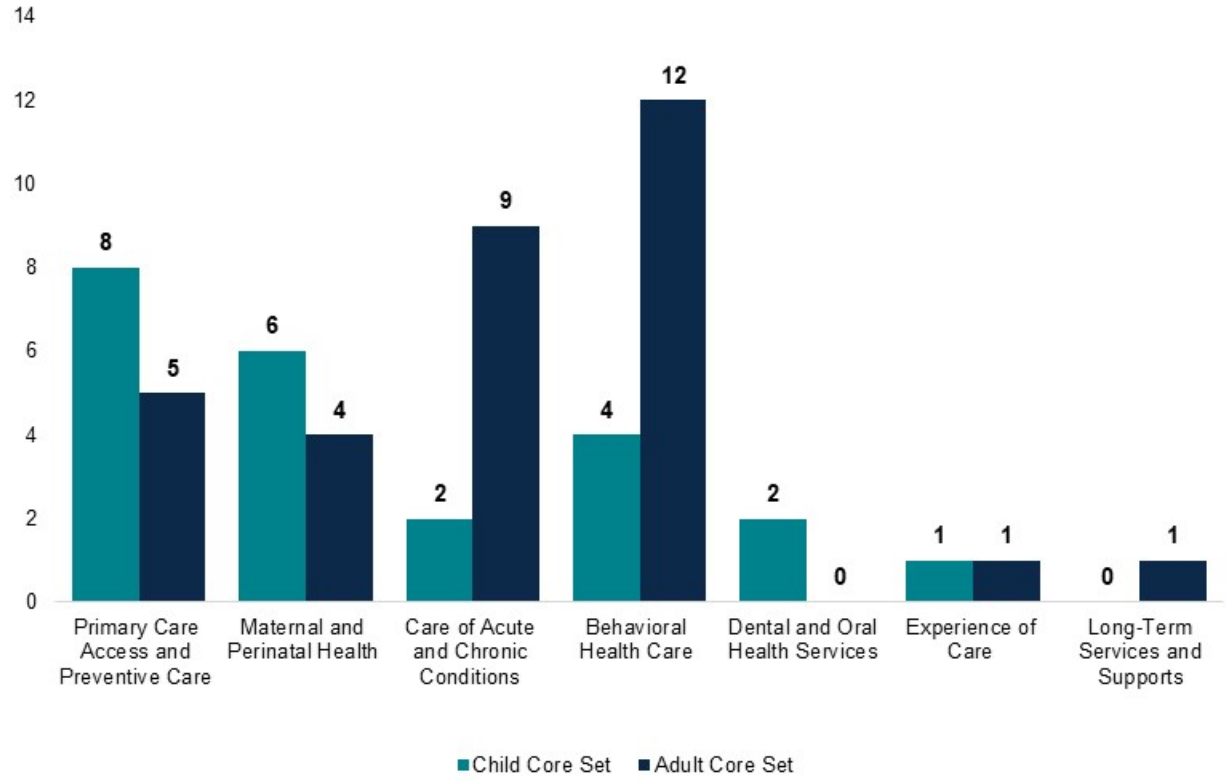
[11] Bipartisan Budget Act of 2018, P.L. 115-123 and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271.

[12] More information about the Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

[13] More information about FFY 2019 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-core-set-reporting.pdf. A chart pack summarizing FFY 2019 Child Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-chart-pack.pdf.

- All states[14] voluntarily reported at least one Child Core Set measure.
- Forty-eight states reported on at least half of the 26 measures in the 2019 Child Core Set.
- Thirty-one states reported on more measures for FFY 2019 than for FFY 2018.
- Forty-eight states reported data on both the Medicaid and CHIP populations.
- The median number of measures reported by states was 20, which was slightly higher than the median number of measures reported for both FFY 2018 and FFY 2017 (18 measures).
- Twenty-three of the 26 Child Core Set measures (88 percent) in the 2019 Child Core Set met CMS's threshold for public reporting of state-specific results.
- The most frequently reported Child Core Set measures for FFY 2019 focused on preventive dental services, low birth weight births, child and adolescent well-care visits, emergency department use, and primary care access. The most frequently reported measures in the Child Core Set are based on existing administrative data sources or are calculated by CMS on behalf of states using alternate data sources.

Exhibit 2. Distribution of 2021 Child and Adult Core Set Measures, by Domain



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

The 2021 Adult Core Set

The 2021 Adult Core Set includes 32 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Experience of Care, and (6) Long-Term Services and Supports.[15] The Long-Term Services and Supports domain was added to the Adult Core Set in the 2020 update.[16] Nearly two-thirds of the 2021 Adult Core Set measures fall into the Care of Acute and Chronic Conditions and Behavioral Health Care domains (Exhibit 2). Behavioral Health Care is the largest domain in the 2021 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, while 84 percent (27 measures) can be calculated using an administrative data methodology.

Highlights for FFY 2019 Adult Core Set reporting,[17] the most recent year of publicly available data, include the following:

- Forty-six states voluntarily reported at least one Adult Core Set measure.
- Forty states reported on at least half of the 33 measures in the 2019 Adult Core Set, an increase of eight states over FFY 2018 reporting. One state reported all 33 measures for FFY 2019.
- Thirty-six states reported more measures for FFY 2019 than for FFY 2018.
- States reported a median of 22.5 measures, an increase of 2.5 measures over FFY 2018.
- Twenty-five of the 33 measures (76 percent) in the 2019 Adult Core Set met CMS's threshold for public reporting of state-specific results.
- The most frequently reported Adult Core Set measures for FFY 2019 focused on chlamydia screening, follow-up after hospitalization for mental illness, breast and cervical cancer screening, medication management, and diabetes testing. The most frequently reported measures in the Adult Core Set were based on existing administrative data sources.

---

[15] More information about the Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

[16] 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.

[17] More information about FFY 2019 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-core-set-reporting.pdf. A chart pack summarizing FFY 2019 Adult Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf.

State Challenges with Reporting the Child and Adult Core Set Measures

Understanding state challenges with reporting the Child and Adult Core Set measures is important to assessing the feasibility of calculating existing measures as well as those suggested for addition to the Core Sets. The most common reason states cited for not reporting the Child and Adult Core Set measures for FFY 2019 was lack of access to data to calculate the measure. States' reasons for lack of access to data for Core Set reporting were multifaceted and reflected the pathways through which the data were 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 or encounter data. For example, common barriers to data availability in FFY 2019 included challenges with accessing the required data sources (including medical records for chart abstraction and linkage to vital records or immunization registries), concerns about the accuracy and completeness of data used in calculating the measure, and resource constraints within the state agencies responsible for Core Set reporting. These challenges were similar to those cited by states for FFY 2018.

Workgroup members were provided with information about states' reasons for not reporting the existing Core Set measures as well as a summary of technical assistance (TA) efforts to improve state reporting on the least-reported measures. These findings informed the Workgroup's discussion 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.[18] As noted previously, CMS annually releases Child and Adult Core Set data for measures that were reported by at least 25 states and met CMS standards for data quality. Pillar I of the Medicaid and CHIP Scorecard, State Health System Performance, also uses data for several Child and Adult Core Set measures.[19]

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMCS supports states and their partners in collecting, reporting, and using the Core Set measures to drive improvement in Medicaid and CHIP, while also striving to achieve several goals for state reporting. These goals include maintaining or increasing the number of states that report the Core Set measures, maintaining or increasing the number of measures reported by each state, and

[18] Chart packs, measure-specific tables, facts sheets, and other Core Set annual reporting resources are available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html and https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

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

improving the quality and completeness of the data reported.[20] CMS also continuously explores opportunities to increase the efficiency of reporting and reduce state reporting burden, streamline Core Set reporting for states, and improve the transparency and comparability of the data reported across states. The TA/AS Program offers states various opportunities to address technical issues related to collecting and reporting the Core Set measures, including a TA mailbox, one-on-one consultation, issue briefs, fact sheets, analytic reports, and webinars.

CMCS has also developed initiatives to drive improvement in health care quality and outcomes using Core Set measures—for example, through the Maternal and Infant Health Initiative and the Oral Health Initiative.[21] 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.

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

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

Description of the 2022 Core Set Annual Review Process

This section describes the 2022 Core Set Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2022 Core Set Annual Review included 29 voting members from state Medicaid and CHIP agencies, professional associations, universities, hospitals, and other organizations from across the country. The Workgroup was selected through a Call for Nominations issued in December 2018 in conjunction with the 2020 Core Set Annual Review. Changes to the Workgroup composition have occurred due to attrition and career transitions. New Workgroup members have been identified, as needed, through outreach to nominating organizations. The Workgroup members for the 2022 Core Set Annual Review are listed on the inside front cover of this report.

The 2022 Core Set Annual Review Workgroup members offered expertise in primary care access and preventive care, acute and chronic conditions, maternal and perinatal health, behavioral health, dental and oral health, LTSS, and health disparities. Although Workgroup members have individual subject matter expertise and some were nominated by an organization, they were asked to participate as stewards of the Medicaid and CHIP programs as a whole and not from their individual points of view. They were asked to consider what measures would best drive improvement in care delivery and health outcomes for the programs.

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

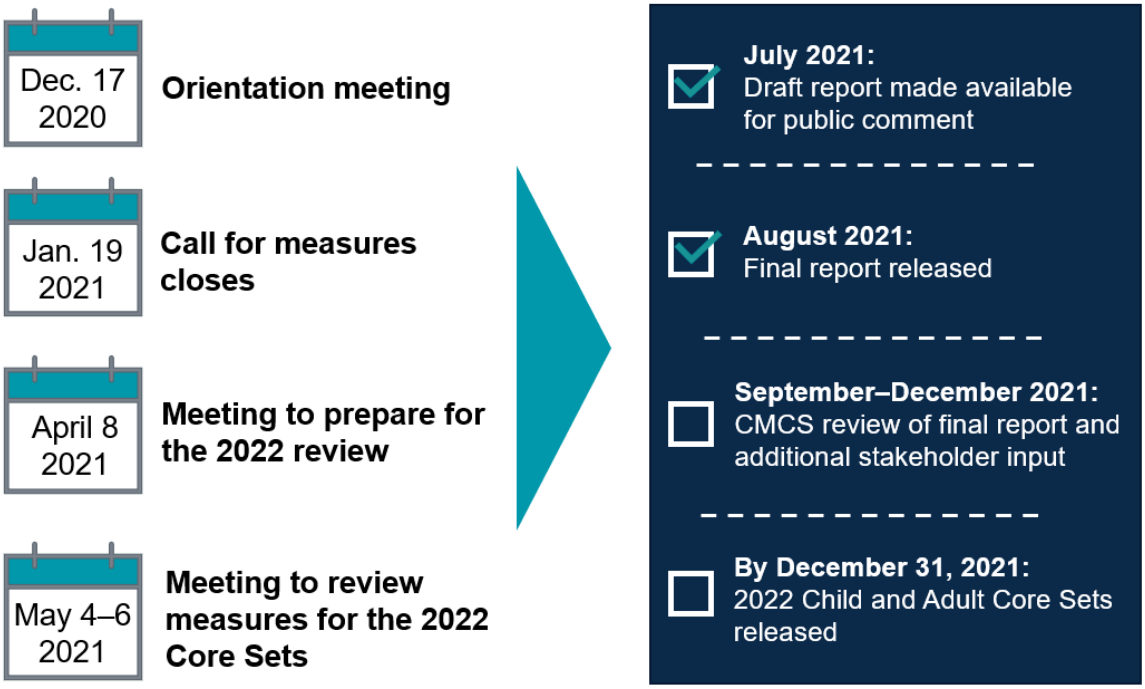
The Workgroup also included nonvoting federal liaisons, who represented eight agencies (see front cover). The inclusion of federal liaisons reflects CMCS's commitment to promoting quality measurement alignment and working in partnership with other agencies to collect, report, and use the Core Set measures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

Workgroup Timeline and Meetings

As shown in Exhibit 3, Mathematica held webinars in December 2020 and April 2021 to orient the Workgroup members to the review process and to prepare them for the 2022 Core Set Annual Review voting meeting, which was convened virtually in May 2021. All meetings were open to the public, and public comment was invited during each meeting. The draft report summarizing the Workgroup recommendations was released on July 1, 2021, and available for public comment until August 6, 2021. This final report incorporates public comments in Appendix D.

CMCS will review the final report and obtain stakeholder input from federal agencies and from state Medicaid and CHIP quality leaders to inform decisions about whether and how to modify the 2022 Child and Adult Core Sets. CMCS will release the 2022 Child and Adult Core Sets through a CMCS Informational Bulletin by December 31, 2021.

Exhibit 3. 2022 Core Set Annual Review Stakeholder Workgroup Timeline



Orientation Webinar

During the orientation webinar on December 17, 2020, Mathematica outlined the Workgroup charge, introduced the Workgroup members, and provided background on the Child and Adult Core Sets.

After providing an overview of the process for the 2022 Core Set Annual Review, Mathematica reviewed the outcomes of the previous year's Workgroup. Mathematica described the additional stakeholder input that would be obtained during the 2022 Annual Review process, including input from federal partners, internal stakeholders within CMS, and CMCS's Quality Technical Advisory Group (QTAG).

Workgroup Charge

The Child and Adult Core Set Stakeholder Workgroup for the 2022 Annual Review is charged with assessing the 2021 Core Sets and recommending measures for removal or addition, in order to strengthen and improve the Core Sets for Medicaid and CHIP.

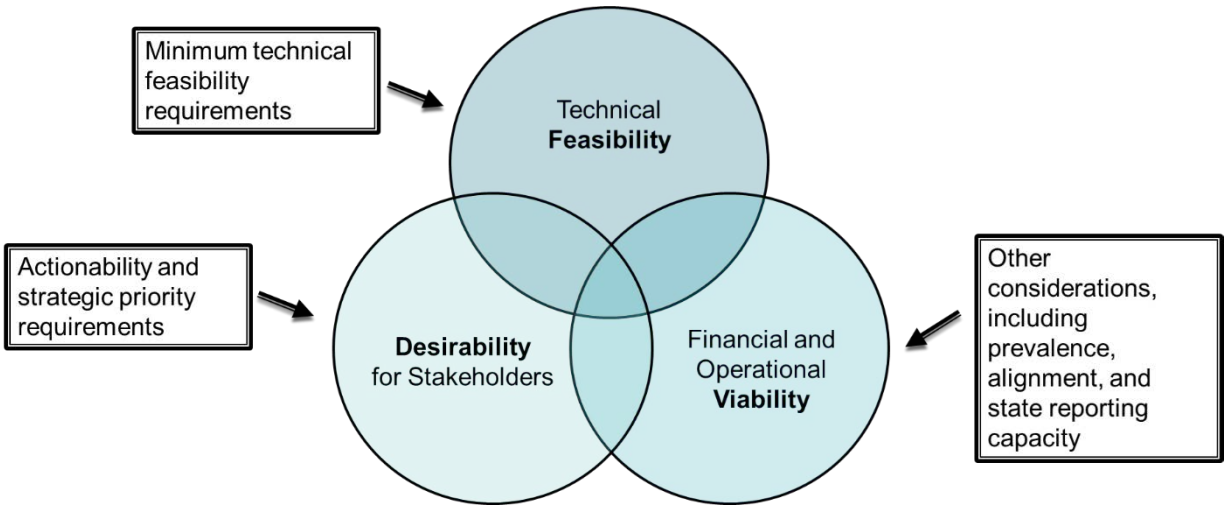
The Workgroup should focus on measures that are actionable, aligned, and appropriate for state-level reporting, to ensure that the measures can meaningfully drive improvement in quality of care and outcomes in Medicaid and CHIP.

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

To operationalize these three components, Mathematica identified a comprehensive set of criteria used to assess measures during all phases of the Workgroup process. As shown in Exhibit 4, the Workgroup was charged with focusing on measures that met the following criteria:

- **Minimum technical feasibility requirements:** Availability of detailed technical specifications that enable production of the measure at the state level; evidence of field testing or use in a state Medicaid or CHIP program; availability of a data source with all the necessary data elements; and ability 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, and can be used to perform comparative analyses; addresses a strategic priority for improving health care delivery and outcomes; and assesses state progress in improving health care delivery in Medicaid and CHIP
- **Other considerations:** Sufficient prevalence of the condition or outcome being measured to produce meaningful and reliable results across states; alignment with measures used in other CMS programs; and capacity for all states to report the measure by 2024

Exhibit 4. Framework for Assessing Measures for the 2022 Core Sets



CMCS provided introductory remarks regarding the Workgroup's charge, emphasizing the importance of the Core Sets across CMCS for measuring the delivery of high quality care for the purpose of improving health outcomes. CMCS noted that Core Set measures function like their

"North Star," signaling the measures that stakeholders believe are important to understanding how well Medicaid and CHIP programs serve beneficiaries.

CMCS explained its decision-making on updates to the 2021 Core Sets, noting why Workgroup recommendations were taken or not taken. CMCS noted that it deferred decision-making on two measures—*Postpartum Depression Screening and Follow-up* and *Prenatal Immunization Status*—due to their use of Electronic Clinical Data Systems (ECDS). ECDS is a Healthcare Effectiveness Data and Information Set (HEDIS) reporting standard for health plans collecting and submitting quality measures to the National Committee for Quality Assurance (NCQA). This reporting standard defines the data sources and types of structured data acceptable for use for a measure. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems, and electronic health records.[22] CMCS is currently assessing the feasibility of these proprietary measures and whether the measure specifications can be made available to states free of charge as part of the Core Sets.

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

Following the orientation meeting, the Workgroup members and federal liaisons were invited to suggest measures for removal from or addition to the Core Sets to strengthen and improve the Core Sets for 2022. Workgroup members used an online form to submit their suggestions for removal or addition, along with the following information:

- 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 Sets
- Whether other measures were proposed to replace measures suggested for removal
- Whether measures suggested for addition were intended to replace current Core Set measures

The Workgroup members and federal liaisons suggested 7 measures for removal and 20 measures for addition. Mathematica conducted a preliminary assessment of these 27 measures and determined that 6 of the 20 measures recommended for addition would not be discussed at the May meeting because they did not meet minimum technical feasibility requirements; 5 measures had not been field tested by state Medicaid and CHIP programs, and 1 measure was not fully specified with a rate, numerator, and denominator.

[22] More information about the ECDS reporting method is available at https://www.ncqa.org/hedis/the-future-of-hedis/hedis-electronic-clinical-data-system-ecds-reporting/.

The Workgroup discussed 21 measures during the May meeting:

- **Seven measures for removal** across five Core Set domains, including 3 of the 23 measures in the 2021 Child Core Set and 4 of the 32 measures in the 2021 Adult Core Set
- **Fourteen measures for addition** across five Core Set domains

Please refer to Appendix B for the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the 2022 Core Sets.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on April 8, 2021. To help Workgroup members prepare for the discussion at the 2022 Annual Review meeting, Mathematica shared a list of the 7 measures to be considered for removal and the 14 measures to be considered for addition. Mathematica also provided a list of the measures suggested for addition that would not be reviewed at the May meeting and noted which feasibility criteria these measures did not meet.

Mathematica provided guidance to the Workgroup about how to prepare for the discussion of the measures at the May 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, a worksheet to record questions and notes for each measure, the Medicaid and CHIP beneficiary profile, the Core Set history table, reasons for not reporting Core Set measures, chart packs and measure-specific tables, and the Core Set resource manuals and technical specifications. Workgroup members were responsible for reviewing all materials related to the measures; completing the measure worksheet; and coming to the Annual Review meeting prepared with notes, questions, and preliminary votes on each measure proposed for removal or addition.

Annual Review Meeting

The 2022 Core Set Annual Review voting meeting took place virtually from May 4 to May 6, 2021. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

The discussion of measures was organized according to the current Core Set domains. The measures that were discussed spanned six of the seven domains.[23] For each domain, Mathematica described the 2021 Core Set measures in the domain, highlighted the measures suggested for removal first followed by the measures suggested for addition, noted the key technical

[23] 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. There were no measures suggested for removal from or addition to the Experience of Care domain during the 2022 Annual Review.

specifications of each measure proposed for removal or addition, and summarized the rationale that Workgroup members provided for suggesting the measures.

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

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

Within each domain, the Workgroup generally voted on measures suggested for removal first, followed by measures suggested for addition. However, if a measure suggested for removal had a replacement measure suggested for addition, the measure suggested for addition was voted on first. This process ensured that gaps were not unintentionally created in the Core Sets by removing an existing measure before the Workgroup had an opportunity to vote on the measure being suggested as a replacement.

For each measure suggested for removal, Workgroup members could select either "Yes, I recommend removing this measure from the Core Set" or "No, I do not recommend removing this measure from the Core Set." For each measure suggested for addition, Workgroup members could select either "Yes, I recommend adding this measure to the Core Set" or "No, I do not recommend adding this measure to the Core Set."

Measures were recommended for removal or addition if two-thirds of the eligible Workgroup members voted yes. The two-thirds voting threshold was adjusted based on the number of eligible Workgroup members present for each measure vote. No fewer than 27 of the 29 Workgroup members were present for a given vote (including one recusal).[24]

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 gaps in the Core Sets is presented later in the report.

[24] 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.

Workgroup Recommendations for Improving the 2022 Core Sets

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

To focus the Call for Measures on measures that would be a good fit for the Core Sets, Mathematica specified detailed criteria for the Workgroup to assess measures for removal from or addition to the 2022 Core Sets in three areas: (1) minimum technical feasibility requirements, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

Based on lessons learned from the 2021 Core Set Annual Review, Mathematica refined the criteria for 2022. Notably, for measures suggested for removal, Mathematica added a technical feasibility criterion related to measures that were being retired by a measure steward. For measures suggested for addition, Mathematica added a technical feasibility criterion to require that technical specifications must be provided free of charge for state use in the Core Sets; this criterion, established by CMCS, was not considered by Workgroup members in their decision making. Under the actionability and strategic priority area for additions and removals, Mathematica expanded a criterion to emphasize language in CHIPRA that the Core Set measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries. Mathematica also amended the remaining two actionability and strategic priority criteria to align more closely with the purpose and uses of 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 or CHIP programs.

Exhibit 5. 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 that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3.	The specifications and data source do not allow for consistent calculations across states.
4.	The measure is being retired by the measure steward and will no longer be updated or maintained.

Exhibit 5 *(continued)*

Criteria Considered for Removal of Existing Measures
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP or does not allow for comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).
2. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3. The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out or improvement is outside the direct influence of Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All states will not be able to produce the measure by FFY 2024.
Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid or 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.
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP and to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries (as specified in the Statute).
2. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
3. The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP.
Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible.
3. All states must be able to produce the measure by FFY 2024, including all 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 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. Mathematica noted that CMS is exploring the use of alternate data sources to calculate current Core Set measures. The goals are to reduce state burden and standardize reporting across states. Current efforts include the following:

- Using data from the Centers for Disease Control and Prevention (CDC) Wide-ranging Online Data for Epidemiologic Research (WONDER) databases to calculate *Low Birth Weight Rate* (LBW-CH, formerly *Live Births Weighing Less Than 2,500 Grams*) and *Low-Risk Cesarean Delivery* (LRCD-CH, formerly *PC-02: Cesarean Birth*)[25]
- Pilot testing the use of data submitted by states and health plans to the Agency for Healthcare Research and Quality (AHRQ) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey Database[26] to report four Core Set measures: the *Child and Adult Medicaid CAHPS Health Plan Survey* measures (CPC-CH and CPA-AD), *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD), and *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD)
- Giving eligible states the option to have CMS generate their FFY 2020 Form CMS-416 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) report using CMS's Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF),[27] which includes the *Preventive Dental Services* (PDENT-CH) measure in the Child Core Set[28]
- Testing the feasibility of using TAF to construct other Core Set measures, prioritizing measures subject to mandatory reporting in FFY 2024

In advance of voting, 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.

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

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

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

[28] More information about Form CMS-416 reporting is available at https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

Summary of Workgroup Recommendations

The Workgroup recommended the following (Exhibit 6):

- Removal of three measures from the Child Core Set
- Removal of one measure from the Adult Core Set
- Addition of seven measures to the Child and Adult Core Sets

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

Exhibit 6. Summary of Workgroup Recommendations for Updates to the 2022 Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Removal from the Child Core Set		
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Centers for Medicare & Medicaid Services (CMS)	Not endorsed
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	National Committee for Quality Assurance (NCQA)	Not endorsed
Audiological Diagnosis No Later than 3 Months of Age (AUD-CH)	Centers for Disease Control and Prevention (CDC)	1360
Measure Recommended for Removal from the Adult Core Set		
PC-01: Elective Delivery (PC01-AD)	The Joint Commission (TJC)	0469/0469e
Measures Recommended for Addition		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17[a]	NCQA	3488
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17[a]	NCQA	3489
Oral Evaluation, Dental Services	American Dental Association (ADA)/Dental Quality Alliance (DQA)	2517
Prevention: Topical Fluoride for Children[b]	ADA/DQA	2528
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058

[29] The Measure Information Sheets for measures suggested for removal are available at https://www.mathematica.org/-/media/internet/features/2021/coreset/coresetreview_2022removals.pdf. The Measure Information Sheets for measures suggested for addition are available at https://www.mathematica.org/-/media/internet/features/2020/coreset/core-set-review_2021-additions.pdf?la=en.

Exhibit 6 *(continued)*

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Long-Term Services and Supports: Comprehensive Care Plan and Update	NCQA	Not endorsed
Colorectal Cancer Screening	NCQA	0034

[a] These measures are currently included in the Adult Core Set (FUA-AD and FUM-AD) for the adult age ranges. The Workgroup recommended these measures for addition to the Child Core Set for the child age ranges.

[b] A Workgroup member suggested a version of this measure that focused on children at elevated caries risk (*Prevention: Topical Fluoride for Children at Elevated Caries Risk)*. In spring 2021, the measure steward modified this measure to include *all* children (not just those at elevated caries risk). Because this change applies to calendar year 2021 reporting, which corresponds to the 2022 Child Core Set, the Workgroup discussed and voted on the modified version of the measure.

Measures Recommended for Removal

This section summarizes the Workgroup discussion of the four measures recommended for removal from the Child and Adult Core Sets.

Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)

The PDENT-CH 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 EPSDT reporting (Form CMS-416).

Two Workgroup members suggested removing the measure from the Child Core Set. One Workgroup member noted concerns with the measure's methodology, indicating that it may be subject to inconsistencies in calculations due to the broad set of codes that states use to calculate the measure. This Workgroup member also noted a potential lack of rigorous testing to establish reliable and consistent calculations across states due to their differences in coding, covered benefits, or data completeness. Both Workgroup members noted that removal of this measure would leave a gap in the Child Core Set, with one Workgroup member suggesting the *Prevention: Topical Fluoride for Children* measure as a replacement and the other recommending the *Oral Evaluation, Dental Services* measure as a replacement.

The PDENT-CH measure was discussed in the context of the two measures suggested as replacements. One Workgroup member who suggested the measure for removal commented that PDENT-CH emphasizes an important aspect of preventive care services, but it is imprecise and difficult to interpret because the measure specifications include a wide range of codes that do not necessarily reflect preventive dental services for children. Notably, the Workgroup member said that one of the codes in the PDENT-CH code set has been used to provide payment for personal protective equipment, which came to the fore during the COVID-19 pandemic. The Workgroup member also noted that the measure assesses only dental services—those provided by or under the supervision of a dentist—leaving out the growing emphasis on topical fluoride application by other types of health care providers, including pediatricians and primary care practitioners. Another Workgroup member expressed support for removing the measure because of concerns with its methodology, specifically that the measure requires only 90 days of eligibility but assesses services throughout the full calendar year.

One Workgroup member questioned whether there would be a gap in the Child Core Set related to optimal oral health for children and adolescents if PDENT-CH was removed but not replaced by the *Oral Evaluation, Dental Services* measure. The Workgroup member noted that the *Sealant Receipt of Permanent First Molars* (SFM-CH) measure in the Child Core Set focuses on children ages 6 to 9 and suggested that much of the focus on fluoride varnish application is also on a younger age group.

In anticipation of mandatory reporting in 2024, another Workgroup member expressed concern from a state resource perspective about replacing the reporting mechanism used to calculate PDENT-CH on behalf of states and shifting the responsibility of implementing new oral health measures onto states. The Workgroup member encouraged CMS to explore opportunities to use alternate data sources to calculate the measures so that states could direct resources toward improving care rather than on developing capacity for reporting the new measures.[30]

Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)

The *Ambulatory Care: Emergency Department (ED) Visits* (AMB-CH) measure assesses the rate of ED visits per 1,000 beneficiary months among children up to age 19. This measure was proposed for retirement by the measure steward, NCQA, for HEDIS measurement year 2020 and was retired from its Medicare and commercial lines of business. However, the measure was retained for the Medicaid line of business due to the inclusion of the measure in the Child Core Set.[31]

The Workgroup member who suggested this measure for removal noted that ED measures that specifically track ED use for high cost and highly prevalent conditions were preferred over general ED measures for quality improvement efforts. The Workgroup member suggested two potential substitutes for this measure: *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA) and *Follow-Up After Emergency Department Visit for Mental Illness* (FUM). Both measures are currently included in the Adult Core Set and were suggested by the Workgroup member for addition to the Child Core Set.

