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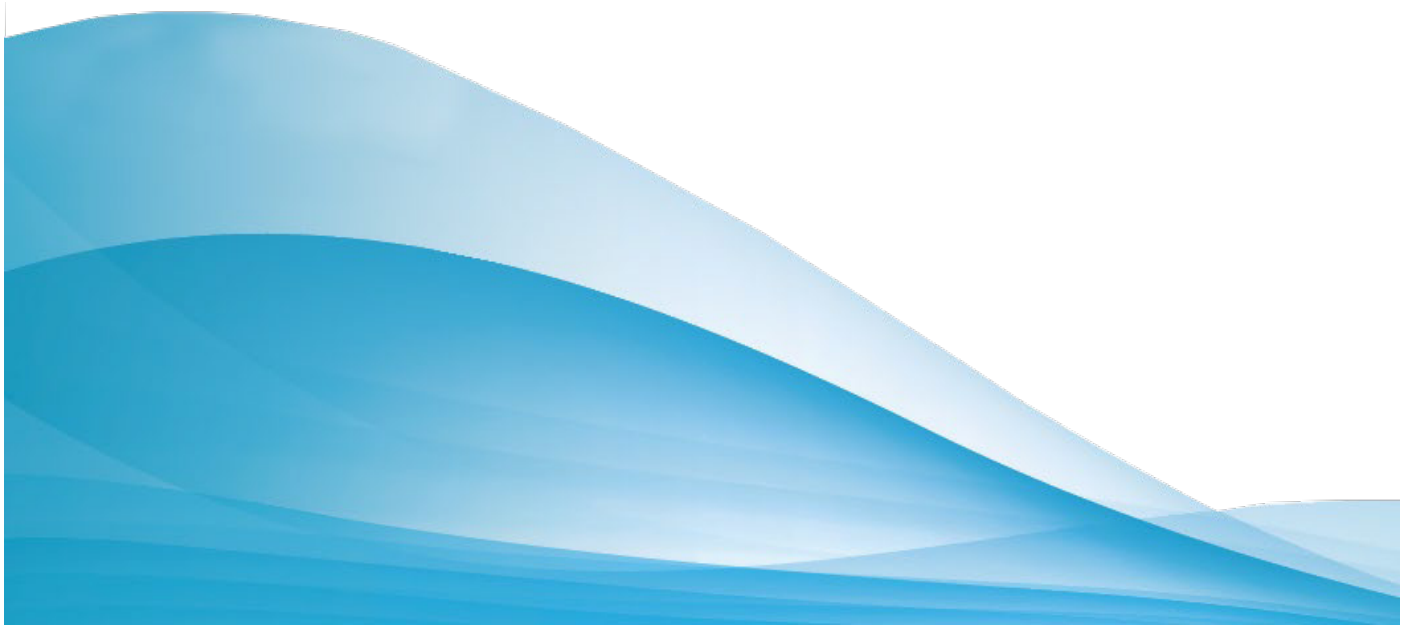
Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

Summary of a Workgroup Review of the 2025 Child and Adult Core Sets

Final Report

August 2023



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

Mathematica also appreciates the comments provided by members of the public during the Workgroup meetings. The diversity of perspectives enriched the discussion about strengthening the Child and Adult Core Sets.

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

Contents

Exhibits

Acronyms

AAPD	American Academy of Pediatric Dentistry
ACOs	Accountable care organizations
ADA	American Dental Association
AHRQ	Agency for Healthcare Research and Quality
ASCVD	Atherosclerotic cardiovascular disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBP-AD	Controlling High Blood Pressure
CCC	Children with Chronic Conditions
CDC	Centers for Disease Control and Prevention
CDF-AD	Screening for Depression and Follow-Up Plan: Age 18 and Older
CDF-CH	Screening for Depression and Follow-Up Plan: Ages 12 to 17
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
COB-AD	Concurrent Use of Opioids and Benzodiazepines
CPA-AD	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Adult Version
CPC-CH	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.1H, Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items
CV	Curriculum Vitae
DQA	Dental Quality Alliance
DUR	Drug utilization review
ECDS	Electronic Clinical Data Systems
ED	Emergency department
EHR	Electronic health record
EPSDT	Early and Periodic, Screening, Diagnostic and Treatment
FFY	Federal fiscal year
FVA-AD	Flu Vaccinations for Adults Ages 18 to 64
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set®
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration

LTSS	Long-Term Services and Supports
MCOs	Managed care organizations
MIPS	Merit-based Incentive Payment System
MME	Morphine milligram equivalent
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
MY	Measurement year
NACHC	National Association of Community Health Centers
NCQA	National Committee for Quality Assurance
NNOHA	National Network for Oral Health Access
NQF	National Quality Forum
NTDC	Non-traumatic dental conditions
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer
PHE	Public health emergency
PQA	Pharmacy Quality Alliance
QTAG	Quality Technical Advisory Group
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support
TAF	T-MSIS Analytic Files
Tdap	Tetanus-Diphtheria-Pertussis
TFL-CH	Topical Fluoride for Children
T-MSIS	Transformed Medicaid Statistical Information System

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to more than 93 million people, including eligible children, pregnant individuals, low-income adults, the elderly, and individuals with disabilities.[1] The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various strategies to help ensure that individuals enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high-quality and equitable care. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort to measure the quality of care and drive improvement in Medicaid and CHIP.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries based on a uniform set of health care quality measures. CMCS and states use the Child and Adult Core Sets measures to monitor access to and quality of health care for beneficiaries, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives. Although state reporting on the Core Sets is currently voluntary, the Child Core Set measures and the behavioral health measures in the Adult Core Set become mandatory for state reporting beginning in federal fiscal year (FFY) 2024.[2]

The Secretary of the U.S. Department of Health and Human Services is required to review and update the Child and Adult Core Sets each year.[3] The Core Sets Annual Review process is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from a variety of interested parties, including but not limited to states, managed care plans, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2025 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 32 members representing a diverse array of affiliations, subject matter expertise, and quality measurement and improvement experience (see inside front cover for list of members).

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[1] The February 2023 Medicaid and CHIP Enrollment Trend Snapshot is available at https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html. Numbers reflect preliminary Medicaid and CHIP enrollment data for February 2023, as of April 24, 2023, as reported by 50 states and the District of Columbia.

[2] Bipartisan Budget Act of 2018, Pub. L. No. 115-123 and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, Pub. L. No. 115-271. On August 22, 2022, CMS released a notice of proposed rulemaking with requirements for mandatory annual state reporting of the Child Core Set measures and behavioral health measures in the Adult Core Set. More information is available at https://www.federalregister.gov/documents/2022/08/22/2022-17810/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set.

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

The Workgroup was charged with assessing the 2023 Child and Adult Core Sets and recommending measures for removal or addition, with the goal of strengthening and improving the 2025 Core Sets.[4] Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Core Sets based on several criteria; these criteria support the adoption of measures that are feasible and viable for state-level reporting, actionable by state Medicaid and CHIP programs, and represent strategic priorities for improving care delivery and health outcomes for Medicaid and CHIP beneficiaries. See Exhibit ES.1 for the criteria Workgroup members considered during the 2025 Child and Adult Core Sets Annual Review.

Exhibit ES.1. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2025 Child and Adult Core Sets

Criteria Considered for Removal of Existing Measures
Technical Feasibility
1. The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3. The specifications and data source do not allow for consistent calculations across states (e.g., there is variation in coding or data completeness across states).
4. The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP.
2. The measure is not suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[5]
3. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid and CHIP beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
4. The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out, trending is not possible, or improvement is outside the direct influence of Medicaid and CHIP programs/providers).

[4] To support states' efforts to meet the 2024 mandatory reporting requirements and to provide sufficient time for states to prepare, CMCS released the 2024 Child and Adult Core Sets updates with the 2023 updates. As a result, this workgroup was charged with assessing the 2023 Core Sets, and there was no separate review of the 2024 Core Sets. More information about the 2023 and 2024 updates is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111522.pdf. More information about the annual review of the Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview.

[5] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

Exhibit ES.1 *(continued)*

Criteria Considered for Removal of Existing Measures
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All states may not be able to produce the measure for Core Set reporting within two years of the reporting cycle under review or may not be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).
Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP programs.
3. An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4. The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Set.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP.
2. The measure should be suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[6]
3. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
4. The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3. All states should be able to produce the measure for Core Set reporting within two years of the measure being added to the Core Set and be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

[6] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

Workgroup members convened virtually from April 25 to April 27, 2023, to review five measures suggested for removal from the 2023 Child and Adult Core Sets and four measures suggested for addition.[7] The nine measures were presented, discussed, and voted on by domain.[8] For a measure to be recommended for removal from or addition to the Child and Adult Core Sets, at least two-thirds of the Workgroup members eligible to vote had to vote in favor of removal or addition.

The Workgroup recommended adding two measures to the 2025 Child and Adult Core Sets: *Oral Evaluation During Pregnancy* and *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* (Exhibit ES.2). The Workgroup did not recommend removing any measures from the Child and Adult Core Sets for 2025.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2025 Child and Adult Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Addition[a]		
Oral Evaluation During Pregnancy	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)	Not endorsed
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	DQA (ADA)	Not endorsed

[a] CMCS assigns new measures to a Core Set and domain as part of its annual update.

CMCS requested that the Workgroup reconsider three measures specified for the Healthcare Effectiveness Data and Information Set (HEDIS®) Electronic Clinical Data Systems (ECDS) reporting method that prior Workgroups had recommended for addition to the Core Sets. The three measures—*Postpartum Depression Screening and Follow-Up, Prenatal Immunization Status*, and *Adult Immunization Status*—had been recommended for addition during the 2021 and 2023 Child and Adult Core Sets annual reviews. CMCS deferred a decision pending further assessment of how the proprietary nature of the ECDS reporting method could impact the feasibility and viability of the measures for state-level reporting in the Core Sets. The Workgroup affirmed support for adding the three ECDS measures to the Child and Adult Core Sets.

[7] Two of the measures suggested for removal are included in both the Child and Adult Core Sets. The Workgroup discussed the child and adult versions of the measures at the same time, and then voted separately on removal from the Child and Adult Core Sets.

