



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

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

Final Report

August 2019



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ACRONYMS

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

ACRONYMS *(continued)*

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

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

^b This measure is no longer endorsed.

NQF = National Quality Forum.

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

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

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

NQF = National Quality Forum.

This report summarizes the Workgroup's review process and recommendations. It also includes the public comments submitted on the draft report. CMCS will use the Workgroup's recommendations, as well as public comments, to inform decisions about how and whether to modify the 2020 Core Sets. CMCS will release the 2020 Core Sets through a CMCS Informational Bulletin by December 31, 2019.

INTRODUCTION

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

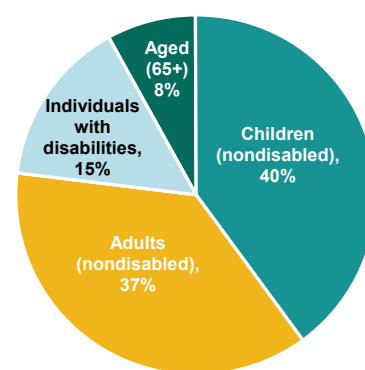
The goal of the Core Sets is to encourage state reporting on a uniform set of measures to facilitate state and national analyses, track performance over time, and use the results to drive quality improvement in Medicaid and CHIP. Currently, state reporting on the Core Sets is voluntary.

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

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

This report provides an overview of the Child and Adult Core Sets, describes the 2020 Core Set annual review process, shares state perspectives on Core Set reporting, summarizes the Workgroup recommendations for improving the Core Sets, and presents the public comments submitted about the draft report. CMCS will use the Workgroup’s recommendations, as well as

Exhibit 1. Distribution of Medicaid Population, 2016



Source: 2017 CMS Actuarial Report (2016 data).

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

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

public comments, to inform decisions about how and whether to modify the 2020 Core Sets. CMCS will release the 2020 Core Sets through a CMCS Informational Bulletin by December 31, 2019.

OVERVIEW OF THE CHILD AND ADULT CORE SETS

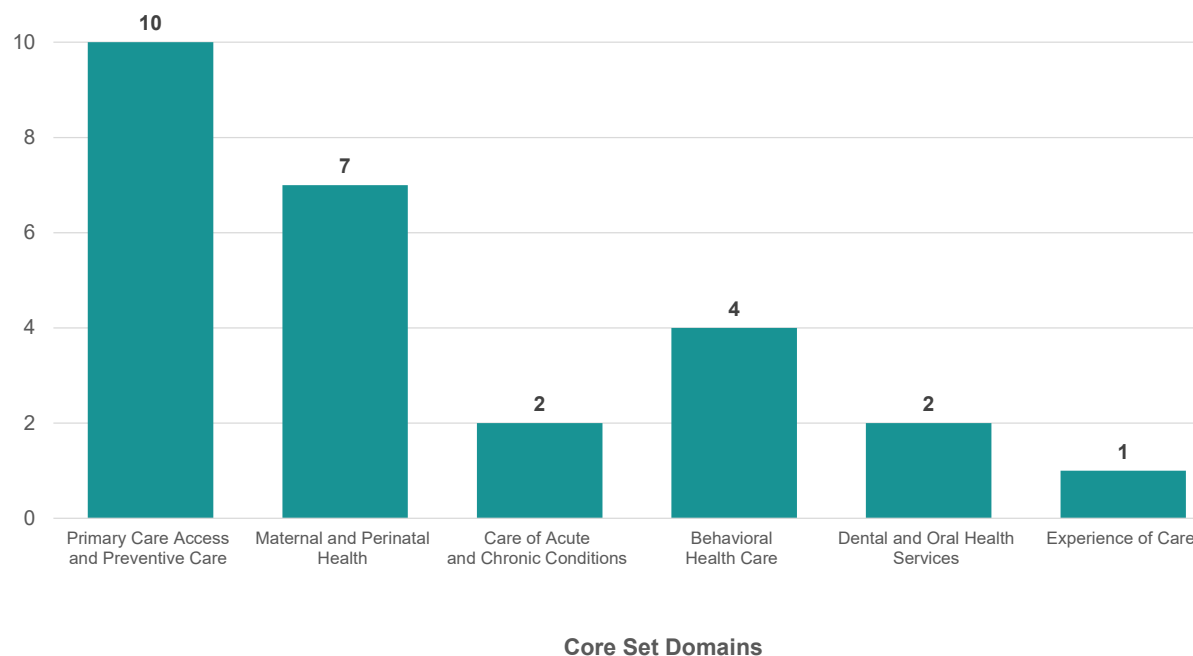
The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions aimed at improving the quality of health care for children in Medicaid and CHIP. CHIPRA required the HHS Secretary to identify and publish a core set of children’s health care quality measures for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

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

The 2019 Child Core Set

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

Exhibit 2. 2019 Child Core Set Measures, by Domain



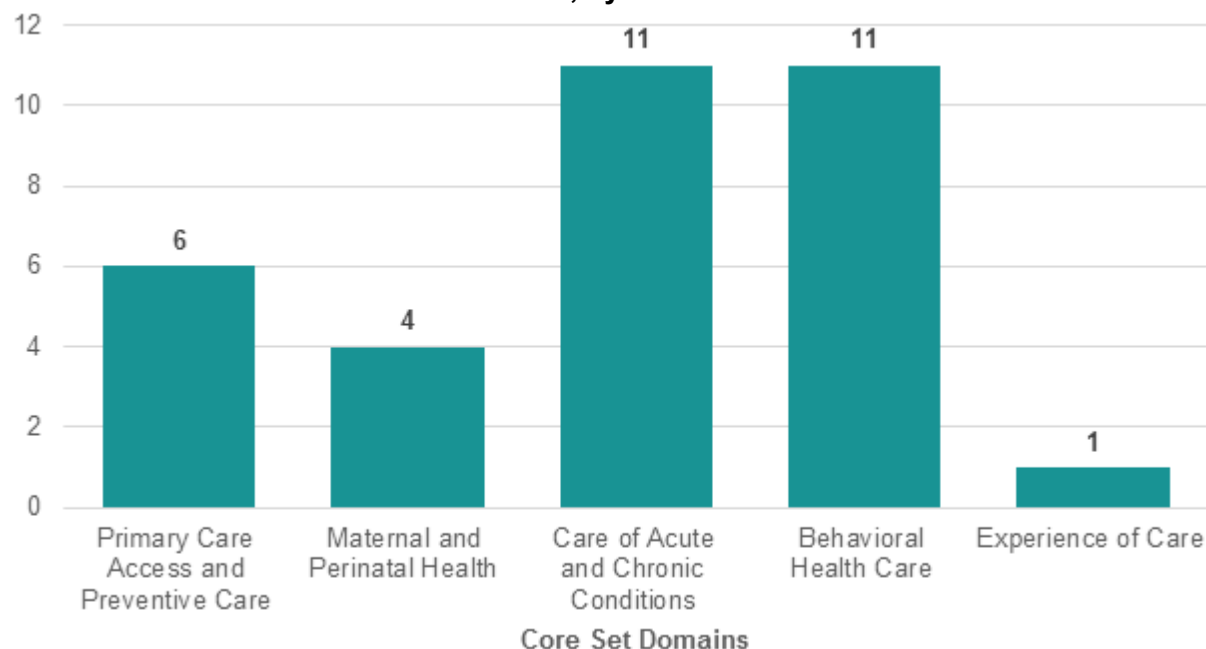
For federal fiscal year (FFY) 2017 reporting, the most recent year for which data are publicly available, all states voluntarily reported on at least one Child Core Set measure and 45 states reported on at least half of the 26 measures in the 2017 Child Core Set. Twenty-one states reported on more measures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

The 2019 Adult Core Set

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

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

Exhibit 3. 2019 Adult Core Set Measures, by Domain



For FFY 2017 reporting, 45 states voluntarily reported on at least one Adult Core Set measure, while 34 states reported on at least half of the 30 measures in the 2017 Adult Core Set. This included 4 states that reported for the first time. Thirty-three states reported more measures for FFY 2017 than for FFY 2016, with states reporting a median of 17 measures. Historically, the Adult Core Set measures most frequently reported by states are spread across the domains.⁷

Use of the Core Set for Quality Measurement and Improvement

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

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

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

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

measures is also included in the Medicaid and CHIP Scorecard to increase public transparency in state health system performance.¹⁰

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

DESCRIPTION OF THE 2020 CORE SET ANNUAL REVIEW PROCESS

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

Call for Nominations

Mathematica issued a call for nominations on December 14, 2018; nomination forms and a resume or CV were due on January 11, 2019. Mathematica distributed the call for nominations electronically to a wide range of state Medicaid and CHIP officials, health care provider associations, and quality measurement experts. Mathematica received 64 nominations. Nominations were reviewed to address legislative requirements for the Core Set annual review, to ensure geographic distribution, and to represent diverse areas of expertise.¹²

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

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

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

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

Workgroup Composition

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

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

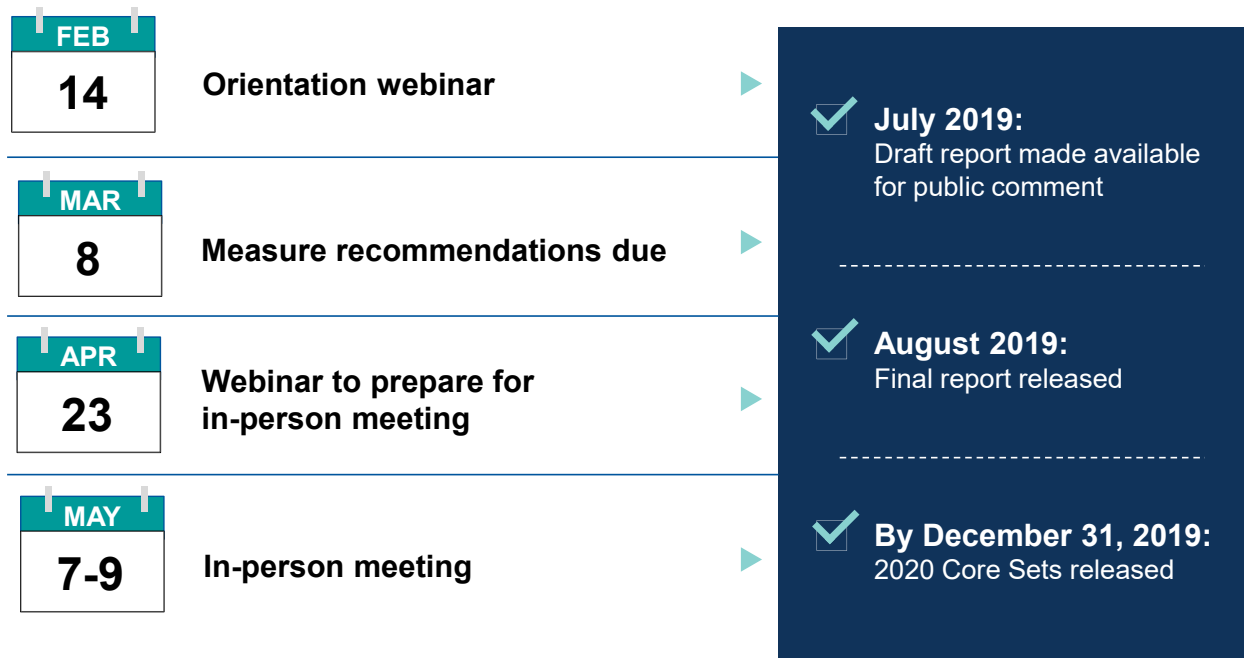
Workgroup Timeline and Meetings

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

The draft report was made available for public comment from July 8, 2019 through August 5, 2019. Forty public comments were submitted. See Appendix C for more information on the public comments received on the draft report. CMCS will release the 2020 Core Sets by December 31, 2019, after taking into account Workgroup recommendations and public comments.

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

Exhibit 4. 2020 Core Set Annual Review Stakeholder Workgroup Timeline



Orientation Webinar

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

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

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

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

Workgroup Charge

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

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

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

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

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

Webinar to Prepare for the In-Person Meeting

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

In-Person Meeting

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

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

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

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

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

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

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

STATE PERSPECTIVES ON CORE SET REPORTING

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

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

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

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

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

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

WORKGROUP RECOMMENDATIONS FOR IMPROVING THE 2020 CORE SETS

Criteria Considered by the Workgroup

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

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

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

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

Summary of Workgroup Recommendations

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

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

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

Measure Name	Measure Steward	NQF # (if endorsed)
Recommended for Removal from the Adult Core Set		
Adult Body Mass Index Assessment (ABA-AD)	NCQA	Not endorsed
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	NCQA	0057
Annual Monitoring for Patients on Persistent Medications (MPM-AD)	NCQA	2371 ^b

^aThe Workgroup recommended that the APC-CH measure be replaced by another measure: Metabolic Monitoring for Children and Adolescents on Antipsychotics.

^bThis measure is no longer endorsed.

NQF = National Quality Forum.

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

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

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

NQF = National Quality Forum.

Measures Recommended for Removal from the Child Core Set

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

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

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

Another Workgroup member noted that relatively high performance on the access to care

measure does not necessarily correlate with children actually receiving the recommended well-child care. It was suggested that the three well-child visit measures in the 2019 Child Core Set could serve as substitutes for this measure. Finally, the measure steward, the National Committee for Quality Assurance (NCQA), proposed retiring the measure in 2018, which raised concerns for the Workgroup about whether the measure would be maintained and updated if NCQA retired the measure and it remained in the Core Set.¹⁶

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

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

The Workgroup members who suggested the measure for removal described it as a documentation measure that does not provide useful or actionable results for state Medicaid and CHIP agencies. They further asserted that this measure does not reflect evidence-based practices for interventions for children with or at risk of obesity. One Workgroup member also noted that the data collection burden for this measure does not support its use, particularly because the measure does not support an evidence-based practice.¹⁷

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

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

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

The CLABSI-CH measure assesses the number of CLABSIs in neonatal intensive care units (ICUs) reported by acute care hospitals. The standardized infection ratios reported for each state compare the observed number of infections reported during the measurement period to the predicted number of infections for that period. Data for the measure are reported by hospitals to

¹⁶ Although the CAP measure was proposed for retirement from HEDIS 2018, the measure remains in HEDIS 2020 as a result of feedback through stakeholder discussions and public comments.

¹⁷ Due to limitations of claims data to calculate this measure, the hybrid data collection method, which uses a combination of administrative and medical records, is typically required to produce accurate results.

the Centers for Disease Control and Prevention (CDC) in the National Health Care Safety Network. Data reported to CDC are for all payers and not limited to Medicaid and CHIP. Although the Core Set specifications include both neonatal and pediatric ICUs, CDC only reports data for neonatal ICUs, so the Core Set data available for this measure include only neonatal ICUs. CMCS obtains data for this measure directly from CDC each year.

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

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

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

The APC-CH measure assesses the number of beneficiaries on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. Thirty-seven states reported this measure for FFY 2017. The measure is currently included on the Medicaid and CHIP Scorecard. This measure will be retired from HEDIS in 2020 and will no longer be updated and maintained by the measure steward (NCQA).

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

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

Measures Recommended for Removal from the Adult Core Set

Adult Body Mass Index Assessment (ABA-AD)

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

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

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

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

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

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

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

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

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

The MPM-AD measure assesses the percentage of beneficiaries age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. The therapeutics agents include angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) and diuretics. Thirty-six states reported on this measure for FFY 2017. This measure will be retired from HEDIS in 2020 and will no longer be updated and maintained by the measure steward (NCQA).

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

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

Measures Recommended for Addition to the 2020 Core Sets

Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia

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

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

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

Metabolic Monitoring for Children and Adolescents on Antipsychotics

This measure assesses the percentage of children and adolescents age 1 to 17 who had at least two antipsychotic medication dispensing events of the same or different medication and had monitoring for the development of abnormal cholesterol and blood sugar levels, which are

known side effects of these medications. An updated version of the measure is currently under consideration that would combine the 1- to 5-year-old and 6- to 11-year-old age groups and add separate rates for blood glucose and cholesterol. This measure was recommended to replace the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) measure, which was recommended for removal from the Child Core Set.

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

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

Use of Pharmacotherapy for Opioid Use Disorder

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

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

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

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

The NCI and NCI-AD assess the experience and outcomes of individuals with intellectual and developmental disabilities and their families, and seniors and adults with physical disabilities, respectively. Both are voluntary efforts undertaken by state developmental disabilities agencies (NCI) and state Medicaid aging and disability agencies (NCI-AD).

- NCI surveys assess the experience of people who receive services from state developmental disabilities agencies. It includes an in-person survey, family surveys for parents and guardians of adults and children who receive supports, and a staff stability survey. Indicators address key areas of concern in five domains: (1) individual outcomes; (2) health, welfare, and rights; (3) system performance; (4) staff stability; and (5) family outcomes. Forty-six states participate in the NCI program; 37 states collected data through NCI’s in-person survey in 2018-2019.

- NCI-AD core indicators are standard measures used across states to assess the outcomes of services provided to seniors and adults with physical disabilities. Indicators address 19 key areas of concern including (1) service coordination, (2) rights and respect, (3) community participation, (4) choice and decision-making, (5) health care, (6) safety, (7) relationships, (8) satisfaction, (9) care coordination, (10) access to community, (11) access to needed equipment, (12) wellness, (13) medications, (14) self-direction, (15) work, (16) everyday living, (17) affordability, (18) control, and (19) person-centered planning. Seventeen states collected NCI-AD data in 2018-2019.

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

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

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

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

Cross-Cutting Themes in Measure Discussions

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

- **Feasibility.** One of the strongest considerations that Workgroup members expressed was the feasibility for states to collect and report the measures. Throughout the meeting, Workgroup members asked colleagues representing state Medicaid programs for their opinions on the feasibility of measures. It was noted that feasibility varies by state, particularly related to whether states have managed care delivery systems and are able to leverage MCOs to support Core Set reporting. The Workgroup noted that measures that use already available administrative data or measures used for other purposes (such as in pay for performance programs) are more feasible. As part of this discussion, some Workgroup members representing states expressed concern about survey-based measures due to the high level of effort and resources required to administer surveys.
- **Appropriateness.** Workgroup members highlighted that the most appropriate measures for the Core Sets are those in which state-to-state comparisons would be helpful in monitoring the quality of care in Medicaid and CHIP. Given variations in state Medicaid programs and delivery systems, the results of some measures may not be meaningful when compared across states. Other measures may be more appropriate to monitor at the plan or provider levels. Workgroup members repeatedly stressed that nothing about the value of the measure or the importance of the topic area should be inferred from the decision not to recommend it for addition to the Core Sets.
- **Readiness.** Workgroup members discussed whether measures were ready for implementation in the Core Sets and for Medicaid and CHIP. For example, there were concerns about using first-year HEDIS measures and measures that had not been tested for use in state Medicaid programs. Workgroup members commented that the Core Sets are not the place to put new measures or measures untested at the state level.
- **Actionability.** Workgroup members noted the importance of ensuring that Core Set measures are actionable, that is, that CMCS and states can use the data to inform program and policy decisions and to improve the quality of care for Medicaid and CHIP beneficiaries. There was ample discussion in support of working toward moving from process to outcome measures as they become feasible and ready. Outcome measures are necessary to more fully understand the quality of care provided to Medicaid and CHIP beneficiaries.

Discussion of Core Set Measure Gaps

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

Workgroup members expressed their preference for having a gap in the Core Set rather than recommending measures that did not meet the specified criteria, and especially to avoid increasing burden on states. In addition, because measures continue to be tested, the Workgroup

noted that many of the measures that were not recommended should be reconsidered in the future. The Workgroup suggested potential gap areas that could be considered for future Core Set measures (Exhibit 8).

Exhibit 8. Potential Gap Areas for Future Core Set Measures

Populations	Health Areas	Health Care Delivery	Other Measure Attributes
<ul style="list-style-type: none"> • Adolescent and young adults • Children in foster care • Maternal health • Men’s health • Individuals with multiple chronic conditions • Elderly individuals, including those who are Medicare-Medicaid dual eligibles • Individuals of all ages with disabilities, including access to services and supports to assist them with living and participating in the community safely 	<ul style="list-style-type: none"> • Immunizations (prenatal, adult) • Obesity • Adverse childhood experiences • Child social and emotional development • LTSS (including rebalancing) • Oral health beyond prevention • Access to oral health care for individuals with special needs • Behavioral health integration in acute medical settings • Depression • Suicide • Trauma-informed care • Rare diseases 	<ul style="list-style-type: none"> • Follow-up on referrals • Care transitions (e.g., from hospital or nursing home to the community) • Appropriateness of care—underutilization and overutilization • Workforce and caregiver supports • Provider accountability • Network adequacy 	<ul style="list-style-type: none"> • Stratification by race and ethnicity • Measures addressing social determinants of health • Measures with life course potential • Measures that cut across Medicaid and Medicare

Additional Workgroup Suggestions for Improving the Core Sets

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

Considering the Various Uses of Quality Measures in Medicaid and CHIP

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

Integrating Health Information Technology

The Workgroup stressed the importance of integrating health information technology, including EHRs and electronic data extraction, into quality reporting efforts. Like New York, other state representatives noted they were on a path toward integrating electronic data into reporting efforts. One Workgroup member noted that states have made substantial investments in hospitals, health systems, and providers to report electronic measures but that many states are not

yet yielding the value of these investments because reporting is difficult. To get to true meaningful use, several members recommended that federal agencies work together to direct resources and attention to electronic initiatives to assist states in collecting electronic quality measures.

Creating Shared Learning and Technical Assistance Opportunities

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

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

NEXT STEPS

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

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

The draft report was available for public comment from July 8, 2019 through August 5, 2019. Forty public comments were submitted. CMCS will use the Workgroup recommendations and the public comments to inform decisions about how and whether to modify the Core Sets for 2020. CMCS will release the 2020 Core Sets through a CMCS Informational Bulletin by December 31, 2019.

Appendix A
Child and Adult Core Set Measures

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

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

Exhibit A.1. (continued)

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

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

*This measure is no longer endorsed by NQF.

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

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

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

Exhibit A.2. (continued)

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

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

*This measure is no longer endorsed by NQF.

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

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

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

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

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

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

Exhibit A.3. (continued)

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

Exhibit A.3. (continued)

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

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

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

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

*This measure is no longer endorsed by NQF.