During the discussion, Workgroup members expressed support for removing the AMB-CH measure, noting that keeping it would detract from alignment efforts because the measure has been removed from NCQA's Medicare and commercial product lines. Workgroup members also indicated that the measure was of limited use because it did not distinguish between avoidable ED visits and those that were truly medically necessary.

Several Workgroup members noted that FUA and FUM are not exact replacements for this measure, given that the measures are focused on behavioral health diagnoses, which are not captured in AMB-CH. Some Workgroup members agreed that while disease-specific measures are helpful, the removal of this measure would leave a gap in the Child Core Set when

[30] Public comments submitted on the *Percentage of Eligibles Who Received Preventive Dental Services* (PDENT-CH) measure can be found in Appendix D.

[31] After the 2022 Core Set Annual Review Workgroup meeting, NCQA indicated that the AMB-CH measure will not be retired until a replacement measure has been identified for the Medicaid line of business.

attempting to look at ED and urgent-care utilization among children. One Workgroup member added that states could continue to use the measure even if it is removed from the Child Core Set (47 states reported this measure in FFY 2019 using Core Set specifications). Another Workgroup member from a state Medicaid program commented that, while it may be a "blunt instrument," the measure helps them understand how their system is functioning. In addition, the Workgroup member noted that their state stratifies the data by race and ethnicity and that this measure is especially informative for areas with poor access to ambulatory and primary care.

One Workgroup member asked the measure steward, NCQA, if AMB-CH had been replaced by a risk-adjusted measure. The Workgroup member proposed potentially retaining the measure in the Child Core Set another year while the Workgroup considers whether there is another measure that assesses ED utilization across all diagnoses and all age bands and is more actionable. The measure steward responded that while there is a risk-adjusted measure that looks across all ED utilization (*Emergency Department Utilization*) that is under consideration for the Medicaid product line, the measure is not currently specified for Medicaid. NCQA does not have a specific timeline for when the Medicaid measure might be available.[32]

Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)

The *Audiological Diagnosis No Later Than 3 Months of Age* (AUD-CH) measure 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 three Workgroup members because of feasibility concerns: the measure requires the use of electronic health record (EHR) data, which many states cannot currently access. Though the measure has been on the Child Core Set since FFY 2016, only two states reported the measure for FFY 2019, and both reported substantial deviations from the Core Set specifications. This raised questions for Workgroup members about whether all states would be able to report the measure when the Child Core Set becomes mandatory for state reporting in 2024.

One Workgroup member who suggested the measure for removal noted that challenges with accessing EHR data may lead to inconsistent calculations across states and incomplete data. Another Workgroup member also questioned the actionability and strategic priority of the measure, commenting that the prevalence of the condition (failed hearing screenings) is very low and may prove difficult for quality improvement activities. Another Workgroup member explained that their state has tried to use administrative claims data to track those who have not received follow-up; however, because the data are transmitted to the CDC by facility or provider and not billed to Medicaid, the state has had challenges identifying gaps in care with this measure. Another Workgroup member commented that hearing screening is generally tracked in public health departments, such that removal of the measure from the Child Core Set would not eliminate monitoring of the issue.

Because the AUD-CH measure was discussed by the Workgroup last year, one Workgroup member who suggested it for removal noted that reconsideration of the measure should assess

[32] Public comments submitted on the *Ambulatory Care: Emergency Department (ED) Visits* (AMB-CH) measure can be found in Appendix D.

CMS's progress in working to identify an alternate data source. Mathematica provided an update that CMS had explored whether the measure could be calculated using alternate data sources, including through development of administrative specifications or through the CDC's Early Hearing Detection and Intervention (EHDI) Program, but CMS determined that an alternate data source was not available for the measure. In response to a Workgroup member's suggestion that CMS explore use of the EHDI data system as an alternate data source, Mathematica clarified that the EHDI system does not stratify by payer, so it could not be used to report on children enrolled in Medicaid or CHIP.

During the Workgroup discussion, Workgroup members reflected on the tension between desirability and feasibility of the measure, highlighting its importance—specifically, that Medicaid covers 40 percent or more of births in many states—but acknowledging that the measure could not be reported by most states through currently available data sources. Several Workgroup members emphasized that this measure will be required for states to report in 2024 if it remains in the Child Core Set. The Workgroup encouraged partnerships with CDC and state public health agencies to improve existing data collection mechanisms and strengthen data linkages that would facilitate Core Set reporting of the measure in the future, including adding a payer indicator to the EHDI data system. One Workgroup member from a state Medicaid program noted improvements being made in their state that may enable future reporting of measures like AUD-CH that require data linkages between Medicaid and public health. The Workgroup member noted, however, that these collaborations are time and resource intensive.

One Workgroup member commented that if the measure is removed from the Core Set, efforts will need to be redoubled to determine how to monitor outcomes for children who do not pass hearing screenings. They noted the responsibility to assure equitable and safe outcomes of care for children and families in Medicaid and CHIP, even as it pertains to low-prevalence conditions.[33]

PC-01: Elective Delivery (PC01-AD)

PC-01: Elective Delivery (PC01-AD) measures the percentage of women with elective vaginal deliveries or elective Cesarean sections at 37 weeks or greater and less than 39 weeks of gestation completed. One Workgroup member suggested the measure for removal from the Adult Core Set due to feasibility concerns, because the measure requires chart review to determine whether a delivery was elective and many states do not conduct chart reviews for Core Set reporting. The Workgroup member noted that only nine states reported the measure for FFY 2019 and five of them deviated from the Core Set specifications by not conducting chart reviews to calculate the measure. The Workgroup member also suggested that the measure may no longer be a strategic priority for states, citing calendar year 2019 data from the measure steward, The Joint Commission, showing low rates (a median rate of 0 percent and a mean rate of 1.83 percent among 2,005 hospitals reporting). The Workgroup member believed these low rates indicated

[33] Public comments submitted on the *Audiological Diagnosis No Later Than 3 Months of Age* (AUD-CH) measure can be found in Appendix D.

that either elective deliveries were no longer being performed or were being justified by providers through coding and charting practices.

During the discussion, other Workgroup members echoed many of the sentiments expressed by the Workgroup member who suggested the measure for removal. This included (1) noting that payment reform may have impacted rates on the measure such that there may no longer be much room for improvement, (2) discussing the difficulty with the data collection methodology for this measure (chart review), and (3) highlighting the differential results yielded through the use of vital records and medical records data. In response to a comment from a Workgroup member about using vital statistics to calculate the measure, Mathematica noted that CMS's exploration of using vital records data in CDC WONDER to calculate the measure was unsuccessful because the clinical criteria to determine the appropriateness of an elective delivery were unavailable. One Workgroup member cautioned that removal of the measure could leave a gap in the Adult Core Set and that the Workgroup should consider how this aspect of maternal health care quality would be measured.

Several Workgroup member comments pertained to racial and ethnic disparities in maternal and perinatal care. One Workgroup member asked whether there were other measures in the Core Sets that would assess differences in perinatal outcomes between women of color and white women if the measure were removed. Mathematica confirmed that the *Low Birth Weight* and *Low-Risk Cesarean Delivery* that are being calculated using CDC WONDER allow for stratification by race and ethnicity as well as other demographic characteristics. A Workgroup member added that the low number of states currently reporting the elective delivery measure and the challenges in reporting the measure do not allow for stratification of elective deliveries by race or ethnicity.[34]

Measures Recommended for Addition

This section summarizes the Workgroup discussion of the seven measures recommended for addition to the Child and Adult Core Sets.

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

The FUA measure assesses the percentage of ED visits for beneficiaries age 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported for this measure: (1) the percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) and (2) the percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). This measure includes stratifications for ages 13 to 17, age 18 and older, and a total rate. The measure was suggested for addition to the Child Core Set for beneficiaries ages 13 to 17 and is currently being reported as part of the Adult Core Set (age 18

[34] Public comments submitted on the *PC-01: Elective Delivery* (PC01-AD) measure can be found in Appendix D.

and older) and the Health Home Core Set (age 13 and older). For FFY 2019, 36 states reported the measure in the Adult Core Set.

The measure steward, NCQA, has proposed changes to the measure for the measurement year 2022 (the 2023 Core Sets). Changes include expanding the denominator to include ED visits due to overdose of drugs with common potential for over-use in any diagnosis position, expanding the numerator to allow follow-up visits with substance use disorder (SUD) indicated in any diagnosis position, and expanding the numerator to include additional follow-up options that do not require a diagnosis of SUD.

The Workgroup member who suggested this measure for addition indicated that the measure would address a gap in quality of care for adolescents diagnosed with SUD and allow for comparative analyses across various populations. The Workgroup member suggested that this measure and the *Follow-Up After Emergency Department Visit for Mental Illness* (FUM) measure, which was also suggested for addition, could replace the *Ambulatory Care: Emergency Department Visits* (AMB-CH) measure in the Child Core Set, which was suggested for removal. The Workgroup member stressed that AOD is a serious public health issue and adolescents often present to the ED for treatment of behavioral health issues. The Workgroup member noted that there is significant room for improvement on this measure because NCQA benchmarks indicated that follow-up care within seven days occurred for 13 percent of ED visits, while follow-up within 30 days occurred for 20 percent of ED visits. The Workgroup member acknowledged that for some states, small cell sizes may be an issue in reporting the measure.

During the discussion, several Workgroup members expressed support for adding the measure to the Child Core Set because it would support alignment with the Adult Core Set. Workgroup members also discussed the importance of addressing SUD among adolescents and ensuring appropriate follow-up care. Two Workgroup members shared that, in their experiences, measures such as FUA and FUM allow health systems to identify opportunities for care coordination. One Workgroup member added that follow-up measures could incentivize providers to identify patients with SUD and intervene appropriately, thereby preventing the continuous cycle of ED utilization that occurs in some populations.

Workgroup members acknowledged that small cell sizes may be an issue for some states; however, they seemed to place more value on addressing a gap in the Child Core Set for measures related to substance use. In response to a question, Mathematica clarified the Core Set reporting requirements related to minimum cell sizes and noted that there were very few instances at the state level where results were suppressed for privacy or precision reasons. Mathematica also noted that a third measure in the Core Sets—*Follow-Up After Hospitalization for Mental Illness* (FUH)—tended to have smaller denominators than the ED follow-up measures and was publicly reported without suppression of any results in both the Child and the Adult Core Sets.[35]

[35] Public comments submitted on the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA) measure can be found in Appendix D.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

The *Follow-Up After Emergency Department Visit for Mental Illness* (FUM) measure assesses the percentage of ED visits for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported for this measure: (1) the percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) and (2) the percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). This measure includes stratifications for ages 6 to 17, ages 18 to 64, and age 65 and older. This measure was suggested for addition to the Child Core Set for beneficiaries ages 6 to 17 as a replacement for the *Ambulatory Care: Emergency Department Visits* (AMB-CH) measure.

The Workgroup member who suggested this measure for addition indicated that there is significant room for improvement on this measure, citing data for Medicaid managed care beneficiaries of all ages showing that 41 percent of all ED visits had a follow-up within 7 days, and 56 percent of all ED visits had a follow-up within 30 days. The Workgroup member also noted that, although there may be a concern about small cell sizes for some states, the denominator should be larger than the FUH measure, which is included in both the Child and Adult Core Sets.

The Workgroup discussed the FUM measure in conjunction with the FUA measure and expressed similar support for including the FUM measure in the Child Core Set. Several Workgroup members recognized that the FUM measure addresses a significant gap in the Child Core Set, with one Workgroup member specifically commenting on the lack of follow-up after an ED visit when there is a diagnosis of mental health, SUD, or a behavioral health condition. The Workgroup member added that the inclusion of this measure would send a strong signal to health systems to move toward integrated care. Another Workgroup member noted that, although they support the intent of the measure, there is a need to move beyond process measures and assess outcomes in this area.[36]

Oral Evaluation, Dental Services

Oral Evaluation, Dental Services measures the percentage of enrolled children younger than age 21 who received a comprehensive or periodic oral evaluation within the reporting year. The measure steward is the American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA). The measure was suggested to replace the PDENT-CH measure in the Child Core Set because the PDENT-CH measure includes codes that would not indicate an evaluation of oral health. The Workgroup member who suggested this measure for addition noted that the measure is currently used by state Medicaid and CHIP programs (including in Texas, Florida, and Massachusetts) and could be used to trend access to oral health care.

[36] Public comments submitted on the *Follow-Up After Emergency Department Visit for Mental Illness* (FUM) measure can be found in Appendix D.

The measure was discussed by the Workgroup in the context of the suggestion to replace PDENT-CH with this measure and/or the *Prevention: Topical Fluoride for Children* measure. In response to questions from other Workgroup members, a Workgroup member and the measure steward noted that this measure was in the diagnostic versus preventive code series and was a marker that a child was fully evaluated, that a diagnosis was recorded, and that a treatment plan was recorded. The measure includes a narrower set of codes than PDENT-CH and was characterized as providing a more precise measurement. One Workgroup member likened the measure to a well-child visit measure for dental care.[37]

Prevention: Topical Fluoride for Children

Prevention: Topical Fluoride for Children measures the percentage of children ages 1 through 20 years who received at least 2 topical fluoride applications as (a) dental OR oral health services, (b) dental services, and (c) oral health services within the reporting year. The measure was suggested for addition to replace the PDENT-CH measure in the Child Core Set.[38]

The Workgroup member who suggested this measure for addition noted that dental caries (tooth decay) is the most common chronic disease in children in the United States, affecting almost half of all children, and the use of topical fluoride is one of the interventions with the strongest evidence base for reducing tooth decay. The Workgroup member also noted that the prevalence of caries, untreated caries, and disparities are significant, and there is substantial room for improvement within Medicaid and CHIP programs. They suggested that the measure could serve as a complement to the dental sealant measure in the Child Core Set (SFM-CH) by helping states assess the extent to which children are receiving evidence-based preventive services and target quality improvement accordingly.

The Workgroup member who suggested the measure for addition noted that the measure has a strong evidence base, including evidence that patients who receive two applications of fluoride within a 12-month period achieve significant reductions in caries. The Workgroup member cited the growing emphasis on topical fluoride application by other types of health care providers, as well as the United States Preventive Services Task Force (USPSTF) recommendations that children receive topical fluoride application. In addition, the Workgroup member discussed their experience using the measure as part of the California 1115 Medi-Cal 2020 waiver and DQA's experience calculating the measure using T-MSIS data. They noted that T-MSIS data could potentially be used as an alternate data source to help reduce the burden of state reporting.

Much of the Workgroup discussion around the measure involved technical questions about the measure specifications, including the age stratifications integrated into the measure specifications. The Workgroup members confirmed that the upper age range for the measure is

[37] Public comments submitted on the *Oral Evaluation, Dental Services* measure can be found in Appendix D.

[38] A Workgroup member suggested a version of this measure that focused on children at elevated caries risk (*Prevention: Topical Fluoride for Children at Elevated Caries Risk*). In spring 2021, the measure steward modified this measure to include all children (not just those at elevated caries risk). Because this change applies to calendar year 2021 reporting, which corresponds to the 2022 Child Core Set, the Workgroup discussed and voted on the modified version of the measure. The modified measure includes an optional stratification by caries risk.

children under age 21 in alignment with the population eligible for EPSDT. DQA also confirmed that the lower age range for the measure starts at age 1 because the measure requires at least 12 months of continuous enrollment for a child to be eligible for the measure, and that children under age 1 would not be captured in the numerator because the measure requires two fluoride applications within the reporting year.

During the discussion, the Workgroup also clarified that water fluoridation is an additive benefit to topical fluoride and not a substitute, it does not impact the accuracy of measure results, and children with fluoridated water are at low risk of dental fluorosis with the most common topical application of fluoride (fluoride varnish). They also noted that fluoride varnish is used by both dental and oral health providers and the measure is stratified by both rendering provider type and child age groups. The Workgroup member who suggested the measure for addition commented that the provider stratification built into the measure allows states to understand how various components of their system are functioning, as well as how the system is functioning overall. The Workgroup member also added that the age stratifications integrated into the measure specifications help states understand where there are gaps in performance and target interventions accordingly.

One Workgroup member representing a state Medicaid program noted that they have had difficulty calculating the measure in their state. DQA, the measure steward, noted that they have successfully calculated the measure using T-MSIS data. Two other Workgroup members representing state Medicaid programs commented that it should be feasible to calculate the measure using claims data. They further noted that they do not have difficulty collecting information on fluoride varnish application using claims.

Another Workgroup member asked DQA whether dental management companies implement barriers or limits making it difficult for a child to receive two fluoride varnishes in a year, and whether there was evidence of this in the T-MSIS analyses. The Workgroup member who suggested the measure for addition noted that under the California Section 1115 waiver, children can receive between two and four fluoride applications per year depending on risk. DQA added that while they did not have information about these types of barriers, the rates they found in T-MSIS were consistent with states that provide coverage for topical fluoride application.[39]

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis

The *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure assesses the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. The latest update to the measure expanded the age range to start at 3 months, rather than 18 years, and updated the denominator to an episode-based versus member-based denominator. These changes took effect in measurement year 2019 and are still under consideration for National Quality Forum (NQF) endorsement. The Workgroup member who suggested this measure for addition indicated that states have used this measure to promote appropriate antibiotic dispensing. They also noted that

[39] Public comments submitted on the *Prevention: Topical Fluoride for Children* measure can be found in Appendix D.

this measure has significant room for improvement, with a bronchitis diagnosis resulting in antibiotic prescriptions in almost half of adult cases and 60 percent of child cases in Medicaid.

This measure was discussed in conjunction with the *Appropriate Treatment for Upper Respiratory Infection* measure, which was also suggested but not recommended for addition to the Core Sets. One Workgroup member noted that the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure is included in the Accountable Care Organizations (ACO)/Patient Centered Medical Homes/Primary Care Consensus Core Set,[40] and would therefore be beneficial to include in the Child and Adult Core Sets for alignment. Two Workgroup members from state Medicaid programs commented that there is considerable room for improvement on the measure among the adult population in their states, however they have seen high performance on a similar antibiotic measure among children. Another Workgroup member noted that the high performance among children may be due to efforts in the pediatric field to avoid unnecessary antibiotic use.

Several Workgroup members voiced support for adding this measure to the Core Sets, indicating that it drives prevention of antimicrobial resistance, as well as avoidance of unnecessary antibiotics. One Workgroup member who supported the measure for addition commented that parents and patients often insist on receiving antibiotics even when they are not necessary. They noted it would be beneficial to have a measure that balances clinical appropriateness with patient satisfaction scores. Another Workgroup member added that with the recent widespread adoption of telehealth due to the COVID-19 pandemic, they anticipate an increase in the rates of inappropriate use of antibiotics (the measure steward, NCQA, included telehealth settings in the measure). They stressed the importance of having a measure that encourages avoidance of unnecessary antibiotics.

Several Workgroup members questioned whether there was enough data to support the inclusion of the measure in the Core Sets given that NCQA implemented updates to the measure beginning in measurement year 2019 (including expanding the age range to include children). One Workgroup member noted that bronchitis in children is clinically ill-defined and may have potential clinical ramifications for diagnosis and treatment. In response to a question about the potential impact of expanding the age range for both measures, NCQA stated that they do not have a good indication of the direction the performance may trend after the age expansion. One Workgroup member suggested that CMS add the measure without the expanded age range until there is enough data and experience from state Medicaid programs to report the revised measure.

The Workgroup also discussed whether it was necessary to add both the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure and the *Appropriate Treatment for Upper Respiratory Infection* measure to the Core Sets, or if one should be added over the other. Several Workgroup members, as well as NCQA, noted that the acute bronchitis/bronchiolitis measure

[40] More information is available at cqmc_aco_pcmh_core_set.pdf.

presents significant room for improvement, with performance on the measure typically lower than on the upper respiratory infection (URI) measure.[41]

Long-Term Services and Supports Comprehensive Care Plan and Update

Long-Term Services and Supports Comprehensive Care Plan and Update measures the percentage of LTSS organization members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified time frame that includes core elements. The measure steward is NCQA. Two rates are reported for the measure: (1) members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members); and (2) members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or during the measurement year (for established members). The measure is calculated using case management records, based on a review of records drawn from a systematic sample with a minimum sample size of 96 beneficiaries.

The Workgroup member who suggested the measure for addition noted that while LTSS constitutes a third of all Medicaid spending, there are no LTSS measures in the Core Sets that assess the quality of care management. They further explained and that this measure addresses whether beneficiaries are engaged in a care planning process that incorporates person-centered principles and looks at all of their needs. The Workgroup member also noted that this measure is currently in use in several states, including Pennsylvania and Florida. As this is a relatively new measure, the Workgroup member suggested that TA may be needed to ensure the measure is calculated consistently and to help states aggregate data across plans and other entities to report at the state level.

The Workgroup provided broad support for adding the measure to the Core Set, with several Workgroup members discussing their experience using the measure. One Workgroup member admitted that the measure is a lot of work but liked that it addresses elements that are used in LTSS, including home- and community-based services (HCBS), and can be inclusive of behavioral health. A Workgroup member representing a managed care entity also acknowledged that the measure was challenging but said it was worth the effort. They added that a measure of care planning is key, as it examines whether people are getting the services they need in a cost-effective way. In addition, the Workgroup member noted that the measure can be used to understand what elements of the care planning process are working for different populations to ensure equity. Another Workgroup member liked that this measure strengthens the person- and family-engagement aspects of care, allowing many opportunities to improve care and outcomes for LTSS members. A Workgroup member from a state Medicaid agency commented that they are working on implementing the measure in their state and support inclusion of the measure as a means to close gaps in the Core Sets. They commented that the state receives stakeholder

[41] Public comments submitted on the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure can be found in Appendix D.

requests regarding care plan issues and this measure addresses the types of care plan issues raised, especially those related to development of care plans by managed care organizations.

Several Workgroup members stated that they like that this measure can be used in both managed care and fee-for-service settings. One Workgroup member asked a technical question about how the sampling methodology is applied in states (versus health plans), including for fee-for-service members. They added that states would likely need TA with the measure to ensure the representativeness of the sample and standardization of the data collection process for comparability of the measure across states. NCQA responded that the sample size requirement was temporarily reduced from 411 to 96 to relieve the high level of burden of manual data abstraction and lower the entry barrier to reporting, but they are hoping to raise it back up to 411 to make statistically significant comparisons in the future. The Workgroup member also commented that the Workgroup has raised considerations throughout the meeting about stratification for purposes of examining disparities and ensuring health equity, and one concern is that the sample size may not allow for this.

The Workgroup also discussed how the measure pairs with patient-reported outcomes information, such as information from CAHPS. One Workgroup member who is currently using this measure in their state Medicaid program noted that their state looks at the measure in conjunction with HCBS CAHPS data and believes they go hand-in-hand. However, they noted that it could be difficult to link the measure to CAHPS because of the small sample sizes for each measure. Another Workgroup member said that states would ideally use this measure with the National Core Indicators for Aging and Disabilities Adult Consumer Survey and the HCBS CAHPS Survey to understand where the process is intact or where it may need improvement. Another Workgroup member said they had looked at this measure in the past in conjunction with the National Core Indicators for Aging and Disabilities to ensure members were being served and that it was not a "checkbox" exercise. The Workgroup member cautioned that the measure would not truly serve LTSS members if it is turned into a "checkbox" opportunity. In response, another Workgroup member commented that it would be important to receive guidance form CMS to avoid the "checkbox" concern, ensure comparability across states, and ensure that states' assessment tools are collecting the information needed to report the measure.

One public commenter asked whether this measure could be used for fee-for-service populations. NCQA confirmed that any organization that coordinates Medicaid-covered LTSS is eligible to report the measure, including community-based organizations and Area Agencies on Aging.[42]

Colorectal Cancer Screening

Colorectal Cancer Screening assesses the percentage of patients ages 50 to 75 who had appropriate screening for colorectal cancer. The measure is specified for administrative, hybrid, and HEDIS ECDS data collection methods. Three Workgroup members suggested the measure for addition to the 2022 Core Sets. While the measure steward, NCQA, has not specified the measure for Medicaid, they have indicated that they plan to specify and test the measure for

[42] Public comments submitted on the *Long-Term Services and Supports Comprehensive Care Plan and Update* measure can be found in Appendix D.

Medicaid in the upcoming year. In addition, the Workgroup members indicated that several states currently use the measure in their Medicaid programs.

The Workgroup members who suggested the measure for addition noted that colorectal cancer is the second leading cause of cancer death in the United States and that colorectal cancer screening effectively identifies precancerous lesions and reduces mortality. They cited data indicating disparities in cancer screening rates for Medicaid beneficiaries compared to those commercially insured, and highlighted evidence that colorectal cancer screening rates have improved in several states that were monitoring and reporting the measure.

Several Workgroup members from state Medicaid agencies discussed their experiences collecting and reporting the measure. A Workgroup member noted that their state has been reporting the measure in several program areas within Medicaid, and that they are discussing alignment on this measure with other programs in the state. One Workgroup member also discussed the approach their state had taken to address the required 10-year look-back period, which has been a concern for the Medicaid population due to churn. They explained that their state coordinates with managed care plans to help identify colorectal cancer screenings through their Medicaid claims and encounter system. They have also seen improvements in collecting and reporting the measure through increased claims-sharing and the use of health information exchanges.

Workgroup members also asked technical questions about the types of screening tests that count toward the measure, including whether all screening modalities, specifically fecal immunochemical testing (FIT), carry equal evidence. Workgroup members, as well as NCQA, confirmed that the measure is in alignment with USPSTF recommendations[43] and that the modalities included in the measure denominator, including FIT, are evidence based. Another Workgroup member asked about whether the majority of community-based members who are dually eligible for Medicare and Medicaid are included in the measure, and how states have been able to obtain data for this population. One Workgroup member noted that they are working with CMS to try to obtain the Medicare data. NCQA noted that members who are dually eligible for Medicare and Medicaid are not excluded from the measure; however, the measure is not yet specified for Medicaid and that they will need to explore guidelines for reporting on this population when it is.

Several Workgroup members commented that the measure is valuable for addressing disparities in the Medicaid population. A Workgroup member from a state Medicaid program stated that they believe the measure touches upon the social determinants of health. In addition, they have made great strides in performance on the measure for the Medicaid population over the past 10 years; they see a nearly 20-point difference between Medicaid and commercial members. In response to a question about whether this measure had been stratified by race, ethnicity, or

[43] The USPSTF updated its recommendations related to colorectal cancer screening after the 2022 Core Set Annual Review Workgroup meeting in early May. The updated recommendation continues to recommend colorectal cancer screening in adults ages 50 to 75 years (A recommendation), and now recommends offering screening starting at age 45 years (B recommendation). There were no changes in the types of screening tests included in the recommendations.

language, NCQA replied that they are proposing to include racial/ethnic stratification as part of the measure in the next iteration. Another Workgroup member raised the importance of monitoring the race and gender of Medicaid members who are screened to ensure that all members have equitable access to all appropriate screening tests, regardless of concerns about whether the test screens positive, becomes diagnostic, and may confer out-of-pocket costs for beneficiaries. One Workgroup member commented that state payment policies had addressed this issue in their state. Several Workgroup members also voiced support for addition of a screening measure that includes the male Medicaid population.

One Workgroup member cautioned that some health plans write the orders for and send out the FIT-DNA kits to their members without involving their primary care provider, which they described as not very good medicine and a potential opportunity for gaming the system. They asked if NCQA had considered implementing guardrails against this as part of the measure specifications. They suggested that NCQA add standards to their specifications that health plans must obtain an order from a member's treating provider to order a test. NCQA noted that the measure specifications require that the FIT test was done, not just sent to a member, and that this would also be part of NCQA's audit. However, the specifications do not currently require an order from a primary care provider.

During the public comment period, representatives of colorectal cancer organizations, health care providers, researchers, and patient advocates spoke in favor of adding the measure to the Core Set. They commented that including the measure would help address disparities in colorectal cancer screening among the Medicaid population, citing evidence of improvements seen in screening rates and cancer outcomes in states that have adopted the measure. They also spoke to the evidence around FIT as being comparable to other modalities of colon cancer screening.

The measure received unanimous support from the Workgroup for inclusion in the Core Set.[44]

Cross-Cutting Themes in Measure Discussions

Several cross-cutting themes emerged from the Workgroup's review of the 7 existing measures suggested for removal from the Core Sets, the 14 new measures suggested for addition, and the Workgroup's reflections about gaps in the Core Sets. The Workgroup discussion revealed an effort to balance the feasibility of state reporting with actionability and strategic priority to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Actionability and Strategic Priority to Drive 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 measures that address health disparities and social determinants of health. During their discussion, Workgroup members routinely encouraged the identification and inclusion of measures that take a whole-person approach to beneficiary health, and consider factors such as housing, food insecurity, and

[44] Public comments submitted on the *Colorectal Cancer Screening* measure can be found in Appendix D.

social isolation. In addition, while discussing gaps in the Behavioral Health Care domain, one Workgroup member noted that ACOs and Medicare are exploring this area in their work, highlighting the momentum for addressing the social determinants of health as part of improving population health. Workgroup members noted that given the socioeconomic challenges that Medicaid and CHIP beneficiaries often face, improving health care delivery and health outcomes will require focusing not just on clinical care, but also on factors outside the medical system.