[8] The measures were organized by the following domains: Maternal and Perinatal Health, Dental and Oral Health Services, Care of Acute and Chronic Conditions, Behavioral Health Care, and Experience of Care.

The Workgroup also discussed stratification of Core Sets measures to advance health equity. This discussion continued a recurring theme from previous years to ensure that Core Sets measures can be stratified to identify and address disparities. Workgroup members discussed the challenges involved in collecting and reporting stratified data but agreed on the importance of stratifying the Core Sets measures by factors such as race, ethnicity, language, and disability status. Workgroup members discussed the technical assistance (TA) opportunities and other resources needed to help support states' capacity for stratification.

Workgroup members shared a desire to align measures across programs and initiatives and emphasized the importance of improving the Core Sets where gaps have been identified. The Workgroup also consistently underscored the importance of understanding the perspectives of the communities Medicaid and CHIP serve, and the value of inviting community and member voices to inform and strengthen the collection and reporting of Core Sets measures.

This report summarizes the Workgroup's review process, discussion, and recommendations and presents the public comments submitted on the draft report. CMCS will use the Workgroup's recommendations, public comments, and additional input from CMCS's Quality Technical Advisory Group and federal liaisons to inform decisions about updates to the 2025 Child and Adult Core Sets. CMCS expects to release the 2025 Child and Adult Core Sets in spring 2024.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) provide health coverage to more than 93 million people, including eligible children, pregnant individuals, low-income adults, the elderly, and individuals with disabilities.[9] This number represents more than one in four individuals in the United States.[10] In 2021, Medicaid and CHIP represented the second-largest source of health insurance coverage in the U.S., behind employer-sponsored coverage, covering more individuals than Medicare.[11] Managed care capitation payments are the largest category of Medicaid and CHIP program expenditures, followed by fee-for-service payments for long-term care (Exhibit 1, next page).

The Center for Medicaid and CHIP Services (CMCS) uses various strategies to help ensure that individuals enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high-quality and equitable care. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort to measure the quality of care and drive improvement in Medicaid and CHIP.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries based on a uniform set of health care quality measures. The Core Sets measures are intended to cover the continuum of preventive, diagnostic, and treatment services for acute and chronic physical, behavioral, dental, and developmental conditions, as well as long-term services and supports (LTSS) and experience of care. CMCS and states use the Child and Adult Core Sets measures to monitor access to and quality of health care for beneficiaries, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives. Although state reporting on the Core Sets is currently

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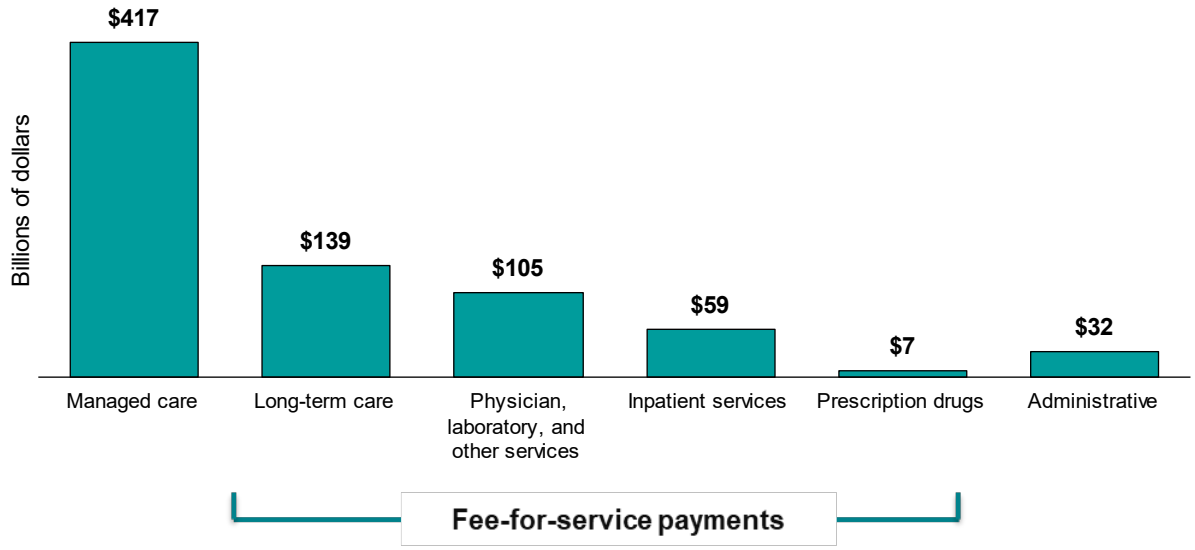
[9] The February 2023 Medicaid and CHIP Enrollment Trend Snapshot is available at https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html. Numbers reflect preliminary Medicaid and CHIP enrollment data for February 2023, as of April 24, 2023, as reported by 50 states and the District of Columbia.

[10] Based on "Monthly Medicaid & CHIP Application Eligibility Determination, and Enrollment Reports & Data." 2022; and U.S. Census Bureau. "National Population by Characteristics: 2020–2022." Estimates of the Resident Population for July 1, 2022. Table SCPRC-EST2022-18+POP. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html; and https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html, respectively.

[11] Keisler-Starkey, Katherine, and Lisa N. Bunch, "Health Insurance Coverage in the United States: 2021." U.S. Census Bureau, Current Population Reports, P60-278, Table 1. U.S. Census Bureau, U.S. Department of Commerce. Washington, DC, September 2022. https://www.census.gov/content/dam/Census/library/publications/2022/demo/p60-278.pdf.

voluntary, the Child Core Set measures and the behavioral health measures in the Adult Core Set become mandatory for state reporting in federal fiscal year (FFY) 2024.[12]

Exhibit 1. Annual Medicaid and CHIP Expenditures, by Service Category, FFY 2021



Source: Center for Medicaid and CHIP Services, Division of Quality and Health Outcomes. 2023 Medicaid and CHIP Beneficiary Profile. Centers for Medicare & Medicaid Services. Baltimore, MD. Released April 2023. https://www.medicaid.gov/medicaid/quality-of-care/downloads/beneficiary-profile-2023.pdf.

Notes: Expenditures by service category do not sum to the total expenditures. Total expenditures also include Medicare payments for some beneficiaries and adjustments to prior year payments. Managed care expenditures cover the same services delivered via fee-for-service. The data do not permit allocation of managed care expenditures to the different service categories. Data are for FFY 2021.

FFY = federal fiscal year.

The Secretary of the U.S. Department of Health and Human Services (HHS) is required to review and update the Child and Adult Core Sets each year.[13] The Child and Adult Core Sets Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from a variety of groups, including but not limited to states, managed care plans, health care providers, and quality experts. The Child Core Set has undergone these annual reviews since January 2013 and the Adult Core Set since January 2014.

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[12] Bipartisan Budget Act of 2018, Pub. L. No. 115-123 and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, Pub. L. No. 115-271. On August 22, 2022, CMS released a notice of proposed rulemaking with requirements for mandatory annual state reporting of the Child Core Set measures and behavioral health measures in the Adult Core Set. More information is available at https://www.federalregister.gov/documents/2022/08/22/2022-17810/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set.

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

CMCS contracted with Mathematica to convene the 2025 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 32 members representing a diverse array of affiliations, subject matter expertise, and quality measurement and improvement experience (see inside front cover of this report).

The Workgroup was charged with assessing the 2023 Child and Adult Core Sets[14] and recommending measures for removal or addition to strengthen and improve the 2025 Core Sets. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Child and Adult Core Sets based on several criteria that support the use of the Core Sets measures to meaningfully drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

This report provides an overview of the Child and Adult Core Sets, describes the 2025 Core Sets Annual Review process, summarizes the Workgroup's recommendations for improving the Core Sets, and includes public comments on the Workgroup recommendations.

Overview of the Child and Adult Core Sets

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions aimed at improving the quality of health care for children enrolled in Medicaid and CHIP. CHIPRA required the Secretary of HHS to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs (referred to as the Child Core Set). The initial Child Core Set, which was released in December 2009, included 24 measures that covered both physical and mental health. The core set of health care quality measures for adults covered by Medicaid (Adult Core Set) was established in 2010 under the Patient Protection and Affordable Care Act (Affordable Care Act) in the same manner as the Child Core Set. The initial Adult Core Set, released in January 2012, included 26 measures. Currently, state reporting of the Child and Adult Core Sets measures is voluntary. The Child Core Set measures and the behavioral health measures in the Adult Core Set become mandatory for state reporting beginning in FFY 2024.

Appendix A includes tables listing the 2023 Child and Adult Core Sets measures and the history of measures included in the Child and Adult Core Sets. Of the 27 measures in the 2023 Child Core Set, about half were part of the initial Child Core Set. Of the 34 measures in the 2023 Adult Core Set, about half were part of the initial Adult Core Set.

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[14] To support states' efforts to meet the 2024 mandatory reporting requirements and to provide sufficient time for states to prepare, CMCS released the 2024 Child and Adult Core Sets updates with the 2023 updates. As a result, this workgroup was charged with assessing the 2023 Core Sets, and there was no separate review of the 2024 Core Sets. More information about the 2023 and 2024 updates to the Child and Adult Core Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111522.pdf. More information about the annual review of the Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview.

The 2023 Child Core Set

The 2023 Child Core Set includes 27 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Dental and Oral Health Services, and (6) Experience of Care.[15] Nearly 75 percent of the measures (20 measures) in the 2023 Child Core Set fall into the Primary Care Access and Preventive Care, Maternal and Perinatal Health, and Behavioral Health Care domains (Exhibit 2). Eighty-nine percent of the measures (24 measures) can be calculated using an administrative data collection methodology.