Exhibit A.3. (continued)

- ^a The Screening for Depression and Follow-Up Plan: Ages 12 –17 measure was added to the 2018 Child Core Set to align with the Adult Core Set and replace the Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure as a broader measure of behavioral health.
- ^b The stand-alone HPV Vaccine for Female Adolescents measure was retired by the measure steward, and added to the Immunizations for Adolescents measure beginning with the 2017 Child Core Set.
- ^c The California Maternal Quality Care Collaborative Cesarean Rate for Nulliparous Singleton Vertex measure was replaced by The Joint Commission PC-02: Cesarean Birth measure beginning with the 2014 Child Core Set.
- ^d The Audiological Diagnosis No Later Than 3 Months of Age measure was added to the 2016 Child Core Set due to opportunities for quality improvement on the measure and its alignment with the electronic health record incentive program.
- ^e The Frequency of Ongoing Prenatal care measure was retired from the Child Core Set in 2018 because it does not assess the content of the prenatal care visit.
- ^f The Contraceptive Care – Postpartum Women Ages 15–20 measure was added to the 2017 Child Core Set because it measures the provision of contraception to mothers in the postpartum period, which can help women space pregnancies to their desired interpregnancy interval and help to improve future birth outcomes.
- ^g The Contraceptive Care – All Women Ages 15–20 measure was added to the 2018 Child Core Set to assess access to contraceptive care, which has an important role in promoting health equity.
- ^h The Behavioral Health Risk Assessment (for Pregnant Women) measure was removed from the Child Core Set in 2018 due to implementation and data collection challenges. AMA-PCPI was the measure steward for the 2013-2016 Child Core Sets; the measure had no steward for the 2017 Child Core Set.
- ⁱ The Appropriate Testing for Children with Pharyngitis measure was retired from the Child Core Set in 2014 because the clinical evidence for the measure is obsolete.
- ^j The Annual Pediatric Hemoglobin A1C Testing measure was retired from the Child Core Set in 2014 because it affects a small number of children, has a weak evidence base, and was approaching the improvement ceiling.
- ^k The Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children (ages 2-12) measure was retired from the Child Core Set in 2013 because of significant state reporting challenges. AMA-PCPI was the measure steward for the 2012 Child Core Set.
- ^l The Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits measure was retired from the Child Core Set in 2014 due to data quality concerns and the lack of a measure steward.
- ^m Beginning with the 2018 Child Core Set, the Asthma Medication Ratio: Ages 5–18 measure replaces the Medication Management for People with Asthma measure, which was included in the 2013-2017 Child Core Sets.
- ⁿ The age group for the Follow-Up After Hospitalization for Mental Illness measure changed from ages 6 to 20 to ages 6 to 17 for the 2019 Child Core Set.
- ^o The Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment measure was added to the 2015 Child Core Set to target a high prevalence mental health condition that has severe consequences without appropriate treatment. The measure was removed from the Child Core Set in 2018 because of the need for a broader measure of behavioral health.
- ^p The Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measure was added to the 2017 Child Core Set to promote the use of nonpharmacologic, evidence-informed approaches to the treatment of mental and behavioral health problems of Medicaid and CHIP insured children on psychotropic medications.
- ^q The Use of Multiple Concurrent Antipsychotics in Children and Adolescents measure was added to the 2016 Child Core Set to target inappropriate prescribing of antipsychotic medications, which may have adverse health effects.
- ^r The Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk measure was added to the 2015 Child Core Set because it is linked to improved oral health outcomes and responds to a legislative mandate to measure the use of dental sealants in this age group.
- ^s The Percentage of Eligibles That Received Dental Treatment Services measure was retired from the Child Core Set in 2015 because it is not an effective tool for quality improvement; it is unclear if an increase or a decrease in the rate is desirable, and therefore the results are not actionable.

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

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

Exhibit A.4. (continued)

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

Exhibit A.4. (continued)

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

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

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

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

*This measure is no longer endorsed by NQF.

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

Exhibit A.4. (continued)

- ^b The Contraceptive Care – Postpartum Women Ages 21–44 measure was added to the 2017 Adult Core Set because it measures the provision of contraception to mothers in the postpartum period, which can help women space pregnancies to their desired interpregnancy interval and help to improve future birth outcomes.
- ^c The Contraceptive Care – All Women Ages 21–44 measure was added to the 2018 Adult Core Set to assess access to contraceptive care, which has an important role in promoting health equity.
- ^d The Comprehensive Diabetes Care: LDL-C Screening measure was replaced by the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure beginning with the 2015 Adult Core Set. The Comprehensive Diabetes Care: LDL-C Screening measure was retired from the Adult Core Set because clinical guidelines underpinning this measure were in flux and because NCQA removed it from HEDIS 2015. The Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) measure addresses the prevalent condition of diabetes and facilitates state efforts to drive quality improvement on the risk factor of poor HbA1c control.
- ^e The Annual HIV Medical Visit measure was replaced by the HIV Viral Load Suppression measure beginning with the 2014 Adult Core Set. The Annual HIV Medical Visit measure lost NQF endorsement after the 2013 Adult Core Set was published. The HIV Viral Load Suppression measure is a regularly collected clinical indicator that is predictive of overall outcomes.
- ^f The Asthma Medication Ratio: Ages 19–64 measure was added to the 2018 Adult Core Set and aligns with changes made to the 2018 Child Core Set.
- ^g The age group for the Follow-Up After Hospitalization for Mental Illness measure changed from age 21 and older to age 18 and older for the 2019 Adult Core Set.
- ^h Two measures focused on quality of care for adults with substance use disorders and/or mental health disorders were added to the 2016 Adult Core Set: (1) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population; and (2) Use of Opioids at High Dosage in Persons Without Cancer is a measure of potential overuse that addresses the epidemic of narcotic morbidity and mortality.
- ⁱ The Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (FUA/FUM-AD) measure was added to the 2017 Adult Core Set because it addresses priority areas of access and follow-up of care for adults with mental health or substance use disorders. In the 2017 and 2018 Adult Core Sets, this was included as a single measure (FUA/FUM-AD). For the 2019 Adult Core Set, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) and Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) are included as two separate measures.
- ^j The Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure was added to the 2017 Adult Core Set because it addresses chronic disease management for people with serious mental illness, and assesses integration of medical and behavioral services by reinforcing shared accountability and linkage of medical and behavioral healthcare services.
- ^k The Adult Core Set includes the NCQA version of the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure, which is adapted from the CMS measure (NQF #1879).
- ^l The Concurrent Use of Opioids and Benzodiazepines measure was added to the 2018 Adult Core Set because it addresses early opioid use and polypharmacy.
- ^m The Timely Transmission of Transition Record measure was retired from the Adult Core Set in 2017 due to the low number of states reporting this measure, a decrease in the number of states reporting over time, and the challenges states have described in collecting it.
- ⁿ The Adult Core Set includes the NCQA version of the CAHPS® Health Plan Survey 5.0H, Adult Version (Medicaid) measure, which is adapted from the AHRQ measure (NQF #0006).

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

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

Primary Care Access and Preventive Care

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

The Workgroup discussed the accuracy and reliability of the data needed for the immunization measures, many of which rely on patient recall or administrative data that may be incomplete for people who cycle in and out of Medicaid plans. Furthermore, because influenza vaccines can be administered in a variety of settings, data on them might be incomplete. Workgroup members noted that while all states have immunization registries, there is considerable variability in their completeness. In the case of the *Prenatal Immunization Status* measure, Workgroup members acknowledged its importance and strong connection to improved outcomes, but had concerns about the feasibility of the new data collection method¹⁸ and were reluctant to recommend a first-year HEDIS measure that might not be ready for state reporting.

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

¹⁸ The *Prenatal Immunization Status* and *Adult Immunization Status* measures are specified for the Electronic Clinical Data Systems (ECDS) data collection method, which includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.

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

Maternal and Perinatal Health

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

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

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

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

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

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

Care of Acute and Chronic Conditions

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

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

the measure methodologies, including whether these conditions are coded accurately in administrative data, and whether changes in coding practices could be mistaken for quality improvement.

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

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

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

Behavioral Health Care

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

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

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

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

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

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

Dental and Oral Health Services

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

Experience of Care

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

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

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

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

Long-Term Services and Supports

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

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

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

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

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

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

Other Measures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Appendix C
Public Comments on the Draft Report

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The draft report was available for public review and comment from July 8, 2019 through August 5, 2019 and stakeholders were invited to submit comments via email. A total of 40 public comments were received. Commenters included state and federal agencies, professional associations, stakeholder organizations, research firms, and health plans. Mathematica appreciates the time and effort taken by commenters to prepare and submit their comments on the draft report.

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

In summary, public comments were submitted on all seven measures the Workgroup recommended for removal from the Core Sets, and all five measures recommended for addition. Comments were also received on 12 measures considered by the Workgroup, but not recommended for removal from or addition to the 2020 Core Sets.

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

Topic	Commenter
General Comments	<ul style="list-style-type: none"> • Adult Vaccine Access Coalition • American Academy of Pediatrics • American Association on Health and Disability and the Lakeshore Foundation • American Society of Hematology • Anthem • Association for Community Affiliated Plans • California Department of Health Care Services • Children's Dental Health Project • Children's Hospital Association • CVS Health • Kaiser Permanente • National Association of State Directors of Developmental Disability Services • Novo Nordisk • Office of Infectious Disease and HIV/AIDS Policy • YMCA of the USA
Measures Recommended for Removal from the Child Core Set	
Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)	<ul style="list-style-type: none"> • Association for Community Affiliated Plans • California Department of Health Care Services

Topic	Commenter
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	<ul style="list-style-type: none"> • American Academy of Pediatrics • Association for Community Affiliated Plans • Christopher Bolling • California Department of Health Care Services • Children’s Health Integrated Program in Childhood Obesity • CVS Health • Healthy Weight Partnership Inc. • Kentucky Department for Medicaid Services • Michael & Susan Dell Center for Healthy Living • National Association of Community Health Centers • New Balance Foundation for Obesity Prevention Center, Boston Children’s Hospital • Novo Nordisk • Obesity Care Advocacy Network • Redstone Center, Milken Institute School of Public Health • Trust For America’s Health • University of Texas School of Public Health • YMCA of the USA
Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)	<ul style="list-style-type: none"> • Association for Community Affiliated Plans • California Department of Health Care Services
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	<ul style="list-style-type: none"> • Anthem • Association for Community Affiliated Plans • California Department of Health Care Services
Measures Recommended for Removal from the Adult Core Set	
Adult Body Mass Index Assessment (ABA-AD)	<ul style="list-style-type: none"> • Association for Community Affiliated Plans • Christopher Bolling • California Department of Health Care Services • Kentucky Department for Medicaid Services • Novo Nordisk • Obesity Care Advocacy Network • Redstone Center, Milken Institute School of Public Health • Trust For America’s Health • University of Texas School of Public Health • YMCA of the USA
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	<ul style="list-style-type: none"> • Association for Community Affiliated Plans • California Department of Health Care Services • District of Columbia Department of Health Care Finance • Novo Nordisk • YMCA of the USA
Annual Monitoring for Patients on Persistent Medications (MPM-AD)	<ul style="list-style-type: none"> • Association for Community Affiliated Plans • California Department of Health Care Services

Topic	Commenter
Measures Recommended for Addition to the 2020 Core Sets	
Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia	<ul style="list-style-type: none"> • American Board of Pediatrics • American Society of Hematology • Anthem • Association for Community Affiliated Plans • California Department of Health Care Services • Children's Hospital Association • CVS Health • District of Columbia Department of Health Care Finance • Kaiser Permanente • Kentucky Department for Medicaid Services
Metabolic Monitoring for Children and Adolescents on Antipsychotics	<ul style="list-style-type: none"> • Anthem • Association for Community Affiliated Plans • California Department of Health Care Services • Kaiser Permanente
Use of Pharmacotherapy for Opioid Use Disorder	<ul style="list-style-type: none"> • Anthem • Association for Community Affiliated Plans • California Department of Health Care Services • CVS Health • District of Columbia Department of Health Care Finance • Kaiser Permanente
National Core Indicators	<ul style="list-style-type: none"> • American Association on Health and Disability and the Lakeshore Foundation • Anthem • Association for Community Affiliated Plans • California Department of Health Care Services • Connecticut Department of Developmental Services • District of Columbia Department of Health Care Finance • Human Services Research Institute • Indiana Division of Disability and Rehabilitative Services • Kaiser Permanente • Kentucky Department for Medicaid Services • Maryland Department of Health • Minnesota Department of Human Services • Missouri Division of Developmental Disabilities • National Association of State Directors of Developmental Disability Services
National Core Indicators for Aging and Disabilities	<ul style="list-style-type: none"> • American Association on Health and Disability and the Lakeshore Foundation • Anthem • Association for Community Affiliated Plans • California Department of Health Care Services • District of Columbia Department of Health Care Finance • Human Services Research Institute • Kaiser Permanente • Kentucky Department for Medicaid Services • Minnesota Department of Human Services

Topic	Commenter
Measures Considered and Not Recommended for Addition by Domain	
Primary Care Access and Preventive Care Domain	<ul style="list-style-type: none"> • Adult Vaccine Access Coalition • Biotechnology Innovation Organization • Connecticut Children’s Office for Community Child Health/Help Me Grow National Center • Kaiser Permanente Washington Health Research Institute
Maternal and Perinatal Health Domain	<ul style="list-style-type: none"> • Connecticut Children’s Office for Community Child Health/Help Me Grow National Center
Care of Acute and Chronic Conditions Domain	<ul style="list-style-type: none"> • American Board of Pediatrics • Children's Hospital Association • CVS Health
Behavioral Health Care Domain	<ul style="list-style-type: none"> • CVS Health
Dental and Oral Health Services Domain	<ul style="list-style-type: none"> • American Academy of Pediatrics • Children's Dental Health Project • Kaiser Permanente
Long Term Services and Supports Domain	<ul style="list-style-type: none"> • Aging and Disability Policy and Leadership Consulting, LLC • American Association on Health and Disability and the Lakeshore Foundation • Anthem • Human Services Research Institute • Indiana Division of Disability and Rehabilitative Services • Maryland Department of Health • Minnesota Department of Human Services (Missouri Division of Developmental Disabilities)
Gap Areas	<ul style="list-style-type: none"> • Adult Vaccine Access Coalition • American Association on Health and Disability and the Lakeshore Foundation • Biotechnology Innovation Organization • Children's Dental Health Project • Connecticut Children’s Office for Community Child Health/Help Me Grow National Center • Allison LaRussa

PUBLIC COMMENTS LISTED ALPHABETICALLY BY AGENCY/ORGANIZATION NAME OR INDIVIDUAL COMMENTER'S LAST NAME

Adult Vaccine Access Coalition (Abby Bownas)

The Adult Vaccine Access Coalition (AVAC) appreciates the opportunity to comment on Mathematica's Summary of a Multi-stakeholder Review of the 2020 Child and Adult Core Sets. We appreciate the Workgroup's interest in strengthening and improving the Medicaid Child and Adult Health Care Quality Core Sets for 2020, and their recognition of the importance of quality measures to improve the health of individuals and entire communities.

AVAC encourages the Workgroup take a focused, concerted approach to adult immunizations as a means of improving population health as well as the overall health of Medicaid patients. We hope that as part of your final recommendations, the Workgroup will reconsider adoption of two recent HEDIS immunization measures.

- **Adult Immunization Status (AIS).** Add the new Adult Immunization Status (AIS) measure, to replace the current adult influenza vaccine measure based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The new AIS measure is a composite of the age-recommended vaccines for adults, including influenza vaccine.
- **Prenatal Immunization Status.** Add the new Prenatal Immunization Status, which measures prenatal immunizations of Tdap and influenza. Retain the other two current immunization measures: Childhood immunization status (CIS) and Immunization of Adolescents (IMA).

AVAC consists of over 50 organizational leaders in health and public health that are committed to addressing the range of barriers to adult immunization and to raising awareness of the importance of adult immunization. AVAC works towards common legislative and regulatory solutions that will strengthen and enhance access to adult immunization across the health care system. Our priorities and objectives are driven by a consensus process with the goal of enabling the range of stakeholders to have a voice in the effort to improve access and utilization of adult immunizations.

Potential Gap Areas for Future Core Set Measures

We appreciate the draft Workgroup report noted gaps in terms of immunization quality measures, particularly with regard to prenatal and adult populations. Significant racial and ethnic disparities currently exist in adult immunization¹ coverage rates and the failure to improve these rates among the Medicaid population only exacerbates these disparities. Opportunities to assess the immunization status of Medicaid beneficiaries, particularly pregnant women and medically vulnerable adults with chronic conditions such as diabetes and heart disease, should be done by the range of clinicians who care for them, including primary care and specialty providers. Taking advantage of each and every patient encounter to facilitate counseling and education on vaccines, based on their age and health status, and to offer a strong provider recommendation have been found to improve the likelihood of a patient being immunized.

Published literature indicates that integrating immunization assessment and additional providers offering these critical preventive services will result in greater opportunities for immunization.² The National Vaccine Advisory Committee's (NVAC) Adult Immunization Standards call for all providers caring for adult patients to assess, recommend, vaccinate or refer, and document vaccinations. Immunization quality measures are a crucial tool for health care quality improvement and have demonstrated effectiveness in improving immunization coverage across adult populations. Quality measures, such as the adult immunization status measure and the prenatal immunization status measure can help to fill gaps while eliminating disparities around adult immunization moving forward.

Adult Immunization Status Measure

AVAC recommends that the Workgroup replace the current adult influenza vaccine measure based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The new AIS measure is a composite of several age-recommended vaccines for adults, including the influenza vaccine. An adult immunization composite measure would provide a sound, reliable and comprehensive means to assess the receipt of routine adult vaccinations recommended by the Advisory Committee on Immunization Practices (ACIP). The Adult Immunization Status (AIS) measure should be adopted as a final recommendation of the Workgroup because it includes more vaccines than the current immunization measure (FVA-AD) and would help states monitor recommended adult immunization use beyond influenza.

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

In the Value and Imperative of Quality Measures for Adult Vaccines, renowned vaccine experts explain how quality measures that capture and create incentives for appropriate adult vaccinations can prevent illness and death, reduce caregiving demands, avoid unnecessary healthcare spending, and set the foundation for healthy aging.⁴ There is evidence that a composite measure of the adult immunization schedule, such as those demonstrated by the Northwest Tribal Epidemiology Center and by the National Nursing Home Quality Care Collaborative, can improve patient health outcomes⁵. Adoption of an AIS measure would put vaccination coverage rates into a larger context and encourage a more systematic approach for all vaccines. Additionally, the HHS Office of Infectious Disease and HIV/AIDS Policy (OIDP) and the Centers for Disease Control and Prevention (CDC) in collaboration with the National Adult Immunization and Influenza Summit Quality Working group were instrumental in spearheading the development and testing of a the AIS measure, along with the composite measure for prenatal immunization, which has been adopted as part of HEDIS. We understand that the

Workgroup expressed concerns with states' ability to accurately and reliably report the immunization measures. The measures draw from Electronic Clinical Data Systems (ECDS), which include immunization information systems (IIS), case management registries, claims, and electronic health records (EHRs). We understand that while state Medicaid and CHIP programs can access member claims, encounters, and the corresponding state/local Immunization IIS, it may be more of a challenge for many state Medicaid agencies to capture EHR data. Therefore, states could choose to assess different models of data capture, such as encouraging providers to report to a community, regional or state-based health information exchange, in order to build capacity for measures that rely on electronic clinical information. The National Committee for Quality Assurance (NCQA) tested both measures in Medicaid and commercial health plans, concluding that while the specifications are new and innovative, they are feasible to implement. In addition, workgroup members representing state Medicaid programs expressed their commitment to establishing the infrastructure by which to report these new data sources. Because reporting measures within the Adult Core Set is currently voluntary, inclusion of these new immunization measures would signal prioritization of this critical public health gap, while allowing states to work on this new method of data collection and measure reporting. AVAC supports the Workgroup member recommendation that CMCS consider an affinity group or grant opportunity to help drive state coordination between Medicaid and public health registries, particularly immunization registries. Immunization information systems, or registries are an essential tool in managing immunization record data that enables providers to have accurate information regarding a Medicaid beneficiary's immunization status.

Prenatal Immunization Status Measure

AVAC urges the Workgroup to reconsider adoption of the prenatal immunization status measure, which includes Tdap and influenza for 2020. Maternal and perinatal health has been identified in prior reviews as an area to strengthen in the quality measure sets.

Like the AIS, the Prenatal Immunization Status measure will help to address substantial disparities in prenatal immunization rates. Immunizing mothers during their third trimester protects 9 in 10 babies from pertussis infections serious enough to need treatment in a hospital.⁶ Currently, prenatal immunization levels are lower among Medicaid members compared to privately insured women. Getting a flu shot reduces a pregnant woman's risk of hospitalization by 40% and helps protect the newborn before he/she is old enough to be vaccinated. We appreciate that the Workgroup members acknowledged the importance of the prenatal immunization status measure and its strong connection to improved health outcomes for young infants. However, we respectfully disagree with the decision not to adopt the measure because of data collection concerns.

The development and implementation of two new HEDIS 2019 measures—and adult immunization composite measure comprising influenza, pneumococcal, zoster, and Tdap vaccines and a prenatal (maternal) immunization measure comprising Tdap and influenza vaccines—illustrates the recognition of the importance of adult immunization in protecting health and the preventing disease in these medically vulnerable groups.⁷ Adoption of these two quality measures would provide useful and actionable results for state Medicaid and CHIP programs,

especially if they publicly post results and require reporting by Medicaid managed care plans. Such performance assessment and feedback can drive quality improvement efforts to raise immunization coverage rates. At the same time, the addition of these two new measures to the Adult and Child Core set is critical to improving the health of adult and prenatal populations. Again, thank you for the opportunity to share our perspective on this draft report. AVAC looks forward to working with Mathematica on this important endeavor. Please contact an AVAC Coalition Manager at (202) 540-1070 or info@adultvaccinesnow.org if you wish to further discuss our comments. To learn more about the work of AVAC visit www.adultvaccinesnow.org.

Citations

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

² Quilici et al. “Role of vaccination in economic growth.” J Mark Access Health Policy; (2015) 3:10.3402/jmahp.v3.27044.

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

⁴ <https://dev-adultvaccinesnow.pantheonsite.io/wp-content/uploads/2016/07/AVN-White-Paper-FINAL.pdf>.

⁵ https://www.hhs.gov/sites/default/files/tab_10.05_weiser_adult_iz_composite-measures.pdf.

⁶ <https://www.cdc.gov/pertussis/pregnant/mom/vacc-effectiveness.html>.

⁷ <https://www.ncqa.org/news/ncqa-updates-quality-measures-for-hedis-2019/>.

Aging and Disability Policy and Leadership Consulting, LLC (Lowell Arye)

I am writing to provide comments on the 2020 Core Set Review. As a member of the Workgroup, I want to thank you for all the work you did in facilitating the meetings (both face to face and the webinars). I also believe that the draft report does a good job in providing a synopsis of our discussions and our recommendations.

My only comment is that I believe there needs to be more specificity included in some of the reasons for the additions/deletions which were recommended. Specifically, in the area of Long Term Services and Supports (LTSS), I believe that it would be useful to explain that approximately 32% of all Medicaid expenditures are for LTSS and that it the workgroup found it important to include measurements in the Core Set for almost a third of all Medicaid expenditures. Similar information could be useful for the other additions as well.

I believe that inclusion of this information provides the case to CMS for inclusion of these measurements in the Core Set. Thank you for all of your work. I look forward to the final report.

American Academy of Pediatrics (Kyle E Yasuda)

Thank you for the opportunity to review and provide 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 2020 Child and Adult Core Sets. The American Academy of Pediatrics (AAP) is an organization of 67,000 pediatricians, pediatric medical sub-specialists, and pediatrics surgical specialists dedicated to the health, safety, and wellbeing of infants, children, adolescents, and young adults. We have a long history of supporting our members to ensure that “every child gets the right care every time” through a range of programs, activities, and resources.