Similarly, Workgroup members frequently expressed a desire to stratify measures by demographic factors, including race, ethnicity, language, and disability. They encouraged measure stewards to include demographic stratifications in their measure specifications to allow states to identify inequities among Medicaid and CHIP populations and opportunities for improvement. Mathematica indicated that states are able to report stratified data for Core Set measures in the CMS web-based reporting system, regardless of whether the stratifications are included in the measure technical specifications. One Workgroup member encouraged CMS to publicly report the stratified Core Set data that states already report and urged CMS to consider requiring all states to report stratified data for a subset of population health measures. Another Workgroup member commented that failing to look at the measures through a health equity lens may perpetuate disparities.

Workgroup members also encouraged the identification of outcomes-based measures for the Core Sets. For example, during discussion of the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* and *Follow-Up After Emergency Department Visit for Mental Illness* measures, Workgroup members noted that while these measures address a significant gap in care, they would prefer measures that identify beneficiaries before their condition leads them to the ED. A similar comment was made about the *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* measure, which was not recommended by the Workgroup for addition.

In recommending measures for addition to the Core Sets, the Workgroup often emphasized the strategic priority and actionability of a measure, sometimes over the resource demands a measure may entail. For example, the *Long-Term Services and Supports Comprehensive Care Plan and Update* measure was described by several Workgroup members as challenging but worth the effort, because the measure assesses important aspects of the care planning process for LTSS members and families. The Workgroup also recommended the *Colorectal Cancer Screening* measure despite the 10-year look-back period required for one screening test, emphasizing the potential for the measure to reduce disparities in cancer screening and outcomes for Medicaid beneficiaries.

For those measures that were suggested to replace current Core Set measures, the Workgroup often prioritized the addition of measures that may help states act upon a strategic priority, over the feasibility of reporting existing measures. For example, the Workgroup recommended the removal of the preventive dental services measure (PDENT-CH), which CMS calculates on behalf of states using an alternate data source. The Workgroup recommended that the PDENT-CH measure be replaced with two measures they believe would more accurately reflect the

receipt of evidence-based dental and oral health preventive care in children: *Oral Evaluation, Dental Services* and *Prevention: Topical Fluoride for Children*.

Similarly, the Workgroup recommended removal of the AMB-CH measure despite its feasibility (47 states reported the measure for FFY 2019), in favor of replacement measures deemed more actionable for states: *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA) and *Follow-Up After Emergency Department Visit for Mental Illness* (FUM).

Finally, Workgroup members encouraged moving toward the use of electronic data collection in Medicaid and CHIP. While they agreed that a significant investment is required for states to transition to electronic data sources, they noted that activities such as the implementation of interoperability rules and the development of state and federal partnerships may help drive Medicaid and CHIP programs toward increased use of electronic data sources. The Workgroup ultimately voted to retain two CAHPS-based survey measures on smoking cessation and influenza immunization instead of replacing them with measures that can be reported using EHR or registry data. However, Workgroup members acknowledged the increasing importance of electronic data and looked forward to additional evidence to support states' readiness to report these measures.

Feasibility and Viability for State Reporting

The Workgroup discussed the ability of states to collect and report the Core Set measures suggested for removal and addition. As CMS and states approach mandatory reporting in 2024, Workgroup members considered longstanding feasibility issues on existing measures. Workgroup members who represent state Medicaid programs, in particular, expressed concern about retaining measures in the Child Core Set if most states are unable to report or an alternate data source is not identified. For example, while several Workgroup members underscored the importance of early hearing screening, they recommended the removal of the *Audiological Diagnosis, No Later Than 3 Months of Age* measure due to feasibility concerns (the measure was reported by only two states for FFY 2019). The Workgroup raised concerns over the lack of an alternate data source for the measure, coupled with the mandatory reporting of Child Core Set measures. The Workgroup similarly voted to remove the *PC-01: Elective Delivery* measure—a measure that has been in the Adult Core Set since its inception—due to difficulties associated with the measure's chart review data collection methodology, the lack of an alternate data source, and limited opportunities for improvement on the measure.

Workgroup members, especially those from state Medicaid programs, often expressed a preference for measures that allowed states to leverage existing data sources to reduce reporting burden, while also emphasizing the need for data linkages at the federal and state levels to build state capacity for reporting. Workgroup members also noted the need to centralize data, with some state Medicaid representatives highlighting that their programs are often constrained by limited resources, thereby necessitating more streamlined data collection processes.

Some Workgroup members noted the low and decreasing survey response rates on CAHPS surveys, and the impact of these declining rates on future directions for quality measurement where another data source may exist. Workgroup members were hesitant to replace or remove two CAHPS-based measures, *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD) and *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD). However, they noted the increasing potential of EHRs and registries to report electronic measures in the future.

Lastly, throughout the measure discussions, Workgroup members were mindful of the burden of state reporting and the capacity of states for reporting. The Workgroup's recommendation of the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure over the *Appropriate Treatment for Upper Respiratory Infection* measure is a reflection of their careful deliberation in recommending measures for the addition to the 2022 Core Sets. Workgroup members often vocalized their attempt to balance state capacity and burden concerns with the actionability and strategic priority of measures.

Discussion of Core Set Measure Gaps

During the 2022 Core Set Annual Review, the Workgroup discussed Core Set measure gaps by domain and overall. Within each domain, Mathematica asked the Workgroup to identify what types of measures or measure concepts are missing, whether there are any existing measures that could fill the gaps, or whether new measures would need to be developed. After completing domain-specific discussions, the Workgroup had a cross-cutting discussion focused on what measure gaps should be considered for future Core Sets, as well as the implications for developing new quality measures for Medicaid and CHIP, followed by a final opportunity for public comment.

Exhibit 7 synthesizes the gaps mentioned during Workgroup discussions and the public comment period. The gaps are organized first by cross-cutting themes and then by Core Set domain. The exhibit does not attempt to prioritize the suggested gaps or assess their feasibility or fit for the Child and Adult Core Sets.

Across nearly every discussion about Core Set gaps, Workgroup members expressed a desire to use the Core Set measures to better identify and address health disparities among Medicaid and CHIP beneficiaries. Many of the gaps identified by the Workgroup spoke to this priority, including suggestions to stratify measures by demographic characteristics such as race and ethnicity and a suggestion to emphasize stratification and public reporting of existing measures, rather than adding new health disparity measures to the Core Sets. The Workgroup also suggested focusing on social determinants of health, including whether a domain focused on social factors should be included as a new Core Set domain in the future.

In addition, the Workgroup identified opportunities for improving care integration through measurement, both within Medicaid and CHIP programs and across the health care system as a whole. Recognizing the role of Medicaid and CHIP in the health care system, the Workgroup identified gaps in measures and measure concepts that promote health system collaboration

across different sectors and settings. Examples include the integration of behavioral health and primary care, and care for children and youth with complex care needs.

The Behavioral Health Care domain is the largest domain in the Adult Core Set and some Workgroup members discussed the need to streamline and prioritize the current measures in this domain and better balance the existing measures. Other Workgroup members identified gaps in this domain that address more whole-person care, such as measures of adverse childhood experiences and trauma-informed care.

Workgroup members also proposed several methodological considerations, including the concept of multi-generational measurement and the bundling of associated measures across a family unit, and global measures of treatment outcomes for chronic conditions.

The Workgroup's reflections about gaps in the Child and Adult Core Sets provide a strong starting point for future discussions about updates to the Core Sets as well as longer-term planning for the Core Sets.[45]

Exhibit 7. Synthesis of Workgroup Discussions About Potential Gaps in the Child and Adult Core Sets

Themes from Cross-Cutting and Domain-Specific Gap Discussions
Cross-Cutting Gap Areas
• Stratification of new and existing measures by race, ethnicity, language, and disability • Social determinants of health, including housing insecurity, social isolation, and poverty status • Integration and data linkages across sectors and settings, particularly for beneficiaries with complex needs and social risk factors • Impact of telehealth on access, utilization, disparities, and identification of social risks • Continuity of coverage for beneficiaries
Cross-Cutting Methodological Considerations
• Electronic measures that leverage data sources beyond claims and encounters (e.g., EHRs, registries) • Leveraging existing data sources to realize efficiencies in reporting and reduce state burden (e.g., T-MSIS) • Technical assistance from CMS to help states link Medicaid and Medicare data for dually eligible beneficiaries • Measurement considerations for conditions with small populations • Consideration of how to improve response rates for patient experience surveys, like CAHPS
Primary Care Access and Preventive Care
• Integration of behavioral health care into primary care • Preventive care and access measures for the LTSS population, or ability to stratify by disability status • Prevention and access to care for male beneficiaries
Maternal and Perinatal Health
• Content of prenatal and postpartum care: mental health and substance use, immunizations, and dental care • Interagency and health care system collaboration on screenings and social needs • Multi-generational care and measurement, including bundled measures for the family unit

[45] Public comments submitted on potential Core Set measurement gaps can be found in Appendix D.

Exhibit 7 *(continued)*

Themes from Cross-Cutting and Domain-Specific Gap Discussions
Care of Acute and Chronic Conditions
• Appropriate emergency department utilization for children, including development of a risk-adjusted measure • Identification and intervention for adverse childhood experiences and health-related social needs • Injuries, injury prevention, and mitigation • Global measure(s) of treatment outcomes for chronic conditions
Behavioral Health Care
• Integration of behavioral health and physical health, particularly through primary care • Suicide deaths, suicidal ideation and self-harm, and suicide prevention • Child social-emotional screenings, child welfare, and adverse childhood experiences • Anxiety disorders • Prioritization and balance of measures within this domain
Dental and Oral Health Services
• Adult oral health and access to dental care
Long-Term Services and Supports
• Outcome measures that address whether programmatic goals and beneficiary care needs are being met • Beneficiary experience of care measures for all LTSS populations • Access to care for vulnerable or socially isolated beneficiaries • Predictors or indicators of elder abuse • Integrated care for children with complex care needs

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

In addition to recommending specific measures to remove from or add to the Core Sets, Workgroup members were asked to provide input about TA opportunities to support state reporting of the Core Sets as well as suggestions for improving the Core Set Annual Review process.

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. The opportunities focused primarily on building a data infrastructure to address the current gaps in data availability and completeness, as well as support for reporting new or updated measures.

Workgroup members encouraged CMS to continue exploring the use of alternate data sources to support states in Core Set reporting—and strengthening these systems where needed—as well as helping states develop partnerships to support reporting capacity. For example, when discussing the *Colorectal Cancer Screening* measure, one Workgroup member encouraged CMS to work with states and provide linkages at the federal level to allow them to more accurately report on individuals who are dually eligible for Medicare and Medicaid. They also suggested CMS and other federal partners provide TA to support infrastructure for quality measurement, including building capacity to use data from health information exchanges, moving toward electronic quality measurement, and leveraging immunization registries. One Workgroup member also

suggested TA on how to accurately collect and report beneficiary data by race and ethnicity. For future planning, several Workgroup members requested that CMS provide further information on plans and priorities for LTSS measurement, and guidance about requirements for mandatory reporting in 2024.

In addition, Workgroup members suggested that CMS provide a "glide path" for states as they navigate the adoption of new or updated Core Set measures and move toward mandatory reporting. They stressed that states often need time, guidance, and other resources to prepare for reporting new measures and using data collection methods, while still maintaining the data collected through current reporting mechanisms. As described by one Workgroup member, this "glide path" would reduce barriers to reporting new measures and allow for a more seamless process while transitioning to new reporting mechanisms.

Improving the Core Set Annual Review Process

Workgroup members also suggested enhancements to the Core Set Annual Review process. One Workgroup member requested that Mathematica provide information on whether measures have been or can be stratified by demographic characteristics, including race, ethnicity, language, and disability status. This suggestion complements the language in the "Call for Measures," which notes that states should be able to use measures to perform comparative analyses of racial, ethnic, and socioeconomic disparities among Medicaid and CHIP beneficiaries. As the Workgroup member noted, adding this component to the review process would help ensure that the Core Set measures are used to promote health equity in Medicaid and CHIP. The Workgroup also suggested ensuring that the beneficiary voice and perspectives are incorporated into the Annual Review process.

In addition, Workgroup members suggested enhancements to the Workgroup meeting format and logistics. This included adding a video component to the virtual meetings to allow for a more robust discussion and adding a chat function to virtual meetings to allow for Workgroup members to communicate with one another during meetings. Some Workgroup members also expressed a preference to reconvene in person when safe to do so.

Next Steps

The 2022 Core Set Annual Review Workgroup considered 7 measures for removal from the Core Sets and 14 measures for addition. Workgroup members recommended removing four measures and adding seven measures to the Core Sets for 2022. The Workgroup considered multiple factors when making their recommendations, including the feasibility for state reporting, alignment with strategic priorities, 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 preventive care, children's oral health, behavioral health care, antibiotic stewardship, and LTSS.

During the discussions, Workgroup members frequently expressed a desire to use the Core Set measures to better identify and address health disparities in Medicaid and CHIP, such as by stratifying measures by demographic characteristics such as race, ethnicity, disability status, and language, and increasing the focus on social determinants of health.

As CMS and states move one year closer to 2024, Workgroup members consistently raised the issue of mandatory reporting for the Child Core Set and the behavioral health measures in the Adult Core Set. They recommended removing measures from the Core Sets that were less feasible for states to report. They also advocated for continued opportunities to leverage existing alternate data sources for reporting. Looking ahead, they suggested transitioning to electronic data sources, such as EHRs and clinical registries, when state capacity to capture data from these sources has improved.

The draft report was available for public comment from July 1, 2021 through August 6, 2021. Forty-four public comments were submitted. These comments are included in Appendix D. CMCS will review the final report to inform decisions about whether and how to modify the 2022 Child and Adult Core Sets. Additionally, CMCS will obtain stakeholder input from federal agencies and from state Medicaid and CHIP quality leaders to ensure that the Core Set measures are evidence-based and promote measure alignment within CMS and across the federal government.[46] CMCS will release the 2022 Child and Adult Core Sets through a CMCS Informational Bulletin by December 31, 2021.

[46] More information about the decision making process is available in the CMCS fact sheet, Medicaid and CHIP Child and Adult Core Sets Annual Review and Selection Process, at https://www.medicaid.gov/medicaid/quality-of-care/downloads/annual-core-set-review.pdf.

APPENDIX A:
Child and Adult Core Set Measures

Exhibit A.1. 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418*/0418e*	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)^	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)**	Administrative
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)***	Administrative
Maternal and Perinatal Health			
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
NA	CDC	Low-Risk Cesarean Delivery (LRCD-CH)****	State vital records
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)^	Administrative

Exhibit A.1 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
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
Dental and Oral Health Services			
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Administrative (Form CMS-416)
NA	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)*****	Administrative
Experience of Care			
0006******	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

More information on 2021 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

* This measure is no longer endorsed by NQF.

** The Well-Child Visits in the First 15 Months of Life (W15-CH) measure was modified by the measure steward. It now includes two rates: (1) six or more well-child visits in the first 15 months and (2) two or more well-child visits from 15 to 30 months. The NQF number refers to the endorsement of the W15-CH measure.

*** The Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH) and Adolescent Well-Care Visits (AWC-CH) measures were modified by the measure steward into a combined measure that includes rates for Ages 3 to 11, 12 to 17, 18 to 21, and a total rate. The NQF number refers to the endorsement of the W34-CH measure.

**** The Low-Risk Cesarean Delivery (LRCD-CH) measure replaced the PC-02: Cesarean Birth measure in the 2021 Child Core Set. To reduce state burden and report a cesarean birth measure consistently across all states, CMS will calculate the LRCD-CH measure on behalf of states using National Vital Statistics System Natality data that are submitted by states and obtained through CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) starting in FFY 2021.

***** This measure was added to the 2021 Child Core Set. It replaces the Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH) measure, which was retired by the measure steward.

****** AHRQ is the measure steward for the survey instrument in the Child Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

^ This measure is part of the Behavioral Health Core Set. The complete list of 2021 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-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; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs.

Exhibit A.2. 2021 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
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

Exhibit A.2 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)^	Administrative or EHR
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)^	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)^	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)^	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)^	Administrative or hybrid
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)^	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)^	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)^	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)^	Administrative
NA**	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)^	Administrative
Experience of Care			
0006***	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)	Survey
Long-Term Services & Supports			
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)	Survey

More information on 2021 Updates to the Child and Adult Core Set Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

* This measure is no longer endorsed by NQF.

Exhibit A.2 *(continued)*

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

*** AHRQ is the measure steward for the survey instrument in the Adult Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

^ This measure is part of the Behavioral Health Core Set. The complete list of 2021 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-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; NA = Measure is not NQF endorsed; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

Exhibit A.3. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2012–2021

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Primary Care Access and Preventive Care														
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)[a]	X	X	X	X	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	X	X	X	X	X	X	X	X	X	X	X	X
0038	NCQA	Childhood Immunization Status (CIS-CH)	X	X	X	X	X	X	X	X	X	X	X	X
0418*/0418e*	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)[b]	--	--	--	--	--	--	--	--	X	X	X	X
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)[c]	X	X	X	X	X	X	X	X	X	X	X	X
1407	NCQA	Immunizations for Adolescents (IMA-CH)	X	X	X	X	X	X	X	X	X	X	X	X
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	X	X	X	X	X	X	X	X	X	X	X	X
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)[d]	X	X	X	X	X	X	X	X	X	X	X	X
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV-CH)[e]	--	--	--	X	X	X	X	--	--	--	--	--
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)[d]	X	X	X	X	X	X	X	X	X	X	X	--
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)[f]	X	X	X	X	X	X	X	X	X	X	--	--

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Maternal and Perinatal Health														
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)[g]	X	X	X	X	X	X	X	X	X	X	--	--
0471	TJC	PC-02: Cesarean Birth (PC02-CH)[h]	X	X	X	X	X	X	X	X	X	X	X	--
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)[i]	--	--	--	--	--	--	X	X	X	X	X	X
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)[j]	X	X	X	X	X	X	X	X	X	X	X	X
1391*	NCQA	Frequency of Ongoing Prenatal Care (FPC-CH)[k]	X	X	X	X	X	X	X	X	--	--	--	--
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	X	X	X	X	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)[l]	--	--	--	--	--	--	--	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)[m]	--	--	--	--	--	--	--	--	X	X	X	X
NA	No current measure steward	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)[n]	--	--	--	X	X	X	X	X	--	--	--	--
NA	CDC	Low-Risk Cesarean Delivery (LRCD-CH)[h]	--	--	--	--	--	--	--	--	--	--	--	X
Care of Acute and Chronic Conditions														
0002*	NCQA	Appropriate Testing for Children with Pharyngitis (CWP-CH)[o]	X	X	X	X	--	--	--	--	--	--	--	--
0060*	NCQA	Annual Pediatric Hemoglobin A1C Testing (PA1C-CH)[p]	X	X	X	X	--	--	--	--	--	--	--	--

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
0657	AAOH-HNSF	Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children: Ages 2 to 12 (OME-CH)[q]	X	X	X	--	--	--	--	--	--	--	--	--
1381*	Alabama Medicaid	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One of More Asthma-Related Emergency Room Visits (ASMER-CH)[r]	X	X	X	X	--	--	--	--	--	--	--	--
1799*	NCQA	Medication Management for People with Asthma (MMA-CH)[s]	--	--	--	X	X	X	X	X	--	--	--	--
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)[s]	--	--	--	--	--	--	--	--	X	X	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	X	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	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)[t]	X	X	X	X	X	X	X	X	X	X	X	X
1365	PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)[u]	--	--	--	--	--	X	X	X	--	--	--	--
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)[v]	--	--	--	--	--	--	--	--	--	--	X	X
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[w]	--	--	--	--	--	--	--	X	X	X	X	X

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[v]	--	--	--	--	--	--	X	X	X	X	--	--
Dental and Oral Health Services														
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)[x]	--	--	--	--	--	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	X
NA	CMS	Percentage of Eligibles That Received Dental Treatment Services (TDENT-CH)[y]	X	X	X	X	X	--	--	--	--	--	--	--
NA	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)[z]	--	--	--	--	--	--	--	--	--	--	--	X
Experience of Care														
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)[aa]	X	X	X	X	X	X	X	X	X	X	X	X

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

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

More information on 2021 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf.

*This measure is no longer endorsed by NQF.

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

Exhibit A.3 *(continued)*

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

[c] The Well-Child Visits in the First 15 Months of Life (W15-CH) measure was modified by the measure steward. It now includes two rates: (1) six or more well-child visits in the first 15 months and (2) two or more well-child visits from 15 to 30 months. The NQF number refers to the endorsement of the W15-CH measure.

[d] The Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34-CH) and Adolescent Well-Care Visits (AWC-CH) measures were modified by the measure steward into a combined measure that includes rates for Ages 3 to 11, 12 to 17, 18 to 21, and a total rate. The NQF number refers to the endorsement of the W34-CH measure.

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

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

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

[h] The California Maternal Quality Care Collaborative Cesarean Rate for Nulliparous Singleton Vertex measure was replaced by The Joint Commission PC-02: Cesarean Birth measure beginning with the 2014 Child Core Set. The PC-02: Cesarean Birth measure was replaced in the 2021 Child Core Set with the Low-Risk Cesarean Delivery (LRCD-CH) measure. To reduce state burden and report a cesarean birth measure consistently across all states, CMS will calculate the LRCD-CH measure on behalf of states using National Vital Statistics System Natality data that are submitted by states and obtained through CDC Wide-ranging Online Data for Epidemiologic Research (CDC WONDER) starting in FFY 2021.

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

[j] The Live Births Weighing Less Than 2,500 Grams measure was modified for the 2021 Core Set. To reduce burden on states and increase the feasibility of assessing performance across all states, CMS will calculate the measure on behalf of states starting in FFY 2021 using National Vital Statistics System Natality data that are submitted by states and obtained through CDC WONDER.

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

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

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

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

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

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

[q] The Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2 to 12) measure was retired from the 2013 Child Core Set because of significant state reporting challenges. The measure was not collected by CMS for the 2012 Child Core Set. AMA-PCPI was the measure steward for the 2010-2012 Child Core Sets.

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

Exhibit A.3 *(continued)*

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

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

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

[v] The Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure was added to the 2016 Child Core Set to target inappropriate prescribing of antipsychotic medications, which may have adverse health effects. The measure was retired from the 2020 Child Core Set because it was retired by the measure steward. It was replaced by the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure, which was added to the 2020 Child Core Set to monitor medication safety for children on psychotropic medications by identifying any gaps in their metabolic follow-up.

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

[x] The Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk measure was added to the 2015 Child Core Set because it is linked to improved oral health outcomes and responds to a legislative mandate to measure the use of dental sealants in this age group. The measure was removed from the 2021 Child Core Set because it was retired by the measure steward.

[y] 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.

[z] The Sealant Receipt on Permanent First Molars measure was added to the 2021 Child Core Set to provide data on the percentage of children who have ever received sealants on permanent first molar teeth by their 10th birthdate. This measure replaces the SEAL-CH measure.

[aa] AHRQ is the measure steward for the survey instrument in the Child Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

Exhibit A.4. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2013–2021

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
Primary Care Access and Preventive Care											
0032	NCQA	Cervical Cancer Screening (CCS-AD)	X	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	X	X	X	X	X	X	X	X	X
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	X	X	X	X	X	X	X	X	X
0418*/0418e*	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	X	X	X	X	X	X	X	X	X
2372	NCQA	Breast Cancer Screening (BCS-AD)	X	X	X	X	X	X	X	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)[a]	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	X
0476	TJC	PC-03: Antenatal Steroids (PC03-AD)[b]	X	X	X	X	X	X	--	--	--
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	X	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)[c]	--	--	--	--	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)[d]	--	--	--	--	--	X	X	X	X
Care of Acute and Chronic Conditions											
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	X	X	X	X	X	X	X	X	X
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)[e]	X	X	X	X	X	X	X	--	--

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)[f]	--	--	X	X	X	X	X	X	X
0063*	NCQA	Comprehensive Diabetes Care: LDL-C Screening (LDL-AD)[f]	X	X	--	--	--	--	--	--	--
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	X	X	X	X	X	X	X	X	X
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	X	X	X	X	X	X	X	X	X
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	X	X	X	X	X	X	X	X	X
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	X	X	X	X	X	X	X	X	X
0403*	NCQA	Annual HIV/AIDS Medical Visit (HMV-AD)[g]	X	--	--	--	--	--	--	--	--
1768*	NCQA	Plan All-Cause Readmissions (PCR-AD)	X	X	X	X	X	X	X	X	X
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)[h]	--	--	--	--	--	X	X	X	X
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)[g]	--	X	X	X	X	X	X	X	X
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)[i]	X	X	X	X	X	X	X	--	--
Behavioral Health Care											
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	X	X	X	X	X	X	X	X	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	X	X	X	X	X	X	X	X	X
0105	NCQA	Antidepressant Medication Management (AMM-AD)	X	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[j]	X	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)[k]	--	--	--	X	X	X	X	X	X
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[l]	--	--	--	--	X	X	X	X	X
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[k]	--	--	--	X	X	X	X	X	X
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)[m]	--	--	--	--	--	X	X	X	X
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)[n]	--	--	--	--	--	--	--	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)[o]	--	--	--	--	X	X	X	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)[o]	--	--	--	--	X	X	X	X	X
NA	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)[p]	X	X	X	X	X	X	X	X	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021
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)[q]	X	X	X	X	--	--	--	--	--
Experience of Care											
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)[r]	X	X	X	X	X	X	X	X	X
Long-Term Services and Supports											
NA	NASDDDS/HSRI	National Core Indicators Survey (NCIDDS-AD)[s]	--	--	--	--	--	--	--	X	X

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

AHRQ = Agency for Healthcare Research & Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; 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 2021 Updates to the Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf.

*This measure is no longer endorsed by NQF.

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

[b] 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.

[c] 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.

[d] 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.

[e] 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.

[f] 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:

Exhibit A.4 *(continued)*

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.

[g] 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.

[h] 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.

[i] 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.

[j] 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.

[k] 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.

[l] 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.

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

[n] The Use of Pharmacotherapy for Opioid Use Disorder measure was added to the 2020 Adult Core Set to fill a gap in the Core Sets by tracking the appropriate treatment of opioid use disorders and improving the understanding of the quality of care for substance use disorders.

[o] 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).

[p] 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).

[q] 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.

[r] AHRQ is the measure steward for the survey instrument in the Adult Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

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

APPENDIX B:
Measures Suggested for Review at the 2022 Core Set Annual Review, by Domain

Exhibit B.1. Measures Suggested for Review at the 2022 Child and Adult Core Set Annual Review, by Domain

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Primary Care Access and Preventive Care				
Removal	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	NCQA	0039	Survey
Addition	Preventive Care and Screening: Influenza Immunization (Suggested as a replacement for FVA-AD)	NCQA (formerly PCPI)	0041 /0041e	EHR or clinical registry
Addition	Colorectal Cancer Screening	NCQA	0034	Administrative, hybrid, or ECDS[a]
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Prediabetes: Screening for Abnormal Blood Glucose	AMA	NA	EHR
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Intervention for Prediabetes	AMA	NA	EHR
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Retesting of Abnormal Blood Glucose in Patients with Prediabetes	AMA	NA	EHR
Maternal and Perinatal Health				
Removal	PC-01: Elective Delivery (PC01-AD)	TJC	0469/ 0469e	Hybrid or EHR
Removal	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	CDC	1360	EHR
Care of Acute and Chronic Conditions				
Removal	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	NCQA	NA	Administrative
Addition	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	NCQA	0058	Administrative
Addition	Appropriate Treatment for Upper Respiratory Infection	NCQA	0069	Administrative
Addition	Proportion of Days Covered: Diabetes All Class	PQA	0541	Administrative
Addition	Proportion of Days Covered: Renin Angiotensin System Antagonists	PQA	0541	Administrative
Addition	Proportion of Days Covered: Statins	PQA	0541	Administrative

Exhibit B.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	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	NA	EHR or clinical registry
Behavioral Health Care				
Removal	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	NCQA	0004	Administrative or EHR
Removal	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	NCQA	0027	Survey
Addition[a]	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (suggested as a replacement for MSC-AD)	NCQA (formerly PCPI)	0028/ 0028e	Administrative, EHR, or clinical registry
Addition[a]	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA, suggested for addition to the Child Core Set for ages 13-17 as a replacement for AMB-CH)	NCQA	3488	Administrative
Addition[a]	Follow-Up After Emergency Department Visit for Mental Illness (FUM, suggested for addition to the Child Core Set for ages 6-17 as a replacement for AMB-CH)	NCQA	3489	Administrative
Addition: Measure will not be reviewed because it has not been field tested in Medicaid/CHIP	Tobacco Use and Help with Quitting Among Adolescents	NCQA	2803 (No longer endorsed)[b]	Administrative or EHR
Dental and Oral Health Services				
Removal[a]	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	CMS	NA	Administrative (Form CMS-416)[c]
Addition[a]	Oral Evaluation, Dental Services (suggested as a replacement for PDENT-CH)	ADA/DQA	2517	Administrative
Addition[a]	Prevention: Topical Fluoride for Children at Elevated Caries Risk (suggested as a replacement for PDENT-CH)	ADA/DQA	2528	Administrative
Addition[a]	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	ADA/DQA	NA	Administrative

Exhibit B.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Long-Term Services and Supports				
Addition	Long-Term Services and Supports Comprehensive Care Plan and Update	NCQA	NA	Case management record review
Addition: Measure will not be reviewed because it has not been fully specified	State Use of Experience of Care Surveys for Beneficiaries Using Long-Term Services and Supports	CMCS	NA	CMS count of surveys administered

Notes: Data collection methods for each measure are current as of April 2021. 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] 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/.