Highlights of FFY 2020 Child Core Set reporting,[16] the most recent year for which data are publicly available, include the following:

- All states[17] voluntarily reported at least one Child Core Set measure.
- Forty-eight states reported on at least 12 of the 24 measures in the 2020 Child Core Set.
- Twenty states reported on more measures for FFY 2020 than for FFY 2019.
- Fifty states reported data on both the Medicaid and CHIP populations, an increase from 48 states for FFY 2019.
- The median number of measures reported by states was 19, which is higher than the number of measures reported for FFY 2018 (18 measures) but lower than the median number of measures reported for FFY 2019 (20 measures).
- Twenty-one of the 24 measures in the 2020 Child Core Set (88 percent) met CMCS's threshold for public reporting of state-specific results.[18]
- The most frequently reported Child Core Set measures for FFY 2020 focused on primary care access and preventive care, emergency department (ED) use, preventive dental service use, and behavioral health care.

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

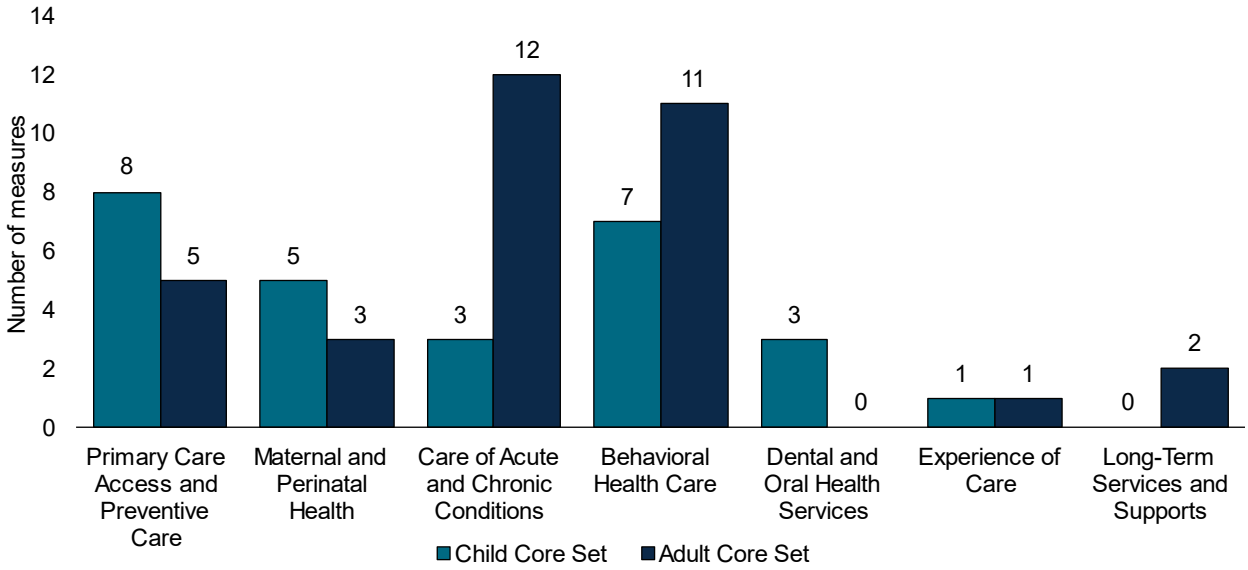
[16] More information about FFY 2020 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2020-core-set-reporting.pdf. A chart pack summarizing FFY 2020 Child Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-child-chart-pack.pdf.

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

[18] CMCS publicly reports Child and Adult Core Sets measures that were reported by at least 25 states and met CMCS standards for data quality.

- The least frequently reported Child Core Set measures for FFY 2020 focused on Cesarean birth, depression screening and follow-up, and audiological diagnosis.[19] These measures may require electronic health record (EHR) data, medical records review, or data linkages when claims/encounter data sources are incomplete.

Exhibit 2. Distribution of 2023 Child and Adult Core Sets Measures, by Domain



The 2023 Adult Core Set

The 2023 Adult Core Set includes 34 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Experience of Care, and (6) Long-Term Services and Supports.[20] More than half of the 2023 Adult Core Set measures fall into the Care of Acute and Chronic Conditions and Behavioral Health Care domains (Exhibit 2). Care of Acute and Chronic Conditions is the largest domain in the 2023 Adult Core Set. Eighty-five percent of the measures (29 measures) can be calculated using an administrative data collection methodology.

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[19] The 2020 Child Core Set contained a low-risk Cesarean birth measure that required the hybrid methodology (PC02-CH). Beginning with the 2021 Child Core Set, this measure has been replaced with an alternate specification that can be calculated administratively (LRCD-CH). CMCS will calculate this measure on states' behalf using vital records submitted by states and compiled by the National Center for Health Statistics. CMCS removed the *Audiological Diagnosis No Later than 3 Months of Age* (AUD-CH) measure from the 2022 Core Set because of state challenges with reporting.

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

Highlights of FFY 2020 Adult Core Set reporting,[21] the most recent year for which data are publicly available, include the following:

- Fifty states voluntarily reported at least one Adult Core Set measure, an increase from 46 states for FFY 2019.
- Idaho, Maine, North Dakota, and Puerto Rico were included in Adult Core Set reporting for the first time.
- Forty-three states reported on at least 16 of the 33 measures in the 2020 Adult Core Set.
- Twenty-three states reported more measures for FFY 2020 than for FFY 2019.
- States reported a median of 22 measures, similar to 22.5 measures for FFY 2019, and an increase from 20 measures for FFY 2018.
- Twenty-eight of the 33 measures in the 2020 Adult Core Set (85 percent) met CMCS's threshold for public reporting of state-specific results.
- The most frequently reported Adult Core Set measures for FFY 2020 focused on access to primary and preventive care, behavioral health care, asthma management, and postpartum care visits.
- The least frequently reported measures for FFY 2020 focused on depression screening and follow-up, HIV viral load suppression, diabetes care for people with serious mental illness, and elective delivery.[22] These measures may require EHR data, medical records review, or data linkages when claims/encounter data sources are incomplete.

Use of the Child and Adult Core Sets for Quality Measurement and Improvement

CMCS and states use the Child and Adult Core Sets to monitor and improve the quality of care provided to Medicaid and CHIP beneficiaries at the national and state levels, and to measure progress over time. CMCS publicly reports information on state performance on the Child and Adult Core Sets annually through chart packs and other resources.[23] Pillar I of the Medicaid and

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[21] More information about FFY 2020 Core Set reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2020-core-set-reporting.pdf. A chart pack summarizing FFY 2020 Adult Core Set results is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2021-adult-chart-pack.pdf.

[22] CMS removed the PC-01: *Elective Delivery* (PC01-AD) measure from the 2022 Adult Core Set because of state challenges with reporting and concerns that the measure was topped out.

[23] Chart packs, measure-specific tables, fact sheets, and other Core Sets annual reporting resources are available for the Child Core Set at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-

CHIP Scorecard, State Health System Performance, also includes data for several Child and Adult Core Sets measures.[24]

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMCS supports states and their partners in collecting, reporting, and using the Core Sets measures to drive improvement in Medicaid and CHIP. CMCS strives to achieve several goals for state reporting: maintaining or increasing the number of states that report the Core Sets measures, maintaining or increasing the number of measures reported by each state, and improving the quality and completeness of the data reported.[25] CMCS also continuously explores opportunities to increase the efficiency of reporting and reduce state reporting burden, streamline Core Sets reporting for states, and improve the transparency and comparability of the data reported across states. The TA/AS Program offers states various opportunities to address technical issues related to collecting and reporting the Core Sets measures, including a TA mailbox, one-on-one consultations, issue briefs, fact sheets, toolkits, analytic reports, and virtual learning opportunities. The Centers for Medicare & Medicaid Services' (CMS) Quality Conference also provides states with information to support their quality measurement and improvement efforts.

CMCS has developed initiatives to drive improvement in health care quality and outcomes using Core Sets measures—for example, through the Maternal and Infant Health Initiative and the Oral Health Initiative.[26] The TA/AS Program supports CMCS and states in designing and implementing quality improvement initiatives focused on the Core Sets measures through affinity groups, online training opportunities, one-on-one and group coaching, and other approaches.

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child-health-care-quality-measures/childrens-health-care-quality-measures/index.html and for the Adult Core Set at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

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

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

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

Description of the 2025 Child and Adult Core Sets Annual Review Process

This section describes the 2025 Child and Adult Core Sets Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2025 Child and Adult Core Sets Annual Review included 32 voting members from state Medicaid and CHIP programs, managed care plans, professional associations, universities, hospitals, consumer advocacy groups, and other organizations across the country. The Workgroup members for the 2025 Child and Adult Core Sets Annual Review are listed on the inside front cover of this report. Mathematica held a call for nominations between September 7 and September 30, 2022. Of the 32 voting members on the 2025 Workgroup, 15 were new members. During the review cycle, additional Workgroup members were identified through outreach to nominating organizations, when former Workgroup members resigned due to career transitions.

The 2025 Child and Adult Core Sets Annual Review Workgroup members offered expertise in behavioral health and substance use, dental and oral health, care of acute and chronic conditions, LTSS, maternal and perinatal health, primary care access and preventive care, and health equity. Although Workgroup members had individual subject matter expertise and some were nominated by an organization, they were asked to participate as stewards of the Medicaid and CHIP programs as a whole and not represent their individual organizational points of view. They were asked to consider what measures would best drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

