

Child and Adult Core Set Stakeholder Workgroup: Measures Suggested for Addition to the 2021 Core Sets

Measure Information Sheets

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PRIMARY CARE ACCESS AND PREVENTIVE CARE

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Adult Immunization Status
Description	The percentage of beneficiaries 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, and pneumococcal. Note: The Medicaid rate includes beneficiaries ages 19-65 and excludes pneumococcal vaccines.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process / Composite
Recommended to replace current measure?	Flu Vaccinations for Adults Ages 18-64 (FVA-AD)

Technical Specifications	
Ages	Ages 19-65 at the start of the Measurement Period.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.)
Denominator	This measure includes denominators for three individual vaccine rates and a composite rate: 1. Influenza rate: Beneficiaries ages 19-65 at the start of the Measurement Period who also meet criteria for participation* minus exclusions. 2. Td/Tdap rate: Beneficiaries ages 19-65 at the start of the Measurement Period who also meet criteria for participation* minus exclusions. 3. Zoster rate: Beneficiaries ages 50-65 at the start of the Measurement Period who also meet criteria for participation* minus exclusions. 4. Composite rate: The sum of denominators for the three individual vaccine rates. *Participation is defined as the identifiers and descriptors for each organization's coverage used to define beneficiaries' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.
Numerator	This measure includes numerators for three individual vaccine rates and a composite rate: 1. Influenza rate: Beneficiaries in the influenza rate denominator who received an influenza vaccine on or between July 1 of the year prior to the Measurement Period and June 30 of the Measurement Period,

	or who had a prior influenza virus vaccine adverse reaction any time before or during the Measurement Period. 2. Td/Tdap rate: - Beneficiaries in the Td/Tdap rate denominator who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the Measurement Period and the end of the Measurement Period, <i>or</i> - Beneficiaries in the Td/Tdap rate denominator with a history of at least one of the following contraindications any time before or during the Measurement Period: - Anaphylaxis due to Tdap vaccine, anaphylaxis due to Td vaccine or its components. - Encephalopathy due to Tdap or Td vaccination (post-tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, post-pertussis vaccination encephalitis). 3. Zoster rate: Beneficiaries in Zoster rate denominator who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the beneficiary's 50th birthday before or during the Measurement Period; or who had prior adverse reaction caused by zoster vaccine or its components any time during or before the Measurement Period. 4. Composite rate: The sum of the numerators for the three individual vaccine rates.
Exclusions	Exclude beneficiaries with any of the following: - Active chemotherapy any time during the Measurement Period. - Bone marrow transplant any time during the Measurement Period. - History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia and HB-S disease or cerebrospinal fluid leaks any time during the beneficiary's history through the end of the Measurement Period. - In hospice or using hospice services during the Measurement Period.
Continuous enrollment period	The Measurement Period (January 1 – December 31).
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	Proposed specifications for HEDIS Measurement Year 2020: https://www.ncqa.org/wp-content/uploads/2020/02/20200212_16_AIS.pdf
Information on testing or use at state Medicaid/CHIP level	Pennsylvania Medicaid is requiring Medicaid health plans to report this measure beginning in Measurement Year 2020. According to the measure steward, 21 Medicaid health plans located in 14 states reported data on this measure in Measurement Year 2018.
Description of required data source and data elements, including any barriers or limitations	ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries. While administrative claims can be used to identify immunizations, states may need to supplement administrative data sources with electronic data sources to identify vaccinations that occurred outside of medical appointments. Medicaid and CHIP agencies vary in their ability to identify immunizations in electronic clinical data or immunization registries.
Description of potential variations that could affect consistency of calculations	Not specified.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The Workgroup member (WGM) who suggested this measure noted that receipt of recommended vaccinations is important to protect the health of adults and reduce illness and death from vaccine-preventable diseases. There are currently no measures of Td/Tdap, zoster, or pneumococcal vaccination in the Adult Core Set.
How measure promotes effective care delivery in Medicaid and CHIP	The WGM stated that national surveillance data show coverage for recommended adult vaccines is generally lower for adults with public health insurance compared to privately insured adults. Use of this measure would help Medicaid programs increase vaccination rates in their adult beneficiary populations and reduce the disparity.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM provided a link to the 2017 Advisory Committee on Immunization Practices (ACIP) recommended vaccine schedule for adults: https://www.cdc.gov/mmwr/volumes/66/wr/mm6605e2.htm .
How state Medicaid and CHIP programs can drive improvement on measure	Not specified.
Is there room for improvement on measure?	Not specified.
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	As noted earlier, national surveillance data show coverage for recommended adult vaccines is generally lower for adults with public health insurance compared to privately insured adults. Use of this

	measure would help Medicaid programs increase vaccination rates in their adult beneficiary populations and reduce the disparity.
Can measure be trended over time?	Not specified.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	The following information is for US adults with health insurance coverage through Medicaid, CHIP, or any other state or local government program that pays for health care at the time of the survey: • Influenza: 35.8 percent of adults ages 19-65 reported receiving a flu vaccine in the past 12 months. • Td/Tdap: 56.7 percent of adults ages 19-65 reported receiving a tetanus shot in the past ten years. • Zoster: 8.5 percent of adults ages 50-65 reported ever receiving a vaccine for shingles. Source: National Health Interview Survey 2018. Accessed via IPUMS NHIS site: https://www.nhis.ipums.org.
Use of measure in other CMS programs	No other programs listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure	State Medicaid agencies vary in their ability to identify immunizations in electronic clinical data. Lack of experience using ECDS technical specifications to calculate quality measures could be another barrier.
Technical assistance resources that would facilitate state reporting	Not specified.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Prenatal Immunization Status
Description	The percentage of deliveries in the Measurement Period in which women had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Not specified.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS) (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.)
Denominator	Deliveries during the Measurement Period where the beneficiary also meets the criteria for participation.* *Participation is defined as the identifiers and descriptors for each organization's coverage used to define beneficiaries' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period (28 days prior to delivery date though delivery date).
Numerator	This measure includes numerators for two individual vaccine rates and a combination rate: 1. Influenza rate: Deliveries where beneficiaries received an adult influenza vaccine on or between July 1 of the year prior to the Measurement Period and the delivery date; or deliveries where beneficiaries had an influenza virus vaccine adverse reaction any time during or before the Measurement Period. 2. Tdap rate: Deliveries where beneficiaries received at least one Tdap vaccine during the pregnancy (including on the delivery date); or deliveries where the beneficiary had any of the following: a. Anaphylactic reaction to Tdap or Td vaccine or its components any time during or before the Measurement Period; b. Encephalopathy due to Td or Tdap vaccination (post-tetanus vaccination encephalitis, post-diphtheria vaccination encephalitis, or post-pertussis vaccination encephalitis) any time during or before the Measurement Period. 3. Combination rate: Deliveries that met criteria for both Influenza and Tdap numerators.
Exclusions	• Exclude deliveries that occurred at less than 37 weeks gestation.

	Exclude deliveries in which beneficiaries were in hospice or using hospice services during the Measurement Period.
Continuous enrollment period	28 days prior to delivery date through the delivery date.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria

Link to current technical specifications	See HEDIS 2020 Vol. 2 for current measure specifications. The 2019 specifications are available at https://www.ncqa.org/wp-content/uploads/2018/10/HEDIS-2019-Volume-2-Technical-Update.pdf .
Information on testing or use at state Medicaid/CHIP level	One Workgroup member (WGM) noted that multiple states are testing the measure or have calculated prenatal immunization levels for Medicaid populations using similar approaches: - Colorado calculated the prenatal measure as specified using immunization information systems and claims data from 2017-2018. - California is in the process of testing this measure as specified. - New Mexico calculated prenatal immunization levels for 2017-2018 using Medicaid claims, but alternative specifications were used. - Wisconsin and Minnesota calculated prenatal immunization levels using immunization information systems and claims data, but alternative specifications were used. - Pennsylvania Medicaid is requiring Medicaid health plans to report the measure beginning in Measurement Year 2020. One WGM noted that states using data from immunization information systems for Child Core Set reporting could replicate their methods to calculate this measure. Mathematica estimates that at least 10 states used immunization information systems data (in addition to Medicaid administrative data) to calculate Child Core Set immunization measures between FFY 2016 and FFY 2018.
Description of required data source and data elements, including any barriers or limitations	ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries. While administrative claims can be used to identify immunizations, states may need to supplement administrative data sources with electronic data sources to identify vaccinations that occurred outside of medical appointments. Medicaid and CHIP agencies vary in their ability to identify immunizations in electronic clinical data or immunization registries.
Description of potential variations that could affect consistency of calculations	Not specified.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	Two WGMs recommended this measure for addition. One WGM noted that pregnant women are more likely to have severe illness from flu, possibly due to changes in immune, heart, and lung functions during pregnancy. Whooping cough, known as pertussis, can be serious for anyone, but for a newborn, it can be life-threatening. The WGM also noted that receipt of recommended vaccinations is a critical strategy to improve the health of pregnant women and their neonates. Another WGM noted that maternal and perinatal health has been identified as an area to strengthen in the Core Sets. There are currently no prenatal immunization measures in either the Adult or Child Core Sets. However, prenatal immunization coverage levels are not adequate, and prenatal influenza immunization levels are lower among Medicaid beneficiaries compared to those who are insured through commercial plans. The WGM further noted that this measure serves as an important indicator of receipt of recommended preventive services for maternal and perinatal health. Since nearly half of all U.S. births are covered by Medicaid, improving prenatal vaccination offers significant opportunities to improve the health of Medicaid and CHIP beneficiaries while reducing costs to state Medicaid programs.
How measure promotes effective care delivery in Medicaid and CHIP	One WGM noted that, since 2004, the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) and the American College of Obstetricians and Gynecologists (ACOG) have recommended that all women who are pregnant or who might be pregnant in the upcoming influenza season receive the influenza vaccine, regardless of trimester. To prevent pertussis in young infants who are at greatest risk for severe morbidity and mortality from pertussis, in 2013, ACIP recommended that women should receive a dose of Tdap during each pregnancy, preferably from 27 through 36 weeks gestation; this recommendation was also made by ACOG and ACNM. This measure encourages states to meet these nationally accepted immunization guidelines.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	One WGM provided a link to the ACIP recommended vaccine schedule for adults: Kim, D.K., L.E. Riley, K.H. Harriman, P. Hunter, C.B. Bridges. 2017. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years or Older — United States, 2017." MMWR Morb Mortal Wkly Rep 66:136–8. DOI: http://dx.doi.org/10.15585/mmwr.mm6605e2.
How state Medicaid and CHIP programs can drive improvement on measure	One WGM listed strategies to drive improvement, including education to pregnant women; public reporting of immunization rates; pay-for-performance programs; and performance assessment and feedback.
Is there room for improvement on measure?	One WGM noted that during the 2014–15 influenza season, the CDC analyzed data from an Internet panel survey conducted during March 31–April 6, 2015. Among 1,702 survey respondents who were pregnant at any time during October 2014–January 2015, 50.3 percent reported

	receiving influenza vaccination before or during pregnancy, similar to the reported coverage in previous influenza seasons (Ding 2015). These data indicate nearly 50 percent of all pregnant women were without protection from influenza for themselves and their babies. The WGM also noted that only a small proportion of women enrolled in Medicaid receive Tdap during pregnancy, and that rates are lower for non-white beneficiaries. Tdap vaccination is not a covered benefit in all state Medicaid programs. Research suggests that a lack of medical benefits for Tdap vaccination may impact coverage rates. In Florida, where Medicaid-covered pregnancy-related services did not include Tdap vaccination prior to 2019, researchers at the University of Florida found that 68.6 percent of pregnant women enrolled in private insurance received the Tdap vaccine, while 13.4 percent of pregnant women enrolled in Medicaid received the vaccine in 2016-2018. Sources: https://bit.ly/37PjHBL https://www.cdc.gov/flu/fluview/pregnant-women-nov2016.htm
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	One WGM highlighted that Medicaid plays a key role in the prevention of disease by facilitating access to vaccines and vaccine activities, and the other WGM noted that Medicaid covers a large proportion of pregnancies among low-income women. Therefore, Medicaid is positioned to be a key driver of prenatal immunization rates.
Can measure be trended over time?	This measure will be publicly reported for the first time for HEDIS Measurement Year 2020 (reported June 2021). Thus, the measure is not yet trendable.