[b] NQF endorsement was removed because the committee did not reach consensus on evidence. In 2020, the U.S. Preventive Services Taskforce released an updated recommendation related to tobacco use in adolescents. The updated recommendation rated evidence related to tobacco cessation interventions in adolescents as "Insufficient" due to the lack of high-powered studies looking at cessation interventions in this population.

[c] Beginning with federal fiscal year (FFY) 2020 Form CMS-416 reporting due April 1, 2021, states may opt to use the Form CMS-416T report generated by CMS on behalf of states using Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF).

ADA = American Dental Association; AMA = American Medical Association; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMCS = Center for Medicaid and CHIP Services; CMS = Centers for Medicare & Medicaid Services; DQA = Dental Quality Alliance; ECDS = Electronic Clinical Data System; EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PCPI = Physician Consortium for Performance Improvement; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

APPENDIX C:
Summary of 2022 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 2022 Child and Adult Core Sets. The discussion took place during the 2022 Core Set Annual Review Stakeholder Workgroup meeting that was held May 4 to May 6, 2021. The summary is organized by Core Set domain. For more information about the measures discussed and not recommended for removal or addition, please refer to Exhibit C.1 at the end of this appendix. Exhibit C.1 includes the measure name, measure steward, National Quality Forum (NQF) number (if endorsed), measure description, data collection method, and key points of discussion about each measure.

Primary Care Access and Preventive Care

Workgroup members discussed two immunization measures: *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD), which was suggested for removal from the Adult Core Set; and *Preventive Care and Screening: Influenza Immunization*, which was suggested as a replacement for the FVA-AD measure. The FVA-AD measure is based on self-reported data collected through the CAHPS survey. The measure is defined as the percentage of beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS survey was completed. The FVA-AD measure was suggested for removal because survey completion varies widely across demographic groups, and the measure may not be representative of the population across counties and states. The Workgroup member who suggested the measure for removal also acknowledged that, while the Centers for Medicare & Medicaid Services (CMS) pilot has shown it is feasible to calculate the measure using data from the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database, the data are incomplete due to lack of submissions from some states and health plans. During the Workgroup meeting, Mathematica noted that while 25 states reported the FVA-AD measure for Federal Fiscal Year (FFY) 2019, it was not publicly reported due to CMS concerns about data quality. However, preliminary results from FFY 2020 Core Set reporting suggest that this measure may have reached the public reporting threshold for FFY 2020.

The *Preventive Care and Screening: Influenza Immunization* measure is defined as the percentage of patients ages 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization or who reported previous receipt of an influenza immunization. The measure was suggested to replace FVA-AD and is collected using electronic health records (EHRs) or clinical registries. The Workgroup member who suggested adding this measure to the Core Sets noted that the measure had been tested at the provider level using Medicare data. They also noted that the measure is currently used in selected Medicaid and Children's Health Insurance Program (CHIP) value-based purchasing programs in their state; however, it has not been used statewide in Medicaid and CHIP. In addition, the Workgroup member stated that the flu vaccine is important for reducing morbidity and mortality in Medicaid and CHIP beneficiaries, and that it could be stratified to perform comparative analyses. They also noted that the measure could be calculated using immunization registry data, and that states could benefit from technical assistance in this area, which would also benefit other immunization measurement efforts.

During the discussion, some Workgroup members expressed concern about the validity, reliability, and representativeness of the FVA-AD measure given the low CAHPS response rates. One Workgroup member, however, challenged this assertion suggesting that they have not seen evidence that CAHPS results substantially under-report influenza immunization rates, noting that CAHPS results still appear to benchmark well with other data sources. While several Workgroup members noted that the wider age range of the *Preventive Care and Screening: Influenza Immunization* measure is an improvement over FVA-AD, the Workgroup also discussed potential difficulties collecting the measure, including variation in states' use of immunization registries, especially for adult populations. Workgroup members noted this was in contrast to the availability of CAHPS, and the progress seen in more states being able to report the measure.

Some Workgroup members suggested the need for a glide path to encourage movement toward newer data collection methods, such as utilizing EHRs, while not losing insight into current reporting mechanisms, like CAHPS. Some Workgroup members noted the increasing potential of EHRs and immunization registries. One Workgroup member highlighted that immunization registries are being used with the administration of COVID-19 vaccines and the possibility of a forthcoming COVID-19 vaccine measure that could be leveraged for measuring flu vaccination in the future.

Care of Acute and Chronic Conditions

The Workgroup discussed the *Appropriate Treatment for Upper Respiratory Infection* measure but did not recommend it for addition to the Core Sets. This measure assesses the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. The Workgroup considered this measure alongside the *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis* measure, which they recommended for addition to the Core Set.

A Workgroup member suggested the *Appropriate Treatment for Upper Respiratory Infection* measure for addition to help identify the inappropriate over-prescribing of antibiotics for a common condition (URI). They added that the Core Sets currently do not address appropriate use of antibiotics. During the discussion, other Workgroup members agreed that appropriate antibiotic use and prevention of antimicrobial resistance were important issues to address, however they questioned whether it was necessary to add both measures to the Core Sets, or if one measure was sufficient to address the issue. One Workgroup member raised concerns about the potential to game the URI measure, explaining that there are ways to subvert measure performance through coding. Other Workgroup members pointed out that when looking at commercial and Medicaid health maintenance organization (HMO) data from the National Committee for Quality Assurance (NCQA), URI measure performance is high relative to performance on *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis*. This indicates that improvement on the bronchitis/bronchiolitis measure would be more impactful than on the URI measure.

The Workgroup also considered three measures related to medication management for chronic conditions: *Proportion of Days Covered: Diabetes All Class; Proportion of Days Covered:*

Renin Angiotensin System Antagonists; and *Proportion of Days Covered: Statins. Proportion of Days Covered: Diabetes All Class* measures the percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for diabetes medications during the measurement year. One Workgroup member suggested this measure for addition because non-adherence to diabetes medications leads to higher rates of hospitalization and places a cost burden on the health care system. The Workgroup member also noted that the inclusion of this measure in the Core Set may drive patient education at the provider, pharmacy, and health plan levels. They added that this measure is included in the Medicare Part D Star Ratings program, and adherence rates in the Medicare population are higher than those in the Medicaid population.

Proportion of Days Covered: Renin Angiotensin System Antagonists measures the percentage of individuals 18 years and older who met the PDC threshold of 80 percent for renin angiotensin system (RAS) antagonists during the measurement year. The Workgroup member who suggested this measure for addition to the Core Set provided similar reasons as those for the *Proportion of Days Covered: Diabetes All Class* measure, with the intent of improving adherence to hypertension medications in Medicaid. *Proportion of Days Covered: Statins* measures the percentage of individuals 18 years and older who met the PDC threshold of 80 percent for statins during the measurement year. The Workgroup member who suggested the measure for addition presented many of the same reasons as those listed for the previous two measures, with a focus on medication adherence to statins for high cholesterol. They added that high cholesterol, hypertension, and diabetes are prevalent conditions among the adult Medicaid population.

During the Workgroup discussion, several Workgroup members expressed concern about the appropriateness of adding the three measures mentioned above to the Core Set. As one Workgroup member noted, the measures only indicate if the patient picked up the medication, not whether they adhered to taking it or whether the medication was prescribed appropriately. Furthermore, Workgroup members were hesitant to add more process measures to the Core Set, with one Workgroup member emphasizing that CMS is moving toward more outcome-based measures. The Workgroup member who suggested the three measures for addition noted that they are outcome measures with considerable room for improvement.

Several Workgroup members also raised concerns about implementing measures that calculate the rate at which prescriptions are filled; they noted that some beneficiaries struggle to afford or fill their prescriptions. For example, one Workgroup member stated that some providers prescribe a higher dosage than necessary and tell patients to split their medications, so they last longer and cost less. A few Workgroup members added that physicians may adjust medications frequently, which can interfere with adherence measurement. In addition, one Workgroup member questioned why insulin is excluded from the diabetes measure. The measure steward, Pharmacy Quality Alliance (PQA), responded that insulin requires frequent dosage adjustments, complicating data collection.

One Workgroup member questioned if it was necessary to add the *Diabetes All Class* measure when the *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* (HPC-AD) measure is already in the Adult Core Set. The Workgroup member who suggested the

measure responded that the *Diabetes All Class* measure would complement the HPC-AD measure, adding that both measures are in the Health Insurance Exchange Quality Rating System. In addition, Workgroup members noted that there is already an outcome measure that addresses hypertension (*Controlling High Blood Pressure [CBP-AD]*).

Workgroup members stated that the statins measure may be a better fit for the Core Set, given the generality of the population included in the measure, the prevalence of high cholesterol among Medicaid beneficiaries, and the lack of existing measures related to cholesterol in the Core Set. They noted that this is particularly important for beneficiaries with behavioral health disorders, especially for those on antipsychotics. However, another Workgroup member said that other measures may be better suited to address high cholesterol among specific populations, such as those with behavioral health conditions.

Behavioral Health Care

The *Initiation and Engagement of Alcohol or Other Drug Abuse or Dependence Treatment* (IET-AD) measure assesses the percentage of beneficiaries ages 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: (1) initiation of AOD treatment, which captures the percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis; and (2) engagement of AOD treatment, which captures the percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. This measure is stratified into four diagnosis cohorts: alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence, and total alcohol and other drug abuse or dependence.

One Workgroup member suggested removing the IET-AD measure because they felt it was duplicative of other measures, such as the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence* (FUA-AD) and the *Use of Pharmacotherapy for Opioid Use Disorder* (OUD-AD) measures. Therefore, they noted, the removal of the IET-AD measure would not leave a gap in the Adult Core Set. They added that the FUA-AD and OUD-AD measures are more specific to the treatment of substance use disorders (SUD), whereas IET-AD measures new substance use events and does not consider an existing substance use event. The Workgroup member stated that it often takes more than the initial engagement to treat patients with SUD and they find it difficult to get patients to come in after the initial screening. As a result, they have not seen significant improvement in their state on the measure. They acknowledged that SUD is a critical issue to address but questioned whether IET-AD was the best measure to achieve the best possible outcome.

During the discussion, Workgroup members voiced concern about removing the IET-AD measure from the Core Set given the prevalence of alcohol and drug misuse in the Medicaid population. Many Workgroup members thought that given the breadth of settings captured through the measure, removal of the measure would leave a gap in the Core Set that could not be replaced by measures with a narrower focus. Some Workgroup members acknowledged that

components of the IET-AD measure overlap with other measures in the Core Set. However, they also noted that there are important differences. For example, they noted that the IET-AD measure addresses treatment for the general population, while the FUA-AD measure addresses follow-up care for the population that ends up in the emergency department (ED).

One Workgroup member commented that many clinicians (such as primary care providers and general psychiatrists) often treat SUD inadequately because they are not addiction specialists. They suggested that the IET-AD measure motivates health systems to ensure that patients receive proper care when they are identified as having AOD use or dependence. On the other hand, a federal liaison suggested that the IET-AD measure could potentially discourage providers from reporting a diagnosis of SUD to "activate" the measure, and the measure is difficult to meet (i.e., 7-day follow up), especially in areas where the diagnosis is prevalent. Several Workgroup members agreed that while the IET-AD measure was not necessarily the best measure, it is a fundamentally good measure that looks beyond what happens in the ED, and supplements the existing follow-up measures in the Core Set.

Workgroup members discussed two tobacco use cessation measures: *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD), which was suggested for removal from the Adult Core Set; and *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention*, which was suggested as a replacement for the MSC-AD measure. The MSC-AD measure is based on self-reported data collected through the CAHPS survey. It includes three components: (1) advising smokers and tobacco users to quit, (2) discussing cessation medications, and (3) discussing cessation strategies. One Workgroup member suggested the removal of this measure from the Adult Core Set. They noted that survey response rates for the CAHPS survey are low and rates overall have been decreasing over time, with their own state having a 20 percent response rate. They acknowledged that it may be feasible to calculate the measure using data from the AHRQ CAHPS Database; however, the data are incomplete due to lack of submissions for some states or plans. They then expressed concerns about the feasibility of mandatory reporting for this measure based on the CAHPS survey.

As a replacement for the MSC-AD measure, the Workgroup member suggested adding the *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention* measure, which assesses the percentage of patients ages 18 and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user. The measure has three rates: (1) percentage of patients ages 18 years and older who were screened for tobacco use one or more times within 24 months, (2) percentage of patients ages 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention, and (3) percentage of patients ages 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user. This measure can be calculated using administrative, EHR, and registry data. The measure is being used in California at the program level, but due to COVID-19, it has not yet been implemented at the state level.

The Workgroup discussed data collection of both measures. Despite concerns expressed about low CAHPS response rates, some Workgroup members felt that the MSC-AD measure is more feasible for states to report given that CAHPS is already collected by many states. The *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention* measure allows for use of claims, EHR, or registry data. This measure would have a larger denominator than MSC-AD and could allow for stratification by race, ethnicity, and other characteristics to better understand disparities. However, one Workgroup member asked if there was concern that the use of different data sources could introduce variability across states. The Workgroup member who suggested the measure for addition noted that other programs, such as Medicare, are working toward EHR measures, and more states will soon be adopting EHR data into their Medicaid and CHIP programs. Some Workgroup members did not believe there was enough evidence to support state-level reporting of the measure, questioning whether the measure met the criteria for having been tested in a state Medicaid and/or CHIP program. They noted that they did not have concerns about the merit of the *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention* measure and encouraged follow-up from California after the measure has been implemented at the state level.

Dental and Oral Health Services

The *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* measure focuses on dental and oral health of adults. This measure was suggested for addition to the Core Set but was not recommended. The measure is defined as the number of ED visits for ambulatory care sensitive non-traumatic dental conditions, per 100,000 beneficiary months. The measure was suggested to address a gap in oral health care for adults in the Core Set, and was described as an indicator of state Medicaid program performance in minimizing acute dental conditions in adults. The Workgroup member who suggested the measure for addition noted that ED use for non-traumatic dental conditions has been a growing public health concern across the United States. They further noted that Medicaid is a primary payer of dental-related ED visits. The measure aims to divert dental care out of the ED by increasing preventive care, early identification of disease, treatment of acute dental issues, and appropriate follow-up after ED visits. The Workgroup member acknowledged that dental benefits for adults enrolled in Medicaid vary across states and this may lead to variation in state performance on the measure. They noted this should not result in any inconsistencies in calculations, given that dental claims are not required to calculate the measure.

The Workgroup discussed whether the measure is appropriate for the Core Sets, given that some state Medicaid programs do not have an adult dental benefit, and the benefit varies among the states that do. The Workgroup member who suggested the measure indicated that about a third of states provide comprehensive benefits (including routine dental care), and the remainder provide limited benefits or emergency-only dental care, except for three states that provide no coverage at all.

While Workgroup members agreed on the importance of equitable access to dental care for adults, some felt that the Core Set should focus on services that have more consistent benefits across states so that data are more comparable and actionable. For example, one Workgroup

member noted that the measure would not be actionable in their state due to limited adult dental coverage.

Workgroup members discussed whether the intention was to add the measure to the Core Set to promote a change in Medicaid policy around adult dental benefits, and questioned whether this was an appropriate purpose of the Core Set. One Workgroup member believed that adding the measure was appropriate to draw attention to address a Core Set gap in adult dental care, while another disagreed. Another Workgroup member mentioned that having an adult dental ED measure would be a starting place toward better integration of dental and medical care; would serve to identify variability, gaps, and disparities; and would ideally be used to drive preventive efforts aimed at reducing dental-related ED visits. Additionally, they noted that given challenges with integrating dental and medical data, this measure is a more feasible starting place for addressing the gap in the Core Set. [47]

[47] Public comments submitted on the *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* measure can be found in Appendix D.

Exhibit C.1. Measures Discussed by the 2022 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			
Measure discussed and not recommended for removal from the 2022 Core Sets			
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 survey was completed Data collection method: Survey (CAHPS 5.0H/5.1H Adult Medicaid Survey)	• Suggested for removal due to concern about the validity, reliability, and representativeness of the measure given low CAHPS response rates • Concern about variation in survey responses across demographic groups may result in rates that are not consistent across states • Concern that data in the AHRQ CAHPS Database are incomplete due to lack of submissions from states and plans • Comment that there is no evidence that CAHPS data are under-reporting flu vaccination rates • Acknowledgment that states are making progress in reporting the measure; measure may meet threshold for public reporting for FFY 2020
Measure discussed and not recommended for addition to the 2022 Core Sets			
Preventive Care and Screening: Influenza Immunization Measure steward: NCQA (formerly PCPI)	0041/0041e	Percentage of patients ages 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization Data collection method: EHR or clinical registry	• Suggested to replace FVA-AD • Suggested for addition because the measure can be calculated using electronic data and could be stratified to perform comparative analysis by race, ethnicity, or other characteristics • Concern about availability of electronic data, including immunization registry; although data may become more complete as a result of the emphasis on gathering COVID-19 vaccination data • The measure captures a wider age range than FVA-AD

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Care of Acute and Chronic Conditions			
Measures discussed and not recommended for addition to the 2022 Core Sets			
Appropriate Treatment for Upper Respiratory Infection Measure steward: NCQA	0069	The percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event Data collection method: Administrative	• Suggested for addition because URI is a common condition for which antibiotics are commonly prescribed, even though they may not be an appropriate treatment • Suggested alongside the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis measure; however, some Workgroup members felt that only one measure was necessary • Commercial and Medicaid HMO data show that performance among children on this measure is high, relative to adult performance on the bronchitis/bronchiolitis measure, indicating there is more room for improvement on the bronchitis/bronchiolitis measure • Concern that the measure could be gamed by providers through coding practices
Proportion of Days Covered: Diabetes All Class Measure steward: PQA	0541	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for diabetes medications during the measurement year Data collection method: Administrative	• Suggested for addition because non-adherence to diabetes medications could lead to higher hospitalization rates and place a cost burden on the health care system • Comment that the measure could drive patient education at the provider, pharmacy, and health plan levels • Hesitation in adding this measure because the Adult Core Set currently includes two measures that address diabetes • Comment that medication adherence in Medicare is higher than in Medicaid, suggesting room for improvement • Concern that the measure does not indicate if the prescription is appropriate or whether the patient took the medication

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Proportion of Days Covered: Renin Angiotensin System Antagonists Measure steward: PQA	0541	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for renin angiotensin system (RAS) antagonists during the measurement year Data collection method: Administrative	• Suggested for addition to improve adherence to hypertension medications in Medicaid • Comment that Medicare rates are higher than those for Medicaid, suggesting room for improvement • Hesitation in adding this measure because the Adult Core Set currently includes another measure that addresses high blood pressure • Concern that the measure does not indicate if the prescription is appropriate or whether the patient took the medication
Proportion of Days Covered: Statins Measure steward: PQA	0541	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 80 percent for statins during the measurement year Data collection method: Administrative	• Suggested for addition to improve medication adherence to statins for high cholesterol • No measures in the Core Set address high cholesterol, but a suggestion that there may be better measures that address more specific conditions • Comment that Medicare rates are higher than those for Medicaid, suggesting room for improvement • Concern that the measure does not indicate if the prescription is appropriate or whether the patient took the medication

Exhibit C.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 2022 Core Sets			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) Measure steward: NCQA	0004	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit Data collection method: Administrative or EHR	• Suggested for removal because the measure is duplicative of other Core Set measures, such as FUA-AD and OUD-AD. Measure focuses on new substance use events and does not consider an existing substance use event • Concern that removing the measure could leave a gap in the Core Set because it is broader in scope and settings than the FUA-AD and OUD-AD measures. IET-AD measure addresses treatment for the general population, while the FUA-AD measure addresses follow-up care for the population that ends up in the ED • Comment that the measure could incentivize health systems to ensure that patients are receiving proper care when they are identified as having AOD use or dependence

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) Measure steward: NCQA	0027	The following 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. 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/5.1H Adult Medicaid Survey)	• Suggested for removal due to low CAHPS survey response rates, incomplete CAHPS data from some states and health plans, and concerns about feasibility for mandatory reporting in 2024 • Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention was suggested as a replacement • Comment that there is not yet enough data to support state-level reporting of the Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention measure • Acknowledgment that states are making progress in reporting the measure; measure may meet threshold for public reporting for FFY 2020 • Hesitation to remove this measure since CAHPS is already collected by many states. Discussion that more states may report the MSC measure through the CAHPS Database

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measure discussed and not recommended for addition to the 2022 Core Sets			
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Measure steward: NCQA (formerly PCPI)	0028/0028e	Percentage of patients 18 and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: 1. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Data collection method: Administrative, EHR, or clinical registry	• Suggested as a replacement for MSC-AD • Question about whether differences in the data collection method may lead to variation in measure results across states • Concern around lack of reporting at the state level. Used at the program level in California but has not yet been implemented at the state level • Comment that the data could allow for stratification across demographic characteristics to better understand disparities • Comments encouraging follow-up from California after the measure has been implemented at the state level

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Dental and Oral Health Services			
Measure discussed and not recommended for addition to the 2022 Core Sets			
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults Measure steward: ADA/DQA	Not endorsed	Number of 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 Set around oral health care for adults. Could promote diversion of dental care out of the emergency department through increased preventive care and treatment of acute dental issues • Comment that the measure could be used to identify variation, gaps, and disparities in adult oral health care quality • Concern about the appropriateness of the measure in the Core Set as not all states provide dental coverage for adults. Comment that the Core Set should focus on measures with consistent benefits across states for comparability and actionability • Suggestion that the measure can be used as a starting place toward better integration of dental and medical care and to drive efforts aimed at reducing the occurrence of dental-related ED visits

APPENDIX D:
Public Comments on the Draft Report

The draft report was available for public review and comment from July 1, 2021 through August 6, 2021 at 8 p.m. Eastern Time, and stakeholders were invited to submit comments via email. Mathematica received a total of 44 public comments. Commenters included state agencies, professional associations, policy and advocacy organizations, universities, research firms, and individuals. Mathematica appreciates the time and effort taken by commenters to prepare and submit their comments on the draft report.

Exhibit D.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, 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, stakeholders submitted public comments on the four measures the Workgroup recommended for removal, the seven measures recommended for addition, and remaining gap areas, including the lack of measures related to adult dental care. The majority of comments relate to the colorectal cancer screening measure and dental and oral health care measures.

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

Topic	Commenter
General Comments	• California Pan-Ethnic Health Network • Children Now • Kenneth Cooperman • The Joint Commission • The Lewin Group
Measures Recommended for Removal from the Child Core Set	
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	• Association for Community Affiliated Plans • National Association of Community Health Centers • National Network for Oral Health Access • New England Medicaid Quality Collaborative • Ohio Department of Medicaid
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	• Association for Community Affiliated Plans • National Association of Community Health Centers • New England Medicaid Quality Collaborative • Ohio Department of Medicaid
Audiological Diagnosis No Later than 3 Months of Age (AUD-CH)	• Association for Community Affiliated Plans • Children Now • National Association of Community Health Centers • New England Medicaid Quality Collaborative • Ohio Department of Medicaid
Measure Recommended for Removal from the Adult Core Set	
PC-01: Elective Delivery (PC01-AD)	• Association for Community Affiliated Plans • National Association of Community Health Centers • New England Medicaid Quality Collaborative • Ohio Department of Medicaid
Measures Recommended for Addition to the 2022 Core Sets	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17[a]	• Association for Community Affiliated Plans • California Pan-Ethnic Health Network • Community Catalyst • National Association of Community Health Centers • New England Medicaid Quality Collaborative • Ohio Department of Medicaid
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17[a]	• Association for Community Affiliated Plans • California Pan-Ethnic Health Network • Community Catalyst • National Association of Community Health Centers • New England Medicaid Quality Collaborative • Ohio Department of Medicaid

Exhibit D.1 *(continued)*

Topic	Commenter
Oral Evaluation, Dental Services	• Academy of General Dentistry • American Academy of Pediatric Dentistry • American Dental Association • American Dental Hygienists' Association • American Institute of Dental Public Health • Association for Community Affiliated Plans • Association of State and Territorial Dental Directors • California Pan-Ethnic Health Network • CareQuest Institute • Children Now • Community Catalyst • Dental Quality Alliance • Florida Voices for Health • Justice in Aging • The Los Angeles Trust for Children's Health • National Association of Community Health Centers • National Network for Oral Health Access • New England Medicaid Quality Collaborative • Ohio Department of Medicaid • Oral Health Progress and Equity Network • Oral Health Progress and Equity Network - Data & Measurement Network Response Team • Partnership for Children's Oral Health • Southern Plains Tribal Health Board • Virginia Health Catalyst
Prevention: Topical Fluoride for Children[b]	• Academy of General Dentistry • American Academy of Pediatric Dentistry • American Dental Association • American Dental Hygienists' Association • American Institute of Dental Public Health • Association for Community Affiliated Plans • Association of State and Territorial Dental Directors • California Pan-Ethnic Health Network • CareQuest Institute • Children Now • Community Catalyst • Dental Quality Alliance • Florida Voices for Health • Justice in Aging • The Los Angeles Trust for Children's Health • National Association of Community Health Centers • National Network for Oral Health Access • New England Medicaid Quality Collaborative • Ohio Department of Medicaid • Oral Health Progress and Equity Network

Exhibit D.1 *(continued)*

Topic	Commenter
	• Oral Health Progress and Equity Network - Data & Measurement Network Response Team • Partnership for Children's Oral Health • Southern Plains Tribal Health Board • Virginia Health Catalyst
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	• Association for Community Affiliated Plans • New England Medicaid Quality Collaborative • Ohio Department of Medicaid • Washington State Health Care Authority
Long-Term Services and Supports: Comprehensive Care Plan and Update	• ADvancing States • Arizona Health Care Cost Containment System • Association for Community Affiliated Plans • Community Catalyst • The Lewin Group • National Association of Community Health Centers • New England Medicaid Quality Collaborative • Ohio Department of Medicaid • Danny van Leeuwen

Colorectal Cancer Screening	• American College of Radiology
	• Arizona Health Care Cost Containment System
	• Association for Community Affiliated Plans
	• California Colorectal Cancer Coalition
	  • James Allison
	  • Daniel Stonewall Anderson & Margaret Hitchcock
	  • John M. Greif
	  • Margaret Hitchcock
	• Cancer Early Detection Alliance
	• Colorado Cancer Coalition
	• Exact Sciences
	• Fight Colorectal Cancer
	• National Association of Community Health Centers
	• New England Medicaid Quality Collaborative
	• Ohio Department of Medicaid
	• Samir Gupta
	• Virginia Colorectal Cancer Roundtable

Exhibit D.1 *(continued)*

Topic	Commenter
Gap Areas	
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	• Academy of General Dentistry • American Dental Association • American Dental Hygienists' Association • American Institute of Dental Public Health • Association of State and Territorial Dental Directors • California Pan-Ethnic Health Network • CareQuest Institute • Children Now • Community Catalyst • Dental Quality Alliance • Florida Voices for Health • GlaxoSmithKline Consumer Healthcare • Justice in Aging • The Los Angeles Trust for Children's Health • National Network for Oral Health Access • Oral Health Progress and Equity Network • Oral Health Progress and Equity Network - Data & Measurement Network Response Team • Partnership for Children's Oral Health • Southern Plains Tribal Health Board • Virginia Health Catalyst
Other Gap Areas	• ADvancing States • American Academy of Pediatric Dentistry • American Dental Hygienists' Association • California Pan-Ethnic Health Network • Cancer Early Detection Alliance • Children Now • Community Catalyst • The Lewin Group • National Network for Oral Health Access • University of Detroit Mercy School of Dentistry

[a] These measures are currently included in the Adult Core Set (FUA-AD and FUM-AD) for the adult age ranges. The Workgroup recommended these measures for addition to the Child Core Set for the child age ranges.

[b] A Workgroup member suggested a version of this measure that focused on children at elevated caries risk (*Prevention: Topical Fluoride for Children at Elevated Caries Risk)*. In spring 2021, the measure steward modified this measure to include *all* children (not just those at elevated caries risk). Because this change applies to calendar year 2021 reporting, which corresponds to the 2022 Child Core Set, the Workgroup discussed and voted on the modified version of the measure.