The development and implementation of national pediatric measures has moved considerably slower than those of adults due to lack of evidence, risk adjustment, unreliable data sources, and small patient populations for chronic pediatric conditions. Despite these challenges, the AAP has remained a strong advocate supporting the harmonization of national quality measurement efforts that promote child health and can be used for value-based payment. The AAP promotes quality measures that: 1) Have a meaningful impact on child health and promote the health of every child, 2) Utilize an evidence based or evidence informed approach when determining impact on child health and development, 3) Are feasible for pediatricians and those who care for children to collect and, 4) Reflect the diversity of pediatric care by covering the broad range and complexity of pediatrics within a social determinants context.

Overall, the Academy agrees with the goals set forth by the workgroup to focus on measures that are actionable, aligned, and appropriate for state-level reporting to drive improvement in the quality of care and health outcomes. We strongly agree with the need to address gaps in the core set pertaining to the social determinants of health. We also applaud Mathematica’s transparency around the criteria for the recommended removal and additions from the CHIPRA core set; as they are mostly in alignment with the Academy’s criteria for impacting child health. We do however offer several suggestions for improvement on the process for assessing measures as well as specific comments on several measure removals.

Regarding improvements on the process of measure assessment, we encourage Mathematica to examine measures within and across domains for children. Children differ from adults and models for pediatric quality measurement should take this diversity into account. Unique differences between children and adults are often described in the literature include development, dependency, differential epidemiology, demographics, and dollars. Children have an upward developmental trajectory, with needs and abilities changing over time. Effectively measuring children’s health requires more of a systems approach and examination of measures across domain areas with further consideration on how these measures interact as a core set. The types of care (prevention/wellness, acute care, mental/behavioral health), sites of care, (inpatient, outpatient, school-based), healthy behaviors, overuse and appropriate treatment, family and community engagement should all be considered.

The Academy is concerned about the removal of measures pertaining to oral health and body mass index (BMI). Dental caries is the most common chronic condition of childhood –

disproportionally affecting children in Medicaid/CHIP and has implications on pain, Emergency Department use, school (individual and group success), and long-term systemic health. The oral health measures were removed without replacement, speaking against the 4th characteristic (new or alternate measure) as mentioned in Exhibit ES.1. The AAP recommends that the oral health measures should remain on the table for consideration in future sets due to the importance of children's oral health to overall health.

We also urge you to reconsider the removal of the Weight Assessment and Counseling in Children. While we understand that the high performance of this measure is the reason for removal, it is because of the current requirement, pediatricians across the country now check BMI at every visit. Furthermore, children with disabilities have many competing demands during their visits, and healthy weight counseling often gets overlooked. With decreased emphasis on BMI measurement, children and teens that are just starting to increase their BMI and may miss the opportunity for early intervention.

The AAP recognizes the effort Mathematica has put into the review process and the development of the report. We applaud you for your commitment to improving health outcomes. Thank you again for considering comments from the Academy. Please feel free to contact Vanessa Shorte, Senior Director of Quality, at vshorte@aap.org should you have questions.

American Association on Health and Disability and the Lakeshore Foundation (Clarke Ross)

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

Overview

As a member of various related National Quality Forum committees since 2012 and as an observer of this CMS-Mathematica Core Set Workgroup considerations, we find the report an accurate and thoughtful description and summary of the workgroup's discussions and decisions. Thank you.

We reinforce the page 28 (pages when viewing the document from a web browser) Theme:

The Workgroup focuses on "a holistic approach to measuring the quality of care provided to diverse populations and subpopulations enrolled in Medicaid and CHIP." Numerous NQF meetings and reports have emphasized the importance of the populations and subpopulations when discussing quality and the Medicaid program. Thank you.

In discussing the Theme and overall approach, it might be helpful to remind the Medicaid and CHIP audiences of the National Quality Strategy "Triple Aim" as a reference guide to the nation's approach to quality measurement in health and related services and supports. The Triple Aim priorities are: (1) Improving the Patient Experience of Care; (2) Improving the health of the population; and (3) Reducing the per capita cost of health care.

Long-Term Services and Supports: Overview

We appreciate the Appendix, page 54 (pages when viewing the document from a web browser) concluding observation: "Workgroup members noted the importance of adding LTSS measures, as this population comprises a large and growing share of the Medicaid beneficiaries and Medicaid expenditures and existing measures do not capture the unique needs and experiences of this populations."

Further, the Appendix, page 55 states: Workgroup members recognize that “it is important to find a way to better understand the experiences of people receiving LTSS.” And further on page 55: “In light of the significant resources that states invest in LTSS, it is important to provide feedback to the Medicaid program.”

We recommend that these observations be moved from the Appendix discussion of particular LTSS proposed measures to the actual text of the report.

And, we concur and support the comments submitted on the draft report for public comment by Workgroup member Lowell Arye: “There needs to be more specificity included in some of the reasons for the additions/deletions which were recommended. Specifically, in the area of Long Term Services and Supports (LTSS),it would be useful to explain that approximately 32% of all Medicaid expenditures are for LTSS and that the workgroup found it important to include measurements in the Core Set for almost a third of all Medicaid expenditures. Similar information could be useful for the other additions as well.....Inclusion of this information provides the case to CMS for inclusion of these measurements in the Core Set.”

We appreciate the page 28 Theme observation that Medicaid wraparound services are not being captured by the current core set.

Long-Term Services and Supports (LTSS): National Core Indicators and National Core Indicators-Aging and Disability

We are delighted that the Workgroup voted to recommend to CMS the addition to the 2020 Core Measure Set: both NCI and NCI-AD (pages 9, 21, 26, 27) (pages when viewing the document from a web browser). We reinforce the need and importance of such recommendations.

Long Term Services and Supports (LTSS): CAHPS HCBS Experience Survey and Personal Outcome Measures

The draft report for public comment Appendix discussion of CAHPS HCBS and POM is accurate and helpful (pages 54, 55, 63, and 65). Missing from the report is the recognition that the CAHPS HCBS failed recommendation for inclusion into the 2020 core set by one vote. This recognition would enhance the significance of this measure compared with the many other measures not endorsed for 2020 inclusion.

The Appendix discussion for both CAHPS HCBS and POM emphasize Workgroup concern with the high-cost and time intensiveness of collecting data through these mechanisms. This is an accurate reporting. We suggest that the report reference the NQF HCBS final report; home and community-based services and supports are person-centered and highly individualized, a reason for time intensive individual engagements.

Gaps

Thank you for the very helpful identification of measure gaps on page 29. To AAHD and the Lakeshore Foundation, we particularly reinforce: individuals of all ages with disabilities including

living and participating in the community; LTSS including rebalancing; behavioral health integration with primary care and physical health; care transitions; and addressing social determinants of health.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkross10@comcast.net.

American Board of Pediatrics (David Nichols)

The American Board of Pediatrics strongly supports the inclusion of the two core set measures related to sickle cell disease:

1. Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia (NQF #3166)
2. Transcranial Doppler Ultrasonography Screening for Children with Sickle Cell Anemia (NQF #2797)

The percentage of children with sickle cell disease who receive recommended antibiotic prophylaxis and transcranial doppler screening is persistently low and in some cases, even falling. The inclusion of these measures would have an immediate and dramatic impact of focusing pediatricians on the importance of these care elements. This simple step would go a long way in reducing a glaring health care disparity in the United States. Other chronic illnesses of childhood (e.g., cystic fibrosis, inflammatory bowel disease) have seen dramatic improvements in care, but sickle cell disease has not, in part because of the absence of validated measures.

We urge the adoption of these core set measures in the strongest possible terms.

American Society of Hematology (Emily Cahill)

The American Society of Hematology (ASH) strongly supports the draft report Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and Chip: Summary of a Multistakeholder Review of the 2020 Child and Adult Core Sets, including the inclusion of the following core set measure related to sickle cell disease:

Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia (NQF #3166)

With this inclusion, ASH commends the Workgroup for formally recognizing the marked quality gap in clinical care provided for children with sickle cell disease. The antibiotic prophylaxis measure, characterized as a continuity of care measure that should be universally applied and is captured by claims data, is an appropriate addition to the 2020 Child Core Set. ASH appreciates the opportunity to comment on this important work and to highlight this great opportunity to drive improvement in the clinical care of children with sickle cell disease.

ASH is committed to addressing the burden of sickle cell disease (SCD) and is in the midst of a multifaceted initiative to improve outcomes for individuals with the disease both in the United States and globally. ASH is leading a number of activities to ensure that individuals with SCD have access to high quality of care, including the development of new clinical practice guidelines on the management of acute and chronic complications of SCD, and expanded SCD-focused education and training.

Please let me know if you have any questions or would like to discuss further.

Anthem (Anthony Mader)

Anthem, Inc. (Anthem) appreciates this opportunity to comment on Mathematica's draft report "Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP," released in July 2019.

We appreciate Mathematica's convening of the 2020 Child and Adult Core Set Annual Review Stakeholder Workgroup (Workgroup) and the Workgroup's thoughtful assessment of the Centers for Medicare & Medicaid Services' (CMS) Medicaid and CHIP Child and Adult Core Sets (Core Sets) of healthcare quality measures. Anthem largely supports the Workgroup's recommended changes to the Core Sets for 2020 based on its review of the 2019 Core Sets. However, we ask that the Workgroup consider the comments provided below as the Workgroup finalizes its recommendations.

Detailed Comments

Workgroup Recommendations of Measures to Remove from the 2020 Core Sets

Anthem generally agrees with the Workgroup's recommendations to remove certain measures from the 2020 Core Set. In cases where the measure is due to be retired by its steward, it is logical to remove it from the Core Set. However, we recommend the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (ACP-CH) be retained in the Child Core Set. The Workgroup framed this measure as potentially "topped out," but we believe there is still both value and room for improvement, particularly for the Medicaid population, including children and youth supported by the child welfare system.

The Workgroup recommended that the measure be replaced by Metabolic Monitoring for Children and Adolescents on Antipsychotics. While we recommend that Use of Multiple Concurrent Antipsychotics in Children and Adolescents (ACP-CH) be retained, we also support adding this new measure, as both would add value to the Child Core Set.

Workgroup Recommendations of Measures to Add to the 2020 Core Sets

The Workgroup proposes to add two National Core Indicators (NCI) measure sets. We support the concept of adding more quality measures pertaining to individuals requiring Long-Term Services and Supports (LTSS). However, we are concerned that these survey measures were not designed for use as health plan quality measures. The measure specifications are not in the public domain and they would rely on time-intensive in-person interviews. If the individuals conducting the in-person interviews have not had adequate training in interview techniques, the validity of these surveys may be questionable. In addition, the sample size is small, so although these interviews can provide valuable insights into the experiences of individuals, the information may be limited. There are more appropriate ways for CMS to encourage states' use of the NCI and NCI-Aging and Disabilities (NCI-AD) instruments, and we recommend CMS consult with Human Services Research Institute (HSRI) about the potential difficulties of

individual health plans using these measure sets before proceeding with adding them to the Core Set(s).

Understanding that it may be too late in the process to recommend alternative measures for 2020, we instead recommend considering alternative measures for 2021 that would still achieve the goal of measuring quality for the LTSS Medicaid population, while also being more broadly impactful. For example, earlier this year, CMS, with help from Mathematica and the National Committee for Quality Assurance (NCQA), released technical specifications for measures being developed specifically for individuals accessing LTSS through Managed Care Organizations (MCOs), some of which are aligned with Healthcare Effectiveness Data and Information Set (HEDIS) measures. Data collection for these measures can be collected through case management record review or administratively, making them likely less burdensome as well.

We are also concerned with the addition of the Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia and the Use of Pharmacotherapy for Opioid Use Disorder measures, specific to states that carve-out pharmacy from the medical benefit. Health plans operating in carve-out markets have little opportunity to improve quality on these measures because we do not directly manage the benefit. The ability for MCOs to provide whole-person care for its members by fully integrating medical and pharmacy care is extremely helpful in maximizing the quality of care and services for our members. Anthem is invested in whole-person care to achieve optimal health outcomes, and a carve-out limits our ability to holistically coordinate and manage care for our members.

We welcome the opportunity to discuss our recommendations to ensure the delivery of robust benefits and access to quality care and services via the Medicaid and CHIP programs. Should you have any questions or wish to discuss our comments further, please contact Lisa Watkins at (202) 508-7889, or lisa.watkins2@anthem.com.

Association for Community Affiliated Plans (Margaret A Murray)

The Association for Community Affiliated Plans (ACAP) appreciates the opportunity to submit comments on proposed changes to Child and Adult Core Measures. ACAP is an association of 66 nonprofit and community-based Safety Net Health Plans located in 29 states. Collectively, ACAP health plans provide coverage to 20 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicaid and CHIP as well as other publicly-supported programs. We first will provide some general comments and then respond to specific measure recommendations below.

General Comments

Overall Criteria: ACAP member plans agree with overarching criteria for removing measures in which performance is going well and focusing on areas of known needed improvement. We also support the use of measures where they are populated via administrative data (encounters/claims) versus manual file review. Finally, we support selecting measures that are impactable and would encourage the use of strategic workgroups that include the provider community to be engaged with improving outcomes for select measures that remain challenging year-over-year.

Outcomes vs Process Measures: In general, ACAP understands and appreciates the interest in moving from process measures to outcomes measures. However, we know that peer-reviewed publications are providing increasing evidence that there are confounding variables (beyond the scope of influence by plans and providers) that impact outcomes measures more than they impact process measures. These confounding variables are issues related to social determinants of health (SDoHs). While Safety Net Health Plans (and other health plans) are moving into the realm of addressing SDoHs, it is uncharted territory. Until this new evidence matures, and interventions that effectively impact SDoHs are funded by state and federal sources, we are concerned that replacing all process measures with outcomes measures does not sufficiently recognize those SDoH-related confounding variables that may impact outcomes rates due to issues not in control of health plans.

Proposed Measures for Removal

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

Support.

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

Support with Concern.

While ACAP supports the removal of this measure in general based on many of its limitations noted in the report, we remain concerned about the absence of a replacement measure that addresses obesity. We understand that simple measurement without a planned, evidence-based intervention may seem less impactful, but obesity is the major health problem in the U.S. and is increasing. Measuring BMI signals to primary care providers the importance of the issue and marks a place to start. As noted in the report, a federal liaison voicing support remarked that "...there is evidence to support BMI screening in the primary care setting and that BMI screening is part of American Academy of Pediatrics and USPSTF recommendations for both children and adults." Indeed, this report, as evidenced by Exhibit 8, notes that "Obesity" is a potential gap area for future core set measures.

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

Support.

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

Support.

Adult Body Mass Index Assessment (ABA-AD)

Support with Concern.

While ACAP supports the removal of this measure in general based on many of its limitations noted in the report, we remain concerned about the absence of a replacement measure that addresses obesity. We understand that simple measurement without a planned, evidence-based intervention may seem less impactful, but obesity is the major health problem in the U.S. and is increasing. Measuring BMI signals to primary care providers the importance of the issue and marks a place to start. As noted in the report, a federal liaison voicing support remarked that "...there is evidence to support BMI screening in the primary care setting and that BMI screening is part of American Academy of Pediatrics and USPSTF recommendations for both children and adults." Indeed, this report, as evidenced by Exhibit 8, notes that "Obesity" is a potential gap area for future core set measures.

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

Support with Concern.

While ACAP supports the removal of this measure in general based on many of its limitations noted in the report, this is an example of replacing a process measure with an outcomes measure (Comprehensive Diabetes Care: Hemoglobin A1c [HbA1c] Poor Control) where we have concerns as noted above. A valid hypothesis is that process measures may better measure the quality of the care provided, while outcomes measures are influenced by social determinants of health (SDoHs). It is important to measure SDoHs and develop interventions to address them, but until meaningful progress is made in addressing SDoHs, it is also desirable to minimize confounding variables in measuring the quality of care provided. Keeping the

Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD) alongside the Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (HPC-AD) could allow comparison of the process and outcome measures which can help inform a better understanding of the effects of SDoHs. If the hypothesis proves true, the other unintended consequence of removing the process measure will be to penalize providers who provide care for the most needy and underserved (e.g., FQHCs) and could result in providers or managed care plans ‘cherry picking’ patients with fewer SDoHs in order to achieve better scores. This concern of possible confounding influence of SDoHs warrants analysis of process and outcomes measures to ensure they are measuring the factors they are intended to measure.

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

Support.

Proposed Measures for Addition

Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia

Support.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

Support.

Use of Pharmacotherapy for Opioid Use Disorder

Do not support.

ACAP is concerned that plans will not be able to access full data relating to this measure. First, plans may have trouble identifying plan enrollees with opioid use disorders, as services for those members are carved out to the state, county, or subcontracted managed behavioral health/substance use disorder organizations in some jurisdictions. For the same reason, it may not be possible for plans to track the full range of services provided. While in these jurisdictions some medication assisted treatment may be provided by the plan, it would be difficult or impossible for those plans to collect and deliver a full picture of the data required under this proposed measure.

Second, regardless of whether behavioral health and substance use disorder services are carved in or out of a Medicaid managed care plan, outdated federal regulations that pre-date current models of care create significant barriers to holistic care for people with SUD and impact the ability for health plans to capture the data needed to inform measures related to that care. These barriers – found in 42 CFR Part 2 and requiring individualized and specific patient consent before providers and plans can disclose a SUD to coordinate care – undermine efforts to integrate behavioral and physical health services for people with SUD, ultimately leading to worse health outcomes. We harbor concerns that the prohibitions on sharing data in 42 CFR

Part 2 will severely hinder plans' efforts to report on any measure related to opioid overuse treatment or any other SUD treatment.

National Core Indicators (NCI)

Do not support.

While ACAP supports the eventual addition of these indicators, our plans are concerned about their ability to immediately adhere to this measure. Given that these measures are collected via a survey, they are time-intensive for the Medicaid beneficiary and expensive to conduct. In addition, the implementation of this survey may involve contract modifications between state Medicaid agencies and health plans. Overall, we would recommend a staged addition of these measures would be preferable to their proposed immediate inclusion.

We do note that these surveys are currently being conducted in a substantial number of states. If the surveys were to be administered through other mechanisms, organizations, or agencies rather than through Medicaid managed care plans, we would withdraw our "Do not support" position as that position is primarily based on financial, operational, and timeline concerns.

While not of direct concern with regard to the use by the CMCS of the NCI survey to evaluate the state, our plans would like further clarification on its potential impact on them and how the state Medicaid agencies may use the results of that survey in their evaluation of the MCOs—we understand this may be a state-by-state concern.

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

Do not support.

While ACAP supports the eventual addition of these indicators, our plans are concerned about their ability to immediately adhere to this measure. Given that these measures are collected via a survey, they are time-intensive for the Medicaid beneficiary and expensive to conduct. In addition, the implementation of this survey may involve contract modifications between state Medicaid agencies and health plans. Overall, we would recommend a staged addition of these measures would be preferable to their proposed immediate inclusion.

We do note that these surveys are currently being conducted in a substantial number of states. If the surveys were to be administered through other mechanisms, organizations, or agencies rather than through Medicaid managed care plans, we would withdraw our "Do not support" position as that position is primarily based on financial, operational, and timeline concerns.

While not of direct concern with regard to the use by the CMCS of the NCI-AD survey to evaluate the state, our plans would like further clarification on its potential impact on them and how the state Medicaid agencies may use the results of that survey in their evaluation of the MCOs—we understand this may be a state-by-state concern.

Additional Comments: Other Measures Discussed but Not Recommended for Addition

Two other measures discussed by the Workgroup but ultimately not recommended for adoption included Continuity of Insurance: Informed Participation and Health-Related Social Needs (HRSN) Screening. Upon review of the discussion text, we understand and appreciate the concerns raised by numerous Workgroup members.

ACAP member plans continue to be interested in being able to track issues related to coverage churn and being able to measure continuity of insurance, including Medicaid coverage. ACAP believes it is critical that some measure of the churning issue be included in the measurement set as soon as possible. Churning has a direct impact on quality and the potential success of quality improvement efforts. We would urge CMS and AHRQ to specifically undertake a study of the impact of churning on the reliability and state-to-state comparability of the measurement set. In addition, our plans see the value in better measuring the screening and assessment of members' social determinants of health. As such, we would urge CMCS to encourage measure developers to continue to work on improving potential measures that address these two issues with an expectation that they may be considered for future inclusion in the Core Measures.

Again, we thank you for this opportunity to comment on these important proposed modifications to the Core Measures. Please feel free to contact me (mmurray@communityplans.net, 202-204-7509), or Enrique Martinez-Vidal, Vice President for Quality and Operations (emartinez-vidal@communityplans.net, 202-204-7527), if you would like to discuss any of these issues in greater depth.

Biotechnology Innovation Organization (Phyllis Arthur)

The Biotechnology Innovation Organization (BIO) appreciates the opportunity to provide comments on Mathematica’s Summary of a “Multi-stakeholder Review of the 2020 Child and Adult Core Sets.”

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO’s members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these diseases, or to prevent them in the first place. In that way, our members’ novel therapeutics, vaccines, and diagnostics not only have improved health outcomes, but also have reduced healthcare expenditures due to fewer physician office visits, hospitalizations, and surgical interventions. BIO membership includes biologics and vaccine developers and manufacturers who work closely with myriad stakeholders, including the public health and advocacy communities, to support policies that help ensure access to innovative and life-saving medicines and vaccines for all individuals. BIO appreciates the Workgroup’s recognition of the importance of quality measures in improving patient health as well as its efforts to strengthen the Medicaid Adult and Child Health Care Quality Core Sets for 2020. We encourage the Workgroup to consider adoption of two recent Healthcare Effectiveness Data and Information Set (HEDIS) immunization measures¹:

1. Add the new Adult Immunization Status (AIS) measure, to replace the current adult influenza vaccine measure based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The new AIS measure is a composite of the age-recommended vaccines for adults, including influenza vaccine.
2. Add the new Prenatal Immunization Status (PIS), which measures prenatal immunizations of Tdap (tetanus, diphtheria, and acellular pertussis) and influenza.

With the addition of the AIS and PIS, the two immunization measures currently within the Child Core Set, Childhood Immunization Status (CIS) and Immunization of Adolescents (IMA), should be retained.

Potential Gap Areas for Future Core Set Measures

The Advisory Committee for Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC) guidelines for routine vaccination are evidence-based and developed to improve the health of the U.S. population by preventing disease. Despite this evidence-based guidance, many adults are not being assessed for and offered important ACIP-recommended vaccines, resulting in poor adult immunization coverage rates nationally. Additionally, there are significant ethnic and racial disparities within this cohort of the beneficiary population.^{2,3}

BIO appreciates that the Workgroup identified gaps in immunization quality measures, particularly in prenatal and adult populations. Opportunities to assess the immunization status of Medicaid beneficiaries, especially pregnant women and medically vulnerable adults with chronic conditions such as diabetes and heart disease, should be done by the range of clinicians who care for them. The National Vaccine Advisory Committee’s (NVAC) Adult Immunization

Standards call for all providers caring for adult patients to assess, recommend, vaccinate or refer, and document vaccinations.⁴ Leveraging each and every patient encounter to facilitate education and provider recommendations for vaccines has been found to improve the likelihood of a patient being immunized.⁵

Immunization quality measures are a crucial tool for health care quality improvement and have demonstrated effectiveness in improving immunization coverage across adult populations to prevent illness and death, reduce caregiving demands, avoid unnecessary healthcare spending, and set the foundation for healthy aging.⁶ Quality measures, such as the AIS and PIS measures can help to fill gaps and eliminate disparities in immunization.