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

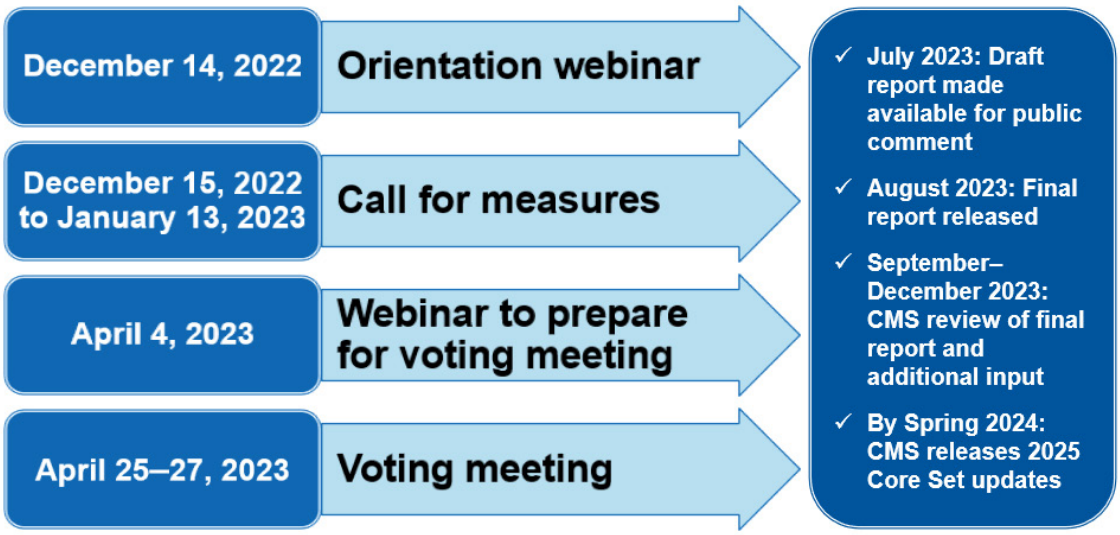
The Workgroup also included nonvoting federal liaisons representing 10 agencies (see inside front cover of this report). The inclusion of federal liaisons reflects CMCS's commitment to promoting quality measurement alignment and working in partnership with other federal agencies to collect, report, and use the Core Sets measures to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Workgroup Timeline and Meetings

As shown in Exhibit 3, Mathematica held webinars in December 2022 and early April 2023 to orient Workgroup members to the review process and prepare them for the 2025 Child and Adult

Core Sets Annual Review voting meeting, which took place virtually in late April 2023. The two webinars and the 2025 Annual Review voting meeting were open to the public, with public comment invited during each meeting.

Exhibit 3. 2025 Child and Adult Core Sets Annual Review Workgroup Timeline



Orientation Webinar

During the orientation webinar on December 14, 2022, Mathematica outlined the Workgroup charge, introduced the Workgroup members, discussed the Disclosure of Interest process, described the timeline for the 2025 Child and Adult Core Sets Annual Review, and provided background on the Child and Adult Core Sets.

After providing an overview of the 2025 Core Sets Annual Review process, Mathematica reviewed the outcomes of the 2023 Annual Review and discussed gaps identified during previous meetings. Mathematica described the additional input that CMCS will obtain during the 2025 Annual Review process, including input from internal partners within CMS, other federal partners, and CMCS's Quality Technical Advisory Group (QTAG).

Mathematica also explained the Call for Measures process, through which Workgroup

Workgroup Charge

The Child and Adult Core Sets Workgroup for the 2025 Annual Review is charged with assessing the 2023 Core Sets and recommending measures for removal or addition in order to strengthen and improve the Core Sets for Medicaid and CHIP.

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

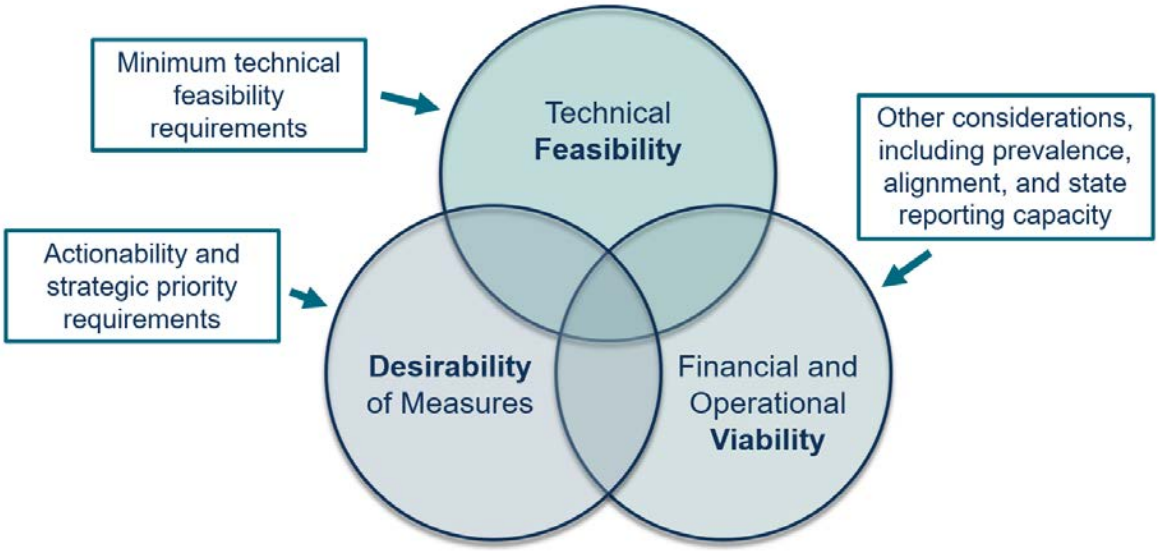
With the mandatory reporting requirements beginning in FFY 2024, the Workgroup should consider the feasibility of state reporting by all states for all Medicaid and CHIP populations, as well as opportunities for advancing health equity through stratification of Core Sets measures.

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

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

- **Minimum technical feasibility requirements.** Availability of detailed technical specifications that enable production of the measure at the state level, evidence of field testing or use in a state Medicaid or CHIP program, availability of a data source with all of the data elements needed to produce consistent calculations across states, and technical specifications provided at no charge for state use.
- **Actionability and strategic priority requirements.** Contributes to estimating the overall national quality of health care in Medicaid and CHIP, together with other Core Sets measures; allows for comparative analyses of disparities by factors such as race, ethnicity, age, rural/urban status, disability, and language; provides useful and actionable results to drive improvement in care delivery and health outcomes; and addresses a strategic performance measurement priority.
- **Other considerations.** Sufficient prevalence of the condition or outcome being measured to produce meaningful and reliable results across states, alignment with measures used in other CMS programs, capacity for all states to report the measure within two years of it being added to the Core Sets, and ability to include all Medicaid and CHIP populations.

Exhibit 4. Framework for Assessing Measures for the 2025 Child and Adult Core Sets



CMCS also provided introductory remarks regarding the Workgroup's charge, underscoring the importance of ensuring a robust, relevant, and reportable set of measures to drive improvements in health outcomes and the delivery of high-quality care to Medicaid and CHIP beneficiaries. CMCS noted that Core Sets data provide valuable information about the services delivered to beneficiaries and allow CMCS to respond to administration priorities, such as advancing health equity. CMCS added that advancing health equity in Medicaid and CHIP depends on the ability to measure disparities in health care access, quality, experience of care, and outcomes to support innovation and adoption of equity-focused interventions and initiatives, and to orient payment and delivery system reforms to improve care for all and close equity gaps. Finally, CMCS stated their commitment to supporting states in the transition to mandatory reporting of Child Core Set measures and behavioral health measures in the Adult Core Set beginning in FFY 2024.

Call for Measures

Following the orientation meeting, Workgroup members and federal liaisons were invited to suggest measures for removal from or addition to the Child and Adult Core Sets. Workgroup members used an online form to submit their suggestions for removal or addition, and were asked to provide the following information about the measure(s):

- The rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for removal or addition
- Whether the measure is suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language
- Whether the measure previously was reviewed by the Workgroup and, if so, information that justifies discussing it again
- Whether removal of the measure would leave a gap in the Core Sets
- Whether another measure was proposed to replace the measure suggested for removal
- Whether a measure suggested for addition was intended to replace a current Core Set measure
- Potential barriers states could face in calculating the measures suggested for removal or addition within two years of the reporting cycle under review

The Call for Measures was open from December 15, 2022, to January 13, 2023. Workgroup members and federal liaisons suggested six measures for removal and six for addition. Mathematica conducted a preliminary assessment of these 12 measures.

- Among the six measures suggested for removal, Mathematica determined that one (*Flu Vaccinations for Adults Ages 18-64*) would not be discussed by the Workgroup because it is being retired by the measure steward for FFY 2024 and from the 2024 Adult Core Set.
- Among the six measures suggested for addition, Mathematica determined that one (*Tobacco Use and Help with Quitting Among Adolescents)* had not been tested or used by one or more Medicaid or CHIP programs. As a result, this measure did not meet minimum technical feasibility requirements and was not discussed by the Workgroup.
- Mathematica determined that a comprehensive review of another measure suggested for addition (*Adult Immunization Status*) was not necessary because it was previously recommended for addition by the Workgroup.

The Workgroup discussed nine measures during the April voting meeting:

- **Five measures for removal** across four Core Set domains (care of acute and chronic conditions, behavioral health care, dental and oral health services, and experience of care), including two measures in the 2023 Adult Core Set, one measure in the 2023 Child Core Set, and two measures in both the 2023 Child and Adult Core Sets[27]
- **Four measures for addition** across three Core Set domains (maternal and perinatal health, care of acute and chronic conditions, and dental and oral health services)

Appendix B provides the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the 2025 Child and Adult Core Sets.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on April 4, 2023. To help Workgroup members prepare for the discussion at the 2025 Annual Review voting meeting, Mathematica provided a list of the five measures to be considered for removal and the four measures for addition. Mathematica also identified the measures suggested for removal or addition that would not be reviewed at the April meeting, and noted why the Workgroup would not discuss them.

Mathematica provided guidance to the Workgroup about how to prepare for the measure discussions, including the criteria that Workgroup members should consider for recommending measures for removal from or addition to the Core Sets and the resources available to facilitate their review. These resources included detailed measure information sheets for each measure, a worksheet to record questions and notes for each measure, the Medicaid and CHIP Beneficiary Profile, Core Sets Reporting History Table, Core Sets Chart Packs and Measure-Specific Tables,

[27] Two of the measures suggested for removal are included in both the Child and Adult Core Sets. The Workgroup discussed the child and adult versions of the measures at the same time, and then voted separately on removal from the Child and Adult Core Sets.

Core Sets Resource Manuals and Technical Specifications, and a list of measures and measure gaps previously discussed by the Workgroup. Workgroup members were responsible for reviewing all materials related to the measures; completing the measure worksheet; and attending the Annual Review meeting prepared with notes, questions, and preliminary votes on the nine measures proposed for removal or addition.