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

Academy of General Dentistry (Bruce L. Cassis)

On behalf of its nearly 40,000 members, the Academy of General Dentistry (AGD) commends the Dental Quality Alliance (DQA) on its continued efforts to advance the development and application of performance measurements intended to improve the oral health, care, and safety of some of our nation's most vulnerable populations.

We have reviewed the July 2021 report, *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets*, and submit the following comments in response.

The AGD supports the inclusion of the recommended Topical Fluoride and Oral Evaluation measures on the basis that:

- Dental caries (tooth decay) is the most common chronic disease in children in the United States, affecting almost half of all children.[1]
- The prevalence of caries, untreated caries, and disparities are significant, and there is substantial room for improvement within Medicaid and CHIP programs.
- Topical fluoride is one of the interventions with the strongest evidence base for reducing tooth decay.
- The topical fluoride measure could serve as a complement to the dental sealant measure in the Child Core Set (SFM-CH) by helping states assess the extent to which children are receiving evidence-based preventive services and target quality improvement accordingly.

The AGD encourages the inclusion of the adult emergency department (ED) measure into the adult core set.

While the AGD is aware that the Workgroup opted against supporting the inclusion of the recommended adult ED measures, we encourage its inclusion because:

- The lack of oral healthcare measures in the adult core set is a gap that should be filled.
- ED visits represent expensive – and avoidable – expenses within the Medicaid program.
    - Even without an adult dental benefit, these programs could seek to improve oral health care outcomes among their beneficiaries and cost for the program by linking them to community-based resources.
- The measure of ambulatory care sensitive ED visits provides a strong starting place for incorporating oral health considerations into the Adult Core Set by providing a systems-level indicator of access to oral health care among Medicaid beneficiaries.

- Many states conduct their own independent studies of ED visits for non-traumatic dental related reasons, but variable methodologies make it difficult to make comparisons across states and to get a national perspective.
    - This measure would enable standardized assessments.

As one of the DQA's founding members and a current member of the Executive and Education Committees, the AGD is honored to partner with other DQA stakeholders in support of efforts to improve oral health, patient care, and safety.

Citations

[1] Figure 1. Prevalence of total dental caries and untreated dental caries in primary or permanent teeth among youth aged 2–19 years, by age: United States, 2015–2016. Available at: https://www.cdc.gov/nchs/products/databriefs/db307.htm#fig1.

ADvancing States (April Young)

ADvancing States represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports (LTSS) directors. Our mission is to design, improve, and sustain state systems delivering LTSS for older adults, people with disabilities, and their caregivers. An important part of fulfilling this mission is assisting states with tracking and improving the quality and outcomes of their LTSS programs. The National Core Indicators – Aging & Disabilities (NCI-AD) project enables states to identify trends and compare LTSS outcomes nationally and with other participating states. As proponents of state efforts to improve publicly funded LTSS programs via various quality initiatives and particularly as the measure stewards for NCI-AD, ADvancing States would like to express our concern around the lack of LTSS measures addressing aging and physical disabilities populations recommended for inclusion in to the 2022 Child and Adult Core Set. While we applaud and recognize the addition of the MLTSS measure *Long-Term Services and Supports Comprehensive Care Plan and Update*, it is a process measure, NOT an outcome measure.

It is important for states, consumers, and the larger health and human services system to know and understand the outcomes of these services, given that LTSS costs are expected to increase as the aging population continues to grow and more people utilize services. The NCI-AD project helps to address this concern by providing person-reported outcomes data on publicly funded LTSS programs and makes this information publicly available on the NCI-AD website. The survey is person-centered and captures a broad array of information about the experience of the person's services, covering 18 different domains plus optional COVID-19 and person-centered planning modules. The project has grown exponentially since it began in 2015, with 27 total participating states over the life of the project. States report unique and varied ways of utilizing NCI-AD data, including futures planning, budget considerations, tracking and trending outcomes data, identifying areas for improvement and formulating quality initiatives, and program decision making.

Cost of LTSS aside, efforts to collect quality of life and outcomes data honor the inherent dignity and worth of older adults and people with physical disabilities. States that collect outcomes data demonstrate a willingness to ensure these populations receive the services and care needed to safely reside in their setting of choice. We are appreciative that LTSS was added as a topic area for measures in the 2020 Core Set and believe recommending NCI-AD for the 2022 core set would have been a meaningful way to emphasize the importance of measuring quality and outcomes for aging and physical disabilities populations. Given the reliability and high quality of the information NCI-AD provides, and its utility to states in monitoring LTSS quality, it is disappointing to ADvancing States and our participating states that NCI-AD was not recommended for inclusion.

During the 2020 Child and Adult Core Set workgroup meeting, NCI-AD was overwhelmingly recommended for inclusion by workgroup members. CMS ultimately decided not to include NCI-AD in the set because the measure was not used in at least 25 states at the time. We were hopeful our measure would help to fill a gap in LTSS measures for aging and physical

disabilities populations and once again be recommended for inclusion by workgroup members for the 2021 Core Set, however the measure did not pass out of the core set workgroup.

Frustratingly, the workgroup members continue to bemoan the lack of – and need for – person-centered outcomes measures that captured individual experiences and quality of life for the person receiving services. NCI-AD is the person-centered survey tool that provides this information. Many domains included in the NCI-AD survey cover the person's experience of services and quality of life, including community participation, experience of care, choice and decision making, and rights and respect. As mentioned above, an optional person-centered module is also offered to states at no additional cost.

Members have also voiced concern that some measures were not appropriate for application across service delivery systems, namely, fee-for-service (FFS) and managed care LTSS. NCI-AD was created with state input and needs in mind, and therefore, since its inception, has been applicable to both FFS and MLTSS systems. In fact, some states formulate their survey sample in such a way so that delivery system outcomes can be reviewed side-by-side. It seemed as if members continue to not understand what NCI-AD truly offers and encompasses.

ADvancing States is grateful for the addition of the Long-Term Services and Supports domain in the 2020 Adult Core Set, but the lack of core set measures specifically addressing aging and physical disabilities populations, whether inclusive of NCI-AD or not, is concerning. State aging and disability agencies put forth consistent effort to be trusted stewards of public funding. Sustaining the measure gap for these two populations sends an inadvertent message that tracking quality for aging and physical disabilities LTSS programs is not needed, while the amount of funding spent on these programs underscores their necessity and importance. Over 30% of all Medicaid expenditures are spent on LTSS, and of that 30%, older adults and physical disabilities programs utilize over 60% of the total cost for LTSS. This far outweighs other LTSS populations.

Since the workgroup discussion of NCI-AD in 2020, CMS included NCI-AD measures in the draft HCBS recommended measure set released for comment in 2020, and we fully expect to see many of them included in the final recommended measure set to be released this fall. Perhaps NCI-AD inclusion in CMS' recommendations for HCBS quality measures will spur the workgroup into considering them for inclusion in the Core Set in 2023.

We appreciate the opportunity to provide public comment and have full faith in the meaningful contributions of the project to the LTSS quality and outcomes measurement field. Through recommendation to be added to the Adult Core Set, NCI-AD would help to fill an obvious LTSS measures gap for aging and physical disabilities populations.

We welcome the opportunity to discuss our comments further if desired. Please contact April Young, Sr. Director of NCI-AD.

American Academy of Pediatric Dentistry

The American Academy of Pediatric Dentistry (AAPD) supports the inclusion of topical fluoride and oral evaluation measures proposed by the Dental Quality Alliance. These are necessary and important measures to help insure the continued improvement in pediatric oral health in the US. Pediatric dentists have been involved in the development and review of these measures and their involvement in the DQA process adds to our overall support of them as meaningful for pediatric oral health.

The adult measures also mean that adults with special needs will enjoy scrutiny of the system's impact on their oral health as they age out of pediatric care and the AAPD is in support of these and their application to help insure that this oft-overlooked group, as well as adults in general, has the benefit of continuous quality measurement of their oral health.

Thank you for the opportunity to offer our support.

American College of Radiology (William T. Thorwarth Jr.)

The American College of Radiology (ACR), representing more than 40,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, appreciates the opportunity to comment on the *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets* draft document. The ACR strongly supports the inclusion of Colorectal Cancer Screening as a Core Set Measure and additionally strongly supports the inclusion of all screening tests that have received an A grade from the United States Preventive Services Task Force (USPSTF) including computed tomography colonography (CTC).

The use of CTC as a colorectal cancer screening test is also endorsed by the American Cancer Society which in 2018 published their updated guidelines for colorectal cancer screening and concluded that adults aged 45 years and older with an average risk of colorectal cancer should undergo regular screening using one of a variety of available screening options, including CTC every 5 years.[1]

Literature shows an increase in colorectal cancer screening rates with the introduction of CTC as a covered screening option. In both the University of Wisconsin and Colon Health Initiative (CHI) experiences, colorectal cancer screening adherence improved with the implementation of CTC.[2,3,4] As opposed to substituting one exam for the other, the inclusion of CTC in the menu of CRC screening options appears to increase overall rates. At the former National Naval Medical Center (now Walter Reed National Military Medical Center), since 2005, colorectal screening has increased by 33 percent with more than 70 percent of beneficiaries compliant with CRC recommendations following the integration of CTC screening with the existing colonoscopic program. Another study demonstrated improved Healthcare Effectiveness Data and Information Set (HEDIS) compliance, up to 84% for colorectal cancer screening with the inclusion of CTC.[5]

Implementation

CTC is easily implemented at sites where there are CT scanners. The ACR provides a simple to use CTC locator tool to assist patients and providers in finding a CTC screening location near them at https://www.acr.org/myctc. CTC is performed without sedation so there is no need for another person to accompany or drive the patient to the imaging center. The patient can resume normal daily activities immediately upon test completion. Additionally, CTC can be performed as a relatively "socially-distanced" examination.[6] Other than during the brief period of rectal tube insertion, greater than 6 feet of separation between patients and healthcare workers can be maintained which is particularly important during a pandemic. Other advantages of CTC include a short procedural time, less direct contact with health care workers given lack of sedation, and extremely low risk of complications requiring in-patient beds. CTC is a structural examination and can triage patients for polypectomy or surveillance depending on lesions found.

Abnormal findings identified by CTC screening may require additional workup by colonoscopy, though small (6-9 mm) polyps can be followed with surveillance CTC, typically performed at a

3-year interval, as most polyps of this size remain stable (38-50%) or regress (27-28%) with a minority (22-35%) of polyps progressing.[7, 8]

Reduced Racial/Ethnic Disparities in Screening

CTC has been found to be a preferred screening test option in vulnerable patients. A study evaluating preferences for colorectal cancer screening among racially and ethnically diverse patients found that ratings of CTC were significantly higher than ratings of colonoscopy, sigmoidoscopy, and fecal occult blood testing in Black and Latinx patients.[9]

A study evaluating the performance of CTC in a screening cohort of 2490 Black adults found that CTC was an effective screening modality with a per-patient CTC positive rate of 9.8% for polyps measuring 6 to 9 mm, 5.4% for polyps measuring 10 to 29 mm, and 1.3% for masses ≥ 30 mm. The referral rate to optical colonoscopy was 13.9%.[1]

Summary

In summary, the ACR strongly supports the proposed inclusion of colorectal cancer screening as a 2022 Core Set measure and the inclusion of all colorectal cancer screening tests that have received an A grade from the USPSTF including CTC.

We appreciate the opportunity to provide these comments. Should you have any questions or comments, we would welcome further dialogue. Please do not hesitate to contact Kathryn Keysor.

Citations

[1] Wolf AMD, Fontham ETH, Church TR, et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. *CA Cancer J Clin*. 2018;68:250-281.

[2] Schwartz DC, Dasher KJ, Said A et al. Impact of a CT colonography screening program on endoscopic colonoscopy in clinical practice. Am J Gastroenterol 2008;103:346-351.

[3] Cash BD, Riddle M, Bhattacharya I et al, 2008 CT Colonography of a Medicare-Aged Population: Outcomes Observed in an Analysis of More Than 1400 Patients. AJR 2012;199: W27-W34. 10.2214/AJR.11.7729.

[4] Benson M, Pier J, Kraft S et al. Optical colonoscopy and virtual colonoscopy numbers after initiation of a CT colonography program: long term data. J Gastrointest Liver Dis 2012; 21(4):391-395.

[5] Cash BD, Stamps K, McFarland EG, Spiegel AR, Wade SW. Clinical use of CT colonography for colorectal cancer screening in military training facilities and potential impact on HEDIS measures. J Am Coll Radiol 2013;10:30-36.

[6] Moreno CC, Yee J, Ahmed FS, et al. CT colonography's role in the COVID-19 pandemic: a safe(r), socially distanced total colon examination. Abdom Radiol 2020. doi: 10.1007/s00261-020-02674-5.

[7] Pickhardt PJ, Kim DH, Pooler BD, Hinshaw JL, Barlow D, Jensen D, Reichelderfer M, Cash BD. Assessment of volumetric growth rates of small colorectal polyps with CT colonography: a longitudinal study of natural history. Lancet Oncol 2013;8:711-20. doi: 10.1016/s1470-2045(13)70216-x.

[8] Tutein Nolthenius CJ, Boellaard TN, de Haan MC, et al. Evolution of Screen-Detected Small (6-9 mm) Polyps After a 3-Year Surveillance Interval: Assessment of Growth With CT Colonography Compared With Histopathology. Am J Gastroenterol 2015;110:1682-90.doi: 10.1038/ajg.2015.340.

[9] Hawley ST, Volk RJ, Krishnamurthy P, et al. Preferences for colorectal cancer screening among racially/ethnically diverse primary care patients. Med Care 2008;46:S10-6.

[10] Moreno CC, Fibus TF, Krupinski EA, Kim DH, Pickhardt PJ. Addressing racial disparity in colorectal cancer screening with CT colonography: experience in an African-American cohort. Clin Colorectal Cancer 2018;17(2):e363-e367.

American Dental Association (Daniel J. Klemmedson and Kathleen T. O'Loughlin)

On behalf of its more than 162,000 members, the American Dental Association (ADA) is pleased to provide comments in response to the request to the draft report for public comment from the 2022 Child and Adult Core Set Annual Review Stakeholder Workgroup, entitled "*Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP*" published on July 1, 2021.

The ADA appreciates the Workgroup recommendations with the proposed additions of the "Oral Evaluation, Dental Services" and "Prevention: Topical Fluoride for Children" measures to the 2022 Child Core Set. In particular, the ADA notes that the addition of these two measures builds on the foundation of state performance improvement from the existing dental/oral health measure "Sealant Receipt on Permanent 1st Molars." This combination of measures promotes receipt of a robust age-appropriate preventive pediatric dental care bundle (sealants, fluoride varnish and oral examination) that encompasses a range of oral healthcare provider types and care settings.

Comment Specific to Gaps in the Core Set

The ADA appreciates the Workgroup's repeated emphasis on lack of oral/ dental health measures for the adult core set[1, 2] and strongly urges CMS to consider the inclusion of the *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults*[3] to the Adult Core Set. Specifically, inclusion of this measure would address the following system-wide concerns:

1. The **use of emergency departments (EDs) for non-traumatic dental conditions** has been a growing public health concern across the United States (US).[4, 5, 6, 7, 8, 9, 10, 11] 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.[12] These visits present a public health challenge because they often have great financial implications for the healthcare system and divert resources away from urgent cases.[13] Medicaid is a primary payer for these visits,[14] including in states without Medicaid dental benefits, because emergency department visits are paid for out of medical benefits. $2.7 billion dollars were spent on hospital emergency department visits, 2.1 million of those visits were due to dental conditions, and 40% of those visits among adults was paid for by Medicaid.[15]
2. These visits are **expensive and are avoidable costs** to the Medicaid program. It is important to recognize that the care provided in the ED is not definitive and does not address the underlying problem; rather, standard emergency care involves addressing infection and pain through prescription medications. Patients must see a dental provider to receive definitive care. Consequently, beneficiaries without access to oral healthcare services are more likely to have repeat visits to the ED for non-traumatic dental conditions. Even without an adult dental benefit, these programs could seek to improve oral healthcare and outcomes among their beneficiaries by linking them to community-based resources. The DQA's analyses of Medicaid administrative claims data from the Transformed Medicaid Statistical

Informational System (TMSIS) Analytic Files (TAFs)[15] suggest higher ED utilization, on average, by adults for non-traumatic dental conditions in states that do not have extensive dental benefits.

3. The measure of ambulatory care sensitive ED visits provides a **strong starting place for incorporating oral health considerations into the Adult Core Set**. This measure is feasible for use across all Medicaid programs and is not dependent upon the variability in dental benefit coverage.
4. Many states conduct their own independent studies of ED visits for non-traumatic dental related reasons, but variable methodologies make it difficult to make comparisons across states and to get a clear national perspective. This measure would **enable standardized assessments**.

Dentistry has been committed to pursuing coordinated, meaningful, and parsimonious measurement from the outset through the Dental Quality Alliance (DQA), convened by the ADA at the request of the CMS. DQA is the only comprehensive multi-stakeholder organization in dentistry that develops dental quality measures through a consensus-based process. Thirty-eight organizations with oral health experience participate in the DQA along with a public member. The ADA strongly encourages the Workgroup as well as the CMS to include this measure of ED use in the Adult Core Set as a first step towards the eventual promotion of appropriate dental care *outside* of the ED through increased preventive care, treatment of acute dental issues, and appropriate follow-up after ED use.

The ADA appreciates the Workgroup's consideration of these comments. If you have any questions, please contact Diptee Ojha.

Citations

[1] 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. Accessed from: https://www.mathematica.org/features/maccoresetreview.

[2] 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 2019. Accessed from: https://www.mathematica.org/features/maccoresetreview.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] Okunseri C, Okunseri E, Thorpe JM, Xiang Q, Szabo AJC, Cosmetic, Dentistry I. Patient characteristics and trends in nontraumatic dental condition visits to emergency departments in the United States. 2012;4:1.

[5] Wall T, Nasseh K. Dental-related emergency department visits on the increase in the United States. Health Policy Resources Center Research Brief 2013; https://www.ada.org/en/~/media/ADA/Science%20and%20Research/Files/HPRCBrief_0513_1. Accessed February 15, 2019.

[6] Wall T. Recent trends in dental emergency department visits in the United States:1997/1998 to 2007/2008. Journal of public health dentistry. 2012;72(3):216-220.

[7] Lee HH, Lewis CW, Saltzman B, Starks H. Visiting the emergency department for dental problems: trends in utilization, 2001 to 2008. American journal of public health. 2012;102(11):e77-83.

[8] Zhou W, Kim P, Shen JJ, Greenway J, Ditmyer M. Preventable Emergency Department Visits for Nontraumatic Dental Conditions: Trends and Disparities in Nevada, 2009–2015. 2018;108(3):369-371.

[9] Seu K, Hall K, Moy E. Emergency department visits for dental-related conditions, 2009: Statistical Brief# 143. In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2012.

[10] Rampa S, Wilson FA, Allareddy V. Trends in dental-related emergency department visits in the State of California from 2005 to 2011. Oral surgery, oral medicine, oral pathology and oral radiology. 2016;122(4):426-433.

[11] Tomar SL, Carden DL, Dodd VJ, Catalanotto FA, Herndon JB. Trends in dental-related use of hospital emergency departments in Florida. J Public Health Dent. 2016 Jun;76(3):249-57

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

[13] Wall T, Nasseh K, Vujicic M. Majority of dental-related emergency department visits lack urgency and can be diverted to dental offices. *Health Policy Institute Research Brief* 2014; https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx.

[14] Okunseri C, Okunseri E, Thorpe JM, Xiang Q, Szabo AJC, Cosmetic, Dentistry I. Patient characteristics and trends in nontraumatic dental condition visits to emergency departments in the United States. 2012;4:1.

[15] HPI Analysis of the 2017 Nationwide Emergency Department Sample, Agency for Healthcare Research and Quality. April 2020. https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0420_1.pdf?la=en. Accessed July 29. 2021.

[16] https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html.

American Dental Hygienists' Association (Ann Battrell)

On behalf of the American Dental Hygienists' Association (ADHA), the largest national organization representing the professional interests of the more than 226,000 licensed dental hygienists across the country, I write to offer ADHA's comments on the July 2021 draft report for public comment entitled: "Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets."

The Medicaid and CHIP child and adult core sets of quality measures are key indicators of the quality of health care that Medicaid and Children's Health Insurance Program (CHIP) beneficiaries receive. ADHA is committed to improving access to and quality of care for all Americans, in particular, for our nation's most vulnerable populations, which includes Medicaid and CHIP beneficiaries.

ADHA worked hard to ensure CHIP now includes a mandatory oral health benefit and ADHA supports a Medicaid oral health benefit for adults and for children. Medicaid does not currently require an adult dental benefit. While ADHA recognizes the resulting variability of state Medicaid oral health benefits for adults, ADHA believes there should be oral health services measures in the adult core set.

Pursuant to the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in the program, Medicaid does provide a dental benefit for children. Regrettably, fewer than half of all Medicaid-eligible children received any dental or oral health service in 2019, according to CMS-416 (National). [1] Improving access to this robust benefit should guide Workgroup members and policymakers alike. Dental hygienists are acutely aware that Americans cannot be healthy without good oral health. True health system transformation and patient-centered care will integrate oral health care into medical care.

ADHA is pleased that the core sets include oral health quality measures and offers the following specific recommendations:

- ADHA strongly supports the Workgroup's recommendation to add an oral evaluation for dental services measure,[2] which measures the percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year. ADHA believes this will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.
- ADHA strongly supports the Workgroup's recommendation to add a topical fluoride measure,[3] which measures the percentage of children aged 1-21 years who received at least

two topical fluoride applications by either dental or oral health providers within the reporting year.

Together, the two measures noted above have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to visit a pediatrician or primary care physician than a dentist. ADHA believes the inclusion of this measure will result in continued progress toward medical-dental integration and interdisciplinary care coordination, which we believe is essential.

- ADHA is disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[4] The Workgroup previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

  Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[5] in largely avoidable health care expenses each year. While Medicaid adult dental coverage varies considerably across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. ADHA urges the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.

- ADHA would also like to underscore the importance of measures that capture all oral health services – regardless of who is providing the service – so that we are measuring and capturing care provided not only by dental hygienists practicing under the direct supervision of a dentist but also by dental hygienists, dental therapists, and other oral health professionals working under general supervision, working with distant dentists via telehealth, working without the supervision of a dentist, etc. Capturing care providing by pediatricians, nurses and others is also important, as topical fluoride applications, for example, are routinely conducted by pediatricians, nurses, and other providers.

  The CMS Medicaid regulation defining dental services was first promulgated in 1978 – more than four decades ago.[6] ADHA urges that Medicaid regulations and policy, including core set quality measures, reflect the way oral health care is actually delivered today. Fully 42 states[7] now allow dental hygienists to initiate treatment outside of a dental office based on their assessment of a patient's needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider patient-relationship in at least some settings.

ADHA is dedicated to improving access to care that Medicaid and CHIP beneficiaries receive and to monitoring and measuring the quality of that care. Thus, ADHA appreciates Mathematica's work on these important quality measures. Please do not hesitate to contact Ann

Lynch, ADHA Director of Advocacy or ADHA Washington Counsel at McDermott Will & Emery, Karen Sealander with questions.

Citations

[1] https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

[2] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[4] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[5] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever/.

[6] 42 CFR § 440.100 Dental services (https://www.law.cornell.edu/cfr/text/42/440.100).

(a) "Dental services" means diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his profession, including treatment of -

(1) The teeth and associated structures of the oral cavity; and

(2) Disease, injury, or impairment that may affect the oral or general health of the beneficiary.

(b) "Dentist" means an individual licensed to practice dentistry or dental surgery.

[7] https://www.adha.org/resources-docs/7513_Direct_Access_to_Care_from_DH.pdf.

American Institute of Dental Public Health (Annaliese Cothron)

As members of the Oral Health Progress and Equity Network (OPEN), we appreciate the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. OPEN is a network of state, national, and community-based partners committed to equitable access to oral health care for everyone. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

Arizona Health Care Cost Containment System (Ruben Soliz)

Arizona appreciates the opportunity to review the Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets. As part of this review, Arizona is providing the following feedback related to two of the measure recommendations:

Long-Term Services and Supports: Comprehensive Care Plan and Update

Arizona previously collected data for this measure for compliance purposes; however, Arizona found this measure to have extensive administrative burden due to the significant amount of time required to extract and review the case management records and the vague guidance included within the associated technical specifications leading to varied interpretation. In addition, the measure included numerous required and supplemental elements which made it difficult to identify priority focus areas for improvement and were not felt to align with Person-Centered Care initiatives. Prior to adding this measure to the CMS Adult Core Set, Arizona requests CMS consider reducing the elements included within this measure as well as increasing focus on Person-Centered Care within the HCBS recommended measures, such as that found with the National Core Indicators (NCI) Survey, in order to reduce the data collection and reporting burden.

Colorectal Cancer Screening

Arizona previously collected data for this measure utilizing the National Committee for Quality Assurance (NCQA) commercial specifications as Medicaid specifications were not available. Arizona also identified limitations with calculating this measure as the look back period is 10 years. Arizona requests CMS consider how States would be able to account for the noted limitation related to the 10 year look back period should 10 years of data not be available. In addition, Arizona requests CMS consider postponing the addition of this measure to the CMS Adult Core Set until Medicaid specifications are developed, tested, and published.

Please feel free to contact Ruben Soliz with any follow-up comments or questions.

Association for Community Affiliated Plans (Enrique Martinez-Vidal)

ACAP Comments on Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP (8.06.2021)

Proposed Measures for Removal

Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)
Support.

Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)
Support.

Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)
Support.

PC-01: Elective Delivery (PC01-AD)
Support.

Proposed Measures for Addition

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
Support with concern

While ACAP plans support tracking adolescent SUD use, many plans voiced the concern that this quality measure would be best complemented with a prevalence measure so that the data can offer actionable next steps. The rates should also include age stratification when possible. An example of this is the number of ER visits for alcohol, or alcohol and other-drug use (AOD) per 1000 beneficiaries who are 13 years and older. Such an age stratification also aligns best with NCQA reporting methods. Some plans also underscored carved-out SUD benefits and a lack of real-time notifications when a beneficiary visits the ED.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)
Support with concern

Similar to the comment for FUA, this measure would be best complemented by a prevalence measure to contextualize how many beneficiaries have follow-up visits after an ED visit for mental illness.

Oral Evaluation, Dental Services
Support

Prevention: Topical Fluoride for Children
Support with recommendation

ACAP plans support this measure and recommend that age stratified reporting will be beneficial so that plans may target interventions to the respective age group.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis
Support with concern

While ACAP plans generally support measures that monitor antibiotic dispersing, actual performance on this measure may be influenced by parental decision making (not filling prescriptions since they do not believe it is necessary), conditional prescription by providers (for use only if the child's symptoms persist), and variability in diagnosis rates across the country. Additionally, plan members voiced concern regarding the use of telehealth and urged an analysis of whether telehealth visits are resulting in higher prescription rates.

Long-Term Services and Supports Comprehensive Care Plan and Update
Support with concern

While ACAP plans support this measure, many plans are concerned that reporting this measure may be resource intensive. Plans underscore several issues – a lack of administrative best practice on how to track this measure, inconsistent population definition issues, and an overlap with existing hybrid measures.

Colorectal Cancer Screening
Support with recommendation

ACAP supports this measure, with the additional recommendation that the measure include race stratification. Specially, ACAP plans recommend that the measure include tracking and reporting for Black beneficiaries between the ages of 45 to 75 years of age, following the recommendation[1] of the US Prevention Task Force.

Citations

[1] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening.

Association of State and Territorial Dental Directors (Christine Wood)

The Association of State and Territorial Dental Directors (ASTDD) appreciates the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. ASTDD is a national non-profit organization representing the directors and staff of state/territorial public health agency programs for oral health. ASTDD formulates and promotes the establishment of national dental public health policy, assists state/territorial dental programs in the development and implementation of programs and policies for the prevention of oral diseases; builds awareness and strengthens dental public health professionals' knowledge and skills by developing position papers and policy statements; provides information on oral health to health officials and policy makers, and conducts conferences for the dental public health community. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year for ED services that generally address the symptoms without resolving the underlying oral problems. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. The differences in adult Medicaid

dental coverage are a good reason for including this measure to compare the effects of Medicaid coverage on ED use for non-traumatic dental conditions across states.

By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

Thank you for your consideration of our comments. Please feel free to contact ASTDD for additional information.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

California Colorectal Cancer Coalition (James Allison)

I am writing to encourage the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS Voting Members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning 2022. I am a Board-Certified Internist and Gastroenterologist with over 50 year's experience as a clinician, educator, researcher at Kaiser Oakland Medical Center and the University of California San Francisco. My work led to my being elevated to Emeritus status at both UCSF and Kaiser Northern California Division of research.

My most quoted and used research has been in screening for Colorectal Cancer (CRC) and, it was my group in 1996 that published the first U.S. study of the Fecal Immunochemical Test for human globin (FIT) in a large average risk population age 50 and older. The results showed the FIT test had superior performance characteristics than the guaiac tests being used in screening of the U.S population.