Additional Information for Consideration

Prevalence of condition being measured among Medicaid and CHIP beneficiaries	During the 2010–11 through 2017–18 influenza seasons, 2,341 influenza-associated hospitalizations among pregnant women were reported to the CDC through FluSurv–NET (seasonal range = 84–523). Pregnant women accounted for 24–34 percent of reported influenza-associated hospitalizations per season among females aged 15–44 years with known pregnancy status (Lindley et al. CDC 2019). Influenza infection in pregnant women is associated with adverse birth outcomes like prematurity and low birthweight. Pertussis poses the highest risk of hospitalization or death to infants younger than 12 months. Nationwide in 2017, there were 1,545 cases in infants under six months of age and nine deaths in infants under one year of age. Despite immense progress in reducing the morbidity and mortality of pertussis through universal infant and childhood immunization, pertussis disease in infants too young to be fully vaccinated remains a public health problem. The overwhelming majority of morbidity and mortality attributable to pertussis infection occurs in infants who are less than or equal to three months of age. Despite the demonstrated health benefits of these vaccinations, studies have found that about half of women do not receive the influenza vaccine and/or the Tdap vaccine during pregnancy. Data from multiple sources indicate pregnant women with public health
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	insurance/Medicaid are less likely than privately insured women to receive indicated vaccines during pregnancy. This difference in coverage likely results in a disproportionate burden of influenza and pertussis disease among Medicaid beneficiaries. Sources: https://www.cdc.gov/mmwr/volumes/68/wr/mm6840e1.htm https://bit.ly/38LZw91
Use of measure in other CMS programs	No other programs listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure	One WGM noted that access to EHR data could be a barrier to states. Additionally, state Medicaid agencies vary in their ability to identify immunizations in electronic clinical data. Lack of experience using ECDS technical specifications to calculate quality measures could be another barrier.
Technical assistance resources that would facilitate state reporting	One WGM suggested assistance in connecting to immunization information systems and EHR systems, if data are not available from other sources.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.

MATERNAL AND PERINATAL HEALTH

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Prenatal Depression Screening and Follow-Up
Description	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. 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.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Maternal and Perinatal Health
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Not specified.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS) (Note: ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.)
Denominator	Denominators for the two rates are: 1. Depression Screening: Deliveries during the Measurement Period (January 1 – December 31). 2. Follow-Up on Positive Screen: All deliveries from the Depression Screening numerator with a positive finding for depression during pregnancy.
Numerator	Numerators for the two rates are: 1. Depression Screening: Deliveries in which women had documentation of depression screening performed during pregnancy, using an age-appropriate standardized instrument. 2. Follow-Up on Positive Screen: Deliveries in which women received follow-up care on or up to 30 days after the date of the first positive screen (31 days total). Follow-up care is defined as any of the following: • An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition. • A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.

- A behavioral health encounter, including assessment, therapy, collaborative care, or medication management.
- A dispensed antidepressant medication.

or

- Receipt of an assessment on the same day and subsequent to the positive screen.
 - Documentation of additional depression screening indicating either no depression or no symptoms that require follow-up. For example, if the initial positive screen resulted from a PHQ-2 score, documentation of a negative finding from a subsequent PHQ-9 qualifies as evidence of follow-up.

Eligible screening instruments with thresholds for positive findings for this measure are:

Instruments for Adolescents (12-17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9) [®]	Total Score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ-9M) [®]	Total Score ≥ 10
PRIME MD-PHQ2 [®]	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS) ^{®*}	Total Score ≥ 4
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥ 9
PROMIS Depression	Total Score (T Score) ≥ 52.5

Instruments for Adults (18+ years)	Positive Finding
Patient Health Questionnaire (PHQ-9) [®]	Total Score ≥ 10
PRIME MD-PHQ2 [®]	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS) ^{®*}	Total Score ≥ 4
Beck Depression Inventory (BDI-II)	Total Score ≥ 14
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Duke Anxiety-Depression Scale (DADS) ^{®*}	Total Score ≥ 30
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥ 9
My Mood Monitor (M-3) [®]	Total Score ≥ 5
PROMIS Depression	Total Score (T Score) ≥ 52.5
Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥ 11

*Proprietary; may be cost or licensing requirement associated with use.

Exclusions	- Exclude deliveries in which women were in hospice or using hospice services during the measurement period. - Exclude deliveries that occurred at <37 weeks gestation.
Continuous enrollment period	28 days prior to delivery date through the delivery date.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria

Link to current technical specifications	See HEDIS 2020 Vol. 2 for current measure specifications. See https://www.ncqa.org/wp-content/uploads/2020/02/20200212_18_Depression_Measures.pdf for proposed changes to the measure.
Information on testing or use at state Medicaid/CHIP level	NCQA has tested this measure at the health plan level in Washington, DC and Hawaii and at the provider organization level in New York and Colorado. Pennsylvania Medicaid is requiring Medicaid health plans to report the measure beginning in 2020. The HEDIS prenatal and postpartum depression screening measures will be reported by commercial and Medicaid health plans for the first time in June 2020 and NCQA will analyze first-year performance data in 2020.
Description of required data source and data elements, including any barriers or limitations	The perinatal depression measures do not simply assess whether women were screened for depression, but also require information on whether a standardized instrument was used, the resulting score, and whether it was a positive finding for depression. Positive results require documentation of follow-up. In NCQA's field test of these measures, they learned that providers are documenting depression screening data in electronic data sources.
Description of potential variations that could affect consistency of calculations	The Workgroup member (WGM) noted that Medicaid coverage for pregnant women is required for all Medicaid programs and that there should be no challenge to calculating this measure consistently across states. However, in NCQA's field test of the perinatal depression measures, they found that health plan ability to access the data and report the measures varied. The measure steward indicated that feasibility of reporting the measures using electronic data is likely to increase over time.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that all states are required to provide Medicaid coverage for pregnant women and in many states, Medicaid covers the majority of births. Identifying and treating pregnancy-related depression is a key opportunity to improve the health of mothers and young children.
How measure promotes effective care delivery in Medicaid and CHIP	The WGM noted that the entire health care system struggles with screening and access to appropriate care following a positive screen. This measure should drive improvement in maternal and child health

	and add focus to the need for health care systems to be responsive to positive depression screens for pregnant women.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM indicated that many states are already focused on maternal depression and that will increase with the recently announced Integrated Care for Kids (InCK) and Maternal Opioid Misuse (MOM) demonstrations. Health plans and states have the ability to incent and drive improvement in this area.
How state Medicaid and CHIP programs can drive improvement on measure	The WGM noted that states can drive improvement in this area by establishing this measure as a priority in performance improvement plans and by putting value-based payment arrangements in place that include performance improvement requirements for this measure.
Is there room for improvement on measure?	The WGM indicated that there is room for improvement on this measure.
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	The WGM noted that women who are enrolled in the Medicaid program have low incomes by definition, and that the data on depression show a link with life stressors (such as resource constraints and new parenthood) as a factor in depression. The WGM indicated that Medicaid and CHIP are uniquely positioned to bring focus to and enhanced treatment for perinatal depression.
Can measure be trended over time?	The WGM indicated that this measure can be trended over time.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	The WGM noted that an estimated 1 in 10 women experience perinatal depression, although the number is thought to be under reported for low-income women, women of color, and young mothers. In 2017, 12 percent of women with a recent live birth reported experiencing depression during pregnancy (Pregnancy Risk Assessment Monitoring System data, available at https://www.cdc.gov/prams/prams-data/mch-indicators.html).
Use of measure in other CMS programs	No other programs listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure	Lack of experience using ECDS technical specifications to calculate quality measures could be a barrier.
Technical assistance resources that would facilitate state reporting	The measure steward indicated that it has several ongoing learning collaboratives with health plans focused on reporting electronic clinical data systems measures that address screening and follow-up for depression and unhealthy alcohol use, as well as the perinatal depression measures. The findings from these collaboratives will include lessons learned and successful approaches collecting data to report such measures. The measure steward plans to disseminate these findings widely to support broader implementation and use of the measures.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Postpartum Depression Screening and Follow-Up
Description	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: The percentage of deliveries in which women were screened for clinical depression using a standardized tool within 12 weeks (84 days) post-delivery. 2. Follow-Up on Positive Screen: The percentage of deliveries in which women received follow-up care within 30 days of screening positive for depression.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Maternal and Perinatal Health
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Not specified.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS) (Note: ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.)
Denominator	Denominators for the two rates are: 1. Depression Screening: Deliveries during September 8 of the year prior to the Measurement Period through September 7 of the Measurement Period. 2. Follow-Up on Positive Screen: All deliveries from the Depression Screening numerator with a positive finding for depression during the 1 to 84 days following the date of delivery.
Numerator	Numerators for the two rates are: 1. Depression Screening: Deliveries in which women had documentation of depression screening performed using an age-appropriate standardized instrument during 1 to 84 days following the date of delivery. 2. Follow-Up on Positive Screen: Deliveries in which women received follow-up care on or up to 30 days after the date of the first positive screen (31 days total). Follow-up care is defined as any of the following: • An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition.

- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
 - A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
 - A dispensed antidepressant medication.
- or**
- Receipt of an assessment on the same day and subsequent to the positive screen.
 - Documentation of additional depression screening indicating either no depression or no symptoms that require follow-up. For example, if the initial positive screen resulted from a PHQ-2 score, documentation of a negative finding from a subsequent PHQ-9 qualifies as evidence of follow-up.

Eligible screening instruments with thresholds for positive findings for this measure are:

Instruments for Adolescents (12-17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9) [®]	Total Score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ-9M) [®]	Total Score ≥ 10
PRIME MD-PHQ2 [®]	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS) ^{®*}	Total Score ≥ 4
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥ 9
PROMIS Depression	Total Score (T Score) ≥ 52.5

Instruments for Adults (18+ years)	Positive Finding
Patient Health Questionnaire (PHQ-9) [®]	Total Score ≥ 10
PRIME MD-PHQ2 [®]	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS) ^{®*}	Total Score ≥ 4
Beck Depression Inventory (BDI-II)	Total Score ≥ 14
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Duke Anxiety-Depression Scale (DADS) ^{®*}	Total Score ≥ 30
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥ 9
My Mood Monitor (M-3) [®]	Total Score ≥ 5
PROMIS Depression	Total Score (T Score) ≥ 52.5

	<table border="1"> <tr> <td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>Total Score ≥ 11</td></tr> </table> *Proprietary; may be cost or licensing requirement associated with use.	Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥ 11
Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥ 11		
Exclusions	Excludes deliveries in which women were in hospice or using hospice services during the measurement period.		
Continuous enrollment period	Delivery date through 60 days following the date of delivery.		
Level of reporting for which specifications were developed	Plan-level.		

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS 2020 Vol 2 for current measure specifications. See https://www.ncqa.org/wp-content/uploads/2020/02/20200212_18_Depression_Measures.pdf for proposed changes to the measure.
Information on testing or use at state Medicaid/CHIP level	NCQA has tested this measure at the health plan level in Washington, DC and Hawaii and at the provider organization level in New York and Colorado. Pennsylvania Medicaid is requiring Medicaid health plans to report the measure beginning in 2020. The HEDIS prenatal and postpartum depression screening measures will be reported by commercial and Medicaid health plans for the first time in June 2020 and NCQA will analyze first-year performance data in 2020.
Description of required data source and data elements, including any barriers or limitations	The perinatal depression measures do not simply assess whether women were screened for depression, but also require information on whether a standardized instrument was used, the resulting score, and whether it was a positive finding for depression. Positive results require documentation of follow-up. In NCQA's field test of these measures, they learned that providers are documenting depression screening data in electronic data sources.
Description of potential variations that could affect consistency of calculations	The Workgroup member (WGM) noted that in non-expansion states, pregnancy related Medicaid coverage ends at 60 days postpartum. And, in some expansion states the income level for pregnancy-related Medicaid coverage is higher than the income level for enrollment through expansion, resulting in a loss of coverage for some women at 60 days postpartum. In NCQA's field test of the perinatal depression measures, they also found that health plan ability to access the data and report the measures varied. They indicated that feasibility of reporting the measures using electronic data is likely to increase over time.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that it is critical that we screen and treat women experiencing perinatal depression to ensure women and young children have a strong start.
How measure promotes effective care delivery in Medicaid and CHIP	The WGM indicated that the measure will address effective delivery of care because it is focused on a period when women often have a disruption in care following the delivery of a child, and a time when care for women is often limited by a focus on the needs of the newborn child.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM noted that this measure, and other measures that focus on perinatal health quality improvement, are currently being used by health plans and states. These efforts have shown that care can be improved.
How state Medicaid and CHIP programs can drive improvement on measure	The WGM indicated that states can establish performance targets in their quality improvement plans and use value-based arrangements or payments for key performance indicators to drive improvement in this area.
Is there room for improvement on measure?	The WGM indicated that there is room for improvement on this measure. Many women experience a disruption in care during the postpartum period and this measure can help incent more cohesive and comprehensive care for women.
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	The WGM noted that depression has been linked to life stressors such as low-income and the addition of a new baby to a family. Women enrolled in the Medicaid program often face these, and additional life stressors such as racism, unstable living arrangements, and others that can increase their experience of depression.
Can measure be trended over time?	The WGM indicated that this measure can be trended over time.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	The WGM noted that an estimated 1 in 10 women experience perinatal depression, although the number is thought to be under reported for low-income women, women of color, and young mothers. In 2017, 12 percent of women with a recent live birth reported experiencing depression during pregnancy (Pregnancy Risk Assessment Monitoring System data, available at https://www.cdc.gov/prams/prams-data/mch-indicators.html).
Use of measure in other CMS programs	No other programs listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure	Lack of experience using ECDS technical specifications to calculate quality measures could be a barrier.
Technical assistance resources that would facilitate state reporting	The measure steward indicated that it has several ongoing learning collaboratives with health plans focused on reporting electronic clinical data systems measures that address screening and follow-up for depression and unhealthy alcohol use, as well as the perinatal



	depression measures. The findings from these collaboratives will include lessons learned and successful approaches collecting data to report such measures. The measure steward plans to disseminate these findings widely to support broader implementation and use of the measures.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.

CARE OF ACUTE AND CHRONIC CONDITIONS

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Proportion of Days Covered - Antiretroviral Medications
Description	The percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 90% for ≥ 3 antiretroviral medications (ARVs) during the measurement year.
Measure steward	Pharmacy Quality Alliance (PQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Outcome
Recommended to replace current measure?	HIV Viral Load Suppression (HVL-AD)

Technical Specifications	
Ages	Age 18 and older as of the first day of the measurement year.
Data collection method	Prescription claims data.
Denominator	Individuals who filled a prescription for ≥ 3 distinct ARVs (as a single agent or as a combination) each with 2 different dates of service during the measurement year.
Numerator	Individuals from the denominator who met the PDC threshold of 90% during the measurement year.
Exclusions	Hospice care at any point during the treatment year.
Continuous enrollment period	The beneficiary's treatment period begins on the index prescription start date (IPSD) and extends through whichever comes first: the last day of enrollment during the measurement year, death, or the end of the measurement year. The treatment period should be at least 91 days. The beneficiary should be continuously enrolled during the treatment period with no allowable gap in coverage. Individuals with greater than a 1-day gap in enrollment during the treatment period are excluded.
Level of reporting for which specifications were developed	Health plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://www.pqaalliance.org/measures-overview#pdc-arv
Information on testing or use at state Medicaid/CHIP level	New Hampshire Medicaid publicly reports this measure on its website. https://medicaidquality.nh.gov/reports/proportion-of-days-covered---antiretroviral-medications-pdc-arv-1 Pennsylvania Medicaid requests managed care organizations submit an annual HIV dashboard, which includes this measure; however, this is not publicly reported by Pennsylvania.

Description of required data source and data elements, including any barriers or limitations	The data sources include pharmacy claims, medical claims, and eligibility files. Only paid, non-reversed prescription claims are included in the calculation of the measure.
Description of potential variations that could affect consistency of calculations	Medicaid programs cover medications even though it is not a mandatory benefit. The pharmacy data is available from managed care organizations, pharmacy benefit managers, and state programs that have a pharmacy carve out.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The Workgroup member (WGM) indicated that this measure gives a proxy for viral load suppression, which is essential in treating HIV. Studies have shown that HIV medication adherence is a major problem, especially within Medicaid. Source: https://www.liebertpub.com/doi/pdf/10.1089/pop.2019.0052
How measure promotes effective care delivery in Medicaid and CHIP	The WGM indicated that there are multiple interventions that can increase medication adherence. An adherence ratio of 90% correlates with viral load suppression. Viral load suppression is essential in preventing the spread of HIV and keeps the person living with HIV healthy. Lack of adherence may lead to viral resistance. Recent studies also indicate medication adherence reduces medical costs for those living with HIV.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM indicated that Medicaid adherence was 36-46% in a 2019 study in Population Health Management by Priest et al. Source: https://www.liebertpub.com/doi/pdf/10.1089/pop.2019.0052 The WGM shared that in Pennsylvania, the rates are about 56% and NH reported a rate of about 53% in 2018.
How state Medicaid and CHIP programs can drive improvement on measure	The WGM indicated that both managed care organizations and local pharmacists can implement medication therapy management programs to increase medication adherence. Specialty pharmacies can provide wraparound services to encourage ongoing patient engagement.
Is there room for improvement on measure?	The WGM noted that there is substantial room for improvement based on the PA and NH rates.
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	The WGM noted that the HIV population is complex and requires a lifetime of antiretroviral therapy to keep them healthy and prevent the spread of HIV.
Can measure be trended over time?	The WGM noted that since this is an administrative measure, it can be trended easily over time.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	According to the WGM, Medicaid is the largest source of insurance coverage for people with HIV, estimated to cover 42% of the adult population, compared to just 13% of the adult population overall. The number of Medicaid beneficiaries with HIV has grown over time as people with HIV are living longer and new infections continue to occur.

	In 2013, there were 282,100 beneficiaries with HIV compared to 212,900 in 2007, a 33% increase. The expansion of the program under the Affordable Care Act (ACA) has also increased coverage for people with HIV. Medicaid beneficiaries with HIV are more likely to be male, Black, dually eligible for Medicare, and to qualify based on disability, compared to beneficiaries overall. Medicaid spending on HIV accounts for 30% of all federal spending on HIV care and it is the second largest source of public financing for HIV care in the U.S. Spending has increased over time, reflecting growing numbers of beneficiaries with HIV and the rising cost of care. Source: https://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/
Use of measure in other CMS programs	The measure is used by CMS's Medicare Part D Patient Safety reporting.
Potential barriers states could face in calculating measure	Regular updating of pharmacy codes.
Technical assistance resources that would facilitate state reporting	The measure steward provides example programming code to calculate the measure, which could be requested by states.
Meaningful Measures area(s) of measure	Promote Effective Prevention and Treatment of Chronic Disease.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Prevention Quality Indicators #92: Prevention Quality Chronic Composite
Description	Number of inpatient hospital admissions for ambulatory care sensitive chronic conditions per 100,000 population, age 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.
Measure steward	Agency for Healthcare Research and Quality (AHRQ)
NQF number (if endorsed)	Not endorsed
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Composite
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Administrative (claims only).
Denominator	Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Numerator	Discharges, for patients age 18 years and older, that meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQIs): • PQI #1: Diabetes short-term complications admission rate • PQI #3: Diabetes long-term complications admission rate • PQI #5: Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate • PQI #7: Hypertension admission rate • PQI #8: Heart failure admission rate • PQI #14: Uncontrolled diabetes admission rate • PQI #15: Asthma in younger adults admission rate • PQI #16: Lower-extremity amputation among patients with diabetes rate Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.
Exclusions	See each component measure for exclusions. https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10_v2019.aspx

Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Area-level.

Minimum Technical Feasibility Criteria

Link to current technical specifications	https://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2019/TechSpecs/PQI_92_Prevention_Quality_Chronic_Composite.pdf
Information on testing or use at state Medicaid/CHIP level	The PQI 92 composite measure is included in the Health Home Core Set and was reported by 23 Medicaid health home programs for FFY 2018. In addition, four PQIs are included in the Adult Core Set (PQI 01, PQI 05, PQI 08, and PQI 15).
Description of required data source and data elements, including any barriers or limitations	The PQIs are calculated using data from the Healthcare Cost and Utilization Project State Inpatient Database (SID). For the purpose of Core Set reporting, the PQI technical specifications have been adapted from the area level to the state level for calculation using Medicaid and CHIP administrative data. The ICD-10-CM/PCS definitions used in the PQIs are updated annually; v2019 includes ICD-10-CM/PCS codes effective as of October 1, 2018 and v2020 will include codes effective as of October 1, 2019.
Description of potential variations that could affect consistency of calculations	AHRQ provides web-based software for calculating the PQIs, which could be used to eliminate variation.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The Workgroup member (WGM) noted that the goal of this measure is to identify hospitalizations that might be prevented with more timely or appropriate outpatient care. The WGM noted that while this is a composite of PQIs measuring hospital care, the PQIs are sensitive to the quality and availability of ambulatory care, and therefore measure access to quality care.
How measure promotes effective care delivery in Medicaid and CHIP	The WGM noted that identification of areas in which the outpatient care fails to prevent hospitalizations could lead to opportunities to improve access to appropriate care.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM shared a link to an AHRQ guide that provides detailed evidence for each of the PQIs. https://www.ahrq.gov/downloads/pub/ahrqqi/pqiguide.pdf
How state Medicaid and CHIP programs can drive improvement on measure	The WGM noted that provider initiatives around appropriate care or contracting can assure access to outpatient care in a timely manner.

Is there room for improvement on measure?	The WGM indicated there is room for improvement.
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	The WGM indicated that beneficiaries with special health care needs and disabilities develop common conditions and hospital admissions could be prevented with appropriate outpatient care.
Can measure be trended over time?	The WGM indicated that the measure is a rate and therefore can be compared across time and across populations/states.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	The WGM noted that the composite includes a set of common conditions that are prevalent in the Medicaid and CHIP populations. Prevalence of relevant health conditions of nonelderly adults enrolled in Medicaid or CHIP in 2017 according to the Medicaid and CHIP Beneficiary Profile: • 28% have ever had hypertension • 19% have ever had asthma • 10% have ever had diabetes • 3% have ever had a heart attack • 3% have ever had coronary heart disease Source: https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile.pdf.
Use of measure in other CMS programs	• Health Home Core Set • Four components of the PQI 92 composite are reported in the Adult Core Set (PQI 01, PQI 05, PQI 08, and PQI 15).
Potential barriers states could face in calculating measure	The WGM noted that there are a number of individual PQIs that make up this composite measure that states might need help coding.
Technical assistance resources that would facilitate state reporting	The WGM noted that each individual component PQI contained within the composite has standard ICD diagnosis codes for calculating indicators, which should make calculating the measure less onerous.
Meaningful Measures area(s) of measure	Promote Effective Prevention and Treatment of Chronic Disease.

DENTAL AND ORAL HEALTH SERVICES

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Annual Dental Visit
Description	Percentage of patients 2-20 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.
Measure steward	National Committee for Quality Assurance (NCQA) Note that this measure is proposed for retirement from HEDIS Measurement Year 2022 (which covers services provided in calendar year 2022 and would align with the FFY 2023 Core Set). The measure was proposed for retirement because it focuses on access to dental care rather than quality. Proposed retirement would take effect for HEDIS Measurement Year 2022 to allow time for NCQA to introduce a new pediatric dental measure into HEDIS. For more information, visit https://www.ncqa.org/wp-content/uploads/2020/02/20200212_01_ADV.pdf .
NQF number (if endorsed)	1388 (no longer endorsed)
Core Set domain	Dental and Oral Health Services
Measure type	Process
Recommended to replace current measure?	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)

Technical Specifications	
Ages	Age 2-20 years as of December 31 of the measurement year. Report six age stratifications and a total rate: • 2–3 years • 4–6 years • 7–10 years • 11–14 years • 15–18 years • 19–20 years • Total
Data collection method	Administrative.
Denominator	Beneficiaries 2-20 years of age.
Numerator	One or more dental visits with a dental practitioner during the measurement year. Any visit with a dental practitioner during the measurement year meets criteria.
Exclusions	Exclude beneficiaries in hospice or using hospice services during the Measurement Period.
Continuous enrollment period	The measurement year.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://www.ncqa.org/wp-content/uploads/2020/02/20200212_01_ADV.pdf
Information on testing or use at state Medicaid/CHIP level	This measure has been part of NCQA accreditation. A total of 118 Medicaid plans (out of 256 plans) reported the measure for HEDIS 2018.
Description of required data source and data elements, including any barriers or limitations	The measure is calculated with claims data and captures dental visit(s) during a one-year time period. The denominator includes all children with dental benefits and the numerator includes those with a claim for a dental visit during the year.
Description of potential variations that could affect consistency of calculations	The Workgroup member (WGM) noted that this measure is a robust measure under HEDIS and is used by managed care plans already. Note that some states carve out dental care to fee-for-service (FFS), and they would need to calculate the measure for their FFS beneficiaries.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that dental and oral health care are critical for children and proposed this measure replace the current measure (PDENT-CH) to align with what is reported through HEDIS.
How measure promotes effective care delivery in Medicaid and CHIP	The WGM noted that this measure assesses the utilization of dental care for children in Medicaid and CHIP.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM noted that low utilization should lead to an analysis of the potential causes and planning for how to address them.
How state Medicaid and CHIP programs can drive improvement on measure	According to the WGM, states can work with professional organizations and departments of health to increase access, such as through additional practitioners and consideration for dental extenders.
Is there room for improvement on measure?	Yes, the HEDIS 2018 mean rate for Medicaid HMOs was 55.9 percent. Source: https://www.ncqa.org/hedis/measures/annual-dental-visit/ .
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	Yes. According to a report by the ADA, 67.1 percent of privately insured children saw a dentist in 2016, compared to 50.4 percent of children in Medicaid and CHIP. Source: https://bit.ly/2vpQ6Bo
Can measure be trended over time?	Yes, and NCQA already uses it for this purpose.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	Dental caries have a very high prevalence (25 percent of children) especially in the Medicaid population and populations that lack access to dental care. Source: https://www.aapd.org/assets/1/7/FastFacts.pdf#xml



Use of measure in other CMS programs	• Qualified Health Plan (QHP) Quality Rating System (QRS) The WGM noted that alignment across CMS is important; however, it is also important to consider alignment to minimize the burden of data collection for plans and states.
Potential barriers states could face in calculating measure	According to the WGM, no barriers are likely, as this is similar to the existing measure and uses the administrative method.
Technical assistance resources that would facilitate state reporting	The WGM responded that this was not applicable, due to a lack of barriers.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Sealant Receipt on Permanent 1st Molars
Description	The percentage of enrolled children who have ever received sealants on permanent first molar teeth: (1) at least one sealant and (2) all four molars sealed by their 10th birthdate.
Measure steward	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Dental and Oral Health Services
Measure type	Process
Recommended to replace current measure?	Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL-CH) (Note: The SEAL-CH measure has been retired by the measure steward and will be removed by CMCS from the 2021 Core Set.)

Technical Specifications	
Ages	10th birthdate during the measurement year.
Data collection method	Administrative (enrollment & claims only).
Denominator	Unduplicated number of enrolled children with their 10th birthdate in the measurement year.
Numerator	Unduplicated number of enrolled children who ever received sealants on a permanent first molar tooth in the 48 months prior to the 10th birthdate: (1) at least one sealant and (2) all four molars sealed.
Exclusions	Children who have received treatment (restorations, extractions, endodontic, prosthodontic or other dental treatments) on all four permanent first molars within the 48 months prior to their 10th birthdate.
Continuous enrollment period	The 12 months prior to the child's 10th birthdate, with a single allowable gap of no more than 45 days (1 month for programs/plans that verify enrollment on a monthly basis).
Level of reporting for which specifications were developed	State-level and dental plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://www.ada.org/~media/ADA/DQA/2020_SealantFirstMolar.pdf?la=en
Information on testing or use at state Medicaid/CHIP level	Measure testing was conducted using data from Medicaid, CHIP, and commercial programs/plans. The measure was tested for the following Medicaid and CHIP programs: Oregon Medicaid (state program level), Louisiana Medicaid (state program level), Texas Medicaid and CHIP programs (plan level by the dental plans participating in the program, effectively representing the statewide population), and Florida Medicaid (plan level by one of two plans participating in the program).

	In addition, testing included data from one academic health center and a commercial dental plan. The testing report is available at https://www.ada.org/~media/ADA/DQA/2019_Sealants.pdf?la=en .
Description of required data source and data elements, including any barriers or limitations	Administrative enrollment and claims data are required. Data elements include beneficiary ID, birthdate, enrollment indicator, dental procedure codes (CDT codes), date of service, tooth number, and surface. All data elements are standard data elements required for billing and reimbursement. Several state Medicaid and CHIP programs have reported challenges obtaining tooth number for the current SEAL-CH measure in the Child Core Set although it is a standard data element typically required for reimbursement.
Description of potential variations that could affect consistency of calculations	As with any procedure, services provided but not billed to Medicaid programs and not otherwise captured in administrative data will not be reflected in the measure. For example, sealants placed as part of school-based sealant programs that are not captured in Medicaid administrative data will not be reflected in the measure. The Workgroup member (WGM) noted, however, that many school-based sealant program providers do file claims that are captured in Medicaid administrative claims data. Additionally, the testing report noted that significant differences in enrollment duration, resulting in differences in the availability of complete treatment history for enrollees, could bias comparisons across programs. However, the testing report also noted that this limitation is not specific to dental measures.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that dental caries is the most common chronic disease in children in the United States, affecting almost half of all children. Untreated caries can lead to pain, infection, school absences, and difficulty eating and speaking. The CDC notes the following: (1) 9 in 10 cavities occur in permanent molars (where there are pits and fissures), (2) dental sealants prevent 80% of cavities in these teeth, (3) children from low-income families are less likely to get dental sealants and more likely to have cavities in their first permanent molars compared with children from higher-income families. Source: https://www.cdc.gov/oralhealth/publications/OHSR-2019-index.html This measure is proposed to replace the existing SEAL-CH measure in the current Child Core Set (which has been retired by the measure steward). The proposed measure improves upon the existing SEAL-CH measure by promoting sealing all molars by a specific age rather than evaluating only whether at least one sealant was placed during the reporting year. (This is similar to evaluating whether children received all recommended immunizations by a certain age rather than checking whether they have received an individual immunization during the reporting year.) The measure assesses sealant placement by the 10th birthdate (similar to assessing receipt of immunizations by a specific

	birthdate). Although the measure focuses on children who turn age 10 during the reporting year, the prevention benefits last for years thereby positively impacting beneficiary outcomes over a broad age span.
How measure promotes effective care delivery in Medicaid and CHIP	The WGM noted that evidence-based clinical guidelines recommend sealant placement as an effective intervention for reducing the incidence of carious lesions on permanent molars (those teeth most likely to get cavities) in children and adolescents. The proposed measure assesses whether children have ever received: (1) at least one sealant and (2) all four sealants on their permanent first molars. The rate for “all four” molars sealed is an appropriate proxy indicator of both effective prevention and population health because it signifies the percentage of children who received sealants on all four molars and do not have disease in any of the permanent first molars.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The measure is grounded in evidence-based clinical recommendations that placing sealants is an effective intervention for reducing the incidence of carious lesions on permanent molars: https://jada.ada.org/article/S0002-8177(16)30473-1/fulltext Also, see the companion systematic review: https://jada.ada.org/article/S0002-8177(16)30475-5/fulltext.
How state Medicaid and CHIP programs can drive improvement on measure	The WGM noted that the most effective improvement strategies for a given Medicaid/CHIP program will vary. However, there are a range of strategies that can be used to improve sealant rates including integrating oral health into overall primary care, establishing bi-directional referral and follow-up between medical and dental providers, providing sealants in non-traditional settings, sharing reports with providers that demonstrate the oral health status of their beneficiaries and preventive care that they have (or have not) received, educating dentists and their teams on evidence-based guidelines, developing oral health toolkits for providers, providing incentives/bonuses to providers for achieving improvement, assisting beneficiaries with making and keeping dental appointments, educating families about their dental benefits and the importance of oral health care, as well as other strategies. Examples of multi-pronged strategies can be found in the Oregon Medicaid program: https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Dental-Sealant-Guidance-Document.pdf and the DQA Quality Innovators Spotlights: https://www.ada.org/~media/ADA/DQA/Preventistry_QIS.pdf?la=en. Through successful strategies, Oregon Medicaid increased the percentage of children 6-14 years receiving at least one dental sealant during the measurement year from 11% in 2014 to 25% in 2018: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/ORALHEALTH/Documents/State-of-Oral-Health-in-Oregon-9-23-19.pdf.
Is there room for improvement on measure?	Yes. National estimates for 2011-2016 indicate that more than 58% of all children aged 6-11 years and 62% of poor children in the same age group did not receive sealants on permanent teeth (CDC 2019). Testing data found that measure scores for ever having at least one sealant placed on a permanent first molar by the 10th birthdate ranged from

	50% to 75% in 2017. The measure scores ranged from 40% to 51% for ever having sealants placed on all four permanent first molars. There is significant opportunity for improving sealant placement rates.
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	Yes. Low-income children are less likely to get sealants and more likely to have untreated cavities than higher-income children (CDC 2019).
Can measure be trended over time?	Yes. Testing included time trend data for the period 2014-2018.

Additional Information for Consideration

Prevalence of condition being measured among Medicaid and CHIP beneficiaries	The prevalence of dental caries (treated and untreated) in permanent teeth among children in households with <100% FPL children aged 6-11 years old was 25% during 2011-2016 (https://www.cdc.gov/oralhealth/pdfs_and_other_files/Oral-Health-Surveillance-Report-2019-h.pdf). Evidence-based guidelines recommend sealants be placed on the permanent molars of all children regardless of caries experience and risk status in order to prevent carious lesions.
Use of measure in other CMS programs	No other programs listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure	The WGM noted that this measure was conceptualized and developed by the DQA in response to the feedback received on the SEAL-CH measure that is currently part of the Child Core Set. DQA's evaluation included the establishment of an ad-hoc workgroup in 2018, comprised of 12 members that represented payers, state Medicaid agencies, providers and health services researchers. Representatives from the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) participated in the workgroup as technical advisors. This measure is recommended to replace the current sealant measure (SEAL-CH) in the Child Core Set. The main impact on states will be the time required to revise the programming code to the new specifications. The WGM compared the existing SEAL-CH measure and newly proposed measure as follows: • Difference in the denominator specification: elevated risk is removed and exclusions are added. Both elevated risk (current measure) and exclusions (proposed measure) require looking back into historical data for specific CDT codes. • Difference in numerator specification: instead of looking for sealant placement in just the reporting year, the measure requires looking back into historical data (48 months) for at least one sealant and for sealants on all four molars. The current SEAL-CH measure also recommended looking back 3 years for evidence of elevated risk.
Technical assistance resources that would facilitate state reporting	The WGM noted that TA resources that summarize the key differences between the old and new sealant measures would be useful for states. The same types of TA that were provided for SEAL-CH, such as a step-by-step guide for calculating the measure and sample SAS code, would



	be beneficial for the proposed measure. The measure steward does have SAS code available which could be adapted as a TA resource.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

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

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Administrative (enrollment and medical claims).
Denominator	All member months for individuals 18 years and older during the reporting year.
Numerator	Number of ED visits with an ambulatory care sensitive non-traumatic dental condition diagnosis code among individuals 18 years and older.
Exclusions	- Exclude all visits from the numerator that resulted in an inpatient admission within 48 hours of the ED visit. - Exclude beneficiary months (and associated claims in those months) from the denominator in which an individual was eligible for both Medicare and Medicaid (i.e., “dual eligible”).
Continuous enrollment period	None.
Level of reporting for which specifications were developed	State-level. Can be used at the plan-level for managed care plans that provide both medical and dental benefits (but cannot be used by plans that have access to dental data only).

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://www.ada.org/~media/ADA/DQA/2019_AdultEDVisits.pdf?la=en
Information on testing or use at state Medicaid/CHIP level	Measure testing was conducted using data from calendar years 2014-2016 from the Iowa and Oregon Medicaid programs. Testing also included data element validation through chart reviews. Feasibility was assessed by (1) evaluating availability of critical data elements; (2) evaluating the calculation logic for complexity and reporting burden; (3) implementing the calculation logic to report measure scores; and (4)

	soliciting stakeholder feedback through public comment periods. The measure steward found that the measure could be calculated using Oregon and Iowa Medicaid administrative data and did not receive stakeholder feedback regarding concerns with feasibility. Measure reliability and validity also were established as part of measure testing.
Description of required data source and data elements, including any barriers or limitations	Administrative enrollment and medical claims data are required. Data elements include beneficiary ID, birthdate, enrollment indicator, Medicare-Medicaid dual eligibility indicator, date of service, medical procedure codes (CPT/HCPCs), facility revenue codes, CMS place of service codes, admission date, ICD-10 diagnosis codes, and facility UB type of bill. All data elements are standard administrative claims data elements.
Description of potential variations that could affect consistency of calculations	Dental benefits for adults in Medicaid programs vary across states. This may lead to variation in state performance on the measure, but should not result in any inconsistencies in calculations, given that dental claims are not required to calculate this measure. Information on adult dental benefits offered by state Medicaid programs is available at https://www.chcs.org/media/Medicaid-Adult-Dental-Benefits-Overview-Appendix_091519.pdf. The measure specifications note that this measure only applies to programs such as Medicaid that provide both medical insurance and dental benefits. Use of this measure for stand-alone dental benefit plans will result in feasibility issues due to lack of access to appropriate data. Use by health plans that provide both medical insurance and dental benefits to a population may be considered after assessment of data element feasibility within the plans' databases.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The Workgroup member (WGM) noted that this measure would address a significant gap in the Adult Core Set as there are currently no adult measures related to oral health care. This measure is applicable to adults of all ages and would provide a measure of access to oral health care services. The WGM also noted that this is an important measure because it allows states to evaluate the extent to which their dental benefits coverage (or lack thereof) may be affecting oral health care outcomes (with potential implications for systemic health) and system-wide resource use. The WGM noted there is a growing body of research indicating important connections between oral health and overall systemic health. Poor oral health appears to impose not only additional individual disease burden but also additional societal costs. For example, studies examining periodontal interventions among individuals diagnosed with systemic health conditions have found the intervention to be associated with lower health care costs.
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How measure promotes effective care delivery in Medicaid and CHIP	The WGM noted that ED use for non-traumatic dental conditions (NTDC) has been a growing public health concern across the United States with over 2 million visits and an average charge per visit of \$994 for adults. Source: https://jada.ada.org/article/S0002-8177(18)30800-6/abstract State-level studies also found an increase in the trend of dental-related ED visits (e.g., https://www.ncbi.nlm.nih.gov/pubmed/31774203, https://www.ncbi.nlm.nih.gov/pubmed/27515432, https://www.ncbi.nlm.nih.gov/pubmed/29346000). NTDC visits are largely preventable through primary prevention, early identification of disease and disease management in primary care outpatient settings. Moreover, care in the ED is not definitive, necessitating a follow-up visit with a dental provider. Consequently, this measure reflects access to effective and timely outpatient oral health care.
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM noted that a study of a community-based intervention in Michigan that provided oral health education and dental services (including screenings, diagnostic services, and treatment) to uninsured adults decreased the number of patients going to the local ED for dental pain by 70% over a six-year period (https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0159). The WGM also noted that implementation of a community dental access program in rural western Maryland was associated with a decrease in ED visits and was estimated to avert 670 ED visits over a four-year period (https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303467?journalCode=ajph). This measure is important in order to promote standardized measurement of dental-related ED visits and to drive improvement that promotes better access to timely and effective outpatient care and reduced use of the ED for NTDC.
How state Medicaid and CHIP programs can drive improvement on measure	The WGM noted that the most effective improvement strategies for a given Medicaid program will vary. However, there are a range of strategies that can be used to improve access to care and reduce NTDC dental visits. Examples include developing an ED referral program, establishing community dental health coordinator programs, improving dental provider participation in Medicaid, expanding the scope of adult dental services covered by Medicaid, and improving medical-dental collaboration and coordination. Examples of strategies can be found at the following links: https://www.ada.org/en/public-programs/action-for-dental-health/10-step-plans-to-improve-oral-health, https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0159, and https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303467?journalCode=ajph.
Is there room for improvement on measure?	Testing data found that NTDC visits ranged from 209 visits per 100,000 beneficiary months in Oregon Medicaid to 310 visits per 100,000 beneficiary months among Iowa Medicaid FMAP enrollees. Each one of these visits generates high health care system resource use without definitive care: enrollees must still follow up with a dental provider to address the underlying problem.

Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	Low-income individuals, including those enrolled in Medicaid, are at greater risk for having NTDC ED visits. As noted above, there are important connections between oral health and overall systematic health.
Can measure be trended over time?	According to the WGM, measure trends can be assessed over time to evaluate program performance and progress.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	State and national estimates indicate that dental-related ED visits account for approximately 2% of total ED visits (e.g., Kelekar et al. 2019; Sun et al., 2014, Tomar et al, 2016). As of 2013, approximately one-third of NTDC ED visits were covered by Medicaid. Medicaid is a primary payer of dental-related ED visits (ADA Health Policy Institute, Kelekar et al. 2019). A study of Oregon’s All Payer All Claims database found that dental-related visits accounted for 2.5% of all ED visits and were the second most common diagnosis in adults aged 20-39 years (Sun et al. 2019). Among state Medicaid programs specifically, Maryland estimated that the rate of dental-related ED visits among adult Medicaid enrollees in FY2016 was 321 per 10,000 Medicaid eligibles. An analysis of frequent ED users in New Hampshire’s Medicaid program found that “disorders of the teeth and jaw” was the leading subcategory of ED visits among low-income adult frequent ED users (having 4 or more outpatient ED visits during the year), representing 1,283 of 10,619 ED visits (12%) among this group. Sources: https://www.ncbi.nlm.nih.gov/pubmed/30922460, https://www.ncbi.nlm.nih.gov/pubmed/27103213, https://www.ncbi.nlm.nih.gov/pubmed/25790415, https://www.mdac.us/file_download/inline/57cb39db-b4f4-4cdb-8829-f062e74fe36c, https://www.dhhs.nh.gov/ombp/documents/emergencyroom.pdf.
Use of measure in other CMS programs	No other programs listed in CMS’s Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure	This measure relies on standard data elements contained with administrative enrollment and claims data. Measure steward testing demonstrated feasibility of this measure.
Technical assistance resources that would facilitate state reporting	The measure steward has programming code available which could be adapted as a TA resource. DQA has also developed a user guide to assist with implementation of this measure: https://www.ada.org/~media/ADA/DQA/2020_AdultMeasuresUserGuide.pdf?la=en.
Meaningful Measures area(s) of measure	Make Care Affordable.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions (NTDC) in Adults
Description	The percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the beneficiary visited a dentist within (a) 7 days and (b) 30 days of the ED visit.
Measure steward	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Dental and Oral Health Services
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Administrative (enrollment & claims only).
Denominator	Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period.
Numerator	Number of ambulatory care sensitive non-traumatic dental condition ED visits in the reporting period for which the beneficiary visited a dentist within (a) 7 days and (b) 30 days of the ED visit.
Exclusions	- Exclude all visits from the numerator that resulted in an inpatient admission within 48 hours of the ED visit. - Exclude beneficiary months (and associated claims in those months) in which an individual was eligible for both Medicare and Medicaid (i.e., “dual eligible”).
Continuous enrollment period	None.
Level of reporting for which specifications were developed	State-level. Can be used at the plan-level for managed care plans that provide both medical and dental benefits).

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://www.ada.org/~media/ADA/DQA/2019_AdultFollowUpAfterED.pdf?la=en
Information on testing or use at state Medicaid/CHIP level	Measure testing was conducted using data from calendar years 2014-2016 from the Iowa and Oregon Medicaid programs. Testing also included data element validation through chart reviews. Feasibility was assessed by (1) evaluating availability of critical data elements; (2) evaluating the calculation logic for complexity and reporting burden; (3) implementing the calculation logic to report measure scores; and (4) soliciting stakeholder feedback through public comment periods. The

	measure steward found that the measure could be calculated using Oregon and Iowa Medicaid administrative data and did not receive stakeholder feedback regarding concerns with feasibility. Measure reliability and validity also were established as part of measure testing.
Description of required data source and data elements, including any barriers or limitations	Administrative enrollment and claims data (medical and dental) are required. Data elements include beneficiary ID, birthdate, enrollment indicator, Medicare-Medicaid dual eligibility indicator, date of service, dental procedure codes (CDT), medical procedure codes (CPT/HCPCs), facility revenue codes, CMS place of service codes, admission date, ICD-10 diagnosis codes, facility UB type of bill, and rendering provider taxonomy codes (e.g., NUCC). All data elements are standard administrative claims data elements.
Description of potential variations that could affect consistency of calculations	The Workgroup member (WGM) noted that dental benefits coverage for adults in Medicaid programs vary across states. Comparisons between programs may be biased depending on the coverage and availability of data, thus, requiring guidance about how to make appropriate comparisons. Information on Adult dental benefits offered by state Medicaid programs is available at https://www.chcs.org/media/Medicaid-Adult-Dental-Benefits-Overview-Appendix_091519.pdf. The measure specifications note that this measure only applies to programs such as Medicaid that provide both medical insurance and dental benefits. Use of this measure for stand-alone dental benefit plans will result in feasibility issues due to lack of access to appropriate data. Use by health plans that provide both medical insurance and dental benefits to a population may be considered after assessment of data element feasibility within the plans' databases.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM noted that this measure would address a significant gap in the Adult Core Set as there are currently no adult measures related to oral health care. This measure is applicable to adults of all ages. The WGM noted that this measure can be used to promote improved health outcomes by allowing programs to identify, monitor, and increase the percentage of Medicaid-enrolled adults with a dental-related ED visit who subsequently receive outpatient dental care. The high rates of prescription drugs for pain management (e.g., opioids) and infection control and lack of definitive treatment suggests the need for timely definitive care in an outpatient dental setting to avoid ongoing pain, worsening of the dental condition stemming from untreated decay, and repeat ED visits. There is a growing body of research indicating important connections between oral health and overall systemic health. Poor oral health appears to impose not only additional individual disease burden, but also additional societal costs. For example, studies examining periodontal interventions among individuals diagnosed with systemic health conditions have found interventions to be associated with lower health care costs.

How measure promotes effective care delivery in Medicaid and CHIP	The WGM noted that ED use for non-traumatic dental conditions (NTDC) has been a growing public health concern across the United States with over two million visits and an average charge per visit of \$994 for adults (https://jada.ada.org/article/S0002-8177(18)30800-6/abstract). NTDC visits are largely preventable through primary prevention, early identification of disease, and disease management in primary care outpatient settings. Moreover, care in the ED is not definitive, providing mainly pain relief and infection control (https://www.ncbi.nlm.nih.gov/pubmed/22584886). Most patients are referred to a dental provider for follow up (https://www.ncbi.nlm.nih.gov/pubmed/20726944, https://www.ncbi.nlm.nih.gov/pubmed/23189415). National and state data suggest that 17 to 25 percent of patients who visit the ED for a dental-related problem have a repeat ED visit for a dental problem, and many patients do not have any type of follow-up dental care (http://www.ncbi.nlm.nih.gov/pubmed/?term=davis+my+tooth+hurts; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4104605/, https://www.ncbi.nlm.nih.gov/pubmed/26562729).
Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM noted that a study of a community-based intervention in Michigan that provided oral health education and dental services (including screenings, diagnostic services, and treatment) to uninsured adults improved dental care access and decreased the number of patients going to the local ED for dental pain by 70 percent over a six-year period (https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0159).
How state Medicaid and CHIP programs can drive improvement on measure	The WGM noted that the most effective improvement strategies for a given Medicaid program will vary. However, there are a range of strategies that can be used to link patients seeking care for dental problems in the ED to dental providers. Examples include developing an ED referral program, establishing community dental health coordinator programs, improving dental provider participation in Medicaid, expanding the scope of covered dental benefits for adults in Medicaid, and improving medical-dental collaboration and coordination. The American Dental Association's Action for Dental Health offers 10-step plans to improve oral health care in underserved communities including different models of ED-Dental Referral programs: https://www.ada.org/en/public-programs/action-for-dental-health/10-step-plans-to-improve-oral-health.
Is there room for improvement on measure?	The WGM indicated that there is room for improvement. Testing data found that only one-third of dental-related ED visits among Medicaid-enrolled adults were associated with a follow-up dental visit within 30 days, and only 20 percent were followed up within 7 days. These results are similar to findings in the peer-reviewed literature. In a study of adults enrolled in the Wisconsin Medicaid program, only 30 percent visited a dental provider within 30 days of the ED visit and only 42 percent subsequently visited a dental provider within six months of the ED visit (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4104605). A

	study of Medicaid-enrolled adults in Iowa found that only 52 percent had a dental visit within six months of a dental-related ED visit (https://www.ncbi.nlm.nih.gov/pubmed/26562729).
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	The WGM noted that low-income individuals, including those enrolled in Medicaid, are at greater risk for having NTDC ED visits. This measure indicates the extent to which those dental problems remain unresolved. As noted above, there are important connections between oral health and overall systematic health.
Can measure be trended over time?	The WGM indicated that measure trends can be assessed over time to evaluate program performance and progress.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	- Approximately two-thirds of adults with dental-related ED visits do not receive follow-up care with a dental provider within one-month of their ED visit (testing data and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4104605/). - State and national estimates show that dental-related ED visits account for about 2 percent of total ED visits (Kelekar et al. 2019; Sun et al. 2014, Tomar et al. 2016). - Medicaid is a primary payer of dental-related ED visits (ADA Health Policy Institute, Kelekar et al. 2019). - Among state Medicaid programs, Maryland estimated the rate of dental-related ED visits in FY 2016 to be 321 per 10,000 Medicaid enrollees. An analysis of frequent ED users in New Hampshire's Medicaid program found that "disorders of the teeth and jaw" was the leading subcategory of ED visits among low-income adult frequent ED users (having four or more outpatient ED visits in a year), representing 1,283 of 10,619 ED visits (12 percent) among this group. https://www.ncbi.nlm.nih.gov/pubmed/30922460, https://www.ncbi.nlm.nih.gov/pubmed/27103213, https://www.ncbi.nlm.nih.gov/pubmed/25790415, https://www.mdac.us/file_download/inline/57cb39db-b4f4-4cdb-8829-f062e74fe36c, https://www.dhhs.nh.gov/ombp/documents/emergencyroom.pdf
Use of measure in other CMS programs	No other programs listed in CMS's Measure Inventory Tool or reported by the measure steward.
Potential barriers states could face in calculating measure	This measure relies on standard data elements contained with administrative enrollment and claims data. Measure steward testing in state Medicaid programs demonstrated feasibility of this measure. However, in states with dental carve-outs (either managed care or fee-for-service), there may be a need to link claims and encounter data between physical health and dental managed care plans or between physical health managed care plans and dental fee-for-service.
Technical assistance resources that would facilitate state reporting	The measure steward has programming code available which could be adapted as a TA resource. DQA has also developed a user guide to assist with implementation of this measure: https://www.ada.org/~media/ADA/DQA/2020_AdultMeasuresUserGuide.pdf?la=en .



Meaningful Measures area(s) of measure	Promote Effective Prevention and Treatment of Chronic Diseases.
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LONG-TERM SERVICES AND SUPPORTS

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Long-Term Services and Supports (LTSS) Admission to an Institution from the Community (MLTSS-6)
Description	The number of admissions to an institutional facility among Managed Long-Term Services and Supports (MLTSS) plan members age 18 and older residing in the community for at least one month. The number of short-term, medium-term, or long-term admissions is reported per 1,000 enrollee months. Enrollee months reflect the total number of months each beneficiary is enrolled in the program and residing in the community for at least one day of the month. The following three rates are reported across four age groups (ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older): 1. Short-Term Stay. The rate of admissions resulting in a short-term stay (1 to 20 days) per 1,000 MLTSS enrollee months. 2. Medium-Term Stay. The rate of admissions resulting in a medium-term stay (21 to 100 days) per 1,000 MLTSS enrollee months. 3. Long-Term Stay. The rate of admissions resulting in a long-term stay (greater than or equal to 101 days) per 1,000 MLTSS enrollee months. Note: This is the managed care version of HCBS-1, which measures Admissions to an Institution from the Community among Medicaid Fee-for-Service (FFS) Home and Community-Based Service (HCBS) Users. A separate measure information sheet has been produced for that measure.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older as of the first day of the measurement year.
Data collection method	Administrative (claims only).
Denominator	Number of enrollee months where the beneficiary was residing in the community for at least one day of the month.
Numerator	The number of Institutional Facility Admissions from a community residence from August 1 of the year prior to the measurement year through July 31 of the measurement year. Admissions are reported in three categories: (1) short-term stay (1 to 20 days), (2) medium-term stay (21 to 100 days), and (3) long-term stay (greater than or equal to 101 days).
Exclusions	None.

Continuous enrollment period	Beneficiary must be enrolled in a Medicaid MLTSS plan for at least 30 days between August 1 of the year prior to the measurement year and December 31 of the measurement year.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria

Link to current technical specifications	https://www.medicaid.gov/medicaid/downloads/mltss_assess_care_plan_tech_specs.pdf See pages 47-51.
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) indicated that the measure is under consideration as part of CMS's "Starter Set" of national HCBS measures. A similar measure is included in the Health Home Core Set and was reported by 16 health home programs for FFY 2018.
Description of required data source and data elements, including any barriers or limitations	The WGM indicated managed care plans would typically have the claims data in-house needed to calculate this measure, and managed LTSS states would then aggregate across plans to report a state-level rate. The measure includes an Institutional Facility Value Set that would need to be reviewed and updated annually.
Description of potential variations that could affect consistency of calculations	The WGM noted that because different states define LTSS waivers differently, demographics and acuity of the population are going to vary across states. The WGM indicated this concern is not specific to this measure and would be a problem for any LTSS measure on the Core Set.

Actionability and Strategic Priority

How measure contributes to measuring overall quality of health care in Medicaid and CHIP	The WGM indicated that this measure is a great way to look at quality of LTSS, which comprised \$167 billion, approximately 30 percent of all Medicaid spending in FFY 2016. Excellent LTSS programs (whether administered by the state or via managed care) ensure community-dwelling consumers have access to the services, supports, and care coordination that are needed to avoid institutional admissions. LTSS remains a conspicuous gap area on the Core Set and the pairing of this measure with MLTSS-6 allows a level playing field for both FFS and managed care states to report. The WGM noted that the only LTSS measure on the Core Set is an experience survey, so this would add a new dimension of LTSS Medicaid program quality.
How measure promotes effective care delivery in Medicaid and CHIP	The WGM noted that the balance of a state's spending between HCBS and institutional care is a well-regarded benchmark of the quality of a state's Medicaid program. Many consumers prefer to "age in place" or receive their LTSS in a community setting, and community-based services are typically lower cost. The WGM indicated the measure demonstrates a state's ability to provide care coordination and a community-based service infrastructure (including in-home workforce) for HCBS members to be maintained in the setting of their choosing.

Evidence that measure could lead to improvement in quality of health care for Medicaid and CHIP beneficiaries	The WGM indicated that every year CMS publishes the balance of spending report (https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf) looking at all 50 states and their relative spending on community-based services. On the managed care side, ADvancing States Demonstrating the Value of MLTSS report shows how states focus on re-balancing as a major LTSS program goal. States like Florida, Arizona, and Tennessee have shown that a multi-year focus on institutional admissions has led to major shifts in the proportion of beneficiaries statewide who receive their LTSS in the community and has saved Medicaid program dollars that can be reinvested.
How state Medicaid and CHIP programs can drive improvement on measure	The WGM noted that managed care states can incentivize health plans to focus on diversion to prevent admissions. Non-managed care states can train and/or incentivize their care coordination entities to ensure that the right services are in place to prevent admissions. There are also a number of policy and system changes states could take on. For example, the WGM noted that some states like TN have taken on initiatives to build up their HCBS workforce (e.g., addressing Medicaid hourly rates, minimum wage, training programs) to ensure support needs can be met in the community.
Is there room for improvement on measure?	The WGM indicated that there is room for improvement, although there is not a strong benchmark beyond what was discovered during testing.
Does measure address unique and complex needs of Medicaid and CHIP beneficiaries?	The WGM indicated that this measure addresses the unique and complex needs of Medicaid and CHIP beneficiaries receiving HCBS.
Can measure be trended over time?	The WGM noted that this measure can be trended over time; the measure could essentially be a leading indicator for what is measured in the balance report.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	LTSS comprises 30 percent of Medicaid spending. Nationally, HCBS comprises 57 percent of LTSS spending and institutional care accounts for 43 percent. The risk of institutional admission is high among HCBS consumers and could impact any HCBS consumer. See https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf for more details.
Use of measure in other CMS programs	Health Home Core Set.
Potential barriers states could face in calculating measure	The WGM indicated that the main barrier is that it is relatively new so there is not a lot of experience producing the measure.
Technical assistance resources that would facilitate state reporting	The WGM noted that training sessions and assistance would likely be helpful to states.
Meaningful Measures area(s) of measure	Promote Effective Communication and Coordination of Care.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	National Core Indicators for Aging and Disabilities (NCI-AD™) Adult Consumer Survey
Description	NCI-AD is a voluntary effort by state Medicaid, aging, and disability agencies to measure and track the performance of their long-term services and supports programs. The core indicators are standard measures used across states to assess the outcomes of publicly funded services provided to older adults and adults with physical disabilities. Indicators address 18 areas: (1) service coordination, (2) rights and respect, (3) community participation, (4) choice and control, (5) health care, (6) safety, (7) relationships, (8) satisfaction, (9) care coordination, (10) access to community, (11) access to needed equipment, (12) wellness, (13) medications, (14) self-direction, (15) work, (16) everyday living, (17) affordability, and (18) person-centered planning.
Measure steward	ADvancing States and Human Services Research Institute (HSRI)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Beneficiary experience and self-reported outcomes
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	In-person survey.
Denominator	Individuals who respond to the survey question or questions from which the indicator is drawn. The sampling frame includes older adults (age 65 or older) or adults 18 years and older with a physical disability (including acquired or traumatic brain injury [ABI/TBI]) who receive publicly funded long-term services and supports (LTSS) at least two to three times a week. There should be no a priori exclusions based on geography, place of residence, level of disability, or any other personal and demographic factors. Individuals receiving LTSS through intellectual and developmental disabilities (IDD)-specific or mental health (MH)-specific waivers or programs are excluded from the sampling frame.
Numerator	Varies based on indicator. Examples of indicators include: • Percentage of people whose service plan includes their preferences and choices • Percentage of people who know whom to contact if they want to make changes to their services • Percentage of people who had someone follow-up with them after being discharged from a hospital or rehabilitation facility in the past year • Percentage of people with concerns about falling or being unstable (risk-adjusted)

	• Percentage of people who always or almost always like how they spend their time during the day (risk-adjusted) • Percentage of people who have a backup plan if their paid support staff do not show up • Percentage of people whose paid support staff change too often • Percentage of people who have adequate support for everyday activities • Percentage of people who have adequate support for self-care • Percentage of people who feel in control of their life • Percentage of people who can eat their meals when they want to • Percentage of people who have transportation when they want to do things outside of their home (non-medical) • Percentage of people who often feel lonely (risk-adjusted)
Exclusions	Varies based on indicator.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	State-level.

Minimum Technical Feasibility Criteria

Link to current technical specifications	The survey instrument is proprietary and is not available online. An implementation guide is available at https://nci-ad.org/resources/implementation-guides/. A memorandum of agreement is available at https://nci-ad.org/images/uploads/2019-21_NCI-AD_MOA_with_TA_Year.pdf.
Information on testing or use at state Medicaid/CHIP level	Twenty-eight states have used NCI-AD in the past, are currently using it, or plan to use it starting in 2020-21. Sixteen states collected data using this tool in 2018-19, the most recent year for which data collection is complete. A list of states is provided in an appendix at the end of this document. More information is available at https://nci-ad.org/states/.
Description of required data source and data elements, including any barriers or limitations	The NCI-AD is a survey. Technical assistance is provided by the NCI-AD Project Team. A link to the implementation guide is available at https://nci-ad.org/resources/implementation-guides/.
Description of potential variations that could affect consistency of calculations	The NCI-AD Project Team provides technical assistance to states to promote completeness and validity of data. State samples may vary based on the state's populations of interest and analysis goals; however, the basic eligibility requirements remain the same across states. NCI-AD also uses risk-adjustment procedures to control for differences in the individual characteristics of people interviewed across states. The following personal characteristics are used for risk adjustment: age, gender, race, rurality, living arrangement (whether the person lives in his/her own home versus somewhere else), whether the person lives alone, mobility, amount of assistance needed for everyday activities,

	amount of assistance needed for self-care, overall health, level of hearing, level of vision, presence of a mental health diagnosis, whether the person has been forgetting things, and whether the proxy version of the survey was used. Outcome measures that may be affected by these characteristics are risk-adjusted by the NCI-AD Project Team.
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Actionability and Strategic Priority	
How measure contributes to measuring overall quality of health care	The Workgroup member (WGM) noted there is only an LTSS measure for people with intellectual and developmental disabilities (I/DD) in the 2020 Core Set and none for older adults and people with physical disabilities. The WGM estimated that more than 30 percent of Medicaid expenditures are for LTSS. According to the WGM, this measure can be used by states to measure quality of care nationally and to compare quality across states.
How measure promotes effective care delivery	The WGM noted the measure provides states with specific information on outcomes for LTSS, consumer experience, and how services impact quality of life, beyond service satisfaction.
Evidence that measure could lead to improvement in quality of health care	The WGM indicated that states participating in NCI-AD are using the measure as part of their quality improvement strategy for LTSS. The WGM noted that four MLTSS states have over-sampled by managed care plan so that quality can be compared across plans. Reports and presentations are available at: https://nci-ad.org/resources/reports/ .
How state Medicaid and CHIP programs can drive improvement on measure	The WGM indicated that the measure is used by states to assess and improve quality of care inside the state.
Is there room for improvement on measure?	The WGM noted that there is always room for improvement in any measure; NCI-AD does not provide benchmarks for acceptable or unacceptable levels of performance.
Does measure address unique and complex needs of beneficiaries?	The WGM indicated that this measure is focused on the unique and complex needs of older adults and people with disabilities receiving LTSS.
Can measure be trended over time?	The WGM noted that this measure can be (and is) trended nationally and at the state level, and states use the indicators to assess how their performance compares to other states.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid and CHIP beneficiaries	The WGM noted that the Baby Boom generation is turning age 65 at a rate of 10,000 persons a day (Pew Research Center 2010). According to the 2017 CMS Actuarial Report, adults age 65 and older and people with disabilities accounted for 23 percent of Medicaid enrollment and 55 percent of Medicaid expenditures in FFY 2016.
Use of measure in other CMS programs	NCI-AD was added to the 2019 Medicaid & CHIP Scorecard as a component of the measure indicating “State Use of Experience of Care Surveys for Beneficiaries Using Long-Term Services and Supports.”
Potential barriers states could face in calculating measure	Some state Medicaid programs have cited the cost of data collection as a reason for not reporting Core Set measures that require the collection of data via surveys.



Technical assistance resources that would facilitate state reporting	The WGM noted that states participating in the NCI-AD receive significant technical assistance from the NCI-AD Project Team in using and reporting this measure. More information is available in the Memorandum of Agreement (https://nci-ad.org/images/uploads/2019-21_NCI-AD_MOA_with_TA_Year.pdf).
Meaningful Measures area(s) of measure	• Promote Effective Communication & Coordination of Care. • Strengthen Person & Family Engagement as Partners in Their Care. • Work with Communities to Promote Best Practices of Healthy Living.

Appendix: List of States That Have Ever Participated in NCI-AD

State	Ever Participated in NCI-AD	Collected Data for 2018-19	Collecting Data for 2019-20
Total number of states	28	16	20
Alabama	Yes	Yes	Yes
Colorado	Yes	Yes	Yes
Delaware	Yes	No	Yes
Georgia	Yes	Yes	Yes
Indiana	Yes	Yes	Yes
Kansas	Yes	Yes	Yes
Kentucky	No (Planning to survey for 2020-21)	No	No
Maine	Yes	No	No
Michigan	No (Planning to survey for 2020-21)	No	No
Minnesota	Yes	Yes	Yes
Mississippi	Yes	No	No
Missouri	Yes	Yes	Yes
Nebraska	Yes	Yes	Yes
Nevada	Yes	No	No
New Jersey	Yes	Yes	Yes
North Carolina	Yes	No	No
Ohio	Yes	Yes	Yes
Oklahoma	No (Planning to survey for 2020-21)	No	No
Oregon	Yes	No	Yes
Pennsylvania	Yes	No	No
South Carolina	Yes	No	Yes
South Dakota	Yes	Yes	Yes
Tennessee	Yes	Yes	Yes
Texas	Yes	No	Yes
Utah	Yes	Yes	Yes
Vermont	Yes	Yes	Yes
Washington	Yes	Yes	Yes
Wisconsin	Yes	Yes	Yes

Source: Unpublished information from ADvancing States, February 2020.

MEASURES THAT WILL NOT BE REVIEWED

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	HIV Screening
Description	Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.
Measure steward	Centers for Disease Control and Prevention (CDC)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 15 to 65.
Data collection method	Electronic health records.
Denominator	Patients 15 to 65 years of age at the start of the measurement period AND who had at least one outpatient visit during the measurement period.
Numerator	Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday.
Exclusions	Patients diagnosed with HIV prior to the start of the measurement period. ICD-9, ICD-10, and SNOMED codes can be used for identifying this exclusion.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Provider-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://ecqi.healthit.gov/ecqm/ep/2020/cms349v2
Information on testing or use at state Medicaid/CHIP level	The measure was tested at three hospitals, and the measure steward is not aware of any testing or adoption of the measure by state Medicaid or CHIP programs to assess access to the required data source and implementation of the specifications.
Description of required data source and data elements, including any barriers or limitations	This measure is an eQIM and requires electronic health record (EHR) generated data. All the data elements used to calculate the measure adhere to minimum standards for certified EHR technology, including the following: 1. Date of encounter 2. Encounter type (e.g., preventive visit, office visit) 3. Patient age at encounter (calculated using date of birth and encounter date information) 4. HIV diagnosis (used for denominator exclusions)



	5. HIV diagnosis data (also used for denominator exclusions) 6. HIV test ordered/performed 7. Date HIV test ordered/performed
Description of potential variations that could affect consistency of calculations	The Workgroup member (WGM) noted that routine HIV screening is covered for most Medicaid eligible populations in most states, so there should not be significant variation tied to differences among states in covered benefits. The WGM also noted that coding and documentation standards for HIV testing and diagnosis have been long established and are unlikely to be a major source of variation—particularly since the measure relies on data categories/classes included in certified EHR requirements, and value sets that have been previously published and are actively maintained as part of MIPS annual updating processes. According to the WGM, the largest source of potential state variability not tied to actual performance differences (i.e., variation not directly attributable to differences in care quality) will likely stem from differences in the extent to which states have made progress toward integrating electronic data into their reporting efforts (i.e., have developed the necessary infrastructure and processes to collect and report eCQMs).

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Global Assessment of Pediatric Patient Safety (GAPPS) Trigger Tool
Description	This measure calculates four rates for patients less than 18 years of age: 1. The rate of adverse events (AEs or patient harm)—defined as unintended physical injury resulting from or contributed to by medical care—per 1,000 patient-days. 2. The rate of adverse events per 100 hospitalizations. 3. The rate of preventable adverse events per 1,000 patient-days. 4. The rate of preventable adverse events per 100 hospitalizations.
Measure steward	Center of Excellence for Pediatric Quality Measurement (CEPQM), Boston Children's Hospital
NQF number (if endorsed)	3136 (Rate #3 only)
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Patients under 18 years of age at discharge.
Data collection method	Electronic health records (EHRs) or medical record review.
Denominator	The denominators used with each rate are 1,000 patient-days (rates 1 and 3) or 100 hospitalizations (rates 2 and 4) for all sampled patients who meet the following criteria: 1. Patients < 18 years of age at discharge. 2. Patients with a length of stay (LOS) greater than or equal to 24 hours. 3. Patients admitted for acute care. Acute care does not include patients in rehabilitation and residential units, non-acute inpatient psychiatric units, and day treatment areas. If a patient is initially admitted acutely but subsequently transferred to inpatient psychiatric care, the acute portion of the hospitalization should be included. 4. Patients who were discharged from or transferred out of the inpatient observation stay and patients who died during the stay. The measure steward recommends that reviewers select a random sample of at least 20 inpatient hospitalizations each month. The hospitalizations should meet eligibility criteria noted above for a minimum of 60 hospitalizations per quarter.
Numerator	The numerators for the four rates are: 1. The number of adverse events identified in all the medical records in the sampling frame (rates 1 and 2) 2. The number of preventable adverse events identified in all the medical records in the sampling frame. (rates 3 and 4)

	The trigger tool consists of an expedited process to identify “triggers” (i.e., red flags) that suggest the likely presence of underlying adverse events. The technical specifications include a trigger list for those manually applying GAPPS and a trigger list for those wishing to automatically flag hospitalizations using their electronic health record systems. A list of the triggers included in GAPPS can be found in the Appendix on the last page of this document. More detailed information on each trigger is available in the technical specifications.
Exclusions	Patients who meet the above inclusion criteria but fall into the following categories are excluded from the sampling frame: • Patients discharged from the emergency department without admission to the hospital. • Patients in newborn nurseries.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Hospital-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The Workgroup member (WGM) indicated this measure was developed as part of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Pediatric Quality Measure Program (PQMP) initiative. The PQMP measure report is available at: https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/acute/chipra-143-fullreport.pdf .
Information on testing or use at state Medicaid/CHIP level	The measure developer tested the draft trigger list in 16 hospitals across the United States. The developer indicated that while the measure has not been tested at the state level, states could require hospitals to do periodic reviews to calculate their adverse events rate and then aggregate those at the state level.
Description of required data source and data elements, including any barriers or limitations	The WGM noted that the GAPPS measure uses data obtained from electronic and/or paper patient medical records. The triggers used in the measure rely on clinical information, such as clinical notes, laboratory results, and medication order histories. This information is recorded during the course of inpatient care and thus is readily available to providers and hospitals. The PQMP measure report linked above noted that manual record review is labor-intensive and time consuming and an automated GAPPS approach using EHR data would improve reliability and efficiency. However, not all hospitals use EHRs, and existing EHR systems vary based on the information they contain and the document formats they use. State Medicaid agencies have also cited a lack of access to EHR data as a reason for not reporting Core Set measures that require EHR data.



Description of potential variations that could affect consistency of calculations	The PQMP measure report linked above noted that the measure relies on manual assessment of medical records by clinician reviewers, which is an inherently subjective process. While studies suggest that experienced reviewers make fairly consistent judgments about whether harm due to health care has occurred, adverse event identification is vulnerable to biases that may affect outcomes measurement. Reviewers' conclusions using trigger tools are also affected by training and clinical expertise, although training in trigger tool methodology eliminates some variability.
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Appendix: List of All Triggers Included in GAPPS

Trigger	Automated	Manual
Serum creatinine doubling	Yes	Yes
Nephrotoxin use (e.g., aminoglycosides, cyclosporine, tacrolimus, vancomycin) and rising creatinine (Cr)	Yes	Yes
Hepatotoxic medications and elevated liver enzymes (AST, ALT)	Yes	Yes
Hypoglycemia (<2 mmol/L or 40 mg/dL)	Yes	Yes
Opiate-related constipation with intermittent laxative use	Yes	Yes
Naloxone (Narcan) administration	Yes	Yes
Pressure ulcer documentation (≥stage 2)	Yes	Yes
Embolus/thrombus documentation	Yes	Yes
Healthcare-associated infections: Positive C. difficile test	Yes	Yes
Healthcare-associated infections: Positive blood culture (only after 48 hours from admission)	Yes	Yes
Healthcare-associated infections: Positive urine culture (only after 48 hours from admission)	Yes	Yes
Healthcare-associated infections: Positive respiratory or gastrointestinal (GI) viral infection (only after 48 hours from admission)	Yes	Yes
Hospital readmission within 30 days	Yes	Yes
Any code or arrest, or rapid response team activation	Yes	Yes
All inpatient deaths	Yes	Yes
Drop of hemoglobin (Hgb) or hematocrit (Hct) of >25 percent in less than 24 hours	Yes	Yes
Mechanical ventilation >48 hours postoperatively	Yes	Yes
Return to surgery	Yes	Yes
Transfer to higher level of care	Yes	Yes
Racemic epinephrine administration (patients mechanically ventilated within last 24 hours)	Yes	Yes
Warfarin triggers: INR >6 Yes No	Yes	No
Elevated drug levels (anti-epileptics): Phenytoin (>30 mcg/ml)	Yes	No
Elevated drug levels (anti-epileptics): Oxcarbamazepine (>45 mcg/ml)	Yes	No
Total bilirubin >25 mg/dL (less than 28 days old)	Yes	No
Flumazenil administration	Yes	No
Infiltrations: Hyaluronidase administration	Yes	No
Oral vancomycin	Yes	No
Operative time >6 hours (non-cardiac patients)	Yes	No
Intraoperative epinephrine, norepinephrine or phenylephrine (non-cardiac patients)	Yes	No
Readmission to ICU within 24 hours after discharge/transfer	Yes	No
Abrupt medication stop	No	Yes
Patient fall	No	Yes
Infiltrations: Infiltration/extravasation or phlebitis documentation	No	Yes
Surgical site infection	No	Yes
Change in procedure	No	Yes
Unplanned endotracheal extubation	No	Yes
Failed endotracheal extubation (reintubation within 24 hours of planned extubation)	No	Yes

Source: Information provided by the measure steward, February 2020.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Admission to an Institution from the Community Among Medicaid Fee-for-Service (FFS) Home and Community-Based Service (HCBS) Users (HCBS-1)
Description	Rate of institutional admissions (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) per 100,000 months of HCBS use among Medicaid FFS beneficiaries age 18 and older. Time frame for rate: one year. Three rates will be reported: 1. Short-Term Stay. The number of admissions results in a short-term stay (1 to 20 days) per 100,000 beneficiary months of HCBS use. 2. Medium-Term Stay. The number of admissions results in a medium-term stay (21 to 99 days) per 100,000 beneficiary months of HCBS use. 3. Long-Term Stay. The number of admissions results in a long-term stay (100 days or greater) per 100,000 beneficiary months of HCBS use. Note: This is the FFS version of MLTSS-6, which measures Long-Term Services and Supports (LTSS) Admission to an Institution from the Community. A separate measure information sheet has been produced for that measure.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older as of the first day of the measurement year.
Data collection method	Administrative (claims only).
Denominator	Number of months of HCBS use in the measurement year (August 1 of the previous calendar year to July 31 of the current calendar year) among Medicaid FFS beneficiaries 18 years of age and older who are using Medicaid HCBS. HCBS use is defined by Medicaid 1915(c) HCBS waiver enrollment or by HCBS state plan benefit service use, provided as state plan benefits, such as personal care services, or state plan benefit options, such as 1915(i), 1915(j), and 1915(k). Dual eligible beneficiaries enrolled in Medicare Advantage or other Medicare managed care plans that may cover their acute, primary, and specialty care should be excluded from the denominator.
Numerator	Number of Institutional Facility Admissions during or following an eligible month of HCBS use in the measurement year (August 1 of the previous calendar year to July 31 of the current calendar year).

Exclusions	None.
Continuous enrollment period	None.
Level of reporting for which specifications were developed	State-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/HCBS-FFS-Tech-Specs.pdf
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) indicated that the measure was developed as part of CMS’s Medicaid Innovation Accelerator Program and is under consideration as part of CMS’s “Starter Set” of national HCBS measures. The measure was developed using CMS’s Medicaid Analytic eXtract (MAX) data linked with Medicare data; the specifications instruct states to obtain Medicare data through ResDAC. The technical specifications have not been field tested by state Medicaid or CHIP programs to assess implementation with a state MMIS and acquisition of Medicare data from ResDAC.
Description of required data source and data elements, including any barriers or limitations	The measure uses state MMIS eligibility and claims files for HCBS, nursing facilities, ICF/IID, and inpatient hospital stays. The measure uses Medicare data to determine Medicare FFS enrollment status and to identify skilled nursing facility and inpatient stays. The technical specifications include links to resources on obtaining and using Medicare data for calculating the measure.
Description of potential variations that could affect consistency of calculations	The WGM notes that the exact array of covered HCBS benefits varies by state but the definitions used in these specifications should level the playing field (as much as is possible) to define someone as an HBCS beneficiary or not.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2021 CORE SET

Measure Information	
Measure name	Safe Environment for Every Kid (SEEK) Parent Questionnaire-R
Description	This is a 20-item self-report questionnaire to screen parents of young children for parental depression, substance abuse, stress, intimate partner violence, use of corporal punishment, and food insecurity.
Measure steward	University of Maryland School of Medicine
NQF number (if endorsed)	Not endorsed
Core Set domain	Other
Measure type	Screening tool
Recommended to replace current measure?	No

Technical Specifications	
Ages	Parents of children ages zero to five years.
Data collection method	Screening tool.
Denominator	Parents of children ages zero to five years.
Numerator	Parents screening positive. A screen is positive if one or more of the following occurs: • Depression: A 'Yes' to "feeling down" or "little interest." • Substance Abuse: A 'Yes' to either question. • Major Stress: A 'Yes' to "child is difficult," "more help," or "extreme stress." • Intimate Partner Violence: A 'Yes' to either question. • Harsh Punishment: A 'Yes' to the "slap or hit" question or "...child is difficult." • Food Insecurity: A 'Yes' to either food-related question.
Exclusions	Not applicable.
Continuous enrollment period	Not applicable.
Level of reporting for which specifications were developed	Person-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	Technical specifications have not been developed to allow production of a state-level measure based on the screening tool. The screening tool is available at https://seekwellbeing.org/wp-content/uploads/2019/09/English_PQ-R.pdf
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) noted that pediatric practices in Baltimore and central Maryland have used this questionnaire, but was not aware of any testing or use by state Medicaid or CHIP programs. Two randomized controlled trials show that using this questionnaire and linking parents to needed services reduces child maltreatment.



Description of required data source and data elements, including any barriers or limitations	In the SEEK program, parents of children under six complete a self-administered questionnaire before their visit with their child’s primary care provider. The questionnaire screens for parental depression, substance abuse, stress, intimate partner violence, use of corporal punishment, and food insecurity. It has 16 “yes/no” questions on one side of a page, takes two to three minutes to complete, and has been validated for use in primary care practice. It should be completed at selected checkups, such as at the two-, nine-, and 15-month, and the two-, three-, four-, and five-year visits. The primary care provider, who has been previously trained in the model (four-hours plus brief boosters every six months), discusses positive screens with the parent and together they decide if the parent should get help from the social worker on-site or by phone. The social worker provides crisis intervention and support and facilitates referrals to community resources. Parents also receive handouts that include information on problems addressed with the social worker, as well as information on local resources. In a recent implementation study, the SEEK questionnaire data were collected and analyzed by study authors using paper chart reviews and electronic medical record data (Eismann et al. 2019).
Description of potential variations that could affect consistency of calculations	In their implementation study, Eismann et al. (2019) noted some inconsistency across sites regarding well-child visits targeted for screening, availability of an on-site social worker, and amount of supplemental training received by providers beyond the online SEEK training. However, the process measures and provider feedback varied little across sites, suggesting that these differences did not have a significant impact on the feasibility or acceptability of the SEEK model. Positive screening rates were found to differ across sites, but this finding was not unexpected given the variability in the sociodemographic characteristics of the patient populations.