Adult Immunization Status Measure

BIO recommends that the Workgroup replace the current adult influenza vaccine measure, based upon Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, with the AIS measure. The AIS measure is a composite of several age-recommended vaccines for adults, including the currently assessed influenza vaccine, and provides a sound, reliable, and comprehensive means to assess the receipt of routine ACIP-recommended adult vaccinations. It would enable states to monitor recommended adult immunization use beyond influenza.

The Indian Health Service (IHS) Northwest Tribal Epidemiology Center and the National Nursing Home Quality Care Collaborative first demonstrated that the AIS is an effective tool that can improve patient health outcomes.⁷ This measure, along with another composite measure for prenatal immunization (see below), subsequently has been adopted as part of HEDIS through efforts of the Department of Health and Human Services (HHS) Office of Infectious Disease and HIV/AIDS Policy (OIDP) [formerly the National Vaccine Program Office (NVPO)] and the CDC in collaboration with the National Adult Immunization and Influenza Summit Quality Working Group. Additionally, the AIS was recently proposed for inclusion in the Medicare Shared Savings Program, starting in performance year 2020, and the Medicare Merit-based Incentive Payment System (MIPS), starting in performance year 2022. Within MIPS, inclusion was proposed in several measure sets: allergy/immunology, family medicine, internal medicine, obstetrics/gynecology, otolaryngology, preventive medicine, nephrology, general surgery, oncology/hematology, infectious disease, rheumatology, geriatrics, skilled nursing facility, and endocrinology. Alignment and harmonization of Medicare and Medicaid quality measures in this way would further the federal government's goals of consistency across quality programs.

We understand that the Workgroup did not recommend AIS for inclusion in the 2020 Medicaid Adult Core Set of measures due to concerns about states' ability to accurately and reliably report this measure. The National Committee for Quality Assurance (NCQA) tested both measures in Medicaid and commercial health plans. NCQA concluded that the fact that the measures are drawn from Electronic Clinical Data Systems (ECDS), which include immunization information systems (IIS), case management registries, claims, and electronic health records (EHRs), makes them feasible to implement.

While we understand State Medicaid programs and Children's Health Insurance Program (CHIP) can access member claims, encounters, and the corresponding state/local IIS, many state Medicaid agencies face new challenges to capture EHR data. NQCA continues to work closely with health plans to provide technical support and to identify approaches to collect this data – states could choose to assess different models of data capture, such as encouraging providers to report to a community, regional or state-based health information exchange, in order to build capacity for measures that rely on electronic clinical information.

As the Adult Core Set is voluntary, inclusion of the AIS would signal a prioritization of adult vaccination while allowing states to further develop approaches to data collection and reporting before all reporting for the Adult Core Set is required in 2024. BIO supports the Workgroup recommendation that CMS consider an affinity group or grant opportunity to help drive state coordination between Medicaid and public health registries, particularly immunization registries, to help support uptake and use of the AIS.

BIO acknowledges that implementation of a quality measure often precedes health system and health plan focus. While reporting challenges remain, they risk being unaddressed if adult immunization is not prioritized and remains unmeasured.

Prenatal Immunization Status Measure

BIO also recommends the Workgroup reconsider adoption of the Prenatal Immunization Status measure for 2020, which includes Tdap and influenza vaccination status. Maternal and prenatal health has been identified in prior reviews as an area to strengthen in the quality measure sets.

Like the Adult Immunization Status measure, the Prenatal Immunization Status measure will help to address substantial disparities in prenatal immunization rates. While maternal immunization in the third trimester protects 9 out of 10 babies from pertussis infections serious enough to require hospitalization, prenatal immunization rates are lower among Medicaid members than those privately insured.⁸ For pregnancies ending in 2016, in the commercial cohort 50% of women received Tdap vaccination and 40% received influenza vaccination compared to 30% for Tdap and 25% for influenza of mothers in the Medicare population.^{9,10} BIO appreciates the Workgroup's acknowledgment of the importance of a prenatal immunization status measure and its strong connection to improved health outcomes for young infants.

BIO notes the Workgroup cites similar concerns on data collection challenges with the AIS in its decision to recommend the Prenatal Immunization Status measure. BIO affirms that, as with the AIS, adoption of this voluntary measure would set a priority for immunization while state CHIP and Medicare programs begin to work with NCQA and other bodies to work towards addressing these challenges.

Adoption of these two quality measures would provide useful and actionable results for state Medicaid and CHIP programs, especially if they publicly post results and require reporting by Medicaid managed care plans. Such performance assessment and feedback can drive quality improvement efforts to raise immunization coverage rates. At the same time, the addition of

these two new measures to the Adult and Child Core sets is critical to improving the health of adult and prenatal populations.

Conclusion

BIO appreciates the opportunity to offer feedback on this draft report and looks forward to working with Mathematica on this critical topic. Please do not hesitate to reach out to Greg Frank, Director, Infectious Disease Policy (gfrank@bio.org / 202-292-4681), if you have any questions.

Citations

¹ <https://www.ncqa.org/news/ncqa-updates-quality-measures-for-hedis-2019/>.

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

³ CDC. MMWR Morb Mortal Wkly Rep. 2017 May 5;66(11):1-28.

⁴ <https://www.cdc.gov/vaccines/hcp/adults/for-practice/standards/index.html>.

⁵ Quilici et al. “Role of vaccination in economic growth.” J Mark Access Health Policy; (2015) 3:10.3402/jmahp.v3.27044.

⁶ <https://dev-adultvaccinesnow.pantheonsite.io/wp-content/uploads/2016/07/AVN-White-Paper-FINAL.pdf>.

⁷ https://www.hhs.gov/sites/default/files/tab_10.05_weiser_adult_iz_composite-measures.pdf.

⁸ CDC. <https://www.cdc.gov/pertussis/pregnant/mom/vacc-effectiveness.html>.

⁹ CDC. MMWR Morb Mortal Wkly Rep. 2013 Feb 22;62(7):131-5.

¹⁰ Harper SA et al. MMWR Recomm Rep. 2005 Jul 29;54(RR-8):1-40.

Christopher Bolling

Please know that as a practitioner of general pediatrics and a provider of pediatric obesity treatment, I am opposed to dropping BMI assessment of children and adults as a HEDIS measure. Removal of this requirement will reduce emphasis on and urgency around the public health crisis of overweight and obesity. Obesity remains a threat to our nation's health and healthcare system. Lessening the focus on overweight and obesity will result less scrutiny of weight status in clinical settings and reduced opportunities to promote healthy weight.

California Department of Health Care Services (Lisa Albers)

We would like to offer the following comments on the draft recommendations for Improving the Core Sets of Health Care quality Measures for Medicaid and CHIP.

- First of all, we would like to echo points put forth by the committee member from New York's Medicaid Agency on core set reporting. In particular, California also uses HEDIS measures to set benchmarks for internal quality calculations and to hold health plans accountable. Measures that are not part of the HEDIS measure set are more difficult to benchmark. Additionally, we agree that provider-based measures, such as those developed for hospitals, are more difficult for health plans and the state to collect and report.
- Regarding the specific measure recommendations, we agree with all of the measures recommended for removal from the Core Sets, namely: Child and Adolescents' Access to Primary Care Practitioners (CAP-CH), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents (WCC-CH), Pediatric Central Line—Associated Bloodstream Infections (CLABSI-CH), Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH), Adult Body Mass Index Assessment (ABA-AD), Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (CDC-HT), and Annual Monitoring for Patients on Persistent Medications (MPM-AD).
 - In particular, we support the removal of the CAP measure and the CLABSI measure from the Child Core Set, and the removal of CDC-HT and MPM from the Adult Core Set. The CAP measure is too broad in its definition of a primary care visit, so it is really just a utilization measure, and the CLABSI measure, being a hospital-based measure, is difficult for the health plans and state to report on as well as take action on, given that the Dept. of Health Care Services (DHCS) holds contracts with its managed care health plans, rather than hospitals.
 - We also support the removal of CDC-HT, given that CDC-H9, an outcome measure, remains on the Core Set and also includes A1c testing.
 - Finally, we also support the removal of MPM as this is a measure with high performance nationally, making it difficult for health plans and states to improve on, and the NCQA has announced the retirement of MPM from its HEDIS measure set.
- Regarding the measures recommended for addition to the Core Sets, we support the addition of Metabolic Monitoring for Children and Adolescents on Antipsychotics and the Use of Pharmacotherapy for Opioid Use Disorder. In particular, the latter measure is a particularly good choice given the underutilization of medication assistant treatment nationally, and in California.
- While the Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia does potentially represent a measure that targets continuity of care for chronic disease, the population that would be targeted by the measure is quite small and rather specialized for the Core Sets.

- While the National Core Indicators (NCI) and National Core Indicators for Aging and Disabilities Adult Consumer Survey (NCI-AD) provide important information about members' experiences, they are in person and family based surveys, which are labor and resource intensive to collect and report on for states and health plans, and would require many states to implement a new requirement of their health plans. These measures do not seem to meet the feasibility and appropriateness for state level reporting criteria outlined by the Core Set workgroup.

Thank you for providing the opportunity to comment.

Children's Dental Health Project (Colin Reusch)

The Children's Dental Health Project (CDHP) appreciates the opportunity to comment on the draft report titled "Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP." CDHP applauds the efforts of the Core Set Workgroup in reviewing and recommending changes to the Medicaid and CHIP Child and Adult Core Sets. As the national organization dedicated to eliminating dental disease as a barrier to child and family success, CDHP recognizes the importance of meaningful measurement in driving care delivery and evaluating the impact of public coverage programs. CDHP has long advocated for the development and implementation of oral health quality measures to track both access to oral health care and improvements in oral health status as a result of coverage and care delivery.¹

While we are disappointed that the 2020 Core Set annual review did not result in the addition of new oral health quality measures, we appreciate the Workgroup's careful deliberation and establishment of a framework for measure evaluation. CDHP recognizes the need to weigh the feasibility of and data sources for each measure. At the same time, we encourage the Workgroup to be ambitious in advancing measures that have the greatest opportunity for improving the health outcomes of children and adults served by Medicaid and CHIP. As such, we hope that during the next review cycle the Workgroup will reconsider the measures related to emergency department visits for dental caries and follow-up care after emergency department visits.

In general, CDHP agrees with the Workgroup's assessment of potential gap areas for future Core Set measures. In particular, we agree that maternal health is an especially glaring gap in the existing measure sets given the importance of health and oral health care during pregnancy — both for women and infants. We also agree that there is a need to implement Core Set measures related to oral health beyond prevention, as the Workgroup indicates in exhibit 8 in the draft report. Moreover, we encourage the Workgroup to consider gaps for oral health measurement with regard to follow-up on referrals, appropriateness of care, and network adequacy. In addition, we suggest that the Workgroup consider how measure attributes, such as stratification by race and ethnicity, as well as how the social determinants of health may be applicable to oral health measures in future iterations of the Core Sets.

CDHP encourages the Workgroup to place considerable emphasis on the degree to which new measures could fill gaps in the existing Core Sets, especially with regard to oral health. Currently there are no oral health measures in the Adult Core Set despite the impact of oral health on other chronic diseases, employment, and earning potential.² In addition, recent research suggests that parents' access to oral health care increases the likelihood that children will access care.³ The two oral health measures in the Child Core Set are focused on utilization and process for dental services, leaving gaps with regard to appropriateness of care, improvements in oral health status, and oral health care delivered in the primary care setting. We encourage the Workgroup to seek input from leading oral health measurement experts, including the Dental Quality Alliance, as they continue to conceptualize, develop, and test new oral health quality measures for both children and adults.

Finally, we strongly support the Workgroup's recommendation that federal agencies, including CMCS, provide technical assistance to states for the purposes of improving data standardization; establishing data linkages across care domains as well as between parents and children; and providing state quality staff with opportunities to learn from one another. CDHP would welcome such efforts. We urge that any technical assistance on quality measurement and data collection in Medicaid and CHIP address oral health measurement and associated data systems.

We look forward to engaging with the Workgroup as they continue to review and recommend changes to the Child and Adult Core Sets. Please do not hesitate to CDHP's Director of Policy, Colin Reusch for additional information at: creusch@cdhp.org.

Citations

- ¹ Children's Dental Health Project, Association of State and Territorial Dental Directors, and DentaQuest Foundation (December 2017). Making Oral Health Count: Toward a Comprehensive Oral Health Measurement System. Available at: <https://www.astdd.org/docs/dqf-astdd-cdhp-measurement-brief.pdf>.
- ² Children's Dental Health Project (August 2018). Meeting children's and families' comprehensive health needs: Building two-generation models that incorporate oral health. Available at: https://s3.amazonaws.com/cdhp/Family-Centered/Fact+Sheet+-+Family+centered+efforts+%26+OH_sm+endnotes.pdf.
- ³ Lipton, BJ (April 2019). Adult Medicaid Benefit Generosity and Receipt of Recommended Health Services among Low-Income Children: The Spillover Effects of Medicaid Adult Dental Coverage Expansions. Available at SSRN: <https://ssrn.com/abstract=3364028>.

Children's Health Integrated Program in Childhood Obesity (Sarah Barlow)

I strongly recommend against the removal of weight assessment and nutrition and physical activity counseling from the core quality measures for children.

Quality measures in to address obesity should be retained and strengthened.

Obesity in childhood is highly prevalent, increasing in severity, and leads to high medical costs. Removal of measures related to this health crisis implies lack of importance. Clinicians find addressing this problem difficult, and they may turn their attention away from this problem if this attention is not recognized as important.

Work led by my collaborator, Christy Turer, MD, MS, (in press) demonstrates that EHR markers of clinician attention to BMI and obesity co-morbidities in primary care visits of children with overweight and obesity results in improvement in relative BMI.

Rather than removing these quality markers, this committee should recommend improved markers in this area; the goal should be evidence of clinician attention and action, including offering evidence-based behavior-based interventions.

Children's Hospital Association (Kate Conrad)

On behalf of the nations' children's hospitals, the Children's Hospital Association (CHA) applauds the Workgroup's thoughtful review and deliberations of the 2020 Core Sets for Medicaid and CHIP, and largely supports the recommendations of changes to the measures set that will improve the quality of care and health outcomes for Medicaid and CHIP beneficiaries.

We celebrate the addition of a measure that is widely endorsed to improve the quality of care for children with sickle cell disease (SCD) – a grossly underserved patient population.

- Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia (NQF# 3166).

As most children with SCD are covered by Medicaid, this measure is highly relevant and meets all criteria for measure inclusion: actionable, aligned, and appropriate.

Additionally, we encourage the Workgroup to consider another SCD measure in the 2020 Child Core Set under the same rationale above.

- Transcranial Doppler Ultrasonography Screening for Children with Sickle Cell Anemia (NQF #2797)

This measures also supports the assessment needs in the Sickle Cell Disease and Other Heritable Blood Disorders Act of 2018, and are instrumental in preventing sepsis and stroke in patients with SCD.

Children's hospitals support inclusion of both SCD measures, and thanks to the Workgroup for the opportunity to comment.

Connecticut Children's Office for Community Child Health/Help Me Grow National Center (Paul H Dworkin and Erin Cornell)

Connecticut Children's Office for Community Child Health is a national leader in addressing critical contemporary issues that have the potential to adversely affect children's health and development. The Office not only serves as a critical community resource, but also cultivates innovative and cost-effective solutions to address existing gaps in our health care and child service systems. The Office oversees a variety of community-oriented programs that address a wide range of factors that influence children's health, development, and well-being. One of those programs is the Help Me Grow National Center, which is a system model that promotes integrated, cross-sector collaboration to build efficient and effective early childhood systems that mitigate the impact of adversity and support protective factors among families. Through model implementation in communities and states across the country, Help Me Grow advances early detection and intervention for at-risk children, so all children can grow and thrive to their full potential.

Our efforts within The Office and the Help Me Grow National Center frequently focus on the critical role of the child health provider in promoting the optimal health and well-being of young children and families. This experience has reinforced both the importance and relative scarcity of data that inform us as to the quality and impact of efforts to strengthen child health services in support of children's optimal healthy development. For example, while universal developmental screening by child health providers is recommended, existing data suggests uptake among child health providers is still far below this target, and there is little to no available data to supplement screening rate data, such as whether such screening serves to identify and respond to need or families' experience with the screening, referral, and linkage process. The Child Core Set measures provide a critical opportunity to expand our access to knowledge about national health care quality for children served by Medicaid or CHIP, to leverage such knowledge as a baseline around which states can design future efforts to improve performance, and as a way to enable further investigation into the types of practice transformation strategies that are most effective in increasing quality. We appreciate the opportunity to provide specific feedback on the proposed Medicaid and CHIP Child Core Set:

While the inclusion of developmental and maternal depression screenings is encouraging, we believe it is critical to track the number of children and mothers who are successfully connected to follow-up services to ensure detection leads to assessment and intervention. Excluding follow-up and other metrics that speak to quality of care significantly undermines the potential benefit of screening tools to children and families and risks communicating to providers that because linkage is not measured, it is not essential. In our experience, documentation of successful linkage can be challenging, given the complexity of care coordination activities and the number of transitions families may experience across settings. To circumvent this in our own work, we track instead the proportion of families with concerns for which a provider documents making any type of referral. While referral does not equate with successful linkage, this is arguably a more substantive indicator of quality of service than screening conducted in isolation. It is Help Me Grow's experience that connecting patients to community-based programs and services increases efficiencies by decreasing service duplication and ensuring support for all

children and families, not just those that are high-risk or with specific delays or disorders, given the availability of tertiary intervention for the limited proportion of families with such needs. This also increases the capacity of systems that serve the most vulnerable for adverse health, developmental, and behavioral outcomes.

If factors such as feasibility of collecting the measures prevent the Core Set measures to expand to capture activities beyond screening, we would at a minimum strongly recommend that standard measures of not only developmental screening in the first three years of life, but also social emotional screening be considered as a proposed new measure. While such a measure risks the same limitations as developmental or maternal screening in isolation, expanding to measure social emotional screening in primary care will provide the field with actionable data about the degree to which pediatric primary care providers are responding to the call to action to address children's social emotional development during the early years of life.

The inclusion of screenings for social determinants of health that influence the need for medical care services is an important area of exploration for future health care quality measures. While the core set workgroup has commented that measures around social determinants of health are too new to implement, linking families to community-based resources and capturing the return on investment for doing so contributes to a strong evidence base that may highlight important gaps in the service delivery continuum. This is data that could lead to future actionable outcome measures in the core set and provide a stronger representation of Medicaid services and their utilization. Further, future measures could consider the degree to which such screening reflects a patient/family-led agenda and priority setting; as above, screening for social determinants in a way that reflects family-driven priorities will go further in measuring not just quantity of screenings, but also quality.

Finally, though it is beyond the scope of this review and solicited public comment, we regularly seek to promote visibility of emerging paradigms in how we measure and reflect upon our success in strengthening child and family well-being. We are encouraged by trends such as state-level efforts to measure parental resilience, knowledge of parenting and child development, as well as reporting of population-based measures such as kindergarten readiness. Such measures show us what is possible; we hope they continue to be considered as potential future measures for targeted efforts to strengthen payer-based quality measures in the health care setting.

If you have any questions or require additional information, please contact Ms. Erin Cornell, Associate Director of the Help Me Grow National Center, at ecornell@connecticutchildrens.org or 860-837-5756.

Connecticut Department of Developmental Services (Jordan A Scheff)

Thank you for the opportunity to comment on the report titled “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” The report succinctly and clearly describes the discussions of the work group and provides helpful background information.

I am writing these comments in my role as the Commissioner of the Department of Developmental Services in Connecticut; the state of Connecticut Department of Developmental Services (CT DDS) has participated in NCI for the past 7 consecutive years and plans to participate again this year. As the Commissioner, discussions of reporting on measures in Medicaid Long Term Services and Supports are of significant interest and concern.

Of note, there were 42 distinct measures suggested for inclusion in either the Child or Adult Core Set. Of those 42, only 5 were identified by the workgroup as substantially meeting the characteristics set forth as important for the measure to be recommended. That NCI was among the measures recommended comes as no surprise, with its long history and reputation for providing valid, reliable and most importantly relevant and actionable measures. NCI is well known and heavily used in the national DD system.

I strongly encourage CMS to take up the recommendations of the workgroup to include NCI to fill the gap in LTSS measures for the Medicaid Adult Core Measure set in 2020. To understand how NCI meets the characteristics set forth by CMS and Mathematica, I would like to comment on the specific characteristics for consideration of a New Measure as described in the report.

Characteristics Considered for Addition of a New Measure:

Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?

The NCI provides a multitude of data points that inform an understanding of what support individuals are receiving in CT, an outline of their experiences, and level of satisfaction. Additionally, these data stories provide the evidence for new agency initiatives, necessary policy changes, and adjustments to current CT DDS procedures. The most significant information the NCI provides is how agency policy impacts the individuals supported by the state of Connecticut Department of Developmental Services.

Alignment. Is the measure used in other reporting programs?

The information gathered in the NCI is invaluable as it provides the CT DDS the opportunity to collect information that in some cases is unavailable elsewhere. While the CT DDS data systems collect information about an individual, supports, waiver enrollment, and a variety of other variables, the NCI has been used to help with proxy information that CT DDS simply does not have in other data sources. Legislative requests for information can be challenging, due to the information available. The NCI provides a cornucopia of additional variables that provide

context into many aspects of an individual's life. Additionally, NCI data has been used to respond to queries from the general public, nonprofits, and other state or federal agencies.

CT DDS recently began using a new Individual Plans (IPs) at the beginning of FY19. The IP was altered to increase the person-centered part of planning. As part of the IP Coding Project CT DDS made the decision to test the hypothesis that the changes would allow the individuals input in the plan. The IP Coding Project entails reviewing IPs to collect specific data about the type of goals and social support individuals have, and if the goals listed in the IP match what the individual has expressed interest in achieving within the year. Comparisons about individuals wanting to live somewhere else and about employment match with the percentages expressed in the NCI. Additionally, when the collected data from the new IPs is aggregated by residence, the variation mimics the distribution in the NCI. This provides CT DDS with confidence that the concepts used in the new IP Coding are valid.

Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?

The NCI allows for analytical comparison between states. While the number of states using the NCI varies by year, 46 states have participated in the NCI at some time.

The NCI is one of the only times CT DDS is able to hear from our individuals regarding their experiences and satisfaction. State trends are invaluable and have spurred a variety of initiatives and adjustments to policy as expressed above. The publically available chart generator on the NCI website allows a review of a state to national trends, while the full In Person Survey National Report Part I: Data (found here: https://www.nationalcoreindicators.org/upload/core-indicators/17-18_IPS_National_Report_PART_I_3_20_19.pdf) provides everything necessary to compare between states. Additionally, the In Person Survey National Report Part II: History, Methodology, Appendices provides detailed statistical information required to statistically evaluate the data in Part I.

Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?

Currently the CT DDS gathers the requisite information for the NCI using the following methodology. The data is collected from administrative data sets, case notes, and in person survey with individuals served and/or someone that know the individual. Survey portions of the NCI are completed by state staff and administrative staff enters the information into the provided data collection website. The NCI occurs annually.

Further, CT DDS has begun to utilize the tools available to reduce the burden additional assessments add. By prefilling portions of the NCI Adult In Person Survey and additional training to expand the surveyor pool, data collection has become more efficient. We don't plan to stop there. This year the ability to upload some of the survey was utilized and CT DDS is

planning to use this advantage. HSRI has been responsive in providing instruction and clarifying questions and inquiries about the ability to upload data. In January of 2019, the HSRI staff came to Connecticut for in person training of over 30 new trainers.

Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

NCI provides a Long Term Services and Supports measures needed by state Medicaid agencies to understand the experience of people with developmental disabilities who access and utilize home and community based services. The NCI measure set provides insight, including the data cleaning, analysis, and summary report, which publicly compares all participating state results. The public reporting of NCI results provides a level of accountability needed by CT DDS in order to understand where we have improvement opportunities or need to re-evaluate the effectiveness of our policies or practices.

We agree with the summary of the workgroup discussion, indicating the usefulness of the NCI measures to our state, the flexibility and adaptability to be used by people with multiple types of disabilities. From its inception in 1998, NCI has remained committed to channeling direct input from people with I/DD to the state agency responsible for the administration of the service delivery system. NCI assures the voice of the people is heard directly regarding the supports and services so critical to their day to day well-being. This crucial aspect of NCI – the importance to measure – weighs equally in Connecticut’s decision to continue using NCI.

CVS Health (Kevin Teel)

CVS Health is a healthcare innovation company helping people on their path to better health. We appreciate the consideration of measures to strengthen Medicaid quality for children and adults and are pleased to provide comments. Pharmacy benefit management organizations, pharmacies, and pharmacists play an integral role in health quality outcomes, and yet there are relatively few quality measures today that are specifically tied to the appropriate administration of medication (e.g., Antidepressant Medication Management [AMM-AD]). Prescription medications, medication therapy management, and pharmacy counseling can drive meaningful results and should play a larger roles in the adult and child core set of measures.

With regard to specific measures for inclusion, CVS Health strongly supports the recommendation to include Use of Pharmacotherapy for Opioid Use Disorder. As the U.S. opioid abuse crisis grows worse, CVS Health has added new programs and redoubled our efforts around education, proper medication disposal, utilization management, increased access to naloxone, and ongoing advocacy for legislative solutions. We are enhancing our enterprise initiatives to address prescription opioid misuse and abuse that will be supported by all parts of the company, including our CVS Pharmacy retail presence in nearly 10,000 communities across the country and CVS Caremark, our PBM that manages medications for more than 90 million plan members. We plan to reach patients, providers, payers, advocacy organizations, elected leaders and community health advocates. In addition to the current core set measures of Use of Opioids at High Dosage (OHD-AD) and Concurrent Use of Opioids and Benzodiazepines (COB-AD), the Use of Pharmacotherapy for Opioid Use Disorder will go far to establish the number of people initiating medication assistance treatment.

Additionally, CVS Health supports the recommendation to include Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia. Children with complex medical conditions often rely on specialty drugs for treatment and management of their diseases. While there are many promising new specialty drugs in the pipeline, costs are expected to increase at a rapid pace over the next several years. As the nation's largest specialty pharmacy, CVS Health had developed solutions that improve patient care while helping to control costs. Prescription of antibiotic prophylaxis, and its favorability over more invasive treatment, is well supported by available research and the workgroup members. With the opportunity to provide comprehensive care for children with genetic disorders and avoid costly hospitalizations for infection management, the Appropriate Antibiotic Prophylaxis measure will make an important addition to the Child Core Set.

CVS Health continues to support the addition of pharmacy-focused measures that were discussed but not recommended for inclusion, such as Proportion of Days Covered: Antiretroviral Medications, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease, and Tobacco Use: Screening and Cessation Intervention.

CVS Health is also concerned about the removal of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure while there is still an absence of a measure in the Child Core set that indicates physician use of interventions and referrals for

children with or at risk of obesity. Current data suggests that documentation of an assessment is still not common practice, and may also suggest lack of physician prioritization of obesity. We agree with prior comments that caution against sending a signal about the low priority of this topic if the WCC-CH measure is removed from the Child Core Set without a replacement, and we recommend maintaining the measure until a suitable replacement is found.

Thank you for the opportunity to provide comments in support of these recommendations.

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

Below are DC's comments:

ADDITIONS (5)

Measure Name	DHCF Comments	Rationale
Metabolic Monitoring for Children and Adolescents on Antipsychotic Medications	No comment	
Use of Pharmacotherapy for Opioid Use Disorder	Support	increasing treatment for OUD is a priority issue for DC, will initiate enhanced monitoring due to new 1115 demo
Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Disease	Oppose	Not a priority issue for DC, will maintain routine monitoring
National Core Indicators	Oppose	NCI survey is administered by a separate DC agency, DHCF does not have access to data, data not comparable year over year, no national benchmarks exist
National Core Indicators for Aging and Disabilities Adult Consumer Survey	Oppose	NCI survey is administered by a separate DC agency, DHCF does not have access to data, data not comparable year over year, no national benchmarks exist

REMOVALS (7)

Child Core	DHCF Comments	Rationale
Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)	No comment	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents (WCC-CH)	No comment	
Pediatric Central Line–Associated Bloodstream Infections (CLABSI-CH)	No comment	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	No comment	
Adult Core	DHCF Comments	Rationale
Adult Body Mass Index Assessment (ABA-AD)	No comment	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)	Oppose	This is a MY2018 MCO PIP measure, MCOs are currently not meeting District goal
Annual Monitoring for Patients on Persistent Medications (MPM-AD)	No comment	

Healthy Weight Partnership Inc. (Teresa Earle)

We note that you recommend the Weight Assessment and Counselling for Nutrition and Physical Activity for Children / Adolescents – Body Mass Index Assessment for Children / Adolescents (WCC-CH) measure for removal from the 2020 Core Set.

As an organization that is focused on prevention and management of child obesity, and on behalf of a team that has been engaged in such work for almost 20 years in the USA and internationally, we strongly oppose removing this measure from the Child Core Set in the absence of including an improved measure. Specifically:

1. We agree with the federal liaison who noted that there is evidence to support BMI screening in the primary care setting
2. BMI screening is part of the USPSTF recommendations for both children and adults
3. Removal of this measure will send a strong signal about the low priority of this topic if there is no improved replacement. Something which burgeoning chronic illness in our country cannot afford.
4. Whatever the beneficial impact of it, in and of itself, BMI screening in primary care is a fundamental precursor to effective intervention. If there is no routine measurement for individual patients there will be no trigger for discussion about an intervention to address the issue. This will inevitably result in a reduced referral rate to such interventions
5. BMI screening at an individual level is one enabler of comparative effectiveness of different interventions – both short and longer term
6. The evidence and our own observations indicate that patient interest in, and engagement with interventions is greater if they are aware that they need to address an issue. If the measure is removed and /or deprioritised fewer children and parents will be aware easily that there is an issue and engage with evidence-based interventions
7. Work is taking place at a national level (HCP bodies and CDC-funded collaboratives) to codify, pay for and prioritize evidence-based SCALABLE child weight management interventions with a long overdue view to scaling up such activity – both across states and nationally. This work will be hamstrung by removing this measure.

To be clear, we are not opposed to the removal of the measure per se, AS LONG AS IT IS REPLACED IMMEDIATELY BY AN IMPROVED MEASURE, such as referral to evidence-based care (of which there are sufficient interventions available nationally).

Human Services Research Institute (Julie Bershadsky)

First, thank you for the opportunity to review and comment on the draft report resulting from the work of 2020 Child and Adult Core Set Review Workgroup. I was able to attend the in-person meeting on May 9th and was thoroughly impressed with the thoughtful discussion of the Workgroup.

As director of NCI-AD, I am heartened by the Workgroup's recognition of the critical role of LTSS in so many people lives' and the importance of having valid, reliable and well-recognized measures, keyed to outcomes important to recipients of LTSS and developed with their input. As we have learned, developing and implementing meaningful LTSS measures is not easy, and the importance of technical assistance for implementing them and using resultant data cannot be overstated.

The NCI-AD Adult Consumer Survey has all the above characteristics, which, as evidenced by the program's rapid growth and expansion, are recognized and valued by participating states and state agencies. While participation is voluntary, in 2018-2019, 17 states collected NCI-AD Adult Consumer Survey data; in 2019-2020, we estimate 20-22 surveying states; that number is expected to continue growing every year. Furthermore, the number of surveys conducted in many states is also growing. Current sample sizes range from 400 to almost 4000 surveys per state; many states oversample to target individual programs and various subpopulations within those programs – for example, MCOs, service settings, geographic regions, and, in at least one state, service providers. NCI-AD's feasibility is well-established, and the technical assistance, oversight, project management and centralized data analysis provided by HSRI and its partner, NASUAD, contribute greatly to the program's recognition and expansion. The importance of these elements was evident in the Workgroup members discussion and are reflected in the draft report.

There are a few clarifications and edits to the draft report we would like to suggest:

Page VI: Abbreviation "NCI-AD" stands for "National Core Indicators for Aging and Disabilities", without the "Adult Consumer Survey" at the end.

Page IX, Exhibit ES.3: Similarly, it would be more correct to refer to NCI-AD as "National Core Indicators for Aging and Disabilities (NCI-AD) Adult Consumer Survey".

Page 11, Exhibit 7: Same comment as right above.

Page 16, heading "National Core Indicators (NCI) and National Core Indicators for Aging and Disabilities Adult Consumer Survey (NCI-AD)": Same comment as above.

Page 16, first paragraph under NCI & NCI-AD: Should read "The NCI and NCI-AD measures assess the experience and outcomes of individuals with intellectual and developmental disabilities and their families, and seniors and adults with physical disabilities, respectively".

Page 16, third paragraph under NCI & NCI-AD: Should read “NCI-AD is a voluntary effort by state Medicaid aging and disability agencies to measure and track their performance. The core indicators are standard measures used across states to assess the outcomes of services provided to seniors and adults with physical disabilities. Indicators address nineteen key areas of concern including (1) service coordination, (2) rights and respect, (3) community participation, (4) choice and decision-making, (5) health care, (6) safety, (7) relationships, (8) satisfaction, (9) care coordination, (10) access to community, (11) access to needed equipment, (12) wellness, (13) medications, (14) self-direction, (15) work, (16) everyday living, (17) affordability, (18) control, and (19) person-centered planning. Seventeen states collected NCI-AD data in 2018 and 2019.”

Page 17, last paragraph under NCI & NCI-AD: Should read “Workgroup members acknowledged that adding new survey-based measures to the Core Set would require states to either add requirements for these surveys to managed care contracts or to field them directly. At the same time, measures from other data sources that assess the experience of beneficiaries and their functional status and well-being are not currently available. The NCI and NCI-AD surveys are accessible in multiple languages to people with disabilities who are nonverbal, blind, deaf, or have other disabilities; both are also available in Spanish.”

Again, I appreciate the opportunity to comment and thank the Workgroup for its time and efforts.

Human Services Research Institute (Alexandra Bonardi)

Thank you for the opportunity to review and comment on the draft 2020 Child and Adult Core Set Review Workgroup. Having attended the in-person discussion of the Workgroup during its discussions of the measures considered in the Long Term Supports and Services domain, I commend the workgroup for its consideration and thoughtful discussion of the measures.

I am pleased to have this opportunity to reflect on this report from my perspective as the Director of National Core Indicators at Human Services Research Institute, and to provide some important additional content and clarification specific to the National Core Indicators.

As states continue to support people with complex and long-term support needs, it is critical to have recognized, valid measures against which to benchmark and improve outcomes. I support the identification of LTSS measurement as a strategic priority for states.

The National Core Indicators (NCI) have demonstrated feasibility, with 46 states participating. In 2018-2019, 37 states collected data through the NCI's In-Person Survey. While individual states voluntarily participate, collect data, and are the owners of the data collected analyzed, results are made public through web-based reports generated by HSRI and posted on the NationalCoreIndicators.org website. As partners with states in this data collection effort, HSRI and the National Association of State Directors, support states through robust training support to ensure reliable data collection, direct and ongoing communication with all states to ensure samples produce valid and comparable results, a standardized electronic data collection platform, support to NCI coordinators in all states, and an annual meeting to develop states capacity to collect and use the NCI data. We believe the ongoing participation of states demonstrates that the effort to train surveyors and collect data yields valuable information on quality and outcomes; information that cannot be collected by a means other than a direct survey to service recipients. This was reflected in the workgroup members discussion.

States routinely provide examples of how NCI data is used. The summary data can be downloaded from reports. NCI also provides a chart generator (<https://www.nationalcoreindicators.org/charts/>) which allows visitors to the NCI website to generate basic charts from the in-person survey results on a range of indicators in the population receiving services from their Developmental Disabilities Agency. The NCI staff stability survey is used to objectively examine issues in the direct support workforce across agencies including wages, benefits, staff retention and turnover. Staff stability results have been used to monitor the effects of policy and payment initiatives to increase worker wages, for example.

Finally, there are a few clarifications we would like to offer for your consideration in the draft report:

- Page 16 of the report includes the following description. “The NCI and NCI-AD measures assess the experience and outcomes of individuals with intellectual and developmental disabilities and their families and individuals with physical disabilities and their families, respectively.” To clarify, NCI surveys are intended to provide state agencies and the public

information about the experience of people who receive services from state developmental disabilities agency. It provides an In-Person Survey, Family Surveys for parents and guardians of adults and children who receive supports and a Staff Stability Survey. NCI-AD is intended to provide information from people who are receiving age-related support services and people with physical disabilities through the NCI-AD Adult Consumer Survey which is delivered in-person.

- The first bullet references the staff suitability survey, this should be changed to reflect the tool's name: the Staff Stability Survey.

Thank you again for this opportunity to offer comment.

Indiana Division of Disability and Rehabilitative Services (Kylee B Hope)

Thank you for the opportunity to comment on the report titled "Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP." The report succinctly and clearly describes the discussions of the work group and provides helpful background information.

I am writing these comments in my role as the State Director of Developmental Disability services in the state of Indiana; Indiana has participated in the National Core Indicators (NCI) project for the past seven (7) years and is gearing up for year eight. As the Director, discussions of reporting on measures in Medicaid Long Term Services and Supports is of significant interest and concern. It is extremely important to distinguish between measures of acute or rehabilitative long term care, which typically take place in a facility or institutional setting, from those which are services or supports for daily life, which typically take place in home and community based settings. This distinction is extremely important to make, and would be helpful if described in the report.

Of note, there were 42 distinct measures suggested for inclusion in either the Child or Adult Core Set. Of those 42, only 5 were identified by the workgroup as substantially meeting the characteristics set forth as important for the measure to be recommended. That NCI was among the measures recommended comes as no surprise, with its long history and reputation for providing valid, reliable and most importantly relevant and actionable measures. NCI is well known and heavily used in the national DD system.

I strongly encourage CMS to take up the recommendations of the workgroup to include NCI to fill the gap in LTSS measures for the Medicaid Adult Core Measure set in 2020. To understand how NCI meets the characteristics set forth by CMS and Mathematica, I would like to comment on the specific characteristics for consideration of a New Measure as described in the report.

Characteristics Considered for Addition of a New Measure:

Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?

Indiana has utilized NCI data in a variety of ways. NCI data was used as initial assessment data for Indiana's Statewide Transition Plan for compliance with the HCBS Settings Rule. The data has been shared with legislatures, advocacy groups, and disability tasks forces to affect policy and administrative changes. NCI data is being used as performance measure data for HCBS waivers.

Additionally, NCI data will be used as an assessment of the quality of life for individuals with disabilities living in the community through Indiana's Living Well Grant.

Alignment. Is the measure used in other reporting programs?

On a quarterly and annual basis, Indiana's NCI data is compiled and reviewed for several of the performance measures within Indiana's two HCBS waivers. Indiana is also incorporating NCI data into the Living Well Grant as part of the assessment and evaluation process. The data is included in the annual reports to the grant funder, the Administration for Community Living.

Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?

Indiana has participated in the NCI with 45 other states and the District of Columbia for several years. The high state participation rate and the information to make comparisons between states of similar size or states within our same geographic region is extremely helpful to establish the framework of our system. Additionally, Indiana is able to study and analyze the NCI indicators to reveal how our full system is functioning. As the State Director, this ability is vitally important in my role. Indiana does have processes in place to measure individual providers and individual lives, but NCI is the only systemic measurement system that provides me with already cleaned, analyzed, and publicly reported data. The ability to have a nationally recognized data set that is transparent is a profound step towards effective trust-building and collaboration with our stakeholders. NCI provides a core effort in our stakeholder engagement process.

Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?

Indiana employs an outside vendor to conduct a statistically valid random sample for each of the two HCBS waivers. The vendor generates the random sample from the state's records, populates the background information, conducts the face-to-face interviews, and enters the information into the NCI system. Indiana invests substantial resources, including financial and personnel, to obtain reliable and valid information. Indiana has been investing in NCI for over seven years because the information obtained through the survey is invaluable. NCI data provides insight into the functionality of the entire system as well as how Indiana compares to similar states. Through this data, we can determine areas of strength and weakness, as well as influence system improvements and regulatory changes.

Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

NCI provides Indiana with information necessary to understand the experience of individuals with intellectual and developmental disabilities who are accessing and utilizing Indiana's HCBS waivers. NCI data is cleaned, analyzed, and a comprehensive report is publicly shared which is not available in any other measure set. Because NCI data is publicly reported, my state agency is accountable for the results. Through the NCI results, Indiana analyzes the information to identify opportunities for improvement and/or evaluation of policies or practices.

Indiana agrees with the summary of the workgroup discussion which indicates the usefulness of the NCI measures to our states and the flexibility and adaptability to be used by people with multiple types of disabilities. Since NCI's inception in 1998, NCI has been steadfast in funneling direct input from individuals with intellectual and developmental disabilities to the state agency responsible for the administration of the service delivery system. NCI assures the voice of the people is heard directly through face-to-face interviews regarding the supports and services so essential to their day to day well-being. This fundamental aspect of NCI – the importance to measure – weighs equally in Indiana's decision to continue using NCI.

Kaiser Permanente (Deborah Espinal)

Kaiser Permanente ("KP") appreciates the opportunity to review and comment on the 2020 Core Set Review ("Review") for public comment. KP has the following comments/questions on the Review for consideration:

1. KP notes that there are several measures which include services that are often provided by other entities, separate from providers that directly contract with the managed care health plan. For example, in California, the added measures of "Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia" includes services that may be carved out of managed care to California Children's Services and "Metabolic Monitoring for Children and Adolescents on Antipsychotics" includes services that are typically carved out of managed care to the county mental health system. In addition, measures which fall under "Dental and Oral Health Services" include dental care which is often entirely carved out of managed care. While we understand that each state varies in its service delivery arrangement, it is beneficial to acknowledge in the Review that managed care plans do not always have access to all of the data required to report on every measure and that the state must clearly communicate how and from whom the data should be reported.
2. In addition to the benefit of acknowledging the varying service providers that impact the different measures and determining reporting responsibility, KP would like to comment on the administrative burden managed care plans must undertake to report on these measures. The level of this burden will be greatly increased depending on how the individual state program chooses to administer the reporting program and responsibilities.
3. The Review references alignment with other measures as a main priority (pg. 8 and Exhibit ES.1) and also that the members of the Review Workgroup commented that the Core Sets are not the place to put new or untested measures (pg. 20).² In response, KP would like to note that there are measures in the 2020 Core Set that have an established, well-tested National Commission on Quality Assurance (NCQA) option, yet were not used. The Review also does not provide any rationale for not using the NCQA measure. Some of these measures include "Screening for Depression and Follow-up Plan" at different ages and "Use of Pharmacotherapy for Opioid Use Disorder," which both cite the CMS rather than the NCQA measure. NCQA measures are trusted and well-tested and typically have already been operationalized by managed care plans for easy reporting and more accurate data. KP recommends that where measures can clearly be aligned with NCQA, the NCQA measure is chosen.
4. Finally, KP would like to comment on the election of the two Human Services Research Institute (HSRI), National Core Indicator (NCI) measures to be added for the 2020 Core Set Measures. First, it is difficult to understand what would be required of managed care plans to administer and report on these measures. Second, it is not clear that these measures would provide meaningful information beyond what will already be collected through other measures. Further rationale and basic technical guidance is needed for state programs as well as managed care plans to understand the reasoning and benefit of utilizing these two new measures.

KP appreciates the opportunity to provide comments on the 2020 Core Set Review for Public Comment. Please feel free to reach out to KP with any questions.

Kaiser Permanente Washington Health Research Institute (Beverly B Green)

2020 Core Set Review Public Comment: In support of adding colorectal cancer screening as a core set measure.

Colorectal cancer (CRC) screening decreases mortality and incidence by over 50%¹ and may be cost-saving because of the high costs of CRC treatment.² However, screening rates are low especially among Medicaid insured adults (46%, compared to 70% in Medicare insured adults, HEDIS 2017)³, a disparity that we believe is in part to the fact that Medicaid plans are not required to report CRC rates. In contrast, Medicare plans are required to report CRC screening rates. Medicaid enrollees are also 50% more likely to present with late stage colon cancer or die from it, than those with commercial or Medicare insurance.⁴ Over 75% of CRC deaths occur in adults who are not up to date for CRC screening.⁵ Nationally, the Medicaid population includes about 1.8 million adults overdue for CRC screening.⁴

Direct mailing of fecal immunochemical test (FITs) is low-cost evidence-based effective strategy for increasing CRC screening, with meta-analyses demonstrating 22% increase in screening rates.⁶ Kaiser Permanente Northern California mails over 700,000 FIT kits to adult patients overdue for CRC screening annually to achieve CRC screening rates of over 87%. CRC mortality rates have dropped by 55% since the program began in 2006.⁷

BeneFIT is a Centers for Disease Control and Prevention funded mailed FIT program (U48DP005013) that was implemented in two Medicaid managed care insurance plans,⁸ one in Oregon and one in Washington state. The plans used claims data to identify enrollees overdue for CRC screening and vendors to mail FIT kits directly to over 10,000 enrollees, with over 17% completing FIT within 6 months. In year 2 of the program, the Washington health plan decided to limit the program to only special needs enrollees (those with both Medicaid and Medicare insurance), while the Oregon plan expanded its program. Oregon is one of 4 states that requires insurance plans to report Medicaid CRC screening rates, Washington state does not have a reporting requirement, a key factor in their decision to only offer the program to special needs enrollees.

While a Medicaid CRC quality reporting metric is not enough on its own to decrease Medicaid screening and outcome disparities, it is a necessary first step. Without it plans cannot track progress, learn from best practices, and are less motivated to support community clinic efforts to increase screening rates. The Health Resources and Services Administration (HRSA) require Federally Qualified Health Centers (FQHCs) to report CRC screening rates,⁹ with results publicly available. In Washington state, some FQHCs, with grant support, have successfully implemented their own mailed FIT programs. Medicaid plan support would help them to sustain these programs long-term. Oregon state also includes Medicaid CRC screening rates as one of its incentivized metrics. Since the program began in 2014 CRC screening rates have increased by 11% (from 46.2% to 57.2%).¹⁰ In contrast Washington, a state that does not required plans to report Medicaid CRC screening, rates have only increased by 3% (from 43% to 46%) over the same time period.¹¹

In the draft report two reasons were given for not adding CRC screening to the adult core set. We address each below:

1. The long look back period for screening colonoscopy. This barrier also applies to Medicare and commercially insured patients, but there are solutions. In BeneFIT, clinics review health plan lists to identify people who do not need mailed FITs because of a colonoscopy, and to update documentation.⁸ Patients are also asked in when they are sent an introductory letter prior to FIT mailings (and a number to call if they have had a colonoscopy in the prior 10 years). OCHIN, a nonprofit organization that provides electronic health records (EHR) and support to over 500 health care organizations (mostly FQHCs) in 47 states has deployed EHR reminders and embedded registries to identify age-eligible patients overdue for CRC screening. Provider so providers can order screening tests or update records. These interventions were successfully deployed to over 40,000 low-income patients in the STOP Colon Cancer Trial (Coronado, JAMA Internal Medicine 2018).¹²
2. Lack of testing of the colorectal cancer screening metric. Medicaid health insurance plans already collect HEDIS Medicare CRC rates for special needs patients (adults with both Medicaid and Medicare). Four states, including Oregon require Medicaid health plans to report HEDIS colorectal cancer screening rates.

Below is a review the criteria for adding a new metric to the Medicaid and CHIP Child and Adult Core set of quality indicators. As discussed above, all of the criteria are met.

<u>Actionability:</u> Will the measure provide useful or actionable results for state Medicaid programs?	Yes, effective low-cost strategies exist for increasing CRC screening uptake. Reporting allows plans to track their progress and identify plans with best practices.
<u>Alignment:</u> Is the measure used in other reporting programs?	CRC screening reporting is required by: <ul style="list-style-type: none"> • CMS Medicare - HEDIS • NCQA accreditation - HEDIS • HRSA grantees (Federally Qualified Health Centers)
<u>Appropriateness: for state-level reporting:</u> Has the measure been validated and tested for state-level reporting in one or more states?	Four states have tested and require reporting of HEDIS Medicaid CRC screening. The long look back for screening colonoscopy is a challenge for all insurance plans, but there are solutions. Better documentation decreases under and overuse of screening and follow-up testing.
<u>Feasibility:</u> Will states be able to access the data needed to calculate the measure?	Health plans already collect this data for Medicare and commercially insured enrollees. The CRC screening HEDIS metric is a hybrid measure (claims data and/or chart audit). Audits done for other HEDIS hybrid metrics could include CRC screening.
<u>Strategic Priority:</u> Does the measure fill a gap area in the Child and/or the Adult Core Set?	Yes, breast and cervical cancer are already included in the Adult Core Set. Colorectal cancer screening is not included, even though screening rates are lower and disparities larger.

To, summarize, Medicaid patients experience CRC screening and outcome disparities. Adding the HEDIS CRC screening to the core metric is a necessary first step for change.

Citations

- ¹ Zhang J, Cheng Z, Ma Y, He C, Lu Y, Zhao Y, Chang X, Zhang Y, Bai Y, Cheng N. Effectiveness of Screening Modalities in Colorectal Cancer: A Network Meta-Analysis. *Clin Colorectal Cancer*. 2017;16:252-63.
- ² Ran T, Cheng CY, Misselwitz B, Brenner H, Ubels J, Schlander M. Cost-Effectiveness of Colorectal Cancer Screening Strategies-A Systematic Review. *Clin Gastroenterol Hepatol*. 2019.
- ³ de Moor JS, Cohen RA, Shapiro JA, Nadel MR, Sabatino SA, Robin Yabroff K, Fedewa S, Lee R, Paul Doria-Rose V, Altice C, Klabunde CN. Colorectal cancer screening in the United States: Trends from 2008 to 2015 and variation by health insurance coverage. *Prev Med*. 2018;112:199-206. PMID: PMC6202023.
- ⁴ Medicaid and CHIP Payment and Access Commission. MACStats: Medicaid and CHIP Data Book. 2017 [updated 2017; cited August 3 2019]. Available from: <https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-CHIP-Data-Book-December-2017.pdf>.
- ⁵ Doubeni CA, Fedewa SA, Levin TR, Jensen CD, Saia C, Zebrowski AM, Quinn VP, Rendle KA, Zauber AG, Becerra-Culqui TA, Mehta SJ, Fletcher RH, Schottinger J, Corley DA. Modifiable failures in the colorectal cancer screening process and their association with risk of death. *Gastroenterology*. 2019;156:63-74.e6. PMID:

Kentucky Department for Medicaid Services (Angela W Parker)

I agree with the Workgroup's characteristics for removing or adding measures. However, I am not sure all characteristics were taken into account with some of the recommendations.

I disagree with removing the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-BMI assessment (WCC-CH) and Adult BMI Assessment (ABA-AD) from the Core Set for both children and adults. Obesity is an epidemic. I agree with the federal liaison who voiced support for the measures. I am unsure what clinical evidence to support the measure is lacking, but the answer is to improve on the clinical evidence, not take away the focus. There are multiple health risks associated with obesity.

I disagree with the addition of the antibiotic prophylaxis measure for sickle cell anemia. It is limited in scope due to the prevalence variability by state due to the rarity of the disease. The focus should be on educating the providers who care for these patients and the consumers who have this unfortunate disease.

National Core Indicators (NCI) and National Core Indicators for Aging and Disabilities Adult Consumer Survey (NCI-AD) addition will be a challenge for those states not currently using and could be an administrative burden. It does provide additional information that may be of use for care management programs. However, most Medicaid Managed Care Organizations have tools for identification for those populations.

Allison LaRussa

With thanks to the Center for Medicaid and CHIP Services (CMCS) for the opportunity to comment, I would like to offer the following in response to the draft report “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” The draft report states that the Child and Adult Core Set Stakeholder Workgroup for the 2020 Annual Review is charged with assessing the 2019 Core Sets with focus on measurement that is actionable, aligned, and appropriate. Actionable measures are defined as those whose “results can be used to improve care delivery and health outcomes.” By including measures that have the potential to spur improved quality of care, the Core Set is positioned as a valuable tool for CMCS and participating states.

One integral and actionable aspect of health care quality, equity, was not emphasized in the draft report. Reducing disparities in health care delivery and outcomes between subpopulations is critical to improving quality of care and health care organizations across the country are striving to close gaps in care related to social characteristics. Through the Core Set, CMCS can encourage these efforts by supporting measurement that demonstrates the degree of equity in care. Selecting measures for the Core Set that are sensitive to disparities related to gender, race, ethnicity, geographic location, and socioeconomic status could highlight areas in which state Medicaid and CHIP programs can take action to create more equitable health systems.

Disparities sensitivity should be one of the Core Set’s “characteristics considered for removal of existing measures and addition of new measures,” and measures that are sensitive to disparities should be prioritized for inclusion. Disparities sensitive measures may be those that are prevalent among particular subpopulations or those that have been found to demonstrate gaps in quality between subpopulations. Of note, the Workgroup did recommend to include the disparities sensitive measure Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia for the 2020 Core Set. However, the draft report does not indicate that disparities sensitivity was systematically accounted for in Workgroup recommendations for each measure under consideration. In evaluating measures under consideration for disparities sensitivity, the Workgroup could employ a protocol such as that developed by the National Quality Forum (NQF) in 2012 in which NQF-endorsed measures are identified as being disparities sensitive after assessment using standard criteria.¹

Shared use of the Core Set presents an opportunity for shared focus on promoting health equity and action toward reducing health disparities. In Exhibit 8 of the draft report, “stratification by race and ethnicity” is noted as a gap area for future core measure sets. Further, “racial and ethnic stratification” is listed in the draft report as a suggested area for shared learning opportunities for states. Pursuit of these ideas dovetails with the practice of routinely and systematically considering disparities sensitivity in evaluating measures for inclusion in the Core Set. This approach brings equity to the forefront of quality measurement for Medicaid and CHIP, creating opportunity for widespread data-driven improvements in care that are urgently needed.

Citation

- ¹ National Quality Forum (2012). Healthcare Disparities and Cultural Competency Consensus Standards: Disparities Sensitive Measure Assessment.
https://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx.

Maryland Department of Health (Bernard Simons)

Thank you for the opportunity to comment on the report titled “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” The report succinctly and clearly describes the discussions of the work group and provides helpful background information.

I am writing these comments in my role as the State Director of Developmental Disability services for The Maryland Developmental Disabilities Administration. Maryland has participated in NCI for the past several years. As the Director, discussions of reporting on measures in Medicaid Long Term Services and Supports is of significant interest and concern. It is extremely important to distinguish between measures of acute or rehabilitative long-term care, which typically take place in a facility or institutional setting, from those, which are services or supports for daily life, which typically take place in home, and community-based settings. This distinction is extremely important to make and would be helpful if described in the report.

Of note, there were 42 distinct measures suggested for inclusion in either the Child or Adult Core Set. Of those 42, only five were identified by the workgroup as substantially meeting the characteristics set forth as important for the measure to be recommended. That NCI was among the measures recommended comes as no surprise, with its long history and reputation for providing valid, reliable and most importantly relevant and actionable measures. NCI is well known and heavily used in the national DD system.

I strongly encourage CMS to take up the recommendations of the workgroup to include NCI to fill the gap in LTSS measures for the Medicaid Adult Core Measure set in 2020. To understand how NCI meets the characteristics set forth by CMS and Mathematica, I would like to comment on the specific characteristics for consideration of a New Measure as described in the report.

Characteristics Considered for Addition of a New Measure:

Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?

Maryland has been using the NIC data to make policy decision and provide education and information to our stakeholders based on the trends of our data collection.

Alignment. Is the measure used in other reporting programs?

The Maryland Developmental Disabilities Administration has been using the NCI data in our quarterly reporting to the quality advisory committee to improve our performance measures and basic HCBS waiver performance measures. We have been able to use the data to inform stakeholders of areas where we need to improve and where we are doing outstanding. The data has also been used to improve the health and safety of the person we support.

Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?

NCI has been utilized by our quality assurance department, nurse and incident reporting across four regions for the past several years. NCI indicators demonstrate how our full system is functioning, which is critically important in my role as the State Director. We have mechanisms in place to measure individual providers and individual lives, but NCI is the only systemic measurement system that provides me with already cleaned, analyzed and publicly reported data. This transparency of data forms a significant step towards effective trust-building and collaboration with our stakeholders. NCI provides a core effort in our stakeholder engagement process.

Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?

The Developmental Disabilities Administration is in the process of enhancing its service delivery model and has created a new data based platform that will be use to collect NCI data that focuses on critical information to know to be able to make policy decision as well as funding decisions.

Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

The NCI provides Maryland critical information to be able to understand the experience of people with developmental disabilities who access and utilize home and community-based services and their families. There is no other measure set which provides this insight. The public reporting of NCI results provides a level of accountability needed by my state agency in order to understand where we have improvement opportunities or need to re-evaluate the effectiveness of our policies or practices.

We agree with the summary of the workgroup discussion, indicating the usefulness of the NCI measures to our states, the flexibility and adaptability to be used by people with multiple types of disabilities. From its inception in 1998, NCI has remained committed to channeling direct input from people with I/DD to the state agency responsible for the administration of the service delivery system. NCI assures the voice of the people is heard directly regarding the supports and services so critical to their day-to-day well-being. This crucial aspect of NCI – the importance to measure – weighs equally in state’s decision to continue using NCI.

Michael & Susan Dell Center for Healthy Living (Deanna M Hoelscher)

I am providing public comment on the report, Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multi-Stakeholder Review of the 2020 Child and Adult Core Sets. In particular, I would like to comment on the proposed changes for the core indicator, Weight Assessment and Counselling for Nutrition and Physical Activity for Children / Adolescents – Body Mass Index Assessment for Children / Adolescents (WCC-CH). As a child obesity researcher for more than 25 years, this measurement has been essential to our work in low-income communities, and the omission of this measure (without a suitable substitute) would make it difficult for us to: (1) determine the extent of the child obesity problem in Medicaid and CHIP participants, as well as to (2) document any changes that occur through individual and environmental-level interventions.

My specific objections to the removal of this core indicator are as follows:

1. The U.S. Preventive Services Task Force (USPSTF) recommends that children and adolescents 6 years and older be screened by clinicians, who should also offer behavioral counselling or refer them to a comprehensive, behavioral intervention.¹ This recommendation is graded B, based on the evidence, which indicates that the “net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial”. This was noted by one of the federal liaisons in the report. Thus, this measure (or an appropriate replacement) should be implemented in Medicaid and CHIP populations.
2. Documentation of high levels of children with obesity is necessary to justify the development or implementation of effective interventions in the clinical or community settings. For example, in our study, the Texas Childhood Obesity Research Demonstration (TX CORD) study, we found a decrease in the %BMI_{p95}, a measure of severe obesity, in children who participated in the CORD intervention.² This is consistent with other reviews that have shown the benefit of lifestyle-based interventions for weight management among children and adolescents that have at least 26 hours or more of contact time.³
3. Measuring obesity rates in Medicaid or CHIP populations is also essential to monitor progress in obesity prevention efforts that might be occurring via intensive community-based efforts or through natural experiments in specific regions or states. The utility of these types of measurements are clearly outlined in the Institute of Medicine’s (now the National Academy of Science, Engineering, and Medicine) report on Evaluating Obesity Prevention Efforts.⁴ As the lead author of the chapter on the National Obesity Evaluation Plan, surveillance through existing systems, such as the Medicaid/CHIP core indicators, was considered an essential part of monitoring efforts.
4. Measuring obesity in the physician’s office can be an effective way to bring awareness to parents about their child’s health. Using tools, such as the Next Steps materials from the American Academy of Pediatrics, can help the clinician effectively communicate with the family.

As can be seen, there are several compelling and evidence-based reasons to support the measurement of body mass index in children in Medicaid and CHIP. I strongly encourage you to

re-consider the removal of this core indicator. Please let me know if you need further documentation to support this request.

Citations

¹ <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-children-and-adolescents-screening1>; JAMA 2017.

² Butte et al., *Childhood Obesity*, 2015

³ O'Connor et al., *JAMA*, 2017

⁴ IOM (Institute of Medicine), 2013.

Minnesota Department of Human Services (Alex E Bartolic)

Thank you for the opportunity to comment on the report titled “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” The report succinctly and clearly describes the discussions of the work group and provides helpful background information.

I am writing these comments in my role as the State Director of Disability services in Minnesota. Minnesota has actively participated in the NCI suite of surveys for the past five years. As the Director, discussions of reporting on measures in Medicaid Long Term Services and Supports is of significant interest and concern. It is extremely important to distinguish between measures of acute or rehabilitative long term care, which typically take place in a facility or institutional setting, from those which are services or supports for daily life, which typically take place in home and community based settings. This distinction is extremely important to make, and would be helpful if described in the report.

Of note, there were 42 distinct measures suggested for inclusion in either the Child or Adult Core Set. Of those 42, only 5 were identified by the workgroup as substantially meeting the characteristics set forth as important for the measure to be recommended. The NCI-Aging and Disabilities (AD) Survey and NCI-In Person Survey (IPS) was among the measures recommended, and that comes as no surprise. It has a long history and reputation for providing valid, reliable and most importantly relevant and actionable measures. NCI is well known and heavily used in the national disability services system.

Minnesota participates in the NCI surveys to learn how well home and community-based services are supporting people. The NCI surveys is one way DHS hears directly from people about how well the services and supports they receive help them live, work, and engage in their community.

I strongly encourage CMS to take up the recommendations of the workgroup to include the NCI surveys to fill the gap in LTSS measures for the Medicaid Adult Core Measure set in 2020. To understand how NCI meets the characteristics set forth by CMS and Mathematica, I would like to comment on the specific characteristics for consideration of a New Measure as described in the report.

Characteristics Considered for Addition of a New Measure:

Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?

In recent years, Minnesota has used NCI data to monitor and improve services. An example of this is how Minnesota has used NCI data on community inclusion to help identify and measure progress towards meeting Olmstead goals. Multiple initiatives were developed as part of Minnesota’s Olmstead Plan and NCI results are reported annually to the Minnesota Olmstead Subcabinet to track progress.

Alignment. Is the measure used in other reporting programs?

NCI indicators are used in strategic plan measures, policy proposals, and other high-level planning efforts. NCI indicators are used because they reflect people's quality of life and experience with long-term services and supports. The NCI indicators are used for a number of reasons, including:

- Indicators touch on domains of people's lives that Minnesota does collect elsewhere.
- Surveys are independently administered.
- Surveys gather feedback directly from people.

Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?

The NCI-IPS has been utilized by 46 states and the District of Columbia for several years. The comparisons between states of similar size, states within our same geographic region, and similar LTSS service structure are helpful. In addition, the NCI indicators demonstrate how our full system is functioning, which is critically important in my role as the State Director. We have mechanisms in place to measure individual providers and individual lives, but NCI is the only systemic measurement system that provides Minnesota with already cleaned, analyzed and publicly reported data.

Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?

Minnesota already has implemented a system to collect and analyze state-level NCI data on a yearly basis. We rely on our national partners National Association of State Directors of Developmental Disabilities Services (NASDDDS), the National Association of States United for Aging and Disabilities (NASUAD), and Human Services Research Institute (HSRI) to develop the survey, training materials, and keep us informed of changes to the survey. We contract with Vital Research to hire, train, implement the interviews, and compile/report data back to our national partners for analysis.

Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

NCI provides the Long Term Services and Supports measures needed by state Medicaid agencies to understand the experience of people with physical and developmental disabilities who access and utilize home and community based services. There is no other measure set which provides this insight, including the data cleaning, analysis, and summary report which publicly compares all participating state results. The public reporting of NCI results provides a level of accountability needed by my state agency in order to understand where we have improvement opportunities or need to re-evaluate the effectiveness of our policies or practices.

We agree with the summary of the workgroup discussion, indicating the usefulness of the NCI measures to our states, the flexibility and adaptability to be used by people with multiple types of disabilities. From its inception in 1998, NCI has remained committed to channeling direct input from people with physical disabilities and I/DD to the state agency responsible for the administration of the service delivery system. NCI assures the voice of the people is heard directly regarding the supports and services so critical to their day to day well-being. This crucial aspect of NCI – the importance to measure – weighs equally in state’s decision to continue using NCI.

Missouri Division of Developmental Disabilities (Valerie Huhn)

Thank you for the opportunity to comment on the report titled “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” The report succinctly and clearly describes the discussions of the work group and provides helpful background information.

I am writing these comments in my role as the State Director of Developmental Disability services in Missouri. As the Director, discussions of reporting on measures in Medicaid Long Term Services and Supports is of significant interest and concern. It is extremely important to distinguish between measures of acute or rehabilitative long term care, which typically take place in a facility or institutional setting, from those which are services or supports for daily life, which typically take place in home and community based settings. This distinction is extremely important to make, and would be helpful if described in the report.

Of note, there were 42 distinct measures suggested for inclusion in either the Child or Adult Core Set. Of those 42, only 5 were identified by the workgroup as substantially meeting the characteristics set forth as important for the measure to be recommended. That NCI was among the measures recommended comes as no surprise, with its long history and reputation for providing valid, reliable and most importantly relevant and actionable measures. NCI is well known and heavily used in the national DD system.

I strongly encourage CMS to take up the recommendations of the workgroup to include NCI to fill the gap in LTSS measures for the Medicaid Adult Core Measure set in 2020. To understand how NCI meets the characteristics set forth by CMS and Mathematica, I would like to comment on the specific characteristics for consideration of a New Measure as described in the report.

Characteristics Considered for Addition of a New Measure:

Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?

Missouri uses NCI data for a variety of reasons. Based on the data, the Division of Developmental Disabilities will address areas of enhancements to services and supports through policies and practices, with the goal of providing continuous improvement for people with developmental disabilities. See below to understand how NCI data drives decisions around the states four I/DD Medicaid waivers.

Empowering Through Employment

In October 2016, the Division of Developmental Disabilities (DDD) launched the Empowering through Employment Initiative to assist the growing number of individuals who express an interest in community-based employment. According to National Core Indicators, 51% of individuals receiving home and community-based services express an interest to work in the community; however, fewer than 25% had a goal in their annual plan to support this interest and only 3% of individuals on a monthly basis have services authorized to assist with their

employment pathway. NCI data helped launch this initiative, Missouri understood that people wanted to work. Since Missouri started this effort, there has been a steady increase in the number of individuals accessing employment related services. Today, over 1,000 individuals in Missouri have employment services authorized. A substantial increase over when the state started this effort when only 369 individuals were accessing employment.

Missouri Quality Outcomes

NCI data is used to measure the Missouri Quality Outcomes. The Missouri Quality Outcomes are intended to be a guide to assist the user with facilitating discussion around key areas of importance to the individual and supporting their personal goals, dreams and other areas of interest to the individual that defines quality of life. Improving quality requires continuous efforts on getting to know the person in the settings and situations where they are supported, as well as, consistent interaction and involvement with the individual and their support systems for on-going assessment of their quality of life. Here is a link to the full report:

<https://dmh.mo.gov/dd/docs/ncimissouriqualityoutcomes-fullreport.pdf>, and an additional link to an At-A-Glance report summarizing safety and security:

<https://dmh.mo.gov/dd/docs/qualityoutcomesafetyandsecurity.pdf>.

Alignment. Is the measure used in other reporting programs?

Missouri Quality Outcomes

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<https://dmh.mo.gov/dd/docs/ncimissouriqualityoutcomes-fullreport.pdf>, and an additional link to an At-A-Glance report summarizing safety and security:

<https://dmh.mo.gov/dd/docs/qualityoutcomesafetyandsecurity.pdf>.

NCI – State Budget Request

Missouri also uses NCI data to support state budget measures. Missouri received an in-state performance management award for inclusion of NCI measures in our budget submissions. The division is the only state division to use consumer satisfaction measures in multiple categories. NCI measures are used to demonstrate consumer satisfaction and support quality measures in the annual budget submission. In the link following, pages 934-936 are examples of how NCI measures are incorporated into the division's budget request.

https://oa.mo.gov/sites/default/files/FY_2020_Mental_Health_Budget_Gov_Rec_Book_3.pdf.

Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?

NCI has been utilized by 46 states and the District of Columbia for several years. The comparisons between states of similar size, or states within our same geographic region, is extremely helpful to set the context of our system. In addition, the NCI indicators demonstrate how our full system is functioning, which is critically important in my role as the State Director. We have mechanisms in place to measure individual providers and individual lives, but NCI is the only systemic measurement system that provides me with already cleaned, analyzed and publicly reported data. This transparency of data forms a significant step towards effective trust-building and collaboration with our stakeholders. NCI provides a core effort in our stakeholder engagement process. The NCI Staff Stability Survey utilized in conjunction with the NCI Adult Consumer survey are helping Missouri make our case for identifying ways to address the direct support professional turnover issue. The Adult Consumer Survey tells us if individuals in services believe staff have the right training to meet their needs, while the Staff Stability Survey tells us our state turnover rate. Stakeholders (state government, local government, providers) then utilize this data to help determine the rate of pay for direct support professionals.

Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?

The NCI Team produces reports that inform state efforts to strengthen policy, inform quality improvement activities, evaluate programs and policies, and compare their performance with national norms. Occasionally, NCI will release case examples that examine a hypothetical process and course of action taken by a state to address specific topics. One of these case examples addressed abuse and neglect and gave a scenario of how a Quality Advisory Council used NCI data to propose quality improvement initiatives in their state. Missouri used this to build our own report around safety.

Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

NCI measures are needed by state Medicaid agencies to understand the experience of people with developmental disabilities who access and utilize home and community based services. This measure set helps Missouri get data out about what people in services really want, sometimes that gets lost with guardian involvement and just generally acceptance of past practices. There is no other measure set which provides this insight, including the data cleaning, analysis, and summary report which publicly compares all participating state results. The public reporting of NCI results provides a level of accountability needed by my state agency in order to understand where we have improvement opportunities or need to re-evaluate the effectiveness of our policies or practices.

We agree with the summary of the workgroup discussion, indicating the usefulness of the NCI measures to our states, the flexibility and adaptability to be used by people with multiple types of disabilities. From its inception in 1998, NCI has remained committed to channeling direct input from people with I/DD to the state agency responsible for the administration of the service delivery system. NCI assures the voice of the people is heard directly regarding the supports

and services so critical to their day to day well-being. This crucial aspect of NCI – the importance to measure – weighs equally in state’s decision to continue using NCI.

National Association of Community Health Centers (Ron Yee)

We are pleased to provide comments in response to Recommendations for Improving the 2020 Core Sets of Health Care Quality Measures for Medicaid and CHIP.

NACHC strongly recommends continuation of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body Mass Index measure to improve health outcomes.

1. Our nation is in the midst of an obesity epidemic, and BMI screening is a component of the USPSTF recommendations for both children and adults.
2. Screening is essential for early diagnosis and intervention, leading to improved health outcomes.
3. Food insecurity and poverty adversely affect health center patients leading to obesity.
4. In 2018, health centers screened, counseled on nutrition and physical activity, and referred over 3,549,030 3-17 year old patients with a BMI greater than or equal to the 85th percentile.
5. In addition, health centers referred over 10,860,741 patients 18 years of age and older due to their BMI results.
6. These core sets allow for tracking of pediatric obesity over time for Medicaid and other funders, helping to identify gaps in care and access points.
7. Documenting the BMI using the Medicaid Child Core measure incentivizes clinicians to reduce pediatric obesity and improve health outcomes.

Health centers appreciate Mathematica and the Multi-Stakeholder reviewers. Thank you for the opportunity to comment on this proposed rule. NACHC and its member organizations are willing to provide clarification or answer any follow up information on our comments, please contact

National Association of State Directors of Developmental Disability Services (Mary Lou Bourne)

Thank you for the opportunity to comment on the report titled “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” The report conveys the commitment made by the workgroup to understand a broad spectrum of measures important to State Medicaid agencies. The report also clearly captures the thorough and well organized approach used to consider measures nominated for removal and for addition.

As the Steward for National Core Indicators (NCI), we would like to correct the description of NCI contained on page 16 of the report. Specifically, we would recommend rewriting the first bulleted paragraph under NCI as noted below to ensure factual accuracy:

NCI survey measures are standardized indicators used across by 46 states and the District of Columbia to assess the statewide system performance within a state’s LTSS for individuals age 18 and older with intellectual and developmental disabilities who receive at minimum one service in addition to case management, and their families. The survey’s instruments include in-person surveys, family surveys, and a staff suitability stability survey. Indicators address key areas of concern in five domains: (1) individual outcomes; (2) health, welfare, and rights; (3) system performance; (4) staff stability; and (5) family outcomes. NCI has been used since its launch in 1998, is completely voluntary and was designed by and for State Developmental Disability systems. Forty-six states and the District of Columbia participate in the NCI program. More than 20,000 surveys were entered into the NCI data base in the past data cycle.

On Page 17, the statement “Both sets of indicators have been tested and are believed to be valid and reliable, with strong inter-rater reliability” seems to suggest that validity and reliability has not been demonstrated. We would suggest this be changed to say “NCI indicators have had validity and reliability demonstrated in various ways throughout its 22 year history. Further details on testing including inter-rater reliability and other fidelity analyses, are available through the measure stewards.”

Beyond the factual clarification for direct reference to NCI in the report, please allow us to demonstrate how NCI meets the characteristics used to determine if a measure’s conditions would merit addition to the Adult Core Measure Set. While we believe NCI could meet both the criteria for patient experience and LTSS, we do agree that it fits well as a demonstration of LTSS Medicaid services. Specifically, NCI currently demonstrates these characteristics in the following examples.

Actionability. Will the measure provide useful or actionable results for state Medicaid and CHIP programs?

States use the NCI data for Waiver Assurance and sub-assurance data, in their QIS models, and to identify areas for improvement on an annual basis. States such as Massachusetts, Missouri, Washington and Arizona have used NCI data to prioritize system efforts for many years.

Alignment. Is the measure used in other reporting programs?

State Medicaid I/DD operating agencies align and utilize NCI data in many additional reporting programs. Some states use NCI data within the structure of their 1915(c) Home and Community Based Services (HCBS) Waiver Assurances and Sub Assurance performance measures. Other states utilize NCI as a keystone of their quality improvement system as described in Appendix H of their 1915(c) waiver applications to CMS; states also use NCI as a key stakeholder reporting mechanism, and to inform their improvement or change strategies during waiver re-design activities. States use the NCI annually to inform legislative and budget discussions, thus providing context and outcome based understanding of their large and complex systems. Additionally, states routinely look to NCI data to determine the impact of policy decisions on the lives of people directly affected. Finally, the unparalleled length of time that states have been using NCI provides an unequivocal longitudinal data set, enabling states to view the long-range impacts of systems change(s) and policy determinations over time.

Appropriateness for state-level reporting. Has the measure been validated and tested for state-level reporting? Is it currently used by one or more states?

NCI has been utilized by 46 states and the District of Columbia for several years. The comparisons between states of similar size, or states within the same geographic region, is extremely helpful to set the context of state systems. In addition, the NCI indicators demonstrate how the full system is functioning, thus providing state I/DD agencies with mechanisms to measure systemic performance and identify statewide system improvements. In addition, NCI reporting provides states with cleaned, analyzed and publicly reported data. The transparency is highly valued by many stakeholders.

Feasibility. Will states be able to access the data needed to calculate the measure? Would technical assistance be necessary or helpful to facilitate complete and accurate reporting of the measure by states?

With 46 States plus the District of Columbia already collecting the data, the feasibility is demonstrated each year, with sustainability demonstrated by the 18 states that have used NCI for more than 10 years, and an additional 17 having used NCI for more than 5 years. It is fair to note that in any given year a state may choose to collect data through face to face data collection, through mail-out data collection, or through a direct upload link. While the majority of states collect face-to-face data annually, some states choose to alternate between a data collection year and a data utilization year.

Strategic priority. Does the measure fill a gap that has been identified in the Child or Adult Core Sets?

Medicaid is the largest payer for LTSS in this country. Total Medicaid LTSS expenditures were approximately \$167 billion in FY 2016 and comprised more than 30% of total Medicaid expenditures. Heretofore, there has been a gap in measures on this critically important and sizable portion of the Medicaid program. NCI provides the Long Term Services and Supports

measures needed by state Medicaid agencies to understand the experience of people with developmental disabilities who access and utilize home and community based services. There is no other measure set which provides this insight, including the data cleaning, analysis, and summary report which publicly compares all participating state results. The public reporting of NCI results provides a level of accountability welcomed by state agencies in order to identify improvement opportunities or to re-evaluate the effectiveness of policies or practices.

Thank you again for the opportunity to provide public comment on this report, and many thanks to the workgroup for their many hours of dedication to the task. We are happy to answer any questions and as the measure stewards, we look forward to providing Person Reported Outcome Measures to the LTSS area of the Medicaid Adult Core Measure Set.

New Balance Foundation for Obesity Prevention Center, Boston Children's Hospital (Cara Ebbeling)

Tracking body mass index (BMI) percentile over time provides a reasonable method for screening, monitoring changes in weight status, and identifying children who are at risk for obesity-related morbidities. However, a key question is: Why measure an “outcome” (i.e., BMI percentile) when the “treatment” in primary care settings (i.e., brief counseling for nutrition and physical activity during office visits) is known to be largely ineffective?

When considering effectiveness, the importance of intervention intensity to promote healthful lifestyle behaviors has been highlighted in several literature reviews. Based on a meta-analysis of brief primary care interventions for pediatric weight management, Sim et al.¹ argued that such interventions have only a marginal effect on BMI and emphasized the need for intensive behavioral interventions. In a narrative review of interventions conducted in primary care clinics, Lenders et al.² surmised that increasing intervention intensity could lead to improved weight outcomes. After conducting an evidence review, the US Preventive Services Task Force^{3,4} concluded that comprehensive, intensive interventions result in improved weight status among children with obesity. Using contact hours as an indicator of intensity, the Task Force noted that at least 26 contact hours (e.g., bi-weekly 1-hour visits for 12 months) are necessary to promote weight loss. Behavioral interventions with 52 or more contact hours promote even greater weight loss and some improvements in risk factors for metabolic diseases. In summary, simply measuring BMI percentile and providing brief counseling for nutrition and physical activity is not an evidence-based approach for treating children with obesity.

However, there is reason for optimism as models of integrated care hold promise for enhancing intervention intensity.⁵⁻⁸ These models rely on active and measurable care coordination involving clinicians, nonclinical professionals (e.g., staff at community organizations which provide afterschool programming), and family members with explicit roles for care planning and coordination.^{8,9} Appropriate measures to assess care coordination and intervention intensity are essential to models of integrated care. Until systems for implementing such models are in place nationally, to achieve effective intervention intensity for treating children with obesity, BMI percentile as an outcome measure should be removed from the core set.

Thank you for the opportunity to provide comment.

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Novo Nordisk (Todd M Hobbs)

Novo Nordisk is pleased to provide the following comments on the draft report of the 2020 Child and Adult Core Set Review Workgroup: Recommendations for Improving the Core Set of Health Care Quality Measures for Medicaid and CHIP. Novo Nordisk is a global healthcare company with 95 years of innovation and leadership in diabetes care. This heritage has given us experience and capabilities that also enable us to help people defeat other serious chronic conditions: rare bleeding disorders, growth hormone-related disorders, and obesity. As an organization, we are also committed to ensuring patients have access to high-quality, affordable health care. We support the Centers for Medicare and Medicaid Services' continued efforts to transform the health care delivery system through competition and innovation to provide patients with better value and outcomes.

We appreciate the need to streamline measure systems and reduce reporting burdens on health care providers. However, we urge CMS to retain the Core measures related to care for both children and adults living with diabetes and obesity. Specifically, we recommend that CMS retain the following measures:

- Weight assessment and counseling for nutrition and physical activity for children/adolescents - Body mass index assessment for children/adolescents
- Adult Body Mass Index Assessment
- Comprehensive Diabetes Care: Hemoglobin A1C (HbA1c) Testing

Given the burden of obesity and diabetes on our health care system, patients, and on our society, we believe it is vital that CMS continue to focus on measuring and improvement care for patients with these conditions.

Discussion

As our healthcare system continues to move towards value-based care arrangements that encourage providers to improve patient outcomes and manage overall costs, it is critical to have the right quality measures in place. Novo Nordisk supports CMS's Patients over Paperwork and Meaningful Measure initiatives that reduce clinician burden of data collection and support measures that improve health outcomes and quality of care for patients. However, there are several measures that are suggested for removal from the Medicaid and CHIP Child and Adult Core Sets that Novo Nordisk believes are crucial to promote good quality of care for Medicaid beneficiaries.

Obesity and type 2 diabetes (T2D) are two of the most prevalent and costly chronic conditions in the United States. The prevalence of obesity among adults is 39.6% and 18.5% among youth (aged 2-19), with rates continuing to increase year after year¹, costing the U.S. health care system at least \$147 billion each year.² Diabetes affects 30.3 million people in the U.S., with direct and indirect costs around \$245 billion per year.³ Diabetes and obesity are also cost drivers for Medicaid.⁴ In 2015, diabetes was among the leading causes of death in the United States, with over 79,000 deaths directly attributed to diabetes as the underlying cause.⁵ In

addition, T2D increases the risk of cardiovascular disease, cancer, and other closely related co-morbidities.⁶ Improving overall quality and outcomes is essential for patients with these two conditions.

Novo Nordisk strongly urges CMS to reconsider the removal of the measure Weight assessment and counseling for nutrition and physical activity for children/adolescents—Body mass index assessment for children/adolescents (WCC-CH) from the Child Core Set. We strongly urge CMS to reconsider removal of the measure Adult Body Mass Index Assessment (ABA-AD) from the Adult Core Set. It is imperative that the U.S. continue to make improvements in quality of care, treatment, and outcomes for those with obesity. It is a costly and sometimes debilitating disease that affects a large percentage of the U.S. population, and its impact and prevalence continue to rise.

Screening is the first step for preventing the disease itself, as well as the many associated complications. Currently, many guidelines and recommendations recognize this and include screening for overweight and obesity:

- Recommendations from the United States Preventative Services Task Force (USPSTF) for both children⁷ and adults⁸
- Joint statement from American College of Cardiology (ACC), American Heart Association (AHA) and The Obesity Society (TOS)⁹
- Practice guidelines from the Department of Veterans Affairs (VA) and the Department of Defense (DoD)¹⁰, and;
- Clinical guidelines from the American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE)¹¹.

Removal of the BMI index assessment measures would mean that the Medicaid and CHIP Child and Adult Core Sets of Health Care Quality Measures would be misaligned with current guidelines and recommendations and would signal that screening is considered unimportant or is topped out without room for improvement in the Medicaid and CHIP programs—when in fact neither is the case. State mean performance in 2017 was only 52.3% in the Child Core Set¹² and 62.9% in the Adult Core Set¹³, suggesting these measures need to be maintained in the Core Sets and additional initiatives should be taken to increase provider performance for screening for obesity.

Novo Nordisk also strongly disagrees with the removal of the measure Comprehensive Diabetes Care: Hemoglobin A1C (HbA1c) Testing (HA1C-AD) from the Adult Core Set. The majority of Workgroup members believe that this measure has either topped out with “little room for improvement” or that it is duplicative of a measure currently on the Core Set—Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (> 9.0 percent) (HPC-AD), which is an outcome measure that also assesses whether testing is being conducted. Novo Nordisk disagrees with this recommendation and assessment for the following reasons:

- Nearly 25% of the 30.3 million people in the US with diabetes are undiag-nosed.¹⁴

- Nearly 34% of US adults have prediabetes and less than 12% are aware of it.¹²
- The current USPSTF guideline for screening for abnormal blood glucose recommends screening for abnormal blood glucose as part of a cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. The guideline, which is a comprehensive screening guideline, further states that clinicians should consider screening individuals with one or more of the following characteristics: History of gestational diabetes or polycystic ovarian syndrome, family history of diabetes, or are members of a racial/ethnic group disproportionately impacted by the disease. Furthermore, the guideline suggests that clinicians offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.¹⁵

Novo Nordisk believes that the Hemoglobin A1c (HbA1c) Poor Control (> 9.0 percent) (HPC-AD) is an important measure but that it is primarily focused on adults who have already been diagnosed with diabetes. It is a performance measure that holds health plans accountable for both testing and improved outcomes in this population. The Hemoglobin A1C (HbA1c) Testing (HA1C-AD) measure is an important and distinct measure intended to identify those who have prediabetes who can then be appropriately referred to an evidence-based diabetes prevention program to prevent their progression to full blown type 2 diabetes; and to identify those with diabetes who have not yet been diagnosed. Removal of this measure from the Adult Core Set will send a message that early diagnosis and prevention strategies for type 2 diabetes and its associated complications in this population are not a priority.

Potential New Measures

It is clear there is a need to measure processes and outcomes so that we can drive towards improvements in care for patients with obesity and diabetes – two of the costliest and prevalent chronic conditions in the U.S. Given that future quality measure work will largely focus on outcome measures such as BMI reduction or maintenance, a process measure such as BMI screening, which is currently in the Medicaid/CHIP Core Quality Set, is the first step before an outcome measure can be developed. Novo Nordisk would like to share information on pipeline obesity measure development efforts underway through a partnership between the AMGA, Discern Health, and the National Quality Forum (NQF)¹⁶:

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

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

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

* Modified version of prioritized measure concept from the NQF-convened 2017 strategy session.

Initial measure testing focused on early feasibility assessment only.

Through the AMGA, Discern and NQF obesity measurement project,¹⁷ the team is specifying and testing the following measures:

Measure Title	Description	Numerator	Denominator
Documentation of obesity diagnosis	Percent of patients with documentation of obesity diagnosis (ICD-10 or notation in EHR problem list).	Number of patients with a documented BMI, and if >30, a corresponding obesity diagnosis.	Patients aged 18–79, as of the first day of the reporting period, with 1 or more ambulatory visits/ encounters during the reporting period.
Weight change over time	Percent of patients with an initial BMI ≥ 25 who have achieved at least a 5 percent reduction in weight during the measurement year.	Number of patients who achieved 5 percent or more weight reduction over a 12-month period. Note: The pilot test will explore percent weight loss stratification, as well as a maintenance indicator.	Patients aged 18–79, as of the first day of the reporting period, indicating a BMI ≥ 25 with: 1 or more ambulatory visits/encounters in the reporting period AND weight associated with any visit at least 9 months but no longer than 12 months earlier.

Pilot testing through large health systems/provider practices is wrapping up and we anticipate having finalized measure specifications and more information on the feasibility and scientific acceptability (reliability and validity) of these measures in late 2019. We would welcome the opportunity to discuss CMS' consideration of use of any or all for the Medicaid Adult or Child Core Set.

Summary

Diabetes and obesity are among the most important health management challenges facing the U.S. It is vital that CMS continue to send a strong signal to providers that they should screen for and manage these conditions so that patients get the best care and achieve the best outcomes. Removing the BMI and A1c measures will send the wrong signal that obesity and diabetes are not a top priority for CMS.

Thank you for this opportunity to comment on the draft report of the 2020 Child and Adult Core Set Review Workgroup. Novo Nordisk will continue to work towards improving care. If you have any questions about our comments, please do not hesitate to reach out to me at TDDH@novonordisk.com.

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- ¹⁶ This work is supported by Novo Nordisk Inc.
- ¹⁷ Funding for this work was provided by Novo Nordisk Inc.

Obesity Care Advocacy Network (Jeanne Blankenship, Meredith Dyer, and Joe Nadglowski)

The Co-Chairs of the Obesity Care Advocacy Network (OCAN) are pleased to echo the comments of the Sumner M. Redstone Global Center for Prevention and Wellness regarding the July 2019 draft report, “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Multi-Stakeholder Review of the 2020 Child and Adult Core Sets.”

OCAN’s mission is to unite and align key obesity stakeholders and the larger obesity community around key obesity-related education, policy and legislative efforts in order to elevate obesity on the national agenda. The primary goals of OCAN are to: prevent disease progression; improve access to evidence-based treatments for obesity; improve standards of quality care in obesity management; eliminate weight bias; and foster innovation in future obesity treatments.

For these reasons, OCAN is extremely concerned that CMS is proposing to remove “Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-Body Mass Index Assessment for Children/Adolescents (WCC-CH) and Adult Body Mass Index Assessment (ABA-AD) from the 2020 Child and Adult Core Sets.

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

Eighteen percent of U.S. children and adolescents have obesity. Screening for BMI is a critical initial step in the process of identifying and referring a child with obesity to the comprehensive and intensive behavioral interventions necessary to improve weight and reduce comorbidities associated with obesity. The United States Preventive Services Task Force (USPSTF) recommends screening using BMI for children and adolescents and provides the recommendation with a “B” grade, reflecting a “high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.” Similarly, the American Academy of Pediatrics (AAP) recommends screening for obesity using BMI so that children and adolescents can be effectively treated for obesity. Screening is the initial step in the process of treatment.

The summary for the work group recommendation to remove WCC-CH states that the measure, “does not provide useful or actionable results for state Medicaid and CHIP agencies.” Further, members, “asserted that this measure does not reflect evidence-based practices for interventions for children with or at risk of obesity.” The conclusion that BMI screening does not reflect evidence-based practices is contradicted by both the USPSTF and AAP recommendations which find that screening is a critical part of evidence-based practice for treating obesity in children and adolescents. In addition, we contend that this measure does provide actionable information for Medicaid and CHIP agencies by providing important data related to the extent to which healthy weight is being discussed with patients. While we agree with the work group member who suggested that developing a measure that also examines interventions, such as referrals to care, would be more useful, simply removing the WCC-CH

measure with no replacement is a step backward in improving obesity care and treatment for children and adolescents.

The work group summary also notes that some members asserted that because BMI is recorded under the Promoting Interoperability Program (formerly the Electronic Health Records Incentive Program), most physicians would not be disincentivized from conducting the BMI screening. Unfortunately, we do not have evidence that this is the case. Removing the measure from the core set with no replacement sends the message that obesity identification and treatment is unimportant.

We urge that the final recommendations continue to include the WCC-CH measure to maintain consistency with both the USPSTF and AAP recommendations, align with evidence-based treatment standards for obesity, and ensure that addressing obesity remains a priority.

Adult Body Mass Index Assessment (ABA-AD)

OCAN also opposes the removal of the ABA-AD measurement for the same reasons stated above. The USPSTF also includes BMI screening for adults in their recommendations as part of an evidence-based treatment plan for adults with obesity. In the case of the WCC-CH recommendation, removal of the ABA-AD measure with no replacement both contradicts the USPSTF recommendation and risks lowering the priority of obesity treatment among the health care community.

The workgroup summary for this section indicated that one member noted that obesity may require a broader societal response than other health conditions, which makes it more challenging for the health care system to address. It is certainly true that obesity is a complex disease and that prevention efforts should focus on societal issues, such as access to nutritious food and opportunities to be physically active. However, there are evidence-based interventions and treatments for obesity (community-based programs such as the Diabetes Prevention Program, intensive behavioral therapy, pharmacotherapy and surgery) just as there are for other complex chronic diseases that may be related to broader societal drivers and singling out obesity as requiring a uniquely non-clinical response is not supported by research.

Thank you again for your consideration of these comments, should you have any questions, please feel free to contact OCAN Washington Coordinator Chris Gallagher at 571-235-6475 or via email at chris@potomaccurrents.com.

Office of Infectious Disease and HIV/AIDS Policy (Alice Tsai)

Thank you for your notification and a minor erratum on page 4 (December 14, 2018?) for consideration.

Also, as my organization has undergone a change in June from the National Vaccine Program Office to the Office of Infectious Disease and HIV/AIDS Policy, can you please reflect that on the report? An example is provided below:

Office of Infectious Disease and HIV/AIDS Policy (formerly National Vaccine Program Office)

Redstone Center, Milken Institute School of Public Health (Jeff Hild)

The Sumner M. Redstone Global Center for Prevention and Wellness (Redstone Center) at the Milken Institute George Washington University School of Public Health appreciate the opportunity to submit comments to the draft “Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.” Specifically, we are opposed to the recommended removal of the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents-Body Mass Index Assessment for Children/Adolescents (WCC-CH) in the Child Core Set and the Adult Body Mass Index Assessment (ABA-AD) in the Adult Core Set.

The Redstone Center is one of the leading sources in the United States for promising and evidence-based nutrition and physical activity strategies for the prevention and control of obesity. The Redstone Center is also the home of the Strategies to Overcome and Prevent Obesity Alliance (STOP), a collaboration of consumer, provider, government, labor, health insurers and quality of care organizations working together to drive innovative and practical strategies to combat obesity. The Redstone Center is chaired by Dr. William Dietz, a national expert on obesity prevention and care, a consultant to the Roundtable on Obesity Solutions at the National Academy of Medicine, and the former Director of the Division of Nutrition, Physical Activity, and Obesity at the Centers for Disease Control.

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

The WCC-CH measure assesses the percentage of children ages 3 to 17 who have visited a primary care provider or OB/GYN practitioner and were screened for body mass index (BMI). The report notes that 37 states reported this measure in Fiscal Year 2017.

We oppose the recommended removal of WCC-CH from the core set. Eighteen percent of U.S. children and adolescents have obesity. Screening for BMI is a critical initial step in the process of identifying and referring a child with obesity to the comprehensive and intensive behavioral interventions necessary to improve weight and reduce comorbidities associated with obesity. The United States Preventive Services Task Force (USPSTF) recommends screening using BMI for children and adolescents and provides the recommendation with a “B” grade, reflecting a “high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.” Similarly, the American Academy of Pediatrics (AAP) recommends screening for obesity using BMI so that children and adolescents can be effectively treated for obesity. Screening is the initial step in the process of treatment.

The summary for the work group recommendation to remove WCC-CH states that the measure, “does not provide useful or actionable results for state Medicaid and CHIP agencies.” Further, members, “asserted that this measure does not reflect evidence-based practices for interventions for children with or at risk of obesity.” The conclusion that BMI screening does not reflect evidence-based practices is contradicted by both the USPSTF and AAP recommendations which find that screening is a critical part of evidence-based practice for treating obesity in children and adolescents. In addition, we contend that this measure does

provide actionable information for Medicaid and CHIP agencies by providing important data related to the extent to which healthy weight is being discussed with patients. While we agree with the work group member who suggested that developing a measure that also examines interventions, such as referrals to care, would be more useful, simply removing the WCC-CH measure with no replacement is a step backward in improving obesity care and treatment for children and adolescents.

The work group summary also notes that some members asserted that because BMI is recorded under the Promoting Interoperability Program (formerly the Electronic Health Records Incentive Program), most physicians would not be dis-incentivized from conducting the BMI screening. Unfortunately, we do not have evidence that this is the case. Removing the measure from the core set with no replacement sends the message that obesity identification and treatment is unimportant.

We urge that the final recommendations continue to include the WCC-CH measure to maintain consistency with both the USPSTF and AAP recommendations, align with evidence-based treatment standards for obesity, and ensure that addressing obesity remains a priority.

Adult Body Mass Index Assessment (ABA-AD)

We oppose the removal of the ABA-AD measurement for the same reasons stated above. The USPSTF also includes BMI screening for adults in their recommendations as part of an evidence-based treatment plan for adults with obesity. In the case of the WCC-CH recommendation, removal of the ABA-AD measure with no replacement both contradicts the USPSTF recommendation and risks lowering the priority of obesity treatment amongst the health care community.

The workgroup summary for this section indicated that one member noted that obesity may require a broader societal response than other health conditions, which makes it more challenging for the health care system to address. It is certainly true that obesity is a complex disease and that prevention efforts should focus on societal issues, such as access to nutritious food and opportunities to be physically active. However, there are evidence-based interventions and treatments for obesity, including pharmacotherapy, intensive behavioral therapy, and surgery, just as there are for other complex chronic diseases that may be related to broader societal drivers and singling out obesity as requiring a uniquely non-clinical response is not supported by research.

Again, we urge that the final recommendations continue to include ABA-AD as part of the core set.

Thanks for the opportunity to comment. Please contact Dr. William Dietz (<mailto:bdietz@gwu.edu>) or Jeff Hild (jeffhild@gwu.edu) with any questions about the comment.

Trust For America's Health (John Auerbach)

We are writing you to express our concern for the proposed removal of two quality measures from the 2020 Core Sets of Health Care Quality Measures for Medicaid and CHIP. Trust for America's Health (TFAH) is a non-profit, non-partisan public health organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority. We believe that addressing obesity in the United States is a key component of improving public health more broadly. As we noted in our 2018 "The State of Obesity: Better Policies for a Healthier America" report, obesity rates continue to be alarmingly high, for both youth and adults.¹ Obesity costs the United States \$149 billion in medical expenses annually – with about half of those expenses paid by Medicare and Medicaid.^{2,3,4}

Because obesity is such a pervasive, and costly, national epidemic, all efforts to track and assess weight in Medicaid and CHIP must be maintained and protected, and that removal of these quality measures would harm public health efforts. Health care quality measures for obesity are already limited in use,⁵ and removal of these two measures could seriously hinder wider implementation of healthcare-based efforts to prevent and treat obesity. We hope that the stakeholder workgroup reassesses its preliminary recommendation to remove the weight-related quality measures from the 2020 Core Sets of Health Care Quality Measures for Medicaid and CHIP.

Quality Measure: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)

Children who are overweight or have obesity are more likely to have obesity as adults.⁶ It is important that efforts to track body mass index (BMI) are protected.

TFAH appreciates the workgroup's rationale for removing the measures – namely, "that more integrated and effective models to address obesity than screening along, such as referrals to care, should be prioritized in the Core Set." Measuring BMI is not enough to address obesity; however, how obesity is addressed should be determined on a case-by-case basis. Some cases of childhood obesity may necessitate referrals to community or clinical interventions, while other cases may require ongoing consultation with parents and the patient. The National Quality Forum's own rationale for inclusion of this measure states "for children who are overweight or obese, obesity in adulthood is likely to be more severe. Children's weight status is an important thing to monitor. Children need guidance on maintaining healthy eating and exercising habits."⁷ Likewise, the U.S. Preventive Services Task Force (USPSTF), an independent panel that makes evidence-based recommendations about clinical preventive services, has recommended that clinicians screen for obesity in children and adolescents 6 years and older.⁸ Lastly, the American Academy of Pediatrics (AAP) also recommends screening for obesity using BMI so that children and adolescents can be effectively treated for obesity. Screening is the initial step in the process of treatment.

We urge the workgroup to consider how to expand this measure to include screening and referral, in lieu of eliminating it altogether.

Quality Measure: Adult Body Mass Index Assessment (ABA-AD)

As of 2016, the national adult obesity rate was 39.6 percent, after holding at around 34-35 percent between 2005 and 2012.^{9,10} In 2000, no state had an obesity rate over 20 percent.¹¹ In 2016, Colorado, the state with the lowest obesity rate, had an obesity rate of 22.6 percent.¹² In just 16 years, the ceiling has become the floor.

Now, more than ever, tracking adult BMI is of the utmost importance for demonstrating the need, improving patient health knowledge, and improving care. Many Americans who are overweight or obese do not realize they are overweight or obese. According to a 2016 Gallup poll, while 70.4 percent of American adults are obese or overweight, only 36 percent of those polled thought they had a weight problem.¹³ Although not a perfect measure of health, BMI is widely used as the measurement for CDC thresholds, is an inexpensive screening tool to serve as population-level assessment of obesity prevalence, and is used within clinical practice guidelines for recommending obesity treatment options.¹⁴ In addition, measuring BMI enables providers to track weight over time, counsel those at risk for developing obesity, and ultimately prevent the progression of the condition and its comorbidities.

Similarly, to the workgroup's rationale for removal of the WCC-CH Quality Measure, TFAH acknowledges that the current measure is "a measure of documentation, rather than outcomes or evidence-based practices for combatting obesity." However, no meaningful alternative is offered that would justify removal of the measure. Until a more effective measure is offered, we urge the workgroup to maintain the current measure.

TFAH recognizes that chronic disease, like obesity, may require actions beyond the scope of a health care provider. On top of quality care, obesity requires public health interventions that target social and environmental factors. In order to align health care provider responsibility with meaningful outcomes, a measure should take into account both measurement and referral. However, there are evidence-based interventions and treatments for obesity (community-based programs such as the Diabetes Prevention Program, intensive behavioral therapy, etc.) just as there are for other complex chronic diseases that may be related to broader societal drivers and singling out obesity as requiring a uniquely non-clinical response is not supported by research. The working group does not include any recommended addition that would address this concern.

It is important to note that the USPSTF has recommended that clinicians offer or refer adults with a BMI of 30 or higher to intensive, multicomponent behavioral interventions.¹⁵

TFAH urges the workgroup to keep or expand this measure to include screening and referral, in lieu of eliminating it altogether.

Thank you for your attention on this matter. We stand ready to work with stakeholders and workgroup members to ensure that these quality measures remain included, as they are important to the health and wellbeing of the public. If you have any questions, please contact Dara Lieberman, TFAH's Director of Government Relations at dlieberman@tfah.org.

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- ⁴ Finkelstein EA, Trogon JG, Cohen JW, et al. "Annual medical spending attributable to obesity: payer-and service-specific estimates." *Health Affairs*, 28(5): w822-31, 2009. doi: 10.1377/hlthaff.28.5. w822.
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- ⁹ Hales CM, Carroll MD, Fryar CD, et al. "Prevalence of Obesity Among Adults and Youth: United States, 2015–2016." National Center for Health Statistics, Data Brief 288, October 2017. <https://www.cdc.gov/nchs/data/databriefs/db288.pdf> (accessed April 17, 2018).
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<https://onlinelibrary.wiley.com/doi/pdf/10.1002/oby.21884>.
- ¹⁵ *Final Update Summary: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions*. U.S. Preventive Services Task Force. September 2018.
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University of Texas School of Public Health (Belinda M Reininger)

Thank you for the opportunity to provide input into the Core Set Measures for Children and Adults. I would like to focus my comments specifically on the recommendation to remove weight assessment and counseling for nutrition and physical activity for children / adolescents – Body Mass Index Assessment for Children / Adolescents WCC-CH and the measure of Adult Body Mass Index Assessment (ABA-AD).

As the Regional Dean for the University of Texas School of Public Health in Brownsville and the lead investigator for multiple programs addressing adult and childhood obesity over the last 18 years in partnership with clinics, hospitals and schools, I am completely shocked that these Health Care Quality Measures would be proposed for removal. There are numerous reasons why these measures are necessary to remain in the Core Set of Measures:

1. Low literacy populations need an objective view about their weight and its relationship to chronic diseases. I work in a low income, low literacy population. There are many elements of health care that occur in a clinic visits that are not understood by people living in our region of the country (although I would argue that this is likely true for low literacy populations across the country). However, when a provider conducts a weight assessment and counsels the patient about the importance of maintaining a healthy weight through physical activity and nutrition, this information is often understood. The relationship between weight and disease is becoming better understood. With that being said, an individual's perception of their own weight may not be accurately categorized as "overweight" or "obese". When the provider gives information on BMI based on growth charts or BMI charts, the patient obtains an objective view of their risk for disease through counseling. Many low income, low literacy populations do not have easy access to scales or these charts, so a provider's assessment and counseling is the essential information to understand the importance of a normal BMI.
2. There is no doubt that assessment and information sharing is only part of the solution to our national obesity crisis. We absolutely need additional Quality Measures about referrals to and follow-up from evidence-based interventions for both children and adults. But, an important part of the solution still remains in the screening for overweight and obesity and providing counseling to motivate behavior change. Providers have to remain part of the solution and removing these measures from children and adults dismisses the provider role in the overall crisis.
3. BMI is arguably the most important predictor of youth onset of chronic disease and adult chronic disease. As a healthcare system, fully aware of the obesity epidemic in our country, we must remain vigilant and expect all providers in all states to screen and counsel patients on BMI. Removing these measures signals politicians, providers, community leaders and beyond that we are either ignorant of the research or dismissive of its importance in driving health care costs in the US.
4. Data analyses on health outcomes, without BMI, becomes less useful. BMI is an important co-variate in data analysis of health outcome data. If we do not report BMI on youth and children it becomes even more difficult to examine and explain changing trends in chronic disease rates. In fact, not only is BMI an important variable in health outcomes we expect it is also an

important variable in health outcomes we may not expect. In our past analysis, BMI was an important predictor of risk for H1N1, for extended hospital visits, and for conversion from prediabetes to diabetes.

5. BMI is an important measure for other conditions and is used to monitor changes in health status. Swings in weight may be predictive of cancer, congestive heart failure, kidney disease, etc. BMI should remain a measure so as to not impact other disease monitoring.

There are more reasons that BMI should absolutely not be removed from the quality core measures for children and adults and I would be glad to discuss further if that would be helpful. As a final point, based on the draft report for comment I would like to note that within your expert panel there was mention made of a replacement measure for the current adult BMI assessment (ABA-AD). While this may be a point for further exploration, the recommendation was not put in place. I believe there should be extreme concern about dismantling an important measure without having a replacement measure already launched and tested.

Again thank you for the opportunity to comment.

YMCA of the USA (Katie Adamson)

YMCA of the USA, the national resource office for the nation's 2,700 YMCAs, is pleased to provide comments on the draft Recommendations for Improving the Core Set of Health Care Quality Measures for Medicaid and CHIP. The Y believes that all people—regardless of age, income or background—should be able to live life to its fullest, healthiest potential. As one of the nation's leading nonprofits strengthening communities through youth development, healthy living, and social responsibility, the Y engages 21 million people in more than 10,000 communities across the country.

The Y's reach into communities makes the organization an ideal service network for programs like the YMCA's Diabetes Prevention Program and the YMCA's Healthy Weight and Your Child program. These programs address both living with prediabetes and obesity and children and adolescents living with obesity.

Based on the importance of screening and diagnostic measures in the delivery of these evidence-based programs, we strongly recommend that CMS retain the Core Measures related to care for diabetes and obesity, namely:

- the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)
- the Adult Body Mass Index Assessment
- the Body Mass Index Assessment for Children/Adolescents

Obesity and type 2 diabetes are two of the most prevalent and costly chronic conditions in our nation. Removing these three Core Measures could negatively impact both Medicaid and CHIP recipients by acting as a disincentive for physicians to screen for BMI and HbA1c. Maintaining these measures will continue to incentivize physicians in Medicaid and CHIP to screen, identify and refer patients to evidence-based programs in the community that address prediabetes, adult obesity and childhood obesity.

The YMCA's Diabetes Prevention Program helps adults at high risk of developing type 2 diabetes reduce their risk for developing the disease by taking steps that will improve their overall health and well-being. Research by the National Institutes of Health has shown that programs like the YMCA's Diabetes Prevention Program can reduce the number of new cases of type 2 diabetes by 58%, and 71% in adults over the age of 60.

To qualify for the YMCA's Diabetes Prevention Program an Adult 18+ must be:

Overweight (BMI >25)*

At risk for or have been diagnosed with prediabetes via a blood test with one of the following results:

- Fasting Plasma Glucose between 100–125 mg/dL
- 2-hour Plasma Glucose between 140–199 mg/dL

- A1c between 5.7% and 6.4%
- Or have a previous diagnosis of gestational diabetes
- If a blood test is not available, a qualifying risk score based on a combination of risk factors— family history, age, etc.

As of March 2019, the YMCA's Diabetes Prevention Program has served over 64,000 participants at over 1,100 sites in 42 states across the country. The YMCA's Diabetes Prevention Program uses a CDC-approved curriculum and is part of the CDC-led National Diabetes Prevention Program, and is available to all individuals who qualify, regardless of insurance status or Y membership. Almost 20% of those served were low-income and 20% of those in Y programs were referred by a physician or as the result of a screening program. Referrals to the program are essential and the Y has closely partnered with the CDC and the American Medical Association to help increase screenings, identification of prediabetes and referrals to the program.

The Y was the awardee for the demonstration program from the Centers for Medicare and Medicaid Innovation that resulted in the establishment of the Medicare Diabetes Prevention Program (MDPP) expanded model. Many states are considering including the National Diabetes Prevention Program as covered service in their Medicaid program and a few states have already advanced coverage (e.g. California). As more states move to include the National Diabetes Prevention Program for their Medicaid recipients, both the Adult Body Mass Index and the A1c measure for prediabetes become essential measurements.

Despite the availability and success of this evidence-based health intervention to address prediabetes, many providers and patients are still unaware of prediabetes as a condition. According to CDC, more than 30% of U.S. adults have prediabetes, and less than 12% are aware of it.

Screening, identification and referral modalities are cornerstones in providing quality care through programs like the National Diabetes Prevention Program and the Medicare Diabetes Prevention Program. We urge CMCS to follow the USPSTF recommendations (cited below) regarding both the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD) and the Adult Body Mass Index (BMI) Assessment and to maintain the Core Measures related to care for diabetes and obesity.

The USPSTF Recommendation Statement for Abnormal Blood Glucose and Type 2 Diabetes Mellitus Screening national data estimates from 2012, states that approximately 86 million Americans aged 20 years or older have IFG or IGT.¹ Approximately 15% to 30% of these persons will develop type 2 diabetes within 5 years if they do not implement lifestyle changes to improve their health.² The USPSTF concludes with moderate certainty that there is a moderate net benefit to measuring blood glucose to detect IFG, IGT, or diabetes and implementing intensive lifestyle interventions for persons found to have abnormal blood glucose.³ The USPSTF previously found adequate evidence that intensive behavioral counseling interventions for persons at increased risk for CVD have moderate benefits in lowering CVD risk.⁴ Populations in which these benefits have been shown, include persons who are obese or overweight and

have hypertension, hyperlipidemia or dyslipidemia, and/or IFG or IGT.⁵ Benefits of behavioral interventions include reductions in blood pressure, glucose and lipid levels, and obesity and an increase in physical activity. USPSTF further cited that studies that specifically treat persons who have IFG or IGT with intensive lifestyle interventions to prevent the development of diabetes consistently show a moderate benefit in reducing progression to diabetes. And USPSTF adds that lifestyle interventions have greater effects on reducing progression to diabetes than metformin or other medications.⁶

In the USPSTF Final Recommendation for Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions, the USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions.⁷ Those recommended interventions specifically highlight the Diabetes Prevention Program. Removing the Adult Body Mass Index Assessment from the Core Set Measurement does not maintain consistency with USPSTF recommendations or align with evidence-based treatment standards for obesity and will very likely send the message that obesity identification and treatment is unimportant.

In addition to the burden of prediabetes and obesity among adults, childhood Obesity is a growing problem in the United States. More than one third of children and teenagers, ages 2 to 19, are obese or overweight, and that rate has tripled in the past 30 years. Childhood obesity can have a harmful effect on the body in several ways, putting children at high risk to develop cardiovascular disease, diabetes, sleep apnea, asthma, joint problems, heartburn, and social and psychological problems. Obese children are more likely to become obese adults, leading to more serious health conditions including heart disease, diabetes and some cancers.

The YMCA's Healthy Weight and Your Child is a 25-session evidence-based program for children with obesity. The program includes a Family Information Session followed by 25 sessions delivered over four months. The family-based weight-management program focuses on nutrition education and physical activity to encourage healthier eating habits and an active lifestyle to reach a healthy weight. The Healthy Weight and Your Child curriculum is adapted from the most widely disseminated and extensively evaluated child weight management program in the world (also known as MEND). Studies have shown the program model is effective in reducing a child's body mass index and waist circumference, reducing sedentary behaviors, increasing physical activity, and improving self-esteem.

The Y's Healthy Weight and Your Child program is designed to support youth and families as they seek to achieve positive change including:

- a reduction in the child's body mass index (BMI);
- the adoption of healthier eating habits by the family;
- an increase in daily physical activity; and
- improved self-esteem for participants

Youth must meet the following criteria to qualify to participate in the program:

- The child must be 7 to 13 years old at the start of a group class.
- The child must carry excess weight, with a body mass index of the 95th percentile or higher.
- The child must receive clearance from a health care provider or school nurse to participate in physical activity.

The YMCA's Healthy Weight and Your Child program was only recently launched, but today already more than 100 Ys in 37 states offer the Healthy Weight and Your Child program and have served 1,822 children. More than 60% of the children served were eligible for free or reduced-priced lunches and 57% of referrals have come from a doctor or health care professional.

As the YMCA's Diabetes Prevention Program, which is part of the National Diabetes Prevention Program, became an expanded model program in Medicare, it is our long-term goal to work with partners in the physician and the patient advocacy community to advance state Medicaid coverage of the Healthy Weight and Your Child Program. To remove the BMI assessment for children/adolescents measurement as we are beginning to scale the Healthy Weight and Your Child program with health care providers, including the American Academy of Pediatrics, would hinder efforts to improve the lives of children and adolescents living with obesity.

We want to support a comment of one of your reviewers/panelists who noted that the Final Recommendation Statement of the USPSTF was that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.⁸ Body mass index is the recommended screening test for obesity by the USPSTF and they recognize that "identifying obesity in children and how to address it are important steps in helping children and families obtain the support they need."⁹

In closing, we hope that Mathematica's Technical Assistance and Analytical Support Team and Workgroup, and thus CMCS, will give serious consideration to our comments and retain the Core Set Measurements (BMI for adults and children/adolescents and A1c) that encourage and help providers screen, identify and refer low-income individuals in Medicaid and CHIP to programs that can address prediabetes, adult obesity and childhood/adolescent obesity, improve health outcomes, quality of care, and save substantial medical costs. The recommendations to remove these Core Set Measurements are not in agreement with the latest recommendations by the USPSTF and will hinder providers' ability to provide life-saving interventions to children, families and individuals at-risk of diabetes and obesity and related complications.

Citations

¹U.S. Preventative Services Task Force: Screening for Abnormal Blood Glucose and Type 2 Diabetes. The USPSTF website:
<https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes>

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ U.S. Preventative Services Task Force. Final Recommendation Statement: Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults. The USPSTF website: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-interventions1>

⁸ U.S. Preventative Services Task Force. Final Recommendation Statement Obesity in Children and Adolescents: Screening. The USPSTF website: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-children-and-adolescents-screening1>

⁹ Ibid.



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