In 2003, a small Australian company had a well studied FIT test it wanted to be approved by CMS. The test was called InSure and CMS solicited comments from the community as to what it thought about this FIT. Only 2 people and one Gastroenterology Association (AGA) endorsed it. The two endorsers were Professor Graeme Young MD and me. Many people and groups suggested CMS not endorse it and cited as reasons – not enough studies showing its performance characteristics. Inferior to colonoscopy which is the best/gold standard test, etc. To its credit CMS ignored the criticism and approved it. Shortly thereafter many FITs were cleared for use. Ironically both CMS and the FDA approved Cologuard after one large study of average risk subjects and allowed a 3 year interval between testing with no proof that interval was safe.

Now, 25 years later, there continues to be ignorance about how good FITs are as a screening test for colorectal cancer even though since 2012 no U.S. screening guidelines have continued to call or recommend colonoscopy as the "best/gold standard" screening test. The USPSF most recent recommendations have recommended colonoscopy and FIT as the 2 best screening tests for CRC and don't recommend one over the other.

The lack of knowledge of how good FITs are has hampered screening rates particularly in the uninsured, underinsured U.S. population and was one of the reasons the National Colorectal Cancer Roundtable's campaign of 80% of the U.S. population screened by 2018 did not reach its goals. Large well known Academic Medical Centers have not offered FIT as an alternative until recently and I couldn't find one Internist or PCP who knew what a FIT test was when I visited my 50th medical school reunion 2 years ago.

I have been working for years to get the USPSTF to change the wording in its guidelines from calling a colonoscopy for a positive FIT, a "diagnostic" procedure to a "required or necessary" procedure. That simple step would have solved the problem. Covering the colonoscopy would no longer be a violation of the Affordable Care Act.

About 7 years ago at a national meeting of the American Gastroenterology Association (AGA), I was called out and complimented by the Assistant Secretary of Health and Human Services for this suggestion. Unfortunately, he had to resign when his boss resigned her position, and nothing was done.

Four years ago, the California Colorectal Cancer Coalition (C4) lobbied the CA legislature to cover the copay for a colonoscopy done because of a positive FIT test. It was passed in the Senate and Assembly but was vetoed by the Governor because his lawyers advised him it would be a violation of the Affordable Care Act. How many lives could we have saved if the problem had been fixed then?

There is a lot more I could say about encouraging the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS Voting Members but, if more information is needed, I am willing to share more of my publications on FIT or discuss this in person. My contact information is below, and it contains a link to my bio and publications. Thanks in advance for your willingness to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning 2022.

James Allison MD, FACP, AGAF
Clinical Professor of Medicine Emeritus
Internal Medicine/Division of Gastroenterology
University of California San Francisco (UCSF)
Emeritus Investigator Kaiser Northern CA Division of Research
http://profiles.ucsf.edu/james.allison

California Colorectal Cancer Coalition (Daniel Stonewall Anderson and Margaret Hitchcock)

As President and Vice-President of The California Colorectal Cancer Coalition (C4, a 501-C3 nonprofit) www.cacoloncancer.org, we are writing to encourage the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS Voting Members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning 2022. This email includes arguments in favor of adding colorectal cancer to the CMS Medicaid Adult Quality Measures Core Set.

For the past 5 years, we have been part of a coalition's effort to add colorectal cancer screening to California's Medicaid (Medi-Cal) Required Quality Measures. California's Medicaid provides insurance coverage for approximately one-third of California's insured population. California's Medicaid-insured population's current colorectal cancer screening rate is unknown. When last measured in 2013, California Department of Health Care Services Disparities Report indicated California's Medicaid colorectal cancer screening rate was 19%. The California Cancer Registry more recently reported on the percent of late-stage diagnosis of colorectal cancer in Californians, analyzing years 2012 to 2017, in an updated report released in 2020. In the Medicaid population, the late-stage diagnosis rate (71%) was identical to the late-stage diagnosis of in California's uninsured population (also 71%). During this period, the late-stage diagnosis for the Medicare and Commercially Insured population was 64%. Having Medicaid insurance in California is equivalent to having no insurance for early-stage diagnosis, with only 29% of Medicaid patients (and uninsured) being diagnosed with a cancer stage having >90% five-year survival rate.

Other states, such as Oregon and Washington, have increased their colorectal cancer screening rates after making colorectal cancer screening a Medicaid Reported Quality Measure. The addition of colorectal cancer screening to the CMS Medicaid Adult Quality Core Measures in 2022 will result in colorectal cancer screening being added to California's Medicaid Quality Measures. Since 2019, California has used the CMS Medicaid Adult Quality Core Measures as its required quality measures.

Adding colorectal cancer to the CMS Medicaid Adult Quality Measures Core Set is also important for the entire United States for the following reasons:

- Non-elderly Medicaid patients are racially and ethnically diverse with 84.8% being people of color compared to 25.2% being people of color in the Medicare population (US average, 2019).[1] Failure to include the colorectal cancer screening measure impacts people of color, who are disproportionately impacted by colorectal cancer through access and quality of care issues. Failure to include the colorectal cancer screening measure would perpetuate existing structural racism whereby health systems treating people of color with Medicaid insurance are held to a different quality standard than those caring for patients covered by Medicare or commercial insurance.
- Colorectal cancer is a significant societal burden in the United States and is the second leading cause of cancer deaths.[2] Colorectal cancer causes more deaths than both breast and

cervical cancer, each of which has a screening metric in the CMS Adult Core Set of Health Care Quality Measures. In addition, while men make up 46% of the Medicaid population, no cancer screening measure applies to males in the Medicaid Adult Core Set.

- Nationally, Medicaid covers 9,452,003 patients between the ages 46 to 64, representing about 14% of the Medicaid population.[3] Recently, an unexpected rise of 1% in colorectal cancer incidence rates (2012-2016, the most recent data) was seen in the age 50 to 64-year-old age group. This is in sharp contrast to a 3.3% decline in the colorectal cancer incidence rate for those 65 or older. In most states, many low-income individuals aged 50-64 are insured by Medicaid. This disturbing increase in colorectal cancer incidence illustrates the importance of including colorectal cancer screening as a quality measure in the Medicaid population because: 1) Medicaid insures many 50 to 64-year-olds in the United States with almost 85% being people of color;[1,4] 2) lower rates of screening directly contribute to disparities in colorectal cancer morbidity and mortality;[5] and 3) screening quality measures improve screening rates.[6] The United States Preventive Services Task Force recently updated their screening guidelines, expanding the cohort of normal risk patients needing screening to begin at 45 rather than 50. As indicated previously, this means even more Medicaid patients need to be appropriately screened and adding a colorectal cancer screening quality measure will effectively motivate higher screening rates.

- Recent data suggest that enrollment in Medicaid is increasing amid the coronavirus pandemic.[7] A study by the Center on Budget and Policy Priorities found that enrollment rose 10.9% from February through September 2020 for 36 states.[7] Since May 2020, the number of individuals newly eligible for Medicaid due to job loss has grown by over 4 million from 12,735,000 to 16,791,000,[8] with Kaiser Family Foundation estimating that groups more sensitive to changes in economic conditions (e.g., children, parents, and other expansion adults) will grow faster than the elderly and people with disabilities.[7] Much of this increase can be attributed to changes in the economy and will be sustained for the time being under the Families First Coronavirus Response Act. However, a Kaiser Family Foundation analysis found that a number of states projected enrollment increases prior to the pandemic and did not account for the economic downturn.[7] All of this highlights the importance of establishing colorectal cancer quality metrics for a growing segment of our population to help reduce morbidity and mortality from colorectal cancer.

We strongly support addition of colorectal cancer screening to the CMS Adult Core Set of Quality Measures and we continue to work nationally to garner more support for adding this quality measure.

Citations

[1] *The Kaiser Family Foundation State Health Facts*.; 2019. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi:https://doi.org/10.3322/caac.21654.

[3] Center for Medicaid and CHIP Services D of Q and HO. *Medicaid and CHIP Beneficiary Profile*.; 2020.

[4] American Cancer Society. *Colorectal Cancer Facts & Figures 2020-2022*.

[5] Green BB, Coronado GD, Devoe JE, Allison J. Navigating the Murky Waters of Colorectal Cancer Screening and Health Reform. *Am J Public Health*. 2014;104(6):982-986. doi:10.2105/AJPH.2014.301877.

[6] A Path to Improve Colorectal Cancer Screening Outcomes: Faculty Roundtable Evaluation of Cost-Effectiveness and Utility. AJMC. Accessed July 6, 2021. https://www.ajmc.com/view/faculty-roundtable-evaluation-of-costeffectiveness-and-utility.

[7] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[8] Broaddus M. Medicaid Enrollment Still Rising. Center on Budget and Policy Priorities. Published November 10, 2020. Accessed January 12, 2021. https://www.cbpp.org/blog/medicaid-enrollment-still-rising.

California Colorectal Cancer Coalition (Jon M. Greif)

I am a recently retired cancer surgeon and am writing for myself, and as a founding member of the Board of Directors of the California Colorectal Cancer Coalition (C4). I have over 40 years of personal experience caring for cancer patients, and can attest to the proven, life-saving efficacy of colorectal cancer screening, early diagnosis and intervention. C4 is a spin-off of the State of California's Dialogue on Cancer, and has, over the last ten years, focused its efforts on colorectal cancer screening, providing nearly $100,000/year in grants to Federally Qualified Community Health Centers throughout California to help them develop effective methods, in their communities, for CRC screening. Additionally, through advocacy, C4 has promoted legislation making CRC screening more available and affordable for Californians, and has organized educational programs for communities and health care professionals.

I am writing to encourage the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS Voting Members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning 2022. This email includes arguments in favor of adding colorectal cancer to the CMS Medicaid Adult Quality Measures Core Set:

- Non-elderly Medicaid patients are racially and ethnically diverse with 84.8% being people of color compared to 25.2% being people of color in the Medicare population (US average, 2019).[1] Failure to include the colorectal cancer screening measure impacts people of color, who are disproportionately impacted by colorectal cancer through access and quality of care issues. Failure to include the colorectal cancer screening measure would perpetuate existing structural racism whereby health systems treating people of color with Medicaid insurance are held to a different quality standard than those caring for patients covered by Medicare or commercial insurance.
- Colorectal cancer is a significant societal burden in the United States and is the second leading cause of cancer deaths.[2] Colorectal cancer causes more deaths than both breast and cervical cancer, each of which is has a screening metric in the CMS Adult Core Set of Health Care Quality Measures. In addition, while men make up 46% of the Medicaid population, no cancer screening measure applies to males in the Medicaid Adult Core Set.
- Medicaid covers 9,452,003 patients between the ages 46 to 64, representing about 14% of the Medicaid population.[3] Recently, an unexpected rise of 1% in CRC incidence rates (2012-2016, the most recent data) was seen in the age 50-to-64-year-old age group. This is in sharp contrast to a 3.3% decline in CRC incidence rate for those 65 or older. In most states, many low-income individuals aged 50-64 are insured by Medicaid. This disturbing increase in CRC incidence illustrates the importance of including colorectal cancer screening as a quality measure in the Medicaid population because:
    1. Medicaid insures many 50- to 64-year-olds in the United States with almost 85% being people of color;[1,4]

2. lower rates of screening directly contribute to disparities in CRC morbidity and mortality;[5] and
3. screening quality measures improve screening rates.[6]

- Recent data suggest that enrollment in Medicaid is increasing amid the coronavirus pandemic.[7] A study by the Center on Budget and Policy Priorities found that enrollment rose 10.9% from February through September 2020 for 36 states.[7] Since May 2020, the number of individuals newly eligible for Medicaid due to job loss has grown by over 4 million from 12,735,000 to 16,791,000,[8] with Kaiser Family Foundation estimating that groups more sensitive to changes in economic conditions (e.g., children, parents, and other expansion adults) will grow faster than the elderly and people with disabilities.[7] Much of this increase can be attributed to changes in the economy and will be sustained for the time being under the Families First Coronavirus Response Act. However, a Kaiser Family Foundation analysis found that a number of states projected enrollment increases prior to the pandemic and did not account for the economic downturn.[7]

All of this highlights the importance of establishing colorectal cancer quality metrics for a growing segment of our population to help reduce morbidity and mortality from colorectal cancer. I firmly support addition of CRC screening to the CMS Adult Core Set of Quality Measures.

Citations

[1] *The Kaiser Family Foundation State Health Facts*.; 2019. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi:https://doi.org/10.3322/caac.21654.

[3] Center for Medicaid and CHIP Services D of Q and HO. *Medicaid and CHIP Beneficiary Profile*.; 2020.

[4] American Cancer Society. *Colorectal Cancer Facts & Figures 2020-2022*.

[5] Green BB, Coronado GD, Devoe JE, Allison J. Navigating the Murky Waters of Colorectal Cancer Screening and Health Reform. *Am J Public Health*. 2014;104(6):982-986. doi:10.2105/AJPH.2014.301877.

[6] A Path to Improve Colorectal Cancer Screening Outcomes: Faculty Roundtable Evaluation of Cost-Effectiveness and Utility. AJMC. Accessed July 6, 2021. https://www.ajmc.com/view/faculty-roundtable-evaluation-of-costeffectiveness-and-utility.

[7] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[8] Broaddus M. Medicaid Enrollment Still Rising. Center on Budget and Policy Priorities. Published November 10, 2020. Accessed January 12, 2021. https://www.cbpp.org/blog/medicaid-enrollment-still-rising.

California Colorectal Cancer Coalition (Margaret Hitchcock)

I am Vice President of the California Colorectal Cancer Coalition (C4) and am actively involved in both our statewide and national advocacy efforts to improve access to the care continuum for colorectal cancer in all Californians. Our current CMS efforts aim to reduce the stage of diagnosis and mortality that is associated with colorectal cancer in California's Medi-Cal/Medicaid patients. I am writing on behalf of myself, and as a founding member of the Board of Directors of the California Colorectal Cancer Coalition (C4). I also co-chair the CDPH/California Dialogue on Cancer's colorectal cancer working group focusing on encouraging evidence-based interventions throughout the state. For C4, I also designed and manage the C4 Community Grants program that has distributed over $640,000 to primarily Federally Qualified Health Centers (FQHC) since 2013, increasing the baseline screening rate in the 71 organizations that we have funded by almost 260,000 patients. Much of those efforts focus on improving systems within the FQHC to improve processes related to both colorectal cancer screening and subsequent access to the care continuum for those patients identified with advanced lesions. Additionally, through advocacy and sharing of best practices, C4 has promoted legislation making CRC screening more available and affordable for Californians, and has organized educational programs for communities and health care professionals.

I am writing to encourage the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS Voting Members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning 2022. This email includes arguments in favor of adding colorectal cancer to the CMS Medicaid Adult Quality Measures Core Set. Non-elderly Medicaid patients are racially and ethnically diverse with 84.8% being people of color compared to 25.2% being people of color in the Medicare population (US average, 2019).[1] Failure to include the colorectal cancer screening measure impacts people of color, who are disproportionately impacted by colorectal cancer through access and quality of care issues. Failure to include the colorectal cancer screening measure would perpetuate existing structural racism whereby health systems treating people of color with Medicaid insurance are held to a different quality standard than those caring for patients covered by Medicare or commercial insurance.

Colorectal cancer is a significant societal burden in the United States and is the second leading cause of cancer deaths.[2] Colorectal cancer causes more deaths than both breast and cervical cancer, each of which is has a screening metric in the CMS Adult Core Set of Health Care Quality Measures. In addition, while men make up 46% of the Medicaid population, no cancer screening measure applies to males in the Medicaid Adult Core Set.

Medicaid covers 9,452,003 patients between the ages 46 to 64, representing about 14% of the Medicaid population.[3] Recently, an unexpected rise of 1% in CRC incidence rates (2012-2016, the most recent data) was seen in the age 50-to-64-year-old age group. This is in sharp contrast to a 3.3% decline in CRC incidence rate for those 65 or older. In most states, many low-income individuals aged 50-64 are insured by Medicaid. This disturbing increase in CRC incidence illustrates the importance of including colorectal cancer screening as a quality measure in the Medicaid population because: 1) Medicaid insures many 50- to 64-year-olds in the United States

with almost 85% being people of color;[1,4] 2) lower rates of screening directly contribute to disparities in CRC morbidity and mortality;[5] and 3) screening quality measures improve screening rates.[6]

Recent data suggest that enrollment in Medicaid is increasing amid the coronavirus pandemic.[7] A study by the Center on Budget and Policy Priorities found that enrollment rose 10.9% from February through September 2020 for 36 states.[7] Since May 2020, the number of individuals newly eligible for Medicaid due to job loss has grown by over 4 million from 12,735,000 to 16,791,000,[8] with Kaiser Family Foundation estimating that groups more sensitive to changes in economic conditions (e.g., children, parents, and other expansion adults) will grow faster than the elderly and people with disabilities.[7] Much of this increase can be attributed to changes in the economy and will be sustained for the time being under the Families First Coronavirus Response Act. However, a Kaiser Family Foundation analysis found that a number of states projected enrollment increases prior to the pandemic and did not account for the economic downturn.[7] All of this highlights the importance of establishing colorectal cancer quality metrics for a growing segment of our population to help reduce morbidity and mortality from colorectal cancer.

I strongly support addition of CRC screening to the CMS Adult Core Set of Quality Measures for 2022.

Citations

[1] *The Kaiser Family Foundation State Health Facts*.; 2019. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi:https://doi.org/10.3322/caac.21654.

[3] Center for Medicaid and CHIP Services D of Q and HO. *Medicaid and CHIP Beneficiary Profile*.; 2020.

[4] American Cancer Society. *Colorectal Cancer Facts & Figures 2020-2022*.

[5] Green BB, Coronado GD, Devoe JE, Allison J. Navigating the Murky Waters of Colorectal Cancer Screening and Health Reform. *Am J Public Health*. 2014;104(6):982-986. doi:10.2105/AJPH.2014.301877.

[6] A Path to Improve Colorectal Cancer Screening Outcomes: Faculty Roundtable Evaluation of Cost-Effectiveness and Utility. AJMC. Accessed July 6, 2021. https://www.ajmc.com/view/faculty-roundtable-evaluation-of-costeffectiveness-and-utility.

[7] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[8] Broaddus M. Medicaid Enrollment Still Rising. Center on Budget and Policy Priorities. Published November 10, 2020. Accessed January 12, 2021. https://www.cbpp.org/blog/medicaid-enrollment-still-rising.

California Pan-Ethnic Health Network (Caroline B. Sanders)

On behalf of the California Pan-Ethnic Health Network (CPEHN) we appreciate the opportunity to comment on the Core Set Workgroup's *"2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP."*

CPEHN is a statewide multi-cultural health advocacy organization, dedicated to the elimination of health disparities. We build people power by educating and influencing policymakers through lived experience and community expertise. CPEHN leads several statewide coalitions including: the Having Our Say Coalition,[1] the Behavioral Health Equity Collaborative,[2] and the California Oral Health Progress and Equity Network[3] (CA-OPEN). Through these collaboratives, CPEHN brings together a diverse network of members and unites them around a shared vision and purpose—championing physical, behavioral and oral health equity. Our members are policymakers, providers, consumers, advocates and grassroots organizers who are passionate about using policy and advocacy to address the unmet health needs of BIPOC communities.

We commend the Workgroup for its ongoing commitment to meaningfully measure physical, behavioral and oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members. To that end we share the following comments:

General Comments: Prioritize Equity

California is one of several states that now requires all Child and Adult Core Set Measures to be stratified by demographic data, including by race, ethnicity and primary language. CPEHN joins other Workgroup members in urging CMS to publicly report the stratified Core Set data that states already report and require all states to report this data. Failure to consider these measures through a health equity lens will not only perpetuate disparities, but could inadvertently worsen them. Additionally, we urge measure stewards to include demographic stratifications including for race, ethnicity, language and disability, in their measure specifications to allow states to identify inequities among Medicaid and CHIP populations and opportunities for improvement. We also join other Workgroup members in urging greater consideration of how to improve response rates for patient experience surveys, like CAHPS and broadening surveys to other languages beyond Spanish.

Behavioral Health

CPEHN supports the addition of two new behavioral health measures:

- ***Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*** for beneficiaries age 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence and;
- ***Follow-Up After Emergency Department Visit for Mental Illness (FUM)*** for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness.

The addition of these two new measures[48] will help to address gaps in quality of care while allowing health systems to identify opportunities for care coordination. These types of follow-up measures could incentivize providers to identify patients with mental health conditions and substance use disorders and intervene appropriately, thereby preventing the continuous cycle of ED utilization that occurs in some populations. On average, 4.3% of adult Californians are diagnosed with serious mental illness. Moving forward we urge CMS to require stratification of these measures by race, ethnicity, language, LGBTQ+ status and persons with disabilities. In California Latinx, African American, Native American, multi-racial, and LGBTQ+ adults have rates of serious mental illness above the state average.[4] However, findings from the statewide performance outcome system, shows that Asian and Latinx Californians were half as likely as Whites to initiate and engage in mental health treatment. Black Californians engage with the specialty mental health system at disproportionate rates with poorer health outcomes. Application of these measures could help to identify areas for improvement.

CPEHN also supports the Working Group's recommendation to add measures of adverse childhood experiences and trauma-informed care. California's Medicaid program (Medi-Cal) now encourages and provides payment for screening for adverse childhood events (ACEs).

Oral Health

CPEHN supports the Workgroup's recommendation to add the ***oral evaluation for dental services measure***, which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year. National reports consistently rank California in the lower quartile among states with respect to children's oral health status and receipt of preventive dental services. In California, 54 percent of kindergarteners and 70 percent of third graders have experienced dental caries (tooth decay), and nearly one-third of children have untreated tooth decay (2004 data—most recent available). Latino children and low-income children experience more tooth decay and untreated tooth decay than other children.[5] We believe the addition of this measure will improve oral health outcomes for all children. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add ***the topical fluoride measure***, which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures

[48] These measures are currently included in the Adult Core Set (FUA-AD and FUM-AD) for the adult age ranges. The Workgroup recommended these measures for addition to the Child Core Set for the child age ranges.

will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend ***the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults***. The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states, including California, in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion in largely avoidable health care expenses each year. Although California's Medicaid program now provides access to adult oral health benefits, elimination of these benefits in 2009 led to an immediate and significant increase in dental ED visits by Medicaid-enrolled adults in California at a cost of an additional $1.25 million on average each year on ED visits.[6] While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department.

We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.

Conclusion

We appreciate the opportunity to comment on the Core Set Workgroup's *"2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP"* and look forward to continuing to engage with CMS on future measure set discussions. For more information about these comments, please contact me.

Citations

[1] https://havingoursaycoalition.org/.

[2] https://cpehn.org/what-we-do-2/our-projects/behavioral-health-equity-collaborative/.

[3] https://cpehn.org/what-we-do-2/our-projects/ca-open/.

[4] https://cpehn.org/about-us/blog/existing-disparities-in-californias-system-of-specialty-mental-health-care/.

[5] California Oral Health Plan 2018–2028 JANUARY 2018, https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/Oral%20Health%20Program/FINAL%20REDESIGNED%20COHP-Oral-Health-Plan-ADA.pdf.

[6] Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs, Health Affairs, Vol. 34, No. 5. https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1358.

Cancer Early Detection Alliance

On behalf of Cancer Early Detection Alliance, CEDA, we respectfully submit comments for consideration to CMS regarding the 2022 CMS Adult Core Set of Quality Measures for Medicaid.

CEDA

CEDA consists of national organizations representing a diversity of stakeholders, including patient advocacy organizations, healthcare professional societies, and industry leaders. CEDA's mission is to promote and expand access to quality, equitable early cancer detection and care, with a specific focus on reaching underserved communities and addressing racial and ethnic disparities. To this end, we seek to engage patients, providers, and other allies to promote legislation and regulation for the early detection of cancer, remove barriers to cancer care, and support and advance targeted and meaningful funding opportunities geared toward early detection.

Adding Colorectal Cancer Screening to Adult Core Set of Quality Measures

CEDA encourages CMS to accept the recommendation by the CMS voting members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning in 2022.

Colorectal cancer is the second leading cause of cancer deaths for men and women combined.[1] Currently, the CMS Adult Core Set of Health Care Quality Measures has metrics for both breast and cervical cancer screening, colorectal cancer causes more deaths than both of these cancers. Men make up 46% of the Medicaid population, however, no cancer screening measure applies to males in the Medicaid Adult Core Set.

In addition to benefitting all genders, colorectal cancer screening is critical to advancing health equity, achieving the directive issued by President Biden on January 20, 2021, in the Executive Order (EO) "On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government" (Executive Order on Racial Equity). The EO directed all areas of the federal government to pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Colorectal cancer screening impacts people of color, who are disproportionately impacted by colorectal cancer through access and quality of care issues. Non-elderly Medicaid patients are racially and ethnically diverse with 84.8% being people of color compared to 25.2% being people of color in the Medicare population (US average, 2019).[2]

Furthermore, in January 2021 the President issued an EO "On strengthening Medicaid and Affordable Care Act" which directs federal agencies to make high quality healthcare accessible to every American. Medicaid covers 9,452,003 patients between the ages 46 to 64, the age recommended for screening for colorectal screening, representing about 14% of the total

Medicaid population.[3] Furthermore, enrollment in Medicaid increased over the past year by 10.9% in 36 states because of COVID-19. Among the Medicaid population an unexpected rise of 1% in colorectal cancer occurred in the age group 50-64, according to 2012-2016 data, this is in sharp contrast to a 3.3% decline in colorectal cancer incidence rates for those 65 or older. As highlighted in the EO, the growing Medicaid population deserves access high quality health care, including colorectal screening that will help reduce morbidity and mortality, highlighting the importance of establishing a colorectal quality metric.

Encourage Consideration of Adding Other Cancer Screening Metrics in the Future

The current CMS Adult Core Set Performance Measures includes breast and cervical cancer screening, and soon we hope colorectal cancer. In the future we would like to see other cancer screening quality measures included. Quality measures for cancer screening improve cancer screening rates. We know that early detection identifies cancer when it is most treatable and therefore is critical to increasing survival rates and improving outcomes for cancer patients. Detecting an individual's cancer early in the disease course can help patients and their providers develop a treatment plan sooner, which can help prevent or delay the spread of cancer. For these reasons we encourage the future consideration of adding cancer screening quality measures for all routine cancer screenings to the Child and Adult Core Set Performance Measures.

Thank you for the opportunity to provide comments regarding the 2022 CMS Adult Core Set of Quality Measures for Medicaid. CEDA strongly supports the addition of colorectal cancer screening to the CMS Adult Core Set of Quality Measures and looks forward to working with you in the future for identifying and adding additional early cancer screening quality metrics. Please contact Peggy Tighe or Taryn Couture if you have any questions about the information provided here.

Citations

[1] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi: https://doi.org/10.3322/caac.21654.

[2] *The Kaiser Family Foundation State Health Facts*.; 2019. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[3] Center for Medicaid and CHIP Services D of Q and HO. *Medicaid and CHIP Beneficiary Profile*.; 2020.

CareQuest Institute (Michael Monopoli)

As members of the Oral Health Progress and Equity Network (OPEN), we appreciate the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. OPEN is a network of state, national, and community-based partners committed to equitable access to oral health care for everyone. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

For additional information, please contact Colin Reusch.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

Children Now (Katie Andrew)

Children Now appreciates the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. Children Now is a non-partisan, whole-child research, policy development and advocacy organization dedicated to promoting children's health, education, and well-being in California. The organization also leads The Children's Movement of California, a network of more than 4,100 direct service, parent, youth, civil rights, faith-based and community groups dedicated to improving children's well-being. We commend the Workgroup for its ongoing commitment to meaningfully measure children's health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

We applaud the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year, and believe including this measure will improve oral health outcomes for children. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run. Additionally, per the reasoning among Workgroup Members to recommend the inclusion of this measure as highlighted in the draft report, the oral evaluation for dental services measure will also allow states to better understand the oral health of older children.

We are also in strong support of the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two child-focused oral health measures will have the potential to better evaluate and incentivize the delivery of preventive oral health care across settings, particularly for young children who we know are more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

Given the intrinsic connection between parent oral health and child oral health, we urge the Workgroup to reconsider recommending the ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults[3] for inclusion in the Adult Core Set. Emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department.

Further, in California, the state's Medicaid managed care health plans are increasingly given responsibility for ensuring that their members are being referred to and accessing dental care. The inclusion of the ambulatory care sensitive emergency department visits for non-traumatic dental conditions measure can aid these plans in developing a better understanding of the importance of emphasizing both prevention and moving towards integration to reduce costs while also increasing efficiency within the State's Medicaid program.

Moreover, we recommend that the Workgroup consider differentiating among the adult population to capture transition age foster youth and/or former foster youth (ages 18-26 years) within the ambulatory care sensitive emergency department visits for non-traumatic dental conditions measure. We know that the dental care that children and youth typically receive prior to entering the foster care system is fragmented and sporadic, leading to approximately 35 percent of foster youth entering the system with significant dental and oral health issues. Barriers to accessing routine, preventive care persist for foster youth even after entering and leaving the foster care system. Being intentional about measuring former foster youth's utilization of the emergency department for non-traumatic dental conditions will provide focus and help to inform states on how to better ensure that this special population is connected to regular, prevention-focused dental care.

Also, the early diagnosis of audiological issues is crucial for a child's development. While we understand the challenges that have led the workgroup to recommend removal of the AUD measure from the Core Set, we hope CMS will make efforts to determine how to monitor outcomes for children in Medicaid/CHIP who do not pass hearing screenings.

In addition, we urge CMS and the workgroup to consider the inclusion of reliable prenatal and postpartum measures; efforts to address gaps in measurement disaggregation capability (such as by race, ethnicity, language, and disability, etc.); and establishment of measures that address social determinants of health and that capture disparities in continuity of coverage.

Finally, as Core Set reporting becomes mandatory, we expect that CMS will play a greater role in collection and calculation of the measures for all states, so that states can focus their resources on quality improvement rather than having to put technical resources towards implementing changes to Core Set measures.

For additional information, please contact Katie Andrew, Senior Policy and Outreach Associate, Health, Children Now.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

Colorado Cancer Coalition Colorectal Cancer Task Force (Ian Kahn and Sarah Roberts)

The Colorado Cancer Coalition Colorectal Cancer Task Force appreciates the opportunity to provide comments on the CMS Adult Core Set Quality Measures for Medicaid. The Colorado Cancer Coalition Colorectal Cancer Task Force is a volunteer-based statewide collaboration dedicated to decreasing the burden of colorectal cancer, the number four cancer killer of Colorado citizens.[1] A major goal of our Task Force is to increase the awareness and utilization of high-quality, guideline-adherent colorectal cancer screening. The current five-year survival rate for localized colorectal cancer is 88.5% while a distant diagnosis has a 16.1% five-year survival rate.[2] Identifying cancers sooner through improved early detection practices is key to improving overall survival and quality of life for this patient population. In particular, we want to ensure that colorectal cancer screening is available and utilized in the rural and underserved portions of our state where we know the screening rates are lower.

We are writing to encourage the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS voting members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning in 2022. Adding this measure is important for a number of reasons. Failure to include the colorectal cancer screening measure impacts people of color, who are disproportionately impacted by colorectal cancer through access and quality of care issues. Non-elderly Medicaid patients are racially and ethnically diverse with 84.8% being people of color compared to 25.2% being people of color in the Medicare population (US average, 2019).[3] Not including the colorectal cancer screening measure would perpetuate existing structural racism whereby health systems treating people of color with Medicaid insurance are held to a different quality standard than those caring for patients covered by Medicare or commercial insurance.

Additionally, colorectal cancer is a significant societal burden in the United States and is the second leading cause of cancer deaths for men and women combined.[4] Colorectal cancer causes more deaths than both breast and cervical cancer, each of which has a screening metric in the CMS Adult Core Set of Health Care Quality Measures. In addition, while men make up 46% of the Medicaid population, no cancer screening measure applies to males in the Medicaid Adult Core Set.

Medicaid covers 9,452,003 patients between the ages 46 to 64, representing about 14% of the total Medicaid population.[5] Recently, an unexpected rise of 1% in colorectal cancer incidence rates (2012-2016, the most recent data) was seen in the age 50-to-64-year-old age group. This is in sharp contrast to a 3.3% decline in colorectal cancer incidence rates for those 65 or older. This disturbing trend demonstrates why it is critical that colorectal cancer screening be added as a quality measure in the Medicaid population. Lower rates of screening directly contribute to disparities in colorectal cancer morbidity and mortality and screening quality measures are proven to improve screening rates.[6,7]

Recent data suggest that enrollment in Medicaid is increasing amid the coronavirus pandemic. A study by the Center on Budget and Policy Priorities found that enrollment rose 10.9% from

February through September 2020 for 36 states.[8] Since May 2020, the number of individuals newly eligible for Medicaid due to job loss has grown by over 4 million, with Kaiser Family Foundation estimating that groups more sensitive to changes in economic conditions (e.g., children, parents, and other expansion adults) will grow faster than the elderly and people with disabilities.[9,10] Much of this increase can be attributed to changes in the economy however, a Kaiser Family Foundation analysis found that a number of states projected enrollment increases prior to the pandemic and did not account for the economic downturn.[11] All of this highlights the importance of establishing colorectal cancer quality metrics for a growing segment of our population to help reduce morbidity and mortality from colorectal cancer.

The Colorado Cancer Coalition Colorectal Cancer Task Force strongly supports the addition of colorectal cancer screening to the CMS Adult Core Set of Quality Measures.

If you have any questions, please do not hesitate to contact Ian Kahn and Sarah Roberts.

Kindest Regards,

Ian Kahn and Sarah Roberts
Co-Chairs of Colorectal Cancer Task Force of the Colorado Cancer Coalition

H. Davis Blanton, MD
Faculty Physician - Medical Student Clerkship Director

Karen Wehling
Survivor Advocate

Ryan Kerr
Community Advocate

Andrea Dwyer
Director, Colorado Cancer Screening Program

Allie Bain MS, MPH
Chair, Colorado Cancer Coalition

Citations

[1] https://gis.cdc.gov/Cancer/USCS/#/AtAGlance/.

[2] Central Colorado Cancer Registry, 2011-2015.

[3] The Kaiser Family Foundation State Health Facts.; 2019. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[4] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2021. CA Cancer J Clin. 2021;71(1):7-33. doi: https://doi.org/10.3322/caac.21654.

[5] Center for Medicaid and CHIP Services D of Q and HO. Medicaid and CHIP Beneficiary Profile.; 2020.

[6] Green BB, Coronado GD, Devoe JE, Allison J. Navigating the Murky Waters of Colorectal Cancer Screening and Health Reform. Am J Public Health. 2014;104(6):982-986. doi:10.2105/AJPH.2014.301877.

[7] A Path to Improve Colorectal Cancer Screening Outcomes: Faculty Roundtable Evaluation of Cost-Effectiveness and Utility. AJMC. Accessed July 6, 2021. https://www.ajmc.com/view/faculty-roundtable-evaluation-of-costeffectiveness-and-utility.

[8] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[9] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[10] Broaddus M. Medicaid Enrollment Still Rising. Center on Budget and Policy Priorities. Published November 10, 2020. Accessed January 12, 2021. https://www.cbpp.org/blog/medicaid-enrollment-still-rising.

[11] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

Community Catalyst (Emily Stewart)

Thank you for your dedication to improving health outcomes of children, teens, pregnant persons, seniors, and individuals with low-incomes. As a leading non-profit national health advocacy organization dedicated to advancing health equity and justice, Community Catalyst shares your goals. We believe in collaboratively developing a health care system that works for those not currently well-served, especially people of color, individuals with low incomes, older adults, and those with chronic conditions or disabilities. We partner with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That's why Community Catalyst works every day to ensure people's interests are represented wherever important decisions about health and health care are made: in communities, state houses, and on Capitol Hill.

Community Catalyst focuses on many of the areas addressed by the Workgroup's proposed Core Set changes. Members of our staff are policy experts in oral health, substance use disorders, and mental health supports. While we appreciate the focus on these vital (yet often neglected) disciplines of health, we believe more should be done to address health inequities. Below, we briefly outline our recommendations for a Core Set that best serves all individuals.

Oral Health

We appreciate the Workgroup's ongoing commitment to impactful measurement of oral health indicators for Medicaid and Children's Health Insurance Program (CHIP) members. Specifically, we believe the Workgroup's recommended addition of the Oral Evaluation for Dental Services,[1] which quantifies the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve outcomes. Children must be evaluated early and routinely for risk factors and signs of tooth decay to prevent and manage dental conditions. Systematically assessing the utilization of preventive services can put every child on a path towards lifelong oral health.

Community Catalyst applauds the Workgroup's recommendation to add a topical fluoride measure[2] to track the percentage of children who received at least two fluoride applications (by dental or oral health providers) within the reporting year. Together, the aforementioned measures can improve the evaluation and incentivization of preventive oral health care, particularly for young children who may be more likely to see a primary care physician or pediatrician than a dentist. We believe these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disheartened by the Workgroup's decision to not recommend tracking emergency department visits for non-traumatic dental conditions in adults.[3] The lack of adult oral health measures has been identified as a gap in the Adult Core Set (by the Workgroup). As West Virginia, Maine, Virginia, and Oklahoma join 19 additional states in offering more comprehensive dental coverage for Medicaid covered adults, it is vital that the Centers for

Medicare and Medicaid Services (CMS) and state Medicaid authorities can evaluate the impact of these benefits.

Emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of a lack of access to preventive dental care and account for $2 billion[4] annually in largely avoidable health care expenses. While the availability and breadth of Medicaid adult dental coverage varies state-to-state, the calculation of this measure is not dependent on claims. By systematically measuring the incidence of visits, state programs could be incentivized to implement strategies to decrease oral health problems and accessibility barriers before patients present at emergency departments. We urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.

Behavioral Health

We are encouraged by the Workgroup's recommended addition of two behavioral health measures for children, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 and Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17. Mental health and substance use disorders are increasing among children[5] during the ongoing COVID health emergency, which has hit communities of color the hardest. Medicaid and CHIP now cover more than 38 million children,[6] and calculating the quality of services is more important than ever. These additional measures would provide essential continuity of care data.

We believe the Workgroup's behavioral health recommendations could be more robust and are concerned by the lack of mental health and substance use disorder outcomes measures in the Child and Adult Core Sets. Community-based entities need reliable data on if and how Medicaid and CHIP behavioral health services are helping beneficiaries improve their mental health and achieve the outcomes individuals' seek[7] from their care.

Community Catalyst also appreciates the Workgroup's suggested addition of a measure for adult long-term care, Long-Term Services and Supports: Comprehensive Care Plan and Update, which quantifies whether care plans contain certain key elements. Medicaid is the largest payer of long-term services and supports (LTSS) in the country, and expanding LTSS core measures is essential to improving quality of care. In addition, care planning is a central element in effective LTSS, particularly the Home and Community Based Services (HCBS) many beneficiaries prefer.

However, this measure assesses neither if individuals received planned services, nor the quality or usefulness of services. Community Catalyst urges a focus on closing the gap in LTSS outcomes measures, which has been recognized as problematic by the National Quality Forum and CMS.

From the public perspective, the most important HCBS quality indicators are often measurements of quality of life and engagement in community activities. Beneficiaries are also passionate about individual choice, experience and satisfaction with services and supports, beneficiary control, autonomy, and self-determination. We urge the Workgroup to be a strong

voice for development and use of these measures, and to monitor CMS' development of a HCBS measure set. We also recommend including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) HCBS Experience Survey and the National Core Indicators Aging and Disability survey in the Adult Core Set.

We are grateful to the Workgroup for highlighting measurement gaps, particularly the need to monitor oral screenings; integrate oral health, behavioral health, and primary care; stratify new and existing measures by race, ethnicity, language, and disability; and the need to track social determinants of health, including housing insecurity, social isolation, and poverty status. We implore further attention to harmful gaps in measures for adult oral health, substance use disorders, mental health, and LTSS.

Community Catalyst is available to support you as thought-partners as you continue to develop equitable and impactful Core Set Measures. We thank you for considering these recommendations, and for your commitment to advancing equity. Please contact me if you have any questions or would like to discuss further.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

[5] https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/.

[6] https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during.

[7] https://www.communitycatalyst.org/resources/tools/peers-speak-out.

Kenneth Cooperman

In New York State, there are many children who are born with congenitally missing anterior teeth. The spacing of their dentition prevents their esthetic replacement—or any replacement at all due to issues of spacing and asymmetry.

These are children who are falling between the cracks. Congenitally missing anterior teeth are not included in the list of conditions for which orthodontics may be covered by Medicaid. This is a grievous oversight.

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 2022 Child and Adult Core Sets*.

The DQA appreciates the Workgroup recommendations to update the dental/oral health measure domain with the proposed additions of the "Oral Evaluation, Dental Services" and "Prevention: Topical Fluoride for Children" measures to the 2022 Child Core Set.

The DQA applauds the Workgroup recommendations and notes that the addition of these two measures builds on the foundation of state performance improvement from the existing dental/oral health measure "Sealant Receipt on Permanent 1st Molars." This combination of measures promotes receipt of a robust age-appropriate preventive pediatric dental care bundle (sealants, fluoride varnish and oral examination) that encompasses a range of oral healthcare provider types and care settings.

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 and severity of future lesions. 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 professionally applied topical fluoride and sealant placement, enable programs to assess whether specific recommended services are provided. These measures can also be stratified by age to further identify and target improvement opportunities.

Comment Specific to Gaps in the Core Set

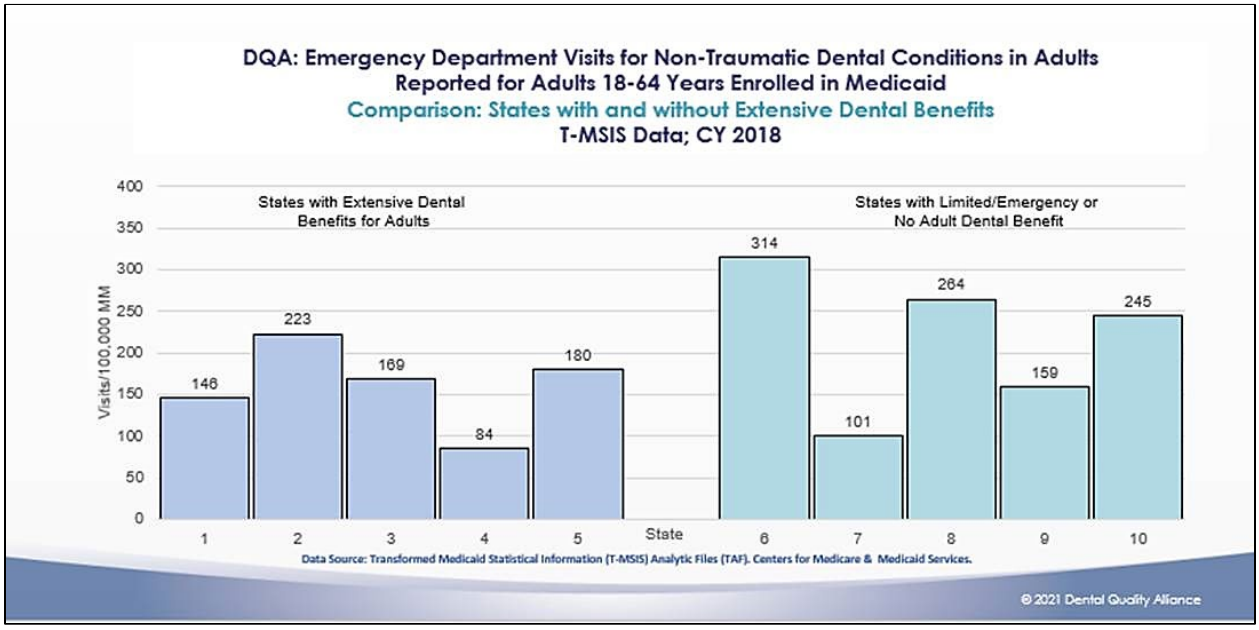
The DQA appreciates the Workgroup's emphasis on lack of oral/ dental health measures for the adult core set. Previous workgroups have also emphasized this gap; however, given the variability in dental benefits coverage across states, some workgroup members have expressed concerns about including dental measures in the Adult Core Set.[1,2]

The DQA strongly urges the Workgroup and the CMS to reconsider inclusion of the DQA *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* to the Adult Core Set. Specifically, inclusion of this measure would address the following system-wide concerns:

1. The **use of emergency departments (EDs) for non-traumatic dental conditions** has been a growing public health concern across the United States (US).[3,4,5,6,7,8,9,10] 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.[11] These visits present a public health challenge because they often have great financial implications for the healthcare system and divert resources away from urgent cases.[12] Medicaid is a primary payer for these visits,[13] including in states without Medicaid dental benefits, because

emergency department visits are paid for out of medical benefits. $2.7 billion dollars were spent on hospital emergency department visits, 2.1 million of those visits were due to dental conditions, and 40% of those visits among adults was paid for by Medicaid.[14]

2. These visits are **expensive and are avoidable costs** to the Medicaid program. It is important to recognize that the care provided in the ED is not definitive and does not address the underlying problem; rather, standard emergency care involves addressing infection and pain through prescription medications. Patients must see a dental provider to receive definitive care. Consequently, beneficiaries without access to oral healthcare services are more likely to have repeat visits to the ED for non-traumatic dental conditions. Even without an adult dental benefit, these programs could seek to improve oral healthcare and outcomes among their beneficiaries by linking them to community-based resources. Our analysis of Medicaid administrative claims data from the Transformed Medicaid Statistical Informational System (TMSIS) Analytic Files (TAFs)[15] suggest higher ED utilization, on average, by adults for non-traumatic dental conditions in states that do not have extensive dental benefits.



3. The measure of ambulatory care sensitive ED visits provides a **strong starting place for incorporating oral health considerations into the Adult Core Set** by providing a systems-level indicator of access to oral health care among Medicaid beneficiaries.

4. Many states conduct their own independent studies of ED visits for non-traumatic dental related reasons, but variable methodologies make it difficult to make comparisons across states and to get a clear national perspective. This measure would **enable standardized assessments**.

Measuring performance is critical to improving quality of care – including this ED measure in the Adult Core Set would be a first step towards the eventual promotion of appropriate dental care *outside* of the ED through increased preventive care, treatment of acute dental issues, and appropriate follow-up after ED use. The value of having an adult dental and oral health services measure focused on ED use would be to highlight the extent to which there are adverse impacts

associated with untreated dental disease in adults that impose significant costs in terms of both beneficiary health outcomes and actual program expenditures. These costs are incurred by *all* Medicaid programs, regardless of whether they provide adult dental benefits or not.

The DQA appreciates the Workgroup's consideration of these comments. If you have any questions, please contact the DQA at dqa@ada.org.

Citations

[1] 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. Accessed from: https://www.mathematica.org/features/MACCoreSetReview.

[2] 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 2019. Accessed from: https://www.mathematica.org/features/MACCoreSetReview.

[3] Okunseri C, Okunseri E, Thorpe JM, Xiang Q, Szabo AJC, Cosmetic, Dentistry I. Patient characteristics and trends in nontraumatic dental condition visits to emergency departments in the United States. 2012;4:1.

[4] Wall T, Nasseh K. Dental-related emergency department visits on the increase in the United States. Health Policy Resources Center Research Brief 2013; http://www.ada.org/~/media/ADA/Science%20and%20Research/Files/HPRCBrief_0513_1.pdf. Accessed February 15, 2019.

[5] Wall T. Recent trends in dental emergency department visits in the United States:1997/1998 to 2007/2008. Journal of public health dentistry. 2012;72(3):216-220.

[6] Lee HH, Lewis CW, Saltzman B, Starks H. Visiting the emergency department for dental problems: trends in utilization, 2001 to 2008. American journal of public health. 2012;102(11):e77-83.

[7] Zhou W, Kim P, Shen JJ, Greenway J, Ditmyer M. Preventable Emergency Department Visits for Nontraumatic Dental Conditions: Trends and Disparities in Nevada, 2009–2015. 2018;108(3):369-371.

[8] Seu K, Hall K, Moy E. Emergency department visits for dental-related conditions, 2009: Statistical Brief# 143. In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2012.

[9] Rampa S, Wilson FA, Allareddy V. Trends in dental-related emergency department visits in the State of California from 2005 to 2011. Oral surgery, oral medicine, oral pathology and oral radiology. 2016;122(4):426-433.

[10] Tomar SL, Carden DL, Dodd VJ, Catalanotto FA, Herndon JB. Trends in dental-related use of hospital emergency departments in Florida. J Public Health Dent. 2016 Jun;76(3):249-57.

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

[12] Wall T, Nasseh K, Vujicic M. Majority of dental-related emergency department visits lack urgency and can be diverted to dental offices. *Health Policy Institute Research Brief* 2014; https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx.

[13] Okunseri C, Okunseri E, Thorpe JM, Xiang Q, Szabo AJC, Cosmetic, Dentistry I. Patient characteristics and trends in nontraumatic dental condition visits to emergency departments in the United States. 2012;4:1.

[14] HPI Analysis of the 2017 Nationwide Emergency Department Sample, Agency for Healthcare Research and Quality. April 2020. https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0420_1.pdf?la=en. Accessed July 29. 2021.

[15] https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html.

Exact Sciences (Mary Doroshenk)

Thank you for the opportunity to provide comments on the 2022 Core Set recommendations. Our comments focus on and support the Primary Care Access and Preventive Care addition of *Colorectal Cancer Screening* as an Adult Core set measure. Exact Sciences is a leading provider of cancer screening and diagnostics tests and developed Cologuard® to screen for one of the most common and most preventable cancers when detected early – colorectal cancer (CRC).[1]

Cologuard is included in the American Cancer Society's (2018) colorectal cancer screening guidelines and the recommendations of the U.S. Preventive Services Task Force (2021) and the National Comprehensive Cancer Network®* (NCCN®) (2021).[2,3,4] Cologuard is indicated to screen adults 45 years of age and older who are at average risk for colorectal cancer by detecting certain DNA markers and blood in the stool.[5] Cologuard is covered by Medicare and most Medicaid programs.[6]

Exact Sciences supports adding *Colorectal Cancer Screening* as a Medicaid measure, as one important step toward closing the gap in CRC screening rate disparities for vulnerable populations.

Colorectal cancer is the second leading cause of cancer deaths in the United States and disproportionately impacts communities of color,[7] yet it can be prevented through screening.[2-4,7,8] Colorectal cancer screening is a USPSTF-recommended preventive screening service that includes several recommended CRC screening options for average risk individuals, including the mt-sDNA test (Cologuard).[3]

Exact Sciences supports all Medicaid patients having access to Cologuard, as a recommended CRC screening option.

While the workgroup recommended that the measure apply to those 50 to 75, it is important to note that the USPSTF, the ACS, and NCCN now recommend CRC screening starting at 45,[2-4] given the increasing trend in colorectal cancer in those under 50.[2] The recently updated USPSTF recommendation also highlights the higher incidence of colorectal cancer before age 50 in African Americans and calls out the need to assure equitable implementation of guideline-recommended screening for African Americans and other vulnerable populations.[3] We respectfully ask CMS to consider implementation of the measure to align with the new recommended CRC screening initiation age of 45.

We would like to address some comments/questions made by workgroup members during the working session on the measure that were captured in the *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP* report.

Modality Evidence

While the workgroup's question on evidence was asked regarding FIT, the evidence for the mt-sDNA test is worth noting. The single application sensitivity of mt-sDNA for all stages of CRC distinguishes it from single marker fecal occult blood tests (FIT/gFOBT). The mt-sDNA pivotal

study (Imperiale et al.), reported 92% sensitivity for CRC[9] (94% sensitive for stage I and stage II cancers[10,5†]) and 87% specificity when nonadvanced adenomas were considered "false positives."[9] Mt-sDNA sensitivity was significantly higher than that of FIT[‡], which had 74% sensitivity for CRC and 70% sensitivity for early-stage CRC with specificity of 95%. Given its high single application sensitivity, mt-sDNA is provided with three years of quality credit in all major CRC screening quality measures (HEDIS®[§], UDS, Medicare Advantage Star Ratings system),[11,12,13] as well as inclusion in all major CRC screening guidelines as mentioned above.[2-4]

Health Plan Shipment of Kits

As noted in the report, kits *shipped* by health plans directly to patients due for CRC screening do not count toward existing measures as completed CRC screening. The test must be completed and returned by the patient for the CRC screening to apply to measure specifications. A comment was made suggesting that NCQA add standards to their specifications that health plans must obtain an order from a member's treating provider to order a test. We suggest that NCQA allow flexibility in the prescribing of colorectal cancer screening. There are other health care providers who are in an ideal position to interact with and help bridge the gap for medically underserved patients who may not have a primary care provider.

We greatly appreciate CMS's commitment to implementation of recommended preventive services for all populations. Please do not hesitate to let us know if you have any additional questions that we can address.

[*]All recommendations are category 2A unless otherwise indicated. The National Comprehensive Cancer Network (NCCN®) makes no representations or warranties of any kind regarding their content, use or application and disclaims any responsibility for their application or use in any way.

[†]Statistic calculated using data from the pivotal study and reported within the Ahlquist review article. Cologuard sensitivity, per stage of cancer: I: 90% (n=29); II: 100% (n=21); III: 90% (n=10); IV: 75% (n=4).[9]

[‡]OC FIT-CHEK, Polymedco, Inc.

[§] sDNA (ie, Cologuard) is one of the methods permitted as part of the National Committee for Quality Assurance's (NCQA) HEDIS® quality measures for colon cancer screening. Third-party guidelines and quality measures do not specifically "endorse" commercial products, and inclusion in same does not imply otherwise.

Citations

[1] JNCI J Natl Cancer Inst (2009) 101 (18): 1225-1227. doi: 10.1093/jnci/djp273 First published online: August 21, 2009: http://jnci.oxfordjournals.org/content/101/18/1225.full.pdf+html.

[2] Wolf A, Fontham E, Church TR, et al. Colorectal cancer screening for average-risk adults: 2018 guideline update from the American Cancer Society. CA Cancer J Clin. 2018;68:250-281. doi:10.3322/caac.21457.

[3] Davidson KW, Barry MJ, Mangione CM, et al. Screening for colorectal cancer - US Preventive Services Task Force recommendation statement. JAMA. 2021;325(19):1965-1977. doi:10.1001/jama.2021.6238.

[4] NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) - Colorectal Cancer Screening. Version 2.2021. Updated April 13, 2021. Accessed August 4, 2021. https://www.nccn.org/professionals/physician_gls/pdf/colorectal_screening.pdf.

[5] Cologuard Physician Brochure. Madison, WI: Exact Sciences Corporation.

[6] CMS. Decision memo for screening for colorectal cancer - stool DNA testing (CAG-00440N). Published October 9, 2014. Accessed August 4, 2021. https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=277.

[7] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2021. CA Cancer J Clin. 2021;71:7-33. doi:10.3322/caac/21654.

[8] ACS. Survival Rates for Colorectal Cancer, by Stage. Accessed August 4, 2021. https://www.cancer.org/cancer/colon-rectal-cancer/detection-diagnosis-staging/survival-rates.html.

[9] lmperiale TF, Ransohoff OF, Itzkowitz SH, et al. Multitarget stool DNA testing for colorectal-cancer screening. N Engl J Med. 2014;370(14):1287-1297. doi:10.1056/NEJMoa1311194.

[10] Ahlquist DA. Multi-target stool DNA test: a new high bar for noninvasive screening. Dig Dis Sci. 2015;60(3):623-633. doi:10.1007/s10620-014-3451-5.

[11] NCQA. Colorectal cancer screening (COL). Accessed August 4, 2021. https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/.

[12] HRSA Health Center Program. 2021 Uniform Data System (UDS) Program Assistance Letter. October 21, 2020. Accessed August 4, 2021. https://bphc.hrsa.gov/datareporting/reporting/udspals/2020-07.

[13] CMS. Announcement of calendar year (CY) 2020 Medicare Advantage capitation rates and Medicare Advantage and Part D payment policies and final call letter. April 2, 2019. Accessed August 4, 2021. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.

Fight Colorectal Cancer (Anjee Davis)

I am writing on behalf of Fight Colorectal Cancer, a national patient advocacy organization dedicated to serving all affected by colorectal cancer through informed patient support, impactful policy change and breakthrough research endeavors.

I am writing to encourage the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS voting members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning in 2022. Adding this measure is important for a number of reasons. Failure to include the colorectal cancer screening measure impacts people of color, who are disproportionately impacted by colorectal cancer through access and quality of care issues. Non-elderly Medicaid patients are racially and ethnically diverse with 84.8% being people of color compared to 25.2% being people of color in the Medicare population (US average, 2019).[1] Not including the colorectal cancer screening measure would perpetuate existing structural racism whereby health systems treating people of color with Medicaid insurance are held to a different quality standard than those caring for patients covered by Medicare or commercial insurance.

Additionally, colorectal cancer is a significant societal burden in the United States and is the second leading cause of cancer deaths for men and women combined.[2] Colorectal cancer causes more deaths than both breast and cervical cancer, each of which has a screening metric in the CMS Adult Core Set of Health Care Quality Measures. In addition, while men make up 46% of the Medicaid population, no cancer screening measure applies to males in the Medicaid Adult Core Set.

Medicaid covers 9,452,003 patients between the ages 46 to 64, representing about 14% of the total Medicaid population.[3] Recently, an unexpected rise of 1% in colorectal cancer incidence rates (2012-2016, the most recent data) was seen in the age 50-to-64-year-old age group. This is in sharp contrast to a 3.3% decline in colorectal cancer incidence rates for those 65 or older. This disturbing trend demonstrates why it is critical that colorectal cancer screening be added as a quality measure in the Medicaid population. Lower rates of screening directly contribute to disparities in colorectal cancer morbidity and mortality and screening quality measures are proven to improve screening rates.[4,5]

Recent data suggest that enrollment in Medicaid is increasing amid the coronavirus pandemic. A study by the Center on Budget and Policy Priorities found that enrollment rose 10.9% from February through September 2020 for 36 states.[6] Since May 2020, the number of individuals newly eligible for Medicaid due to job loss has grown by over 4 million, with Kaiser Family Foundation estimating that groups more sensitive to changes in economic conditions (e.g., children, parents, and other expansion adults) will grow faster than the elderly and people with disabilities.[7,8] Much of this increase can be attributed to changes in the economy however, a Kaiser Family Foundation analysis found that a number of states projected enrollment increases prior to the pandemic and did not account for the economic downturn.[9] All of this highlights the importance of establishing colorectal cancer quality metrics for a growing segment of our population to help reduce morbidity and mortality from colorectal cancer.

Fight Colorectal Cancer strongly supports the addition of colorectal cancer screening to the CMS Adult Core Set of Quality Measures.

Citations

[1] *The Kaiser Family Foundation State Health Facts*; 2019. https://www.kff.org/a0c4a59/.

[2] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi:https://doi.org/10.3322/caac.21654.

[3] Center for Medicaid and CHIP Services D of Q and HO. *Medicaid and CHIP Beneficiary Profile*.; 2020.

[4] Green BB, Coronado GD, Devoe JE, Allison J. Navigating the Murky Waters of Colorectal Cancer Screening and Health Reform. *Am J Public Health*. 2014;104(6):982-986. doi:10.2105/AJPH.2014.301877.

[5] A Path to Improve Colorectal Cancer Screening Outcomes: Faculty Roundtable Evaluation of Cost-Effectiveness and Utility. *AJMC*. Accessed July 6, 2021. https://www.ajmc.com/view/faculty-roundtable-evaluation-of-costeffectiveness-and-utility.

[6] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[7] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[8] Broaddus M. Medicaid Enrollment Still Rising. Center on Budget and Policy Priorities. Published November 10, 2020. Accessed January 12, 2021. https://www.cbpp.org/blog/medicaid-enrollment-still-rising.

[9] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

Florida Voices for Health (Scott Darius)

As members of the Oral Health Progress and Equity Network (OPEN), we appreciate the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. OPEN is a network of state, national, and community-based partners committed to equitable access to oral health care for everyone. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.

For additional information, please contact Scott Darius.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

GlaxoSmithKline Consumer Healthcare (Elizabeth Brewer)

GlaxoSmithKline (GSK) Consumer Healthcare is pleased to submit comments to the *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets*. GSK is a science-led global healthcare company. We have three world-leading businesses that research, develop and manufacture innovative pharmaceutical medicines, vaccines and consumer healthcare products. Within our consumer healthcare division we are the manufacturers of Sensodyne, Paradontax, Polident, Biotene and Aquafresh.

GSK supports policy solutions that transform our healthcare system to one that rewards innovation, improves patient outcomes and achieves higher-value care. GSK would like to offer the following comments for consideration:

GSK encourages CMS to add the *ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults* measure to the Adult Core Set. While the Working Group did not recommend the inclusion of this measure for the Core Set, GSK encourages CMS to reconsider this recommendation and include the measure in the 2022 Adult Core Set. As noted in the 2021 Medicaid Core Set discussions, and reaffirmed during the 2022 discussions, there is a major gap in adult oral health measures within the Adult Core Set.

Dentistry and oral health promotion have not historically been prioritized in the national conversations around quality measure development and measurement improvement.[1,2] It is well known that limited access to dental services and preventive programs adversely impacts oral, as well as overall health. Creating quality measures that incentivize preventative care and quality treatment of common dental conditions, such as periodontal disease, can help providers, payers, and patients evaluate dental care effectiveness and identify gaps for improvement.

Thank you for this opportunity to comment on the draft report. If you have any questions or GSK can provide additional insight, please do not hesitate to reach out to me .

Citations

[1]ADA. https://www.ada.org/~/media/ADA/DQA/2019_Guidebook.pdf?la=en. Accessed July 2020.

[2] Dental Quality Alliance. (2012). Pediatric Oral Health Quality and Performance Measures Concept Set: Achieving Standardization and Alignment. Accessed July 2020.

Samir Gupta

I am writing to in support of recommendations by Centers for Medicare and Medicaid Services (CMS) Voting members to add colorectal cancer screening to the MCS Adult Core Set of Quality Measures for Medicaid patients beginning in 2022. My support is based on the following:

- Colorectal cancer (CRC) is a major public health problem
- Major inequities in incidence and mortality for CRC exist by race, ethnicity, and socioeconomic position, including among populations most commonly served through Medicaid
- Observed inequities in CRC incidence and mortality are most likely attributable to disparities in uptake of CRC screening, with screening rates among Medicaid populations lagging very far behind those observed for individuals insured by Medicare and private insurance
- The single most important public health strategy for addressing screening would be to require measurement and reporting of CRC screening uptake among Medicaid populations. Requiring public reporting for private insurers such as through HEDIS is one of the core reasons that CRC screening rates are much higher for privately insured vs Medicaid populations

My support is informed by 15 years of experience as a gastroenterologist, public health advocate, and researcher in the area of CRC screening and prevention, including inequities in CRC screening.

I urge CMS to support this measure so that all populations can benefit from optimized access to CRC screening.

The Joint Commission (Susan Yendro)

The Joint Commission appreciates the opportunity to comment on the Mathematica draft report *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multistakeholder Review of the 2022 Child and Adult Core Sets*.

On behalf of The Joint Commission, I would like to express our support for the recommendations included in this report. We appreciate the opportunity to participate in the feedback process. As Tricia Elliott represented The Joint Commission during the development process, our comments have already been provided and incorporated into this draft.

Thank you for including us.

Justice in Aging (Jennifer Goldberg)

Justice in Aging appreciates the opportunity to provide comments on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.

Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medicare, with a focus on the needs of low-income enrollees and populations that have been marginalized and excluded from justice such as women, people of color, people with disabilities, LGBTQ individuals, and people with limited English proficiency.

Our comments focus specifically on the oral health components of these measures. As members of the Oral Health Progress and Equity Network (OPEN), we are committed to equitable access to oral health care for everyone. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and CHIP members.

To improve dental health across the lifespan, we support the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year. We also support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

Thank you for the opportunity to comment.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

The Lewin Group (Lisa Alecxih)

The Lewin Group, a health and human services consulting firm with significant expertise in measure development, offers the following comments in response to the Summary of a Multistakeholder Review of the 2022 Adult and Child Core Set. Lewin develops and maintains quality measures for use in Medicare and Medicaid, including outpatient imaging efficiency, emergency care, home and community-based services (HCBS), long-term services and supports (LTSS), and measures of behavioral health/substance use disorders (BH/SUD).

Measures for Addition to the Core Sets

Lewin strongly supports the Centers for Medicare & Medicaid Services' (CMS's) stated goal of adding LTSS measures to the Core Sets to offer states standardized approaches for monitoring and improving quality for LTSS beneficiaries—which represent nearly one-third of Medicaid expenditures—as part of the Core Set requirements. We encourage CMS to require states to submit data for a small number of publicly available LTSS measures, including those specific to HCBS.

Criteria Considered During Core Set Annual Reviews

For the 2022 Core Set Annual Review meeting, Mathematica presented five criteria to assess technical feasibility for measures under consideration to be added to the Core Set, including a requirement for technical specifications (including value or code sets) to be available to states free of charge. We encourage CMS to apply this criterion to the final list of measures selected for addition to the Core Set in 2022 and to consider applying it to its measures already in use in the Core Set. Consistent use of this criterion would help ensure alignment of measures across payment and delivery systems and would promote consistent reporting across programs, allowing for comparisons and benchmarking across states and providers.

The Los Angeles Trust for Children's Health (Maryjane Puffer)

I am writing in support of adding three new measures to the Core Sets:

- the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year
- the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year
- the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults[3]

Thank you for your consideration of these critical measures.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

National Association of Community Health Centers (Julia Skapik)

Please accept the feedback on the Measures from the National Association of Community Health Centers.

1. In regards to the inclusion of LTSS: Comprehensive Care Plan and Update: Strong support. The industry has taken far too long to move from a static, SOAP-note approach to documentation and longitudinal treatment of patient concerns and conditions in a shared decision-making model. CMS' use of these measures may have a significant impact on support for care coordination content and workflow. We believe this measure should be updated in the future to directly reference a FHIR Care Plan specification for the documentation of the MTLSS. We urge CMS to work with EHR vendors and the standards community to further increase the standardization of the template and content and improve the implementation and availability of this content in EHRs.
2. In regards to the inclusion of Colorectal Cancer Screening: Strong support. Would encourage CMS to work with payers and HIEs to improve the availability of this data given the long look-back period of colon cancer screening.
3. In regards to the inclusion of 2 new pediatric dental measures: Strong support. Pediatric dental care is an unmet need in many patients, particularly in underserved communities; however, NACHC encourage CMS to further work to ensure and verify that an adequate number pediatric dentists across the nation, particularly in underserved communities, are accepting Medicaid and CHIP patients.
4. In regards to the inclusion of ED follow up visits for mental health and substance use for pediatric patients: Strong support.
5. In regards to measure removals: each of the workgroup recommendations seems appropriate.

National Network for Oral Health Access (Phillip Thompson and An Nguyen)

National Network for Oral Health Access has been providing robust oral health training and technical assistance to safety-net oral health programs for almost thirty years. Training and support resources go beyond our 4,200 members and are available through NNOHA's website, webinars, conferences, and learning collaboratives to all safety-net programs across the country. In 2019 over 1,100 community health centers employed or contracted with over 19,000 oral health professionals to provide services to more than 6.7 million patients. On behalf of the underserved communities from regions across the United States, NNOHA is pleased to have the opportunity to provide the following comments on the Medicaid and CHIP Child and Adult Core Set 2022 Annual Review Workgroup's recommendations for updates to the 2022 Core Sets.

- NNOHA supports the Workgroup's recommendation to replace the Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH) from the Child Core Set measure with the Oral Evaluation Dental Services and the Prevention: Topical Fluoride for Children measures.
    - NNOHA acknowledges the work many states have done to collect the PDENT-CH measure data and recognizes the potential loss of state-level momentum from discontinuing reporting this measure.
    - Considerations can be made to modify the Oral Evaluation Dental Services measure to apply to adults as well in states with comprehensive adult dental coverage.
- NNOHA supports the addition of the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measure.
    - Between 2015 and 2018, non-traumatic dental problems accounted for approximately 1.5-2 million hospital emergency department visits each year.[1,2,3,4] Most of these visits were for oral health needs that could have been addressed at a dental office, including care delivered through teledentistry.
    - Patients with Medicaid and those with no insurance coverage are more likely to appear at the hospital emergency department with a dental condition than those with other insurance coverage.[5]
    - While there is effort needed to identify best and innovative practices to improve outcomes, a focus on this measure has the potential to address access to oral health care among adults, to improve integration of medical and dental care, and to lead to a cost savings of approximately $1.7 billion per year.[6]

NNOHA recommends that the Workgroup continue to consider the addition of oral health care measures to the Core Sets in the future, including potential metrics to evaluate healthcare integration, program efficacy, and health outcomes. We appreciate the Workgroup's interest in identifying opportunities to measure Medicaid and CHIP beneficiaries who receive evidence-based oral health interventions. On behalf of our membership, thank you for the opportunity to

comment on proposed changes that impact our nation's Medicaid and CHIP programs. For further comment from NNOHA, please contact Dr. Irene Hilton.

Citations

[1] Rui P, Kang K. National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables. Available from: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf. Accessed August 2, 2021.

[2] Rui P, Kang K, Ashman JJ. National Hospital Ambulatory Medical Care Survey: 2016 emergency department summary tables. 2016. Available from: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf. Accessed August 2, 2021.

[3] Rui P, Kang K. National Hospital Ambulatory Medical Care Survey: 2017 emergency department summary tables. National Center for Health Statistics. Available from: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf. Accessed August 2, 2021.

[4] Cairns C, Kang K, Santo L. National Hospital Ambulatory Medical Care Survey: 2018 emergency department summary tables. Available from: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018-ed-web-tables-508.pdf. Accessed August 2, 2021.

[5] Wall T, Nasseh K, Vujicic M. Majority of dental-related emergency department visits lack urgency and can be diverted to dental offices. Health Policy Institute Research Brief. American Dental Association. August 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx. Accessed August 2, 2021.

[6] Wall T, Nasseh K, Vujicic M. Majority of dental-related emergency department visits lack urgency and can be diverted to dental offices. Health Policy Institute Research Brief. American Dental Association. August 2014. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0814_1.ashx. Accessed August 2, 2021.

New England Medicaid Quality Collaborative (Joshua Slen and Julie Trottier)

The New England States Consortium Systems Organization, Medicaid Quality Collaborative would like to provide comments regarding the 2022 Child and Adult Core Set Review Workgroup Draft Report.

Representatives from all six states convened to review the workgroup's recommendations. There is general support for the recommendations, with some exceptions from some states. Comments and suggestions are added in the table below, which also shows which states are in agreement with the NEMQC response.

Please reach out with any questions.

Workgroup Recommendations for Updates to the 2022 Core Sets	New England Medicaid Quality Collaborative (NEMQC) Response	States that are in agreement with the NEMQC Response
Measures Recommended for Removal from the Child Core Set		
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Disagree. This measure should be left in the child core set, but with edits to show how it is defined. Because proactive, preventive dental care is so important to the overall health of children, we recommend this measure is further defined to represent the percentage of eligibles who received key aspects of preventive dental services, which are 1. professional dental cleanings, 2. ADA recommended fluoride treatments, and 3. sealants	New Hampshire Connecticut Rhode Island Maine
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Disagree. This measure should be retained until there is an appropriate replacement. Retaining in the Child Core Set allows for state-to-state comparison on the CMS scorecard page.	New Hampshire Connecticut Rhode Island
Audiological Diagnosis No Later than 3 Months of Age (AUD-CH)	Agree. This measure should be removed because of difficulty in obtaining the data.	New Hampshire Vermont Connecticut Rhode Island Maine Massachusetts
Measure Recommended for Removal from the Adult Core Set		
PC-01: Elective Delivery (PC01-AD)	Agree. This measure should be removed because it doesn't fulfill the intention and states are not able to report it.	New Hampshire Vermont Connecticut Rhode Island Maine Massachusetts
Measures Recommended for Addition		
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17	Agree. This is a useful measure which is on the adult core set and some states are already collecting data for this younger age group.	New Hampshire Vermont Connecticut Rhode Island Maine Massachusetts

Workgroup Recommendations for Updates to the 2022 Core Sets	New England Medicaid Quality Collaborative (NEMQC) Response	States that are in agreement with the NEMQC Response
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17a	Agree	New Hampshire Vermont Connecticut Rhode Island Maine Massachusetts
Oral Evaluation, Dental Services	Agree, with a recommendation to narrowly define the exam codes to those which evaluate the entire mouth, rather than a limited problem focused exam.	New Hampshire Connecticut Rhode Island Massachusetts
Prevention: Topical Fluoride for Children	Agree, with a recommendation to exclude silver diamine fluoride (SDF) from the measure because it is not used as a preventive topical treatment. The only fluoride codes that should be included are: D1206 (fluoride varnish), D1208 (topical fluoride excluding varnish), and CPT code 99188 (medical setting fluoride varnish).	New Hampshire Connecticut Rhode Island Massachusetts
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Agree	New Hampshire Vermont Connecticut Rhode Island Massachusetts
Long-Term Services and Supports: Comprehensive Care Plan and Update	Agree, with the recommendation to add clear definitions of the terms 'LTSS' and 'Comprehensive Care Plan', and to provide technical assistance to states on integrating the measure into 1915(c) waiver sub-assurance monitoring.	New Hampshire Vermont Connecticut Rhode Island Massachusetts
Colorectal Cancer Screening	Agree, with recommendation to allow time for states to develop a process for collecting and reporting this data. New England states agree that this is an important measure to collect, however there are some barriers to implementation due to the 10-year look back and because MCOs have this data.	New Hampshire Vermont Rhode Island Maine Massachusetts

Sincerely,

Joshua Slen, NEMQC Lead
Julie Trottier, NEMQC
Health System Transformation, LLC

State Representatives:

Erin Carmichael | Director of Quality Management
Department of Vermont Health Access

Patrick McGowan, MS, CPHQ
Administrator, New Hampshire Medicaid Quality Program
Bureau of Program Quality

Donna Balaski, D.M.D.
Department of Social Services
Health Services, Integrated Care
CT Dental Health Partnership

Chantele Rotolo
Quality and Adult Behavioral Health
Rhode Island Executive Office of Health and Human Services

Brooke McNaughton
DHHS, Office of MaineCare Services

Linda Shaughnessy
Director, MassHealth Quality Office

Ohio Department of Medicaid (Zamda Lumbi)

The Ohio Department of Medicaid (ODM) supports the recommended removal of the **Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)** measure contingent upon the addition of the **Oral Evaluation, Dental Services and Prevention: Topical Fluoride for Children** measures.

ODM also supports the removal of the **Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)** from the Child Core Set contingent upon the addition of the **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)** and **Follow-Up After Emergency Department Visit for Mental Illness (FUM)** for the child and adolescent populations. ODM agrees with the concern expressed by one of the Workgroup members regarding small cell sizes, which may be an issue in reporting the measure for some states. Given the importance of these measures, it may make sense to report a combined rate (FUM + FUA) for instances where a small cell size would prevent the reporting of one of the two rates (e.g., reporting 7 and 30 day follow-up rates for the combined eligible population with FUM and/or FUA emergency department visits).

ODM supports the removal of the **Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)** and agrees with the rationales expressed by the Workgroup members recommending removal.

ODM would support the addition of the **Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis** measure to the Child Core Set but would prioritize this addition secondary to the FUA and FUM measures & dental measures. Due to the national increase in pharmacy value-based purchasing initiatives and the emphasis on decreasing inappropriate antibiotic prescribing, ODM expects that the importance of this measure in the future would less critical than the other measures recommended for addition to the core set.

ODM supports the removal of the **PC-01: Elective Delivery (PC01-AD) measure from the Adult Core set,** given the national trend indicating decreasing rates.

While ODM acknowledges the requirement for measures such as the **Long-Term Services and Supports Comprehensive Care Plan and Update,** there are concerns about this measure including the labor intensive data collection process and alignment of state-specific care plan elements with those specified in the NCQA measure methodology. It may be more feasible to implement this measure for future reporting cycles, given the time required by states to ensure compliance with the measure criteria.

Regarding the **Colorectal Screening Measure,** there may be issues with the applicability of the measure for the Medicaid population & length of Medicaid eligibility/enrollment related to the lengthy look-back period defined in the specifications (i.e., up to 9 years prior to the measurement year).

Oral Health Progress and Equity Network (Ifetayo B. Johnson)

As members of the Oral Health Progress and Equity Network (OPEN), we appreciate the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. OPEN is a network of state, national, and community-based partners committed to equitable access to oral health care for everyone. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

For additional information, please contact Colin Reusch.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

The Oral Health Progress and Equity Network (OPEN) Data & Measurement Network Response Team (Cherry Houston)

As members of OPEN's Data & Measurement Network Response Team (NRT), we appreciate the opportunity to comment on the Core Set Workgroup's "2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP." This team serves to promote and facilitate an awareness of the oral health data needs of OPEN, federal, state, and local partners, and others. The Data NRT members act as content experts, connectors, catalysts, and advocates. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care-sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department.

We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.

For additional information, please contact Colin Reusch.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

Partnership for Children's Oral Health (Becca Matusovich)

As members of the Oral Health Progress and Equity Network (OPEN), we appreciate the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. OPEN is a network of state, national, and community-based partners committed to equitable access to oral health care for everyone. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

For additional information, please contact Colin Reusch.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

Southern Plains Tribal Health Board (Monica McKee)

As members of the Oral Health Progress and Equity Network (OPEN), we appreciate the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. OPEN is a network of state, national, and community-based partners committed to equitable access to oral health care for everyone. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, children must be evaluated early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Moreover, assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Moreover, emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, state programs may be incentivized to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We, therefore, urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

For additional information, please contact Monica McKee.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

University of Detroit Mercy School of Dentistry (Judith Jones)

Please consider the POQL described in the attached document.[1]

Thank you.

Citations

[1] Huntington NL, et al. Development and validation of a measure of pediatric oral health-related quality of life: the POQL. *J Public Health Dent.* 2011; 71(3): 185–193. The article is available online at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3188947/.

Danny van Leeuwen

I support the LTSS Comprehensive Care Plan and Update measure. As patient-caregiver activist long-term care plans come up often. Regular people find this important, would understand its value and could impact the improvement of the measurement findings.

Virginia Colorectal Cancer RoundTable (Cynthia M. Yoshida and Michael Preston)

We are writing on behalf of the Virginia Colorectal Cancer RoundTable (VCCRT), the Virginia non-profit organization committed to increasing colorectal cancer (CRC) screening rates in the Commonwealth, to request the Centers for Medicare and Medicaid Services (CMS) to accept the recommendation by CMS voting members to add colorectal cancer screening to the CMS Adult Core Set of Quality Measures for Medicaid patients beginning in 2022. Failure to include the CRC screening measure disadvantages Black adults, other people of color, and people who are disproportionately impacted by CRC through access and quality of care issues. Non-elderly Medicaid patients are racially and ethnically diverse, with 84.8% being people of color compared to 25.2% of the Medicare population being Black adults and other people of color (US average, 2019).[1] Not including the CRC screening quality measure would perpetuate existing structural racism whereby health systems treating Black adults and other people of color with Medicaid insurance are held to a different quality standard than those caring for patients covered by Medicare or commercial insurance.

Additionally, CRC is a significant societal burden in the United States and is the second leading cause of cancer deaths for men and women combined.[2] CRC causes more deaths than both breast and cervical cancer, each of which has a screening metric in the CMS Adult Core Set of Health Care Quality Measures. In addition, while men make up 46% of the Medicaid population, no cancer screening measure applies to males in the Medicaid Adult Core Set.

Medicaid covers 9,452,003 patients between the ages 46 to 64, representing about 14% of the total Medicaid population.[3] Recently, an unexpected rise of 1% in colorectal cancer incidence rates (2012-2016, the most recent data) was seen in the age 50-to-64-year-old age group. This is in sharp contrast to a 3.3% decline in colorectal cancer incidence rates for those 65 or older, who are covered by Medicare. This disturbing trend demonstrates why it is critical that CRC screening be added as a quality measure in the Medicaid population. Lower rates of screening directly contribute to disparities in CRC morbidity and mortality and screening quality measures are proven to improve screening rates.[4,5]

Recent data suggest that enrollment in Medicaid is increasing amid the coronavirus pandemic. A study by the Center on Budget and Policy Priorities found that enrollment rose 10.9% from February through September 2020 for 36 states.[6] Since May 2020, the number of individuals newly eligible for Medicaid due to job loss has grown by over 4 million, with the Kaiser Family Foundation estimating that groups more sensitive to changes in economic conditions (e.g., children) will grow faster than the elderly and people with disabilities.[7,8] Much of this increase can be attributed to changes in the economy; however, a Kaiser Family Foundation analysis found that a number of states projected enrollment increases prior to the pandemic and did not account for the subsequent economic downturn.[9] All of this highlights the importance of establishing CRC screening quality metrics for a growing segment of our population to help reduce morbidity and mortality from CRC.

The VCCRT strongly supports the addition of CRC screening to the CMS Adult Core Set of Quality Measures.

Citations

[1] *The Kaiser Family Foundation State Health Facts*.; 2019. https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi: https://doi.org/10.3322/caac.21654.

[3] Center for Medicaid and CHIP Services D of Q and HO. *Medicaid and CHIP Beneficiary Profile*.; 2020.

[4] Green BB, Coronado GD, Devoe JE, Allison J. Navigating the Murky Waters of Colorectal Cancer Screening and Health Reform. *Am J Public Health*. 2014;104(6):982-986. doi:10.2105/AJPH.2014.301877.

[5] A Path to Improve Colorectal Cancer Screening Outcomes: Faculty Roundtable Evaluation of Cost-Effectiveness and Utility. AJMC. Accessed July 6, 2021. https://www.ajmc.com/view/faculty-roundtable-evaluation-of-costeffectiveness-and-utility.

[6] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[7] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

[8] Broaddus M. Medicaid Enrollment Still Rising. Center on Budget and Policy Priorities. Published November 10, 2020. Accessed January 12, 2021. https://www.cbpp.org/blog/medicaid-enrollment-still-rising.

[9] Hinton E, Stolyar L, 2021. Medicaid Spending and Enrollment Trends Amid the COVID-19 Pandemic – Updated for FY 2021 & Looking Ahead to FY 2022. KFF. Published March 12, 2021. Accessed April 1, 2021. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-spending-and-enrollment-trends-amid-the-covid-19-pandemic-updated-for-fy-2021-looking-ahead-to-fy-2022/.

Virginia Health Catalyst (Sarah Holland)

On behalf of Virginia Health Catalyst board, staff, and partners, I appreciate the opportunity to comment on the Core Set Workgroup's 2022 Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP. Virginia Health Catalyst strives to ensure all Virginians have equitable access to affordable, comprehensive health care that includes oral health. We commend the Workgroup for its ongoing commitment to meaningfully measure oral health improvement experienced by Medicaid and Children's Health Insurance Program (CHIP) members.

In particular, we believe the Workgroup's recommendation to add the oral evaluation for dental services measure,[1] which measures the percentage of children who received a comprehensive or periodic oral evaluation within the reporting year, will improve oral health outcomes. Given the progressive nature of dental disease, we must evaluate children early and regularly for risk factors and signs of tooth decay to provide appropriate prevention and disease management services. Assessing the utilization of preventive services in this way can put every child on the trajectory for good oral health in the long run.

We also enthusiastically support the Workgroup's recommendation to add the topical fluoride measure,[2] which measures the percentage of children who received at least two topical fluoride applications by either dental or oral health providers within the reporting year. Together, these two measures have the potential to better evaluate and incentivize the delivery of preventive oral health care across care settings, particularly for young children who may be more likely to see a pediatrician or primary care physician than a dentist. We believe the inclusion of these measures will result in continued progress toward medical-dental integration and interdisciplinary care coordination.

We are, however, disappointed by the Workgroup's decision not to recommend the measure of ambulatory care-sensitive emergency department visits for non-traumatic dental conditions in adults.[3] The Workgroup has previously identified the lack of adult oral health measures as a gap in the Adult Core Set. As states like Virginia, West Virginia, Oklahoma, and Maine join 19 other states in offering comprehensive dental coverage for Medicaid adults, it is increasingly important that CMS and state Medicaid agencies can evaluate the impact of these benefits.

Emergency department visits for non-traumatic dental conditions are one of the most costly outcomes of lack of access to routine and preventive dental care, representing $2 billion[4] in largely avoidable health care expenses each year. While the availability and comprehensiveness of Medicaid adult dental coverage varies across states, the ability to calculate this emergency department measure is not dependent on available dental claims. By systematically measuring the incidence of these visits, it may incentivize state programs to implement approaches that address oral health problems and access barriers before patients present in the emergency department. **We urge the Workgroup to reconsider recommending this measure for inclusion in the Adult Core Set.**

Thank you for your hard work and commitment to improving the oral health of children and adults.

For additional information, please contact Colin Reusch.

Citations

[1] https://www.ada.org/~/media/ADA/DQA/2021_OralEvaluation.pdf?la=en.

[2] https://www.ada.org/~/media/ADA/DQA/2021_DorOHS_TopicalFluoride.pdf?la=en.

[3] https://www.ada.org/~/media/ADA/DQA/2021_AmbulatoryCareSensitiveEmergencyDepartmentVisitsforNonTraumaticDentalConditionsinAdults.pdf?la=en.

[4] https://whatsnew.dentaquest.com/reducing-preventable-dental-related-hospital-emergency-visits-is-more-important-than-ever.

Washington State Health Care Authority (Laura Pennington)

Thank you for the opportunity to provide comments for the 2022 Core Set Review. On behalf of the state of Washington we would like to provide the following feedback:

Overall we support the changes proposed in the draft report, with the exception of the following:

- Addition of Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis Antibiotic Measure (AAB) – Recommend the workgroup reconsider the addition of this measure for the following reasons:
  - As stated in the report performance for children is already high and while there remains an opportunity for improvement in the adult population we do not think this is the right measure for that.
  - Coding for the AAB measure currently allows for manipulation to achieve the best outcome and does not necessarily reflect what is actually occurring.
  - We would recommend the Antibiotic Utilization (ABX) measure instead, as it is a better reflection of antibiotic use and does not allow for manipulation of the coding.

Again, thank you for the opportunity to provide feedback.

Mathematica

Princeton, NJ • Ann Arbor, MI • Cambridge, MA
Chicago, IL • Oakland, CA • Seattle, WA
Tucson, AZ • Woodlawn, MD • Washington, DC

EDI Global, a Mathematica Company

Bukoba, Tanzania • High Wycombe, United Kingdom

mathematica.org