Annual Review Voting Meeting Webinar

The 2025 Child and Adult Core Sets Annual Review voting meeting took place virtually from April 25 to April 27, 2023. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

CMCS staff provided welcome remarks at the outset of the Annual Review voting meeting. They began with an update on current Core Sets measures that are either being retired or under consideration for retirement by their measure stewards and asked the Workgroup to be mindful of these measures when thinking about potential gaps in the Core Sets. They also announced that CMS is identifying a set of measures called the Universal Foundation, which intends to align measures across CMS's quality programs to drive quality improvement and care transformation.[28] They indicated that any changes to program measure sets for Medicaid and CHIP will be made in partnership with states and other interested parties using existing processes, and that the Universal Foundation will align with current Core Sets where applicable. Last, in response to a gap in the Core Sets that previous Workgroups had identified, CMCS noted that they are making progress toward refining social determinants of health measures that are feasible for state-level reporting and ready for review by the Workgroup in the future.

The discussion of measures was organized according to the current Core Set domains, though Mathematica advised the Workgroup that CMCS makes the final determination of the domain most appropriate for a given measure.[29] For each domain, Mathematica described the 2023 Child and Adult Core Sets measures, highlighted the measures suggested for removal or addition, noted the key technical specifications of each measure proposed for removal or addition, and summarized the rationale provided by Workgroup members for removal or addition.

Mathematica then facilitated a discussion of the measures within each domain. Mathematica sought comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. For ease of discussion, if a

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[28] More information about CMS's Universal Foundation is available at https://www.nejm.org/doi/full/10.1056/NEJMp2215539.

[29] The Core Set domains are Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Behavioral Health Care, Dental and Oral Health Services, Experience of Care, and Long-Term Services and Supports. No measures were suggested for removal from or addition to the Primary Care Access and Preventive Care and Long-Term Services and Supports domains during the 2025 Child and Adult Core Sets Annual Review.

measure suggested for removal had a replacement measure suggested for addition, the measures were "paired" and discussed together. For each domain, an opportunity for public comment followed the Workgroup discussion.

Voting took place by domain after the Workgroup discussion and public comment period. Mathematica facilitated the voting on the measures suggested for removal or addition. Workgroup members voted electronically through a secure web-based polling application during specified voting periods. Workgroup members who experienced technical difficulties with the voting tool submitted their vote through the webinar Q&A feature (which was visible only to the Mathematica team) or via email.

Within each domain, the Workgroup generally voted first on measures suggested for removal, followed by measures suggested for addition. However, if measures were "paired," the Workgroup voted first on the measure suggested for addition and then on the one suggested for removal. This process guarded against the unintentional creation of a gap in the Core Sets caused by removing an existing measure before the Workgroup voted on the one suggested for replacement.

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

Measures were recommended for removal or addition if two-thirds of the eligible Workgroup members voted yes. The two-thirds voting threshold was adjusted according to the number of eligible Workgroup members present for each measure vote. Mathematica presented the voting results immediately after each vote and reported whether the results met the two-thirds threshold for a measure to be recommended for removal or addition.

During the annual voting meeting, the Workgroup reconsidered three measures specified for the HEDIS ECDS reporting method that prior Workgroups recommended for addition to the Core Sets, but for which CMCS had deferred a decision.

The Workgroup also discussed stratification of Core Sets measures to advance health equity. This discussion continued a recurring theme from previous years to ensure that Core Sets measures can be stratified to identify and address disparities. Public comment was invited after the Workgroup discussions. A summary of the discussion appears below.

Mathematica reviewed the frequently mentioned gaps identified during the 2020–2023 Core Sets annual reviews and then asked the Workgroup to suggest priorities for future Core Sets, including high-priority gaps not previously identified. To inform the discussion about gaps, two states shared how they use Child and Adult Core Sets measures to drive quality improvement. A summary of the discussion about gaps in the Core Sets is presented later in this report.

Workgroup Recommendations for Improving the 2025 Child and Adult Core Sets

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

To focus the Workgroup discussion on measures that would be a good fit for the Core Sets, Mathematica specified detailed criteria for removal of existing measures and addition of new ones. These criteria are classified into three areas: (1) technical feasibility, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

To be considered by the Workgroup, all measures suggested for addition must meet minimum technical feasibility criteria. As noted earlier, Mathematica conducted a preliminary assessment of suggested measures before the Annual Review meeting to ensure that measures discussed by the Workgroup adhered to the minimum technical feasibility criteria. Appendix B contains the full list of measures suggested by Workgroup members and federal liaisons for removal from or addition to the Core Sets, including those not discussed by the Workgroup during the Annual Review meeting.

Mathematica mentioned additional contextual factors to inform the Workgroup discussion:

- The Workgroup should consider each measure on its own merits according to the criteria. There is no target number of measures—maximum or minimum—for the Child and Adult Core Sets.
- The Workgroup should review, discuss, and vote on all measures as currently specified by the measure steward.
- The Workgroup should not focus on assignment of measures to a Core Set or domain because these assignments are determined by CMCS.

Exhibit 5. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2025 Child and Adult Core Sets

Criteria Considered for Removal of Existing Measures	
Technical Feasibility	
1.	The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2.	States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3.	The specifications and data source do not allow for consistent calculations across states (e.g., there is variation in coding or data completeness across states).
4.	The measure is being retired by the measure steward and will no longer be updated or maintained.

Exhibit 5 *(continued)*

Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP.
2. The measure is not suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[30]
3. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid and CHIP beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
4. The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out, trending is not possible, or improvement is outside of the direct influence of Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All states may not be able to produce the measure for Core Set reporting within two years of the reporting cycle under review or may not be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).
Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP programs.
3. An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4. The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Set.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP.
2. The measure should be suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[31]

[30] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

[31] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

Exhibit 5 *(continued)*

3.	The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
4.	The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid and CHIP programs/providers).
Other Considerations	
1.	The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2.	The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3.	All states should be able to produce the measure for Core Set reporting within two years of the measure being added to the Core Set and be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

Summary of Workgroup Recommendations

The Workgroup recommended adding two measures to the 2025 Child and Adult Core Sets: *Oral Evaluation During Pregnancy* and *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* (Exhibit 6). The Workgroup did not recommend removing any measures from the Child and Adult Core Sets for 2025.

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

Exhibit 6. Summary of Workgroup Recommendations for Updates to the 2025 Child and Adult Core Sets

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Addition[a]		
Oral Evaluation During Pregnancy	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)	Not endorsed
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	DQA (ADA)	Not endorsed

[a] CMCS assigns new measures to a Core Set and domain as part of its annual update.

Measures Recommended for Addition

Oral Evaluation During Pregnancy

Oral Evaluation During Pregnancy measures the percentage of enrolled persons aged 15 through 44 years with live-birth deliveries in the reporting year who received a comprehensive or periodic oral evaluation from a dental provider during pregnancy. The American Dental Association (ADA) is the measure steward on behalf of the Dental Quality Alliance (DQA). The data collection method is administrative (enrollment and medical/dental claims), and the measure is not endorsed by National Quality Forum (NQF).

The Workgroup member who suggested this measure for addition noted that it addresses gaps related to access to and utilization of dental services for pregnant individuals. They added that since October 1, 2022, all states offer dental benefits to pregnant and postpartum Medicaid beneficiaries, addressing previous Workgroup member concerns around adding dental quality measures when there were inconsistencies in dental benefits across Medicaid programs. The Workgroup member shared evidence suggesting the important connection between oral health and overall health during pregnancy, and of the relationship between maternal and child oral health. They noted this measure could address a current performance gap and suggested it can be trended over time to monitor improvement. They acknowledged possible data collection challenges, indicating that some states may need to link medical and dental claims for beneficiaries.

During the discussion, a few Workgroup members questioned the feasibility of adding the measure to the Core Sets, given differences in state coverage of dental services for pregnant individuals. One Workgroup member shared that dental services are not readily available to pregnant individuals in their state, as they are offered only in select circumstances. Another Workgroup member questioned how the measure would be impacted by states that offer only emergency services for pregnant individuals with Medicaid. Another Workgroup member expressed concerns about states' ability to calculate the measure in a consistent and comparable way and the accuracy of the resulting data. The measure steward acknowledged that data collection may be challenging, but presented the technical details for how states would calculate the measure. In response to a Workgroup member asking why the measure was not NQF endorsed, Mathematica explained that NQF endorsement is not a requirement for Core Sets measures. The measure steward added that the measure had undergone testing and was approved by DQA through the same process used for NQF endorsement.

Several Workgroup members showed their strong support for adding this measure to the Core Sets by emphasizing the link between oral health and overall health during pregnancy. One Workgroup member mentioned that maintaining good oral/periodontal health during pregnancy helps prevent pain and infection, resulting in better pregnancy outcomes. They shared their personal experience working at a community health center, where they saw pregnant individuals unable to find a dentist willing to treat them because of their pregnancy. Another Workgroup member expressed support for the measure and suggested extending it to cover postpartum care

for a full year after birth. Although one Workgroup member said they had previously been hesitant to consider adding the measure to the Core Sets due to disparities in coverage across states, they now believed the measure was worth considering, given that almost all states cover oral health services for pregnant individuals.

Throughout the Workgroup discussion, several Workgroup members spoke highly of the measure, emphasizing that it could support the health of both mothers and children. One Workgroup member noted that the measure could have an enormous impact on the life course of both mother and child, adding that it provides a tremendous opportunity to advance equity. Another Workgroup member echoed this sentiment, remarking that investing in the measure could improve long-term health outcomes with relatively low investment. Yet another Workgroup member said they were in full support of the measure given a strong association that preterm labor can be prevented through oral health. They noted that preterm labor and low birth weight were difficult problems for their federally qualified health center to impact directly, despite efforts to address health holistically beyond pregnancy. Two other Workgroup members agreed, remarking that oral evaluation during pregnancy provides an important opportunity to positively impact a child's life. One of the Workgroup members stated that investing in good oral health for parents could lead to a greater appreciation of its importance for their child's oral health.

During the public comment period, the North Carolina Medicaid dental officer and representatives from the National Network for Oral Health Access (NNOHA) and the American Academy of Pediatric Dentistry expressed their support for adding the *Oral Evaluation During Pregnancy* measure to the Core Sets. They all stated that the measure could positively impact the oral health delivery system, promote healthy behaviors, and improve oral health care throughout the United States. The dental officer indicated that all states should work on improving oral health care to prevent adverse birth outcomes because dental benefits are now available to pregnant individuals. A commenter from NNOHA also noted evidence suggesting that when mothers receive dental care, their children are more likely to receive early care, which can help prevent disease. Public commenters also emphasized that dental care during pregnancy is not only safe but necessary for maintaining oral and overall health, consistent with the views expressed by the Workgroup members.[32]

Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults

Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults measures the number of ED visits for ambulatory care sensitive non-traumatic dental

[32] Public comments submitted on the *Oral Evaluation During Pregnancy* measure can be found in Appendix D.

conditions (NTDCs) per 100,000 member months for adults. For this measure, a lower rate indicates better performance. The data collection method is administrative.

The Workgroup member who suggested this measure for addition indicated that NTDC ED visits represent disease that remains untreated due to lack of definitive care in the ED and are associated with high rates of opioid prescribing because care commonly focuses on alleviating pain. They also commented that these visits are disproportionately experienced by Medicaid beneficiaries compared to the commercially insured and reflect racial disparities, among other health inequities. The Workgroup member cited a growing body of research linking oral health and overall systemic health, with even larger implications for beneficiary well-being. They commented that inclusion of this measure in the Adult Core Set would close a gap in measuring adult oral health care and allow for consistent calculations between states and over time due to the standardized code sets used in the measure. They also noted that since the measure was discussed by the Workgroup during the 2021 and 2022 Core Sets Annual Review meetings, all states now offer dental services for pregnancy-related Medicaid coverage and some level of general adult coverage.

One Workgroup member stated that although they see the value of the measure, there might be problems with the data, data sources, and states' ability to dedicate resources to implementation, considering that not all states provide dental coverage for the entire adult Medicaid population. This statement led one Workgroup member to question whether measures should be recommended for addition to the Core Sets to help drive policy change, or whether the Core Sets are intended to measure performance only in the context of existing benefits and services.

There was general consensus that the measure serves as an indicator of systemic failures to provide routine preventive dental care. A Workgroup member noted that the ED might be the first place an individual with a dental issue would seek care, and that it is important to know how often such visits occur among Medicaid beneficiaries. Multiple Workgroup members expressed support for the measure because it aligns with a stated intention of previous Workgroups to add outcomes-based measures to the Core Sets where possible. Workgroup members suggested that the measure could be used to identify missed opportunities for prevention, instances where quality improvement efforts might be falling short, and whether existing efforts to decrease ED use for these conditions are having the intended impact. A few Workgroup members noted that ED utilization for preventable NTDCs is costly and contributes to long wait times. Another Workgroup member added that states are looking to reduce unnecessary ED use following the increased use of the ED during the COVID-19 pandemic.

A few Workgroup members stated that significant racial disparities exist in the rates of utilization of the ED for NTDCs, and that this measure could be used to drive health equity. A Workgroup member noted that this measure not only highlights instances where existing systems are failing, but the populations being failed through these systems. Workgroup members discussed how stratification of the *Ambulatory Care Sensitive Emergency Department Visits for*

Non-Traumatic Dental Conditions in Adults measure by demographic characteristics such as race and ethnicity could lead to an improved understanding of disparities.

Multiple Workgroup members noted the adverse outcomes related to ED prescribing patterns, including for opioids. A few Workgroup members stated that prescribing opioids is the only step that can be taken at the stage where NTDCs result in ED visits, and suggested Workgroup members look at *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* as a measure to reduce the prescribing of opioids for dental care. One Workgroup member suggested considering how the measure may fit into the larger context of the opioid measures currently in the Core Sets. Another Workgroup member commented that antibiotics are also overprescribed for patients with NTDCs in the ED.

Multiple Workgroup members commented that Medicaid beneficiaries are impacted regardless of the extent of dental benefits in a state, and that the measure remains pertinent for several reasons: states still pay for ED visits and would be interested in knowing how many visits are occurring, regardless of the extent of an adult Medicaid dental benefit; adults in states with dental benefits do not always access their benefits; and the measure can help identify problem areas for EDs with increased specificity. Workgroup members also said that there is nothing that precludes states from using other mechanisms to improve oral health and reduce associated ED expenditures.

Workgroup members highlighted the actionability of the measure and how it could be used to guide performance improvement efforts. One Workgroup member provided several examples of existing state quality improvement efforts that could improve performance on this measure by reducing unnecessary ED use and directing individuals to more appropriate care. Citing a related example, another Workgroup member said that their work around ED visits for people with serious mental illness has had a positive impact on care coordination. Within the context of whole-person care, one Workgroup member suggested that the measure could enhance understanding of chronic disease management. They reminded the Workgroup that the oral cavity is not disconnected from the rest of the body, noting the link between dental conditions and other conditions of the body, such as diabetes and cardiovascular disease.

During the public comment period, the North Carolina Medicaid dental officer offered remarks in support of the measure. These remarks echoed the Workgroup members' discussion, noting that the measure is critical in determining the success of efforts to prevent avoidable poor health outcomes and associated increases in health care spending caused by systemic gaps in the delivery of oral health services. Since nearly all state Medicaid agencies cover emergency dental care for adults, they noted it is imperative that the Adult Core Set include a measure that can be used to ascertain whether ED visits for non-traumatic dental reasons are impacting Medicaid expenditures and quality of life for adult beneficiaries. The commenter suggested that the measure can demonstrate to policymakers that the price of inadequate dental coverage can be high in terms of increases in hospital admissions, elevated numbers of opioid prescriptions, lost

productivity, and other health care and societal costs, and could motivate states to expand dental benefits to improve performance on the measure.[33]

Reconsideration of Deferred Electronic Clinical Data System Measures

CMCS requested that the Workgroup reconsider three measures specified for the HEDIS ECDS reporting method that prior Workgroups had recommended for addition to the Core Sets. The three measures—*Postpartum Depression Screening and Follow-Up, Prenatal Immunization Status*, and *Adult Immunization Status*—had been recommended for addition during the 2021 and 2023 Child and Adult Core Sets annual reviews. CMCS deferred a decision pending further assessment of how the proprietary nature of the ECDS reporting method could impact the feasibility and viability of the measures for state-level reporting in the Core Sets.

ECDS is a reporting standard developed by NCQA that provides health plans with a standardized method to collect and report structured electronic clinical data for HEDIS. The eligible data sources used for ECDS reporting are administrative claims, EHRs, health information exchanges and clinical registries, and case management systems. The three measures are defined as follows:

- *Postpartum Depression Screening and Follow-Up* measures the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care. Two rates are reported: a depression screening rate and a follow-up on positive screen rate.
- *Prenatal Immunization Status* measures the percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations. The measure includes two individual vaccine rates and a combination rate.
- *Adult Immunization Status* measures the percentage of adults 19 years and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or Tdap; zoster; and pneumococcal. This measure includes denominators for four individual vaccine rates with varying age groups and is specified for stratification by age, race, and ethnicity. The measure was recommended to replace the *Flu Vaccinations for Adults Ages 18 to 64* (FVA-AD) measure in the Adult Core Set, which will be removed from the 2024 Core Set because the measure steward has retired it.

CMCS explained the context and motivation for asking the Workgroup to reconsider the three measures. They noted that as more health care information is collected, stored, and shared digitally, the future of quality measurement is increasingly digital, providing opportunities for much richer quality data and better information about health outcomes than administrative data

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

sources alone. CMCS explained they wanted to confirm the Workgroup's continued interest in adding these measures to the Core Sets because states are on the cusp of mandatory Core Sets reporting and early in the transition to digital measurement. CMCS indicated that the earliest the ECDS measures would be added, if recommended, is to the 2025 Child and Adult Core Sets.

Noting that feasibility is paramount to the success of the measures, one Workgroup member asked whether it had been determined that ECDS measures are feasible for state-level reporting or will be so by 2025. Representatives from state Medicaid programs shared their experiences reporting ECDS measures, reflecting both successes and challenges. A Workgroup member noted that their state requires managed care organizations (MCOs) to report ECDS measures and those measures have generally been feasible. The Workgroup member added that they believe the immunization measures should be highly feasible because most of the data come from administrative claims supplemented with immunization registry data. In contrast, they saw substantially lower rates on the *Postpartum Depression Screening and Follow-Up* measure when calculated using the ECDS reporting method versus chart review. Still, the Workgroup member expressed support for ECDS measures and for continuing to move toward electronic measurement.

Another Workgroup member said that their state Medicaid program has had success with ECDS measures and commented that ECDS-specified measures do not prevent states without access to electronic data from using administrative data sources to report. They noted that their state often looks across multiple data sources as part of the reporting process. A Workgroup member indicated that their state Medicaid program has also required their MCOs to report ECDS measures for years, but with varying degrees of success. Despite this issue, the Workgroup member agreed with moving toward electronic measurement and acknowledged the need to start somewhere.

Workgroup members raised concerns about the feasibility of ECDS measures in the context of mandatory Core Set reporting. One Workgroup member noted that states will not be able to report these measures for all programs and populations next year, explaining there is no requirement in their state for providers to report electronic health data to the state. The Workgroup member added that it was difficult to vote on the measures without knowing the future operational implications of the decision due to the lack of details about mandatory reporting. Another Workgroup member whose state has had success in reporting ECDS measures requested feedback from CMCS on the distinction between mandatory reporting and public reporting. The Workgroup member noted that states may feel comfortable reporting measures to CMCS but may want to be involved in the decision around what information gets publicly reported. Another Workgroup member, who expressed support for adding ECDS measures to the Core Sets but noted feasibility concerns, said they would like to see the measures added to a Core Set domain that would not be subject to mandatory reporting.

One Workgroup member said that although CMCS determines whether to add or remove Core Sets measures, the secretary has discretion to decide when a measure will be reported if state

readiness is in question. Citing the example of the unwinding of the continuous coverage requirement from the COVID-19 PHE, the Workgroup member noted that CMCS has been sensitive to state reporting challenges and works with states to ensure their compliance with rules and laws. Mathematica reminded the Workgroup that CMCS is still in the middle of rulemaking, so it has not yet been determined whether these measures would be subject to mandatory reporting. Moreover, the criteria for public reporting require that the state-reported data meet CMCS's standards for data quality.

Workgroup members also addressed the actionability of the resulting data. A Workgroup member from a state Medicaid program said that although they are working toward digital quality measurement, they are not prepared to yield meaningful outcomes from mandatory reporting of ECDS measures at this time. They added that the data will be questionable if these measures are required. Acknowledging the importance of the measures, another Workgroup member reflected on the consumer perspective of state readiness for ECDS reporting. They noted that consumers want good, quality data that are accurate and informative, and that mandating states to report bad data will not help either states or consumers. A Workgroup member from a state Medicaid program commented that adding the ECDS measures to the Core Sets could help secure resources for electronic measurement and enable states to do more work in that area. Another Workgroup member agreed, suggesting that adding these measures to the Core Sets could help initiate conversations about how to remove silos and move data systems forward to enable reporting of the measures.

Several Workgroup members suggested strategies to support state use of ECDS measures. A Workgroup member recommended a third tier of reporting for interim, innovative measures that support movement in the direction CMCS and states want to go with measurement and reporting. Another Workgroup member supported the idea of promoting the use of the measures in a non-punitive way until states can better integrate them into reporting.

A few Workgroup members also emphasized the desirability and strategic priority of the *Postpartum Depression Screening and Follow-Up* measure in particular, commenting on the importance of the measure across generations and throughout the life course. One Workgroup member contextualized the impact of maternal depression and the importance of early intervention and detection, citing research that the cost of untreated and undetected maternal depression was more than $14 billion a year in the United States because of the generational impact on both the mother and developing child. They also noted that maternal mental health conditions are the leading cause of preventable pregnancy-related deaths. Another Workgroup member acknowledged that although reporting is not without challenges, the efforts discussed by the state Medicaid program representatives in the Workgroup suggest a path forward in addressing what they described as a universal problem in equity life course.

After a robust discussion, the Workgroup affirmed its support for adding the three ECDS measures to the Child and Adult Core Sets: *Postpartum Depression Screening and Follow-Up*, *Prenatal Immunization Status*, and *Adult Immunization Status*.[34]

Stratification of Child and Adult Core Sets Measures to Advance Equity

Increasing stratification of the Child and Adult Core Sets measures is a priority area for CMCS in its efforts to advance health equity in Medicaid and CHIP. To better understand how CMCS can continue to drive this work, the Workgroup discussed opportunities and considerations for using Core Sets data to advance health equity through stratification. This discussion continued a recurring theme from previous Workgroup annual reviews to ensure that Core Sets measures can be stratified to identify and address disparities. Mathematica provided context about the stratification categories currently available for reporting Core Sets data, including race, ethnicity, geography, and sex, and then solicited feedback on key challenges to collecting, reporting, and using stratified data, and the additional resources needed to advance this effort.

Four Workgroup members representing state and beneficiary perspectives provided opening remarks, highlighting why increased stratification is important for understanding beneficiary experiences and driving improvement. They also acknowledged technical challenges, including collecting data in a transparent and inclusive way; high levels of unknown or missing data; having sufficient administrative support to collect this information; political considerations for how the data are collected and reported; and technical challenges, such as ensuring that variables are structured in a way that aligns with reporting requirements. Following their remarks, the broader Workgroup was invited to join the discussion. The Workgroup acknowledged the challenges associated with collecting and reporting stratified data but shared a clear consensus on the importance of stratification. Workgroup members highlighted several considerations for using the Core Sets to advance health equity.

- **Missing or unknown data.** Workgroup members from state Medicaid and CHIP programs expressed concerns about missing and unknown data, particularly around race and ethnicity. For example, one Workgroup member noted that up to 60 percent of their data was missing or unknown, as enrollees opted not to provide information about their race and ethnicity. Although they recognized the data improved over time, they were apprehensive about drawing conclusions from incomplete data.
- **Multiple sources of data.** Several Workgroup members discussed challenges with having multiple data sources for the various stratification categories. One Workgroup member from a state Medicaid program questioned the "source of truth" when there are conflicts between different data sources—for example, when there are inconsistencies between health plan and

[34] Public comments submitted on the three ECDS measures can be found in Appendix D.

provider data. One Workgroup member shared that their state uses county assistance office data as their source of truth and that their managed care plans work with members and providers to amend the data. Another Workgroup member said that having multiple sources of data for collecting demographic information can add unnecessary administrative burden to states and suggested that the Medicaid application should be the source of truth, with a process in place for individuals to update their information as needed. Two Workgroup members shared similar concerns, adding that as more data are collected at different levels (state, federal, and others), guardrails should be established to avoid undue burden.

- **Alignment of stratification categories.** Two Workgroup members noted the lack of alignment around demographic data collection across federal agencies and other reporting programs and urged CMCS to ensure alignment with reporting standards.
- **State-specific challenges and TA needs.** Workgroup members noted that each state has unique challenges and therefore unique TA needs. For example, a Workgroup member from a state Medicaid program noted that their agency must balance the state's legislative environment while being responsive to CMS reporting requirements. As demographic data collection categories continue to be refined, Workgroup members noted the challenges in incorporating data collection changes into their workflows. For example, one Workgroup member noted that data collection systems in many states may not be able to respond quickly to changes, and another added that competing state priorities (for example, the COVID-19 public health emergency [PHE] unwinding) can make it difficult to allocate resources to update data systems.
- **Engaging Medicaid and CHIP beneficiaries in data collection and interpretation.** Several Workgroup members emphasized the importance of understanding the perspectives of the communities served by Medicaid and CHIP to inform data collection and use of stratified data. Several Workgroup members acknowledged beneficiaries' hesitancy to share personal information. To improve the collection of patient information and navigate conversations around how such information is used, Workgroup members recommended developing initiatives at the local level, such as hosting focus groups and convening learning collaboratives. Additionally, Workgroup members suggested that providers, health plans, and state agencies work with and hire people from the communities they serve, thus equipping staff with the appropriate language and supplemental materials to support data collection and ensure that participants understand the value of the information they share.
- **Sharing and acting on stratified data.** Workgroup members emphasized the importance of acting on the information collected and responding swiftly to close identified gaps. A Workgroup member added that state responsiveness to addressing disparities could help encourage beneficiaries to provide their information. One Workgroup member suggested considering how the data will be used before they are collected, rather than collecting data and then developing a plan for their use. Workgroup members also encouraged CMCS to share the data back to the public.

After the discussion, Mathematica invited public comment on the stratification of Core Sets measures. One public commenter noted that for the 2030 Census, the U.S. Census Bureau is considering updates to the race and ethnicity categories in an effort to improve the quality, accuracy, and usefulness of the data.

Cross-Cutting Themes in Measure Discussions

Two cross-cutting themes emerged from the Workgroup's discussions: (1) a strong commitment to include Core Sets measures that are actionable and strategic to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries, despite concerns about feasibility in the context of mandatory reporting, and (2) strong support for engaging Medicaid and CHIP beneficiaries to advance equity.

Actionability and Strategic Priority for Driving Improvement in Care Delivery and Health Outcomes

The tension between the feasibility of state reporting with the actionability, desirability, and strategic priority of Core Sets measures was woven throughout discussions of the measures suggested for addition or removal. Many Workgroup members, and particularly those from state Medicaid programs, expressed apprehension about recommending measures for addition before publication of the final rule specifying the mandatory reporting requirements. Despite these concerns, the Workgroup demonstrated a commitment to use the Core Sets to focus attention on pressing public health issues, such as depression, maternal health, and oral health, and was reluctant to remove measures that might leave a gap in the Core Sets.

During discussions around the oral health measures, a few Workgroup members questioned whether these measures are feasible and appropriate for the Core Sets, given the variation in adult dental benefits across state Medicaid programs. However, other Workgroup members highlighted the actionability and strategic priority of the measures, and how they could be used to drive improvement in care delivery and health outcomes. Many Workgroup members voiced strong support for the *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* measure, indicating that it could be used to identify system failures, such as missed opportunities for prevention, lack of provider access outside the ED, and the need for improved diversion efforts to decrease avoidable ED use for dental conditions. Workgroup members also linked avoidable ED use for dental conditions to inappropriate opioid and antibiotic prescribing. During discussion of the *Oral Evaluation During Pregnancy* measure, Workgroup members emphasized the link between oral health and overall health during pregnancy and noted that the measure would support improvements in the health of both mothers and children. The Workgroup voted to recommend both measures for addition to the 2025 Core Sets, reflecting the first time the Workgroup voted to recommend an adult dental measure to the Core Sets.

The tension between feasibility and strategic priority was also evident during the Workgroup discussion on whether to remove or retain *Screening for Depression and Follow-Up Plan: Ages 12 to 17* (CDF-CH) and *Screening for Depression and Follow-Up Plan: Age 18 and Older* (CDF-AD). The Workgroup voted to retain the measures in the Child and Adult Core Sets despite acknowledging significant data collection and reporting challenges. Workgroup members were troubled by the idea of removing the measures without replacements, citing increasing rates of depression and suicide ideation, especially among adolescents. With Workgroup members in agreement about the strategic priority of the measures, several shared their state's approach to addressing data challenges, and reflected on TA opportunities. Because these measures will be subject to mandatory reporting, one Workgroup member mentioned that retaining the measures may encourage states to reimburse for depression screening services.

Similarly, the Workgroup voted to retain *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD) and *Concurrent Use of Opioids and Benzodiazepines* (COB-AD). The Pharmacy Quality Alliance (PQA), the measure steward for both measures, noted that they are considering retiring the OHD-AD measure, following the Centers for Disease Control and Prevention's (CDC's) decision to discontinue updates to the morphine milligram equivalents (MME) Conversion File, which is required to calculate the measure. Those who supported retaining the measure voiced concerns about the CDC discontinuing file updates, given the ongoing opioid epidemic, and determined that it was difficult to support removal due to its strategic importance. Workgroup members generally expressed support for the COB-AD measure because of the ongoing opioid epidemic, as well as the high concurrent use of opioids and benzodiazepines among the older adult population. However, some noted concerns about its actionability and wondered if keeping the measure in the Adult Core Set was redundant to other state efforts, such as drug utilization review (DUR) programs. The Workgroup ultimately voted to retain both measures in the 2025 Adult Core Set.

Finally, during the Workgroup reconsideration of the deferred ECDS measures, Workgroup members affirmed support for adding *Postpartum Depression Screening and Follow-Up, Prenatal Immunization Status,* and *Adult Immunization Status*. Although some Workgroup members voiced concerns around the feasibility of reporting the ECDS measures as part of the Core Sets, particularly as states await further details on mandatory reporting, the Workgroup recommended adding all three measures, emphasizing the value of moving forward with digital quality measures.

Engaging Medicaid and CHIP Beneficiaries to Advance Equity

Workgroup members emphasized the importance of engaging the diverse populations served by Medicaid and CHIP and understanding their experiences, particularly during the discussions on stratification of Core Sets measures and the potential removal of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures.

The Workgroup advocated for engaging Medicaid and CHIP beneficiaries in data collection and interpretation to better inform stratification. Workgroup members shared examples of their community-engagement efforts, such as connecting with community partners to reach specific populations and participating in learning collaboratives. Some Workgroup members reflected on gaps in the stratification categories that can be addressed through discussion with community members. For example, one Workgroup member noted that individuals may not identify themselves as belonging to any of the racial and ethnic categories available in current data collection tools.

While deliberating about whether to remove or retain the CAHPS survey measures, Workgroup members were reluctant to remove them without replacements, emphasizing the need to reflect members' experience with care as part of the Core Sets.[35] The Workgroup recognized the challenges around survey data collection and declining response rates, with a few Workgroup members questioning whether there were other means of gathering the data more efficiently and with less burden for beneficiaries. However, the Workgroup was largely in consensus about members' experience of care being a critical aspect of payer and provider accountability as individuals navigate the health care system. A few Workgroup members from state Medicaid programs indicated that the surveys inform many of their internal processes, such as health plan procurement and oversight. Another Workgroup member encouraged those responsible for data collection to consider who administers experience-of-care surveys, suggesting that employing those who come from the communities served may help improve response rates.

Discussion of Child and Adult Core Sets Measure Gaps

During the 2025 Child and Adult Core Sets Annual Review, the Workgroup discussed measure gaps and considerations about how to use the Core Sets to drive improvement of Medicaid and CHIP programs. Mathematica asked Workgroup members to identify and prioritize gaps, as well as opportunities for future measure development, testing, and refinement.

Using the Core Sets to Drive Quality Improvement

Before discussing the prioritization of measure gaps, Mathematica invited Workgroup members from two states to share strategies for using the Child and Adult Core Sets to drive quality improvement and improve outcomes in Medicaid and CHIP. The Workgroup member from Massachusetts shared that they use many of the Core Sets measures across their state Medicaid programs, and that the measures have been essential in framing state quality improvement priorities and monitoring progress. The Workgroup member from Washington State commented that they use multiple data sources, including the Core Sets reporting results, to monitor overall performance within the state and also compare their performance with other states. Both

[35] Refer to Appendix C for more information about the Workgroup discussion of the CAHPS measures. Public comments submitted on the CAHPS measures can be found in Appendix D.

Workgroup members indicated that they use stratified Core Set data to identify gaps in care delivery in their states, as well as understand disparities and drive health equity efforts.

Both Workgroup members discussed opportunities to improve the Core Sets to drive quality improvement. The Workgroup member from Massachusetts remarked that although the Core Sets have allowed them to focus on areas critical to their members' health, they also have surfaced areas beyond the Core Sets in which they have gaps in their information, such as in child health outcomes, perinatal health, and member experience. They encouraged Workgroup members to be mindful of the number of measures in the Core Sets and prioritize improving those areas of the Core Sets where there are gaps. The Workgroup member from Washington emphasized the importance of alignment across programs, indicating that they continue to balance the need to align measures across various quality initiatives with the need to achieve quality outcomes. They added that the current Core Sets can be limited by the timeliness of data collection methods, and digital quality measures could offer improvements in the turnaround time required for reporting and yield better clinical data.

Prioritization of Child and Adult Core Sets Measure Gaps

Mathematica provided an overview of frequently mentioned gaps that have been discussed for at least three of the four years since Mathematica has convened the Workgroup. Mathematica discussed several common themes among the frequently mentioned gaps, including the desire to use the Core Sets to identify and address health disparities among Medicaid and CHIP beneficiaries, and the importance of stratification. Exhibit 7 synthesizes the frequently mentioned gaps identified during the 2020–2023 Child and Adult Core Sets Annual Reviews, as well as the gaps filled by the Core Sets annual review process since 2020. The exhibit does not prioritize the suggested gaps or assess their feasibility or fit for the Child and Adult Core Sets.[36]

Exhibit 7. Frequently Mentioned Gaps During the 2020–2023 Child and Adult Core Sets Annual Reviews

Frequently Mentioned Gaps During the 2020–2023 Child and Adult Core Sets Annual Reviews
Gaps Mentioned All Four Years
• Care integration across sectors and settings of care, especially beneficiaries with complex needs and those needing LTSS • LTSS quality and experience with care • Oral health care access and quality for children and adults • Screening for adverse childhood experiences • Screening for social-emotional needs • Social determinants of health, including the need for measure development and testing • Stratification of measures by race, ethnicity, and disability (among other factors)

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

Exhibit 7 *(continued)*

Frequently Mentioned Gaps During the 2020–2023 Child and Adult Core Sets Annual Reviews
Gaps Mentioned Three of the Four Years
• Colorectal cancer screening • Health care delivery and outcomes for male beneficiaries • Integration of behavioral health and physical health, particularly through primary care • Prenatal and postpartum care content and quality • Screening, follow-up, and treatment for depression, especially maternal depression • Suicide screening, prevention, and treatment
Gaps Filled Through the Core Sets Annual Review Process Since 2020

• Colorectal cancer screening (COL-AD)
• Dental care for children
  - Sealant Receipt on Permanent First Molars (SFM-CH)
  - Oral Evaluation, Dental Services (OEV-CH)
  - Topical Fluoride for Children (TFL-CH)
• LTSS measures
  - National Core Indicators Survey (NCIDDS-AD)
  - Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD)
• ECDS measures deferred by CMS due to licensing and feasibility considerations
  - Adult Immunization Status
  - Prenatal Immunization Status
  - Postpartum Depression Screening and Follow-Up

Mathematica asked the Workgroup to suggest priorities for future Core Sets, including gap areas previously identified by the Workgroup and additional high-priority gaps not previously identified. Mathematica noted that NCQA has proposed to retire the *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD) measure for HEDIS measurement year (MY) 2024 (2025 Core Sets) and asked the Workgroup to consider whether there were any existing measures that could fill this gap.[37] Mathematica also asked the Workgroup to suggest which gaps should be prioritized for future measure development, testing, and refinement. Exhibit 8 synthesizes the cross-cutting gap areas and domain-specific gaps mentioned during the Workgroup discussion, as well as methodological considerations to prioritize for future measures.

Throughout the discussion of gaps, Workgroup members emphasized the importance of advancing health equity through the Core Sets. They expressed interest in stratifying new and existing Core Sets measures not only by race, ethnicity, and language, but also disability status and medical complexity, particularly for children. They discussed the need for continued review

[37] On July 17, 2023, NCQA released a blog post confirming its plan to retire the MSC measure when a replacement measure is ready, which is currently planned for HEDIS Measurement Year 2026 measure (corresponding to the 2027 Core Sets).

of existing measures for stratification and identification of disparities, and opportunities to address those disparities.

The Workgroup noted that LTSS measures continue to be a gap area in the Core Sets, with suggestions to focus on the population dually eligible for Medicare and Medicaid. To promote a whole-person approach to LTSS, Workgroup members suggested including measures that better integrate medical and home and community-based services (HCBS). For example, a Workgroup member noted a gap in the Core Sets related to children receiving LTSS, remarking that most of the measures in the CMS HCBS Quality Measure Set may not be appropriate for children, as they have been tested only for adults.[38] Another Workgroup member said their state uses the CAHPS Home and Community-Based Services Survey (HCBS CAHPS) to understand LTSS participant experience and whether a participant's care plan meets their needs.

The Workgroup also expressed a desire to explore measures oriented toward more person-centered experiences of care. Several Workgroup members emphasized the importance of keeping beneficiaries at the center of the Core Sets Annual Review process, including reflecting on why certain information is being collected, how it is collected, whether it captures adequate representation, how it will help beneficiaries, and how it can be used to drive improvements in care delivery. Workgroup members also discussed opportunities to engage beneficiaries in the development of survey tools and processes.

In addition to identifying measure gaps, the Workgroup proposed several methodological considerations, including the concept of multigenerational measurement, broader measures of treatment outcomes for chronic conditions that include beneficiaries who may not have access to care, and a desire for more outcome-based and "upstream" measures. One Workgroup member noted the movement to look upstream at depression screening in pregnancy, citing data linking depression in pregnancy to adverse birth outcomes such as preterm birth and low birthweight deliveries.

The Workgroup's reflections about gaps in the Child and Adult Core Sets provide further considerations and guidance for prioritization in longer-term planning for the Core Sets.

[38] More information about the HCBS Quality Measure Set is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf.

Exhibit 8. Cross-Cutting and Domain-Specific Gap Discussions During the 2025 Child and Adult Core Sets Annual Reviews

Themes from Cross-Cutting and Domain-Specific Gap Discussions
Cross-cutting Gap Areas
• Advancement of health equity • Stratification of measures by race, ethnicity, language, disability, and medical complexity particularly for children • Subgroup analyses of existing measures for pregnant beneficiaries • Improved engagement with beneficiaries to support measure development and implementation
Cross-cutting Methodological Considerations
• Stratification and identification of disparities in existing measures • Inclusion of more outcome measures • Monitoring value of measures and incorporating use of trend analysis to monitor improvement over time • Development and implