![Mathematica — Progress Together]

Child and Adult Core Set Annual Review Workgroup:
Measures Suggested for Addition to the 2025 Core Sets

Measure Information Sheets

April 2023

Table of Contents

Maternal and Perinatal Health

Care of Acute and Chronic Conditions

Dental and Oral Health Services

Measure That Will Not Be Reviewed

Maternal and Perinatal Health

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET REVIEW WORKGROUP:
MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SET

Measure Information

Measure name	**Oral Evaluation During Pregnancy**
Description	Percentage of enrolled persons aged 15 through 44 years with live-birth deliveries in the reporting year who received a comprehensive or periodic oral evaluation from a dental provider during pregnancy
Measure steward	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Maternal and Perinatal Health
Meaningful Measures area(s)	Wellness and Prevention
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications

Ages	Ages 15 to 44 as of December 31 of the reporting year.
Data collection method	Administrative (enrollment and medical/dental claims).
Denominator	Unduplicated number of enrolled persons aged 15 through 44 years as of December 31st of the reporting year with live-birth deliveries in the reporting year.
Numerator	Unduplicated number of enrolled persons aged 15 through 44 years as of December 31st of the reporting year, with live-birth deliveries in the reporting year, who received a comprehensive or periodic oral evaluation during pregnancy.
Exclusions	None.
Continuous enrollment period	The subject must be enrolled on the delivery date and continuously enrolled for 180 days prior to the delivery date.
	For programs/plans that verify enrollment on a monthly basis, the continuous enrollment criteria should include the month in which the delivery occurred and 6 months prior to the month in which the delivery occurred.
Level of reporting for which specifications were developed	Program-level (including state Medicaid and CHIP programs).

Minimum Technical Feasibility Criteria

Link to current technical specifications	Dental Quality Alliance technical specifications: [2022_oral_evaluation_during_pregnancy.pdf (ada.org)](2022_oral_evaluation_during_pregnancy.pdf)
Information on testing or use at state Medicaid/CHIP level	The Workgroup Member (WGM) who suggested this measure for addition to the Core Sets explained that measure testing conducted by the DQA used Medicaid and CHIP claims and enrollment data available from the T-MSIS Analytic Files for reporting on calendar year 2018. A sample of five states' Medicaid and CHIP beneficiaries were included.
	The measure was approved at the DQA's November 4, 2022 membership meeting; consequently, the measure has not yet been implemented by state programs. However, state Medicaid programs have independently developed utilization reports on dental service use among pregnant beneficiaries, demonstrating both feasibility and interest. For example, Michigan has developed a perinatal oral health care utilization dashboard (https://www.michigan.gov/mdhhs/keep-mi-healthy/communicablediseases/epidemiology/chronicepi/oral-health-epidemiology/oral-health-dashboard_michigan-medicaid-perinatal-oral-health-care-utilization_2018-2021). In addition, the Medicaid	Medicare	CHIP Services Dental Association (MSDA)'s National Profile indicates that 80 percent of states that completed its survey in 2021 used claims data to report dental service use among pregnant women.
	Because of the national interest in quality measures that examine dental services during pregnancy, the DQA developed and rigorously tested a measure to enable reliable and consistent reporting across states.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM indicated that some states would need to be able to link beneficiaries between medical and dental claims databases (to the extent that claims are separate). They noted that states commonly link between claims databases to assess other types of services during pregnancy. The WGM felt that the feasibility of linking medical and dental claims for the purpose of this measure is demonstrated by the independent state reporting noted above.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM asserted that this measure addresses two significant gaps identified during previous Child and Adult Core Set Review meetings:
	1. Access to/use of dental services for pregnant individuals
	2. Access to/use of dental services for adults
	The WGM shared that evidence, including systematic reviews, indicates important connections between oral health and overall systemic health. Among pregnant women: (1) pregnancy is associated with increased risk of gingival inflammation and caries;[1,2] (2) periodontal disease is associated with an increased risk of adverse pregnancy outcomes including preterm birth, low birthweight, and preeclampsia;[3] and (3) maternal oral health is directly associated with

	child oral health.[4,5] The WGM explained that because of the importance of dental care to overall maternal and child health, the American College of Obstetricians and Gynecologists and the American Public Health Association have emphasized the importance of access to oral health care during pregnancy.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM stated that the data source (administrative enrollment and claims data) allows for stratification by race, ethnicity, sex, age, rural/urban status, language and disability. The WGM highlighted that the primary challenges with stratification are common to all Medicaid/CHIP claims-based measures, such as data completeness (e.g., race and ethnicity are less likely to be completely filled than age and sex) and standardized definitions and methodology (e.g., lack of standardized definitions for disability). An increased emphasis by states to capture race and ethnicity data in Medicaid programs will increase the likelihood of successful stratification for this measure.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM highlighted that, effective October 1, 2022, all states and DC offer dental coverage for pregnant and postpartum Medicaid beneficiaries through at least 60 days after pregnancy.[6] This measure would complement existing Maternal and Perinatal Health measures in the Adult Core Set and would strengthen the Core Set of Maternal and Perinatal Health Measures, advancing the goal of a more integrated prenatal health care system. Despite the recommendations that pregnant individuals receive dental care, less than 50 percent do so based on a systematic review that reported estimates ranging from 36 to 49 percent.[7] The rates are even lower among pregnant Medicaid beneficiaries. Using self-reported data from the Pregnancy Risk Assessment Monitoring System (PRAMS), roughly half of women reported having dental cleaning during pregnancy with a lower percentage (38 percent) among women with Medicaid coverage.[8,9] Medicaid covers 40 percent of births and, therefore, implementation of this measure has the potential to significantly improve the wellbeing of both pregnant beneficiaries and their children.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM explained that the measure is grounded in (1) evidence of the bidirectional relationship between oral health and overall health during pregnancy and of the relationship between maternal oral health and child oral health and (2) evidence-based professional recommendations. For example, in Oregon, a subset of Medicaid-enrolled women received home visits and were assigned a dental home. Research found that their children (at two years) were 1.5 times more likely to be caries free than comparison children.[10] The WGM provided additional links to evidence and professional recommendations about oral health evaluation during pregnancy: • Abariga 2016: https://pubmed.ncbi.nlm.nih.gov/27825315/ • Daalderop 2018: https://pubmed.ncbi.nlm.nih.gov/30370334/

4

	• Figuero 2013: https://pubmed.ncbi.nlm.nih.gov/23557432/ • Chaffee 2014: https://pubmed.ncbi.nlm.nih.gov/24356441/ • Da Silva Bastos 2015: https://pubmed.ncbi.nlm.nih.gov/25486222/ • Finlayson 2017: https://pubmed.ncbi.nlm.nih.gov/28577633/ • ACOG: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan • APHA: https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/12/improving-access-to-dental-care-for-pregnant-women • ADA: https://www.ada.org/resources/research/science-and-research-institute/oral-health-topics/pregnancy
How measure can be used to monitor improvement	The WGM noted there is currently a performance gap, with testing measure scores ranging from 14 to 23 percent. The WGM suggested that the measure can be trended over time to monitor improvement. The WGM cited examples of quality improvement strategies that led to increased dental use, such as educating medical and dental providers and pregnant patients about dental care importance and safety during pregnancy, promoting dental referrals, and developing partnerships. For example: • CT: Conducted outreach to OB/GYN and dental offices to connect pregnant beneficiaries to dentists, distributed oral health kits/educational materials, and established collaborations; dental use increased from 29.8 percent in 2005 to 57.6 percent in 2017 (measured with Medicaid claims data).[11] • RI: Increased referrals at federal qualified health centers (FQHCs) by training medical staff on oral health, sharing lists of pregnant women with dental staff, and including oral health in strategic and incentive plans; dental use doubled from 15 to 31 percent at one FQHC.[12] • NY: Low-income pregnant women reporting referral for dental care were 4.6 times more likely to report a dental visit.[13] Additional examples: • APHA: Improving Access to Dental Care for Pregnant Women through Education, Integration of Health Services, Insurance Coverage, an Appropriate Dental Workforce, and Research[14] • ASTDD: Best Practice Approach: Perinatal Oral Health[15]

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM explained that, due to a lack of standardized measures of dental visits during pregnancy, there are limited data available. Among the data available at a national level on Medicaid and CHIP beneficiaries: • Medicaid covers 40 percent of births. • Using self-reported data from the Pregnancy Risk Assessment

	Monitoring System (PRAMS), roughly half of women reported having a dental cleaning during pregnancy with a lower percentage (38 percent) among women with Medicaid coverage.[16, 17] • Testing results for five states found that the percentage of Medicaid and CHIP beneficiaries who received an oral evaluation during pregnancy ranged from 14 to 23 percent.
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure and recommended technical assistance resources	This measure relies on standard data elements contained within administrative enrollment and claims data. Measure steward testing demonstrated feasibility of this measure. The WGM reiterated that some states may need to link beneficiaries between medical and dental claims databases. States commonly link between claims databases to assess other types of services during pregnancy. The WGM emphasized that the feasibility of linking medical and dental claims for the purpose of this measure is demonstrated by the independent state reporting noted above. The DQA offers technical assistance to all measure users and has a user guide to assist with implementation of its claims-based measures.[18]
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	The WGM noted that states' interest in improving dental care access during pregnancy is evident through the adoption of guidelines for oral health during pregnancy by state health departments,[19] selection of National Performance Measure 13 (Preventive Dental Visit during Pregnancy) by more than 20 percent of states as part of HRSA's Title V Maternal and Child Health program, and independent claims-based analyses of dental service use during pregnancy by state Medicaid programs.[20] Medicaid covers 40 percent of births and, therefore, is positioned to be a significant driver of quality improvement for oral health care during pregnancy. The WGM recalled that, historically, the Workgroup has had concerns with adding dental quality measures to the Adult Core Set due to inconsistencies in adult dental benefits across state Medicaid programs. However, the recent change that all states and DC provide dental benefits to pregnant individuals effective October 1, 2022 should help to address this concern. The WGM mentioned that this is the only standardized, tested, and validated claims-based measure of dental care access during pregnancy and will enable Medicaid and CHIP programs to establish baseline performance, set improvement goals, and monitor progress over time. Additionally, this measure promotes dental-medical integration and focuses on improving both maternal and infant outcomes.

Citations

[1] ACOG 2013, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan.

[2] Figuero et al. 2013, https://pubmed.ncbi.nlm.nih.gov/23557432/.

[3] Daalderop et al. 2018, https://pubmed.ncbi.nlm.nih.gov/30370334/.

[4] Finlayson et al. 2017, https://pubmed.ncbi.nlm.nih.gov/28577633/.

[5] da Silva Bastos et al. 2015, https://pubmed.ncbi.nlm.nih.gov/25486222/.

[6] https://www.hhs.gov/about/news/2022/09/22/hhs-approves-12-month-extension-of-postpartum-medicaid-and-chip-coverage-in-north-carolina.html.

[7] Rocha et al. 2018, https://pubmed.ncbi.nlm.nih.gov/29316548/.

[8] Kranz and Estrada-Darley 2022, https://pubmed.ncbi.nlm.nih.gov/35918241/.

[9] Lee et al. 2022, https://pubmed.ncbi.nlm.nih.gov/34323108/.

[10] Milgrom et al. 2010, https://pubmed.ncbi.nlm.nih.gov/20163743/.

[11] https://www.cga.ct.gov/ph/med/related/20190101_Women%20&%20Childrens%20Health%20Committee/20190610/Perinatal%20and%20Infant%20Oral%20Health%20Project.pdf.

[12] https://www.mchoralhealth.org/projects/piohqi.php.

[13] https://www.mdpi.com/1660-4601/18/23/12724#B9-ijerph-18-12724.

[14] https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2021/01/12/improving-access-to-dental-care-for-pregnant-women.

[15] https://www.astdd.org/bestpractices/perinatal-oral-health-bpar-final-2019.pdf.

[16] Lee et al. 2022, https://pubmed.ncbi.nlm.nih.gov/34323108/.

[17] Kranz and Estrada-Darley 2022, https://pubmed.ncbi.nlm.nih.gov/35918241/.

[18] https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2023-measures/2023_dqa_adult_measures_user_guide_final.pdf.

[19] https://www.astdd.org/bestpractices/perinatal-oral-health-bpar-final-2019.pdf.

[20] https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalPerformanceMeasures.

Care of Acute and Chronic Conditions

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET REVIEW WORKGROUP:
MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SET

Measure Information	
Measure name	**Statin Therapy for the Prevention and Treatment of Cardiovascular Disease**
Description	Percentage of the following patients – all considered at high risk of cardiovascular events – who were prescribed or were on statin therapy during the measurement period: • **Population 1.** All patients with an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or ever had an ASCVD procedure; OR • **Population 2.** Patients aged 20 years and older who have ever had a low-density lipoprotein cholesterol (LDL-C) level at or above 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR • **Population 3.** Patients aged 40 to 75 years with a diagnosis of diabetes
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Care of Acute and Chronic Conditions
Meaningful Measures area(s)	Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	• **Population 1:** All ages. • **Population 2:** Age 20 years and older at the beginning of the measurement period. • **Population 3:** Ages 40 to 75 years at the beginning of the measurement period.
Data collection method	Electronic health records (EHR) or clinical registry.

Denominator	• **Population 1:**
	  – **eCQM version:** All patients with an active diagnosis of clinical ASCVD, or ever had an ASCVD procedure.
	  – **MIPS CQM version:** All patients who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure.

	• **Population 2:** Patients age 20 years and older at the beginning of the measurement period who have ever had a laboratory result of LDL-C at or above 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia.
	• **Population 3:** Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes.
	This measure is intended to have one reporting rate, which aggregates all three populations into a single performance rate for reporting purposes.
Numerator	Patients who are actively using or who receive an order (prescription) for statin therapy at any time during the measurement period.
Exclusions	Exclude patients with any of the following: • Patients who are breastfeeding at any time during the measurement period. • Patients who have a diagnosis of rhabdomyolysis at any time during the measurement period. Exclude patients with any of the following *only* if the patients do not meet the criteria for inclusion in the numerator: • Patients with statin-associated muscle symptoms or an allergy to statin medication. • Patients who are receiving palliative or hospice care. • Patients with active liver disease or hepatic disease or insufficiency. • Patients with end-stage renal disease (ESRD). • Patients with documentation of a medical reason for not being prescribed statin therapy.
Continuous enrollment period	None.
Level of reporting for which specifications were developed	Provider-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	Specifications for the eCQM version of the measure are available at: https://ecqi.healthit.gov/ecqm/ec/2023/cms347v6 Specifications for the MIPS clinical registry (CQM) version of the measure are available at: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_438_MIPSCQM.pdf
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who suggested this measure for addition noted that the measure has gone through extensive testing, per CMS requirements for e-specifications.

	Texas currently uses the Merit-based Incentive Payment System (MIPS) version of this measure in its Delivery System Reform Incentive Payment (DSRIP) program.[1] The 38 clinics and hospitals participating in the DSRIP program report the measure to the Texas Health and Human Services Commission (TX HHSC) on the provider level, typically using their EHRs as the data source. TX HHSC publicly reports the measure results, which are stratified by provider and by payer, on their website.[2] The median Medicaid performance rate on the measure among TX's DSRIP providers was 78.3 percent in performance year 4 (ending 12/31/2021).[3]
	The MIPS Performance Year 2022 historical benchmark data for Medicare providers show a mean performance rate of 82.95 percent for the clinical registry version of the measure, and 71.54 percent for the eCQM version of the measure.[4]
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM noted that the data source for this measure is electronic health records and that diagnosis codes, lab values, prescription information, and demographic data are needed for this measure. The WGM did not describe any barriers or limitations in the required data source and data elements for calculating this measure.
	There is also a clinical registry version of the measure specifications available for use within the MIPS program. MIPS clinical registry-based measures typically require manual review and abstraction from the medical record.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that heart disease and stroke are the first and fifth leading causes of death in the U.S., respectively. Studies show that, despite prior decades-long declines in heart disease mortality, from 2010 to 2017 heart disease morality increased among adults aged 35 to 64 years in almost 70 percent of counties in the U.S.[5] A similar trend can be seen in stroke mortality; from 2010 to 2016, stroke mortality increased among adults aged 35 to 64 years in 61 percent of counties in the U.S.[6] For people at high risk of having an ASCVD event, including heart attacks and strokes, taking a high- or moderate-intensity statin, as appropriate, can greatly reduce risk of having an event.
	Because of their generic status, statins are relatively inexpensive and readily available. In addition, statins have been shown through decades of use to be safe and highly effective; as a result, the WGM indicated that this is a highly effective cardiovascular risk reduction strategy and intervention that states should be tracking.
	The WGM noted that this measure is included in the Million Hearts initiative as one of four nationally supported clinical quality measures known as the "ABCS" of cardiovascular health. Million Hearts has worked with partners to include this measure in a variety of quality reporting initiatives (such as the HRSA Uniform Data System, CMS Quality Payment Program, and the IHS Patient Management System, among others).

Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM explained that the data source for this measure is electronic health records which, theoretically, collect data on race, ethnicity, and socioeconomic status; however, those data are not collected as part of the clinical quality measure at this time.
	The measure steward noted that CMS has not comprehensively assessed the feasibility of stratifying this measure by the factors listed.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM stated, at a minimum, states can examine the results at different levels of aggregation (e.g., overall and by managed care organization [MCO], health system, clinic, and individual clinician levels) and use those results to identify potential opportunities for targeted outreach and technical assistance to drive performance improvement. The WGM also suggested that states can compare their performance to that of their state peers and use differences to potentially identify higher-performing peer states from whom they might learn best practices for improving statin therapy implementation across their Medicaid-enrolled populations.
	Finally, states can use changes in performance over time to evaluate the effectiveness of specific performance or quality improvement activities and initiatives. Measuring and tracking performance can be a powerful tool for driving improved access to and delivery of statin treatment among Medicaid beneficiaries. States could further incentivize efforts to translate measured performance into measured improvements by adopting the statin measure as part of the quality measures they use to structure value-based payments (e.g., incentive payments, whether in the form of withholds or bonuses) for MCOs, ACOs, etc.
	The WGM indicated that because the measure is an eCQM and has been validated at the provider/clinic level, states have an opportunity to simultaneously roll it out at multiple (and ideally mutually reinforcing) levels, including provider, clinic, system, plan, and state.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	According to the latest clinical guidelines for managing blood cholesterol and supported by numerous randomized controlled trials and meta-analyses, the WGM indicated that a lowering of LDL-C levels of one percent gives about a one percent reduction in the risk of ASCVD—slightly more at higher baseline LDL-C levels and slightly less at lower baseline levels.[7]
	According to the WGM, high-intensity and moderate-intensity statins lower LDL cholesterol values by 50 or more percent and 30-49 percent, respectively. The WGM noted that even low-intensity statins lower LDL-C values. Thus, the WGM suggests that being on a statin of any kind or intensity could reduce risk of ASCVD events and associated morbidity and mortality.
How measure can be used to monitor improvement	The WGM indicated that a recent analysis of National Health and Nutrition Examination Survey (NHANES) data showed that almost 28 million adults ages 40 to 64 who qualified for statin use per national guidelines were not taking a statin as recommended. An unknown proportion are Medicaid beneficiaries.

The WGM also indicated that HRSA Uniform Data System (UDS) data on this measure show only 73 percent performance across all health centers in 2021.[8] The WGM suggested that, given that almost 50 percent of patients seen by health centers are Medicaid/CHIP beneficiaries, many of these patients are likely Medicaid beneficiaries.

Additionally, the WGM stated that CDC/Million Hearts has been working with 22 health centers and the National Association of Community Health Centers to find at-risk patients who could benefit from being on a statin but are not currently taking one. When the project began in June 2020, about 15,000 high-risk patients were identified as eligible for statin use. As of February 2021, 9,964 patients that were eligible for a statin had an encounter and 1,932 received a prescription. The proportion of those receiving prescriptions has increased every month since June 2020 (from 6.9 percent to 19.4 percent). The WGM suggested that this work could be scaled and spread to all health centers and beyond to address this issue in more Medicaid patients.

Additional Information for Consideration

Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM noted the lack of prevalence data among Medicaid beneficiaries. As stated above, there are 28 million people in the U.S. ages 40 to 64 who are not currently taking a statin though it is recommended they do so. HRSA UDS data shows that about 30 percent of their pertinent high-risk adult population is not currently taking a statin. Approximately 50 percent of health center patients are Medicaid/CHIP beneficiaries.
Use of measure in other CMS programs	- Merit-Based Incentive Payment System (MIPS) Program - Medicare Shared Savings Program (Note: The measure steward indicated that the Medicare Shared Savings Program uses the Web Interface version of the measure. The Web Interface program will sunset after 2024.) - Care Compare - Million Hearts[9] - Medicaid Promoting Interoperability Program (ended December 31, 2021)
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM acknowledged that access to all needed components of electronic health record data could be a barrier for states. However, many states have Health Center Controlled Networks and other health information exchanges or clinical data repositories that could assist.
Summary of prior Workgroup discussions	This measure has been discussed by the Workgroup at two previous Core Set Annual Review meetings. This measure was first discussed during the 2020 Child and Adult Core Set Annual Review meeting but was not recommended by the Workgroup for inclusion in the 2020 Core Sets. The measure was

	suggested for addition given the high prevalence of cardiovascular disease and the relative availability and affordability of statins. Discussion of the measure centered on concerns that the measure assessed whether a statin was ordered, rather than whether it was filled or taken. As with other EHR and registry-based measures, WGMs also raised concerns about feasibility due to limited access to the necessary data at the state level.
	This measure was also discussed during the 2023 Child and Adult Core Set Annual Review but was not recommended by the Workgroup for addition to the Core Sets. During the discussion, WGMs acknowledged the importance of statins as a medical intervention for cardiovascular disease and the value of a measure focused on cardiovascular disease. They also appreciated that the measure looked broadly across three populations. The CDC liaison supported adding the measure to the Core Sets, noting that cardiovascular disease and stroke are the leading causes of death in the United States and that statins are an effective way to address such conditions. They stated that the measure has undergone improvement over time and is included in several quality reporting programs. One WGM expressed hesitation about adding a medication management measure to the Core Sets in place of an outcome measure focused on cardiovascular disease. Another WGM expressed concern that the measure requires EHR or clinical registries, noting that this data collection methodology would impose additional administrative burden on clinicians and states.
Other	The WGM noted that another Million Hearts ABCS measure, NQF 0018 – Controlling High Blood Pressure, is already included in the Medicaid Adult Core Set and a close ABCS measure proxy, NQF 0027 – Medical Assistance with Smoking and Tobacco Use Cessation, is also included. The WGM suggested that if this measure were added to the Adult Core Set, improved performance on the three measures would be extremely effective at comprehensive cardiovascular disease prevention.
	The measure steward indicated that they are planning to make the following changes for the 2024 performance year:
	• For the first population criterion for the eCQM version, CMS is changing the initial population to "All patients who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure," to align with the MIPS CQM version.
	• For the second population criterion for both the MIPS CQM and eCQM versions, CMS is adding an upper age bound (patients aged 20 to 75).
	• For both the MIPS CQM and eCQM reporting modalities, CMS is adding a fourth population to capture patients that are at high risk for ASCVD to align with the 2019 American College of Cardiology (ACC)/American Heart Association (AHA) Guideline on the Primary Prevention of Cardiovascular Disease.

Citations

[1] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants/dy7-10-final-mbp.pdf.

[2] https://www.hhs.texas.gov/regulations/policies-rules/waivers/medicaid-1115-waiver/rhp-summary-information.

[3] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/catc-rhp-summary-workbook-20210611.xlsx.

[4] https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2022.

[5] Ritchey MD, Wall HK, George MG, Wright JS. US trends in premature heart disease mortality over the past 50 years: Where do we go from here? Trends in Cardiovasc Med. 2020 Aug;30(6):364–374.

[6] Hall EW, Vaughan AS, Ritchey MD, Schieb L, Casper M. Stagnating National Declines in Stroke Mortality Mask Widespread County-Level Increases, 2010–2016. Stroke. 2019;50:3355–3359.

[7] Grundy SM, et al. J Am Coll Cardiol. 2019 Jun 25;73(24):e285-e350.

[8] https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6B&year=2021.

[9] https://millionhearts.hhs.gov/data-reports/measures.html.

Dental and Oral Health Services

CHILD AND ADULT CORE SET REVIEW WORKGROUP:
MEASURES SUGGESTED FOR <u>ADDITION</u> TO THE 2025 CORE SET

Measure Information

Measure name	**Topical Fluoride for Children**
Description	The percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Dental and Oral Health Services
Meaningful Measures area(s)	Wellness and Prevention
Measure type	Process
Recommended to replace current measure?	Yes, Topical Fluoride for Children (TFL-CH)

Technical Specifications

Ages	Ages 1–4 years as of December 31 of the measurement year. Report two age stratifications and a total rate: • 1–2 years. • 3–4 years. • Total. The total is the sum of the age stratifications.
Data collection method	Administrative.
Denominator	The eligible population (children ages 1–4 as of December 31 of the measurement year).
Numerator	Two or more fluoride varnish applications during the measurement year, on different dates of service.
Exclusions	Exclude members who meet either of the following criteria: • Members in hospice or using hospice services any time during the measurement year. • Members who died any time during the measurement year.
Continuous enrollment period	Continuously enrolled in the measurement year with no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

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

Minimum Technical Feasibility Criteria

Link to current technical specifications	See HEDIS MY 2023 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	This measure is adapted from the Dental Quality Alliance's (DQA) Topical Fluoride for Children (TFL-CH) measure. NCQA did not conduct separate testing of the measure.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The Workgroup member (WGM) who suggested this measure for addition indicated that calculating the measure should not pose a challenge because it is an administrative measure.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM commented that this measure would allow for a greater focus on the youngest children, by replacing the current TFL-CH measure, which focuses on all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit-aged children.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM indicated that states should be able to analyze the measure on these factors, assuming all the data points are generally available to them in administrative data. The measure steward stated that they did not assess stratification during measure testing, but they do not anticipate any feasibility concerns provided the denominator sizes are sufficient.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM noted that this measure allows for a focus on early comprehensive dental care and building good habits.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	According to the WGM, the benefits of fluoride have long been documented and is a focus of Medicaid and CHIP programs. This measure limits the age range to allow for enhanced targeting of younger children, compared to the existing TFL-CH measure.

How measure can be used to monitor improvement	The WGM noted that this age group is where states have the best ability to make an impact. The WGM stated that the current TFL-CH measure focuses on children ages 1 through 20 and noted that it is already a challenge to get adolescents in for routine dental and oral health services, much less for fluoride application. The WGM stated that this measure is more impactable and focuses on healthy habits at an early age.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	Dental caries is the most common chronic disease in children in the United States. Prevalence of dental caries is higher among low-income children, who are more likely to be enrolled in Medicaid and CHIP. In the period 2011–2016, 33.9 percent of children 2–5 years old in households with incomes less than 100 percent of the Federal Poverty Level (FPL) were twice as likely to experience dental caries than children in households with income over 200 percent FPL.[1]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM did not identify any barriers that states would face when calculating the measure.
Summary of prior Workgroup discussions	This measure has not been discussed previously by the Workgroup.
Other	This is a first year HEDIS measure for MY 2023. The measure was included in HEDIS with the permission of the Dental Quality Alliance (DQA) and American Dental Association (ADA) and is an adaptation of the DQA/ADA measure that is currently in the Child Core Set. The measure steward noted that this measure is aligned with the U.S. Preventive Services Task Force recommendation, which recommends fluoride varnish to children younger than age 5.

Citations

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib062520.pdf.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET REVIEW WORKGROUP:
MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SET

Measure Information

Measure name	**Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults**
Description	Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions (NTDC) per 100,000 member months for adults Lower rates are better for this measure.
Measure steward	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Dental and Oral Health Services
Meaningful Measures area(s)	Affordability and Efficiency
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications

Ages	Age 18 years and older as of the 15th or 30th day of the month as appropriate for when eligibility determinations are made.
Data collection method	Administrative (enrollment and medical claims).
Denominator	All member months for individuals 18 years and older during the reporting year.
Numerator	Number of ED visits with an ambulatory care sensitive non-traumatic dental condition diagnosis code among individuals 18 years and older.
Exclusions	Exclude the following: • Ambulatory care sensitive ED visits for non-traumatic dental conditions resulting in inpatient admission within 48 hours of the ED visit. • All member months (and associated claims in those months) in which an individual was eligible for both Medicare and Medicaid (i.e., "dual eligible").
Continuous enrollment period	None required.
Level of reporting for which specifications were developed	Program-level (including state Medicaid and CHIP programs).

Minimum Technical Feasibility Criteria

Link to current technical specifications	Dental Quality Alliance technical specifications: https://www.ada.org/-/media/project/ada-organization/ada-ada-org/files/resources/research/dqa/dental-quality-measures/2023-measures/2023_dqa_adult_ed_visits.pdf
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) noted that measure testing was conducted using data from the Oregon Medicaid program and the Iowa Medicaid program using data from calendar years 2014–2016.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	This measure relies on standard data elements contained within administrative enrollment and claims data. DQA testing demonstrated feasibility of this measure. DQA has developed a user guide to assist with measure implementation: https://www.ada.org/-/media/project/ada-organization/ada-ada-org/files/resources/research/dqa/dental-quality-measures/2023-measures/2023_dqa_adult_measures_user_guide_final.pdf.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM explained that this measure fills a significant gap in measuring adult oral health care. The WGM noted that 20 organizations submitted public comments on the 2022 Workgroup report, encouraging the inclusion of the Adult ED measure in the Adult Core Set. The WGM indicated that the measure addresses a significant public health concern. The WGM noted that NTDC ED visits: (1) represent untreated disease, which remains untreated due to lack of definitive care in the ED, (2) are associated with high rates of opioid prescribing because care is not definitive and commonly focuses on alleviating pain, (3) are disproportionately experienced by Medicaid beneficiaries compared to commercially insured individuals, (4) reflect racial disparities, and (5) worsen health inequities. The measure is applicable to adults of all ages. In addition to the direct and significant adverse health consequences that these visits represent, there is a growing body of research indicating important connections between oral health and overall systemic health, with even larger implications for beneficiary wellbeing.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM stated that the data source (administrative enrollment and claims data) allows for stratification by race, ethnicity, sex, age, rural/urban status, language, and disability. Also, the testing results demonstrate the feasibility of such stratifications. The measure is specified for stratification by 10 age groups: 18, 19–20, 21–24, 25–34, 35–44, 45–54, 55–64, 65–74, 75–84, 85 and above.

	The WGM highlighted that the primary challenges with stratification are common to all Medicaid/CHIP claims-based measures, such as data completeness (e.g., race and ethnicity are less likely to be completed than age and sex) and standardized definitions and methodology (e.g., lack of standardized definitions for disability).
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM noted that NTDC ED visits are an ongoing public health concern in the U.S., with approximately two million visits by adults and $2.7 billion in costs; Medicaid is a primary payer.[1,2] Cothron et al.'s systematic review confirmed that NTDC ED visits are disproportionately experienced by Medicaid beneficiaries and uninsured individuals.[3] Racial disparities have also been noted.[4] These ED visits are largely preventable through primary prevention, early identification of disease, and disease management in primary care outpatient settings. Moreover, care in the ED is not definitive, requiring follow-up with a dental provider. Because care is not definitive and commonly focuses on alleviating pain, dental pain is a top diagnosis for opioid prescribing in the ED; consequently, efforts aimed at reducing NTDC ED use may also contribute to efforts to reduce opioid use among Medicaid beneficiaries.[5] In addition to the lack of definitive care and signaling untreated dental problems, increased ED crowding increases risk of beneficiary harm in the ED or receiving no care at all if the person leaves without being seen due to long wait times.[6,7] Concern with NTDC ED visits is not limited to the dental community. CMS has highlighted this as a significant problem among adult beneficiaries, and medical professionals have called for action among the medical community.[8,9]
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM who suggested the measure for addition noted that the variation in definitions of NTDC ED visits is a barrier to making comparisons between entities and for monitoring changes over time, calling for consistent calculations using standardized code sets such as those used in the suggested measure.[10] The ability to improve care, even in the absence of a robust dental benefit, is illustrated by the following: • A community-based intervention in Michigan that provided oral health education and dental services (including screenings, diagnostic services, and treatment) to uninsured adults decreased the number of patients going to the local ED for dental pain by 70 percent over a six-year period.[11] • Implementation of a community dental access program in rural western Maryland was associated with a decrease in ED visits and was estimated to avert 670 ED visits over a four-year period.[12] • A Maine hospital opened a dental clinic for low-income adults that sees more than 500 patients per year.[13,14] The WGM also commented that this measure promotes standardized measurement to drive improvement that promotes better access to definitive care and reduces the use of the ED for NTDC.

How measure can be used to monitor improvement	The WGM stated that the measure can be trended over time to assess performance and progress. The most effective improvement strategies for a given Medicaid program will vary. However, there are a range of strategies that can be used to improve access to care and reduce NTDC dental visits. Examples include developing an ED referral program, establishing community dental health coordinator programs, linking patients to community resources, developing dental partnerships, integrating dental providers into medical care settings, improving dental provider participation in Medicaid, and improving medical-dental collaboration and coordination. Examples of strategies can be found at:
	• Dentists' Partnership of Michigan's Calhoun County: A Care Model For Uninsured Populations[15]
	• Impact of a Community Dental Access Program on Emergency Dental Admissions in Rural Maryland[16]
	• How Should Emergency Department Clinicians Respond to Unmet Dental Needs?[17]
	• Helping people find a dental home[18]
	• Action for Dental Health[19]

Additional Information for Consideration

Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	According to the WGM who suggested this measure for addition, national and state estimates indicate that dental-related ED visits account for approximately 2 percent of total ED visits.[20,21,22]
	• Kelekar et al. (2019) estimated that there are 761 dental-related visits per 100,000 people or 1,760 dental visits per 100,000 ED visits nationally (1.76 percent of all ED visits). Medicaid is a primary payer of dental-related ED visits.[23,24]
	• A study of Oregon's All Payer Claims Database found that dental-related visits accounted for 2.5 percent of all ED visits and were the second most common diagnosis in adults ages 20 to 39 years.[25]
	• Maryland estimated that the rate of dental-related ED visits among adult Medicaid enrollees in FY 2016 was 321 per 10,000 Medicaid eligibles.[26]
	• An analysis of frequent ED users in New Hampshire's Medicaid program found that "disorders of the teeth and jaw" was the leading subcategory of ED visits among low-income adult frequent ED users (having 4 or more outpatient ED visits during the year), representing 1,283 of 10,619 ED visits (12 percent) among this group.[27]
	The WGM provided additional links to evidence and professional recommendations about non-traumatic dental care ED visits:
	• https://www.ncbi.nlm.nih.gov/pubmed/30922460
	• https://www.ncbi.nlm.nih.gov/pubmed/27103213
	• https://www.ncbi.nlm.nih.gov/pubmed/25790415

Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure and recommended technical assistance resources	This measure relies on standard data elements contained within administrative enrollment and claims data. Measure steward testing demonstrated feasibility of this measure. DQA has developed a user guide to assist with measure implementation: https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2023-measures/2023_dqa_adult_measures_user_guide_final.pdf.
Summary of prior Workgroup discussions	This measure was discussed during the 2021 and 2022 Core Set Annual Review meetings but was not recommended by the Workgroup for addition. WGMs expressed concerns that dental benefits for adults enrolled in Medicaid vary across states and while WGMs 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 across states and more actionable for improvement.
Other	In 2023, all states offer dental services for pregnancy-related Medicaid coverage and some level of general adult coverage.[28] (Note that three states [MD, NH, and TN] are implementing adult dental benefits in 2023.)

Citations

[1] ADA HPI 2020, https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/community-initiatives/action-for-dental-health/emergency-department-referrals/ed_referral_hpi_infographic.pdf.

[2] Kelekar 2019, https://pubmed.ncbi.nlm.nih.gov/30922460/.

[3] Cothron et al. 2021, https://pubmed.ncbi.nlm.nih.gov/34075587/.

[4] Owens et al. 2021, https://www.ncbi.nlm.nih.gov/books/NBK574495/.

[5] Rui, et al. 2020, https://pubmed.ncbi.nlm.nih.gov/32510308/.

[6] Kelen et al. 2021, https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217.

[7] Janke et al. 2022, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796861.

[8] CMS 2020, https://www.medicaid.gov/medicaid/benefits/downloads/adult-non-trauma-dental-ed-visits.pdf.

[9] Curt and Samuels-Kalow 2022, https://pubmed.ncbi.nlm.nih.gov/35133723/.

[10] Cothron et al. 2021, https://pubmed.ncbi.nlm.nih.gov/34075587/.

[11] Higbea et al. 2013, https://pubmed.ncbi.nlm.nih.gov/24019371/.

[12] Rowland et al. 2016, https://pubmed.ncbi.nlm.nih.gov/27736218/.

[13] https://www.dentistryiq.com/practice-management/insurance/article/16353323/maine-hospital-opens-dental-clinic-to-alleviate-er-burdens.

[14] https://www.penbaypilot.com/article/waldo-county-dental-care-provides-free-reduced-price-dental-work/138917.

[15] Higbea et al. 2013, https://pubmed.ncbi.nlm.nih.gov/24019371/.

[16] Rowland et al. 2016, https://pubmed.ncbi.nlm.nih.gov/27736218/.

[17] Curt and Samuels-Kalow 2022, https://pubmed.ncbi.nlm.nih.gov/35133723/.

[18] https://www.ada.org/resources/community-initiatives/action-for-dental-health/emergency-department-referrals.

[19] https://www.ada.org/resources/community-initiatives/action-for-dental-health.

[20] Kelekar et al. 2019, https://pubmed.ncbi.nlm.nih.gov/30922460/.

[21] Sun et al. 2014, https://pubmed.ncbi.nlm.nih.gov/25790415/.

[22] Tomar et al. 2016, https://pubmed.ncbi.nlm.nih.gov/27103213/.

[23] ADA Health Policy Institute 2020, https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpigraphic_0420_1.pdf?rev=2912d9465aef4958882a485ae5f00665&hash=4B00090BAF2BC8FCBEC83FE9B191F13B.

[24] Kelekar et al. 2019, https://pubmed.ncbi.nlm.nih.gov/30922460/.

[25] Sun et al. 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4386544/.

[26] https://www.mdac.us/file_download/inline/57cb39db-b4f4-4cdb-8829-f062e74fe36c.

[27] https://docplayer.net/18850644-Frequent-outpatient-emergency-department-use-by-new-hampshire-medicaid-members.html.

[28] https://nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/.

Measure That Will Not Be Reviewed

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET REVIEW WORKGROUP:
MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SET

Measure Information	
Measure name	**Tobacco Use and Help with Quitting Among Adolescents**
Description	The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	2803 (no longer endorsed)
	NQF endorsement was removed because the committee did not reach consensus on evidence. In 2020, the USPSTF 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.
Core Set domain	Behavioral Health Care
Meaningful Measures area(s)	Behavioral Health
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 12 to 20 years on the date of the encounter.
Data collection method	Electronic health records (EHR) or clinical registry.
Denominator	All patients aged 12 to 20 years with a visit during the measurement period.
Numerator	Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) AND who received tobacco cessation counseling intervention if identified as a tobacco user.
	Definitions
	• **Tobacco Use Status:** Any documentation of smoking or "tobacco use status," including 'never' or 'non-use.'
	• **Tobacco User:** Any documentation of active or current use of tobacco products, including smoking.

	Numerator Options
	Performance met is denoted by HCPCS codes G9458 or G9459. Performance not met is denoted by HCPCS code G9460.
	Note: The measure steward indicated that the HCPCS codes used to calculate the numerator were created for the explicit purpose of reporting this measure and include e-cigarettes when referring to tobacco use.
Exclusions	Not specified.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Provider-level.

Minimum Technical Feasibility Criteria

Link to current technical specifications	Specifications for the Medicare version of the measure are available at: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_402_MIPSCQM.pdf
Information on testing or use at state Medicaid/CHIP level	This measure was developed as part of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Pediatric Quality Measure Program (PQMP) initiative. The National Collaborative for Innovation in Quality Measurement (NCINQ), the measure developer, conducted field tests to assess the feasibility of the measure for electronic health record (EHR) systems, as well as validity and reliability of the measure itself. The measure developer conducted field testing with data from five pediatric centers located in diverse geographic regions of the United States. Testing results were stratified by payer at three sites.[1]
	Neither the Workgroup member (WGM) who suggested the measure nor the measure steward were aware of any testing or use of the measure by state Medicaid or CHIP programs.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The data needed for calculating the *Tobacco Use and Help with Quitting Among Adolescents* measure are not available in claims data. According to the measure developer, the data are available in the medical record; however, at the time of field testing, the data were not consistently recorded in structured fields that would allow calculation of the measure electronically.
	The measure developer acknowledged that collecting these data items using paper or non-electronic formats can be a difficult and time-intensive task. However, their testing results show that changes in the implementation of EHR capabilities, improved methods for searching text fields, and changes in clinical workflow (such as encouraging documentation in structured fields rather than text-based notes), would improve the feasibility of calculating the measure using electronic data.[2]

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM who suggested the measure noted that the current Child Core Set does not include a tobacco-related measure. The intention of the measure is to encourage tobacco use screening among youth and young adults and, among those who use tobacco products, provide cessation support to help them quit. The measure could help improve individual and population health by driving down tobacco use prevalence, particularly among disproportionately impacted populations including those enrolled in Medicaid and CHIP.
	According to the WGM, cigarette smoking is the leading preventable cause of disease, disability, and death in the United States, and 90 percent of adults who smoke cigarettes daily first tried cigarettes before the age of 18 years. The tobacco product landscape has diversified in recent years to include a variety of other tobacco products that are appealing to youth, including e-cigarettes. The WGM indicated that since 2014, e-cigarettes have been the most commonly used tobacco product among U.S. middle and high school students. In 2022, 16.5 percent of high school students and 4.5 percent of middle school students reported current tobacco product use, including 14.1 percent of high school students and 3.3 percent of middle school students who reported current e-cigarette use.[3]
	According to the WGM, this measure is product agnostic; in other words, it measures screening for "tobacco use" and advice, counseling, and/or assistance with "tobacco use," and therefore, should include e-cigarettes.
	The WGM also indicated that most youth who use tobacco want to quit and have tried to do so; accordingly, measuring delivery of clinical tobacco prevention and cessation services to this age group is important for understanding pediatric clinical care quality. According to the WGM, inclusion of the measure in the Child Core Set could contribute to increased clinical screening and intervention delivery, thereby contributing to decreasing tobacco use prevalence among youth, including among populations disproportionately impacted by tobacco.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM was unsure whether the data source allows for stratification and comparative analysis. The measure steward indicated that they have not explored the feasibility of stratifying the measure, but do not anticipate any feasibility concerns provided that denominator sizes are sufficient.
How measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries and promotes effective care delivery	The WGM was not aware of any data regarding tobacco use among youth enrolled in Medicaid and CHIP but indicated that nearly 9 out of 10 adults who smoke cigarettes daily first tried cigarettes by age 18, and 99 percent first tried smoking by age 26.[4]
	According to the WGM, youth use of tobacco products can lead to adult tobacco use, and chronic illness and nicotine exposure during youth and young adulthood can also adversely impact the developing brain. Furthermore, adolescents who use e-cigarettes may have an increased

	risk of using combustible cigarettes in the future. The WGM indicated that this is important as smoking initiation before age 13 years has been associated with increased risk for cardiovascular/metabolic disease (odds ratio, OR=1.67), pulmonary disease (OR=1.79), and smoking-related cancers (OR=2.1).[5] Additionally, the WGM noted that the findings of a recent study suggest that starting smoking regularly at age 18 to 20 was associated with higher odds of nicotine dependence and lower odds of smoking cessation than starting at age 21 or older.
	The WGM also cited recent data that highlight disparities in current tobacco product use among U.S. youths. Whereas American Indian and Alaska Native students reported the highest prevalence of current use of any tobacco product, current use of any combustible tobacco product, specifically cigar and hookah use, was highest among Black students. In addition, current use of any tobacco product was higher among those students identifying as lesbian, gay, or bisexual (LGB) or transgender, those reporting severe psychological distress, those with low family affluence, and those with low academic achievement.[6]
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM noted that the measure is intended to promote tobacco use screening among youth and young adults, and tobacco cessation interventions for those who use tobacco products. According to the WGM, there is strong evidence that linking tobacco-related clinical quality measures to payment can increase the delivery of cessation interventions. Evidence also suggests that clinic screening systems can increase rates of clinician intervention.
	The WGM indicated that current data suggest that most youth who use tobacco are not receiving advice from healthcare professionals to not use tobacco. For example, the WGM referenced data from the 2017 National Youth Tobacco Survey that show that only 29.5 percent of high school students and 24.6 percent of middle school students who used tobacco had been advised by a doctor, dentist, or nurse to not use tobacco. The WGM noted that the American Academy of Pediatrics (AAP) recommends screening youth age 11 and older for tobacco use at all health supervision visits, delivering tobacco use prevention as part of anticipatory guidance, and offering tobacco dependence treatment and/or referral to adolescents who want to stop smoking. Recently, the AAP released a clinical considerations guide for pediatric health providers to support clinicians in helping young patients quit tobacco use.[7]
	The WGM acknowledged that while the evidence for youth-focused cessation interventions is limited, there is strong evidence that tobacco screening and brief intervention is effective at helping adults, including young adults, quit tobacco use. Smoking cessation among adults is associated with decreased risk for cardiovascular disease, cancer, and chronic obstructive pulmonary disease. The WGM noted that inclusion of the *Tobacco Use and Help with Quitting Among Adolescents*

	measure would complement existing measures in the Child Core Set that pertain to chronic conditions and behavioral health care as well as an existing measure in the Adult Core Set pertaining to tobacco use and cessation support.
How measure can be used to monitor improvement	The WGM was unsure whether there is room for improvement on the measure or whether it could be used to analyze improvement over time.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid and CHIP beneficiaries	The WGM cited national data from 2022, which show that more than 1 in 10 middle and high school students (3.08 million) had used a tobacco product during the past 30 days, including 16.5 percent of high school and 4.5 percent of middle school students.[8] The WGM also noted that the prevalence of tobacco product use among adult Medicaid beneficiaries is known to be higher than that of the general U.S. adult population. In 2020, 28.6 percent of adults insured by Medicaid reported current tobacco use compared to 19.0 percent of U.S. adults overall.[9]
Use of measure in other CMS programs	- Medicare Care Compare - Merit-Based Incentive Payment System (MIPS) Program
Potential barriers states could face in calculating measure and recommended technical assistance resources	No potential barriers were indicated by the WGM.
Summary of prior Workgroup discussions	This measure was suggested for addition to the Child Core Set during the 2022 Core Set Annual Review cycle. However, it was not discussed by the Workgroup because it had not been field tested in Medicaid or CHIP.

Citations

[1] https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/preventive/chipra-0090-fullreport.pdf.

[2] https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/preventive/chipra-0090-fullreport.pdf.

[3] Park-Lee E, Ren C, Cooper M, Cornelius M, Jamal A, Cullen KA. Tobacco Product Use Among Middle and High School Students — United States, 2022. *MMWR Morb Mortal Wkly Rep* 2022;71:1429–1435. DOI: http://dx.doi.org/10.15585/mmwr.mm7145a1.

[4] CDC. Youth and Tobacco Use Fact Sheet. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/.

[5] Choi SH, Stommel M. Impact of Age at Smoking Initiation on Smoking-Related Morbidity and All-Cause Mortality. *Am J Prev Med*. 2017 Jul;53(1):33-41. doi: 10.1016/j.amepre.2016.12.009. Epub 2017 Feb 3. PMID: 28169018. https://pubmed.ncbi.nlm.nih.gov/28169018/.

[6] Park-Lee E et al. 2022, https://www.cdc.gov/mmwr/volumes/71/wr/mm7145a1.htm.

[7] https://www.aap.org/en/patient-care/tobacco-control-and-prevention/youth-tobacco-cessation/tobacco-use-considerations-for-clinicians/.

[8] Park-Lee E et al. 2022, https://www.cdc.gov/mmwr/volumes/71/wr/mm7145a1.htm.

[9] Cornelius ME, Loretan CG, Wang TW, Jamal A, Homa DM. Tobacco Product Use Among Adults — United States, 2020. *MMWR Morb Mortal Wkly Rep* 2022;71:397–405. DOI: http://dx.doi.org/10.15585/mmwr.mm7111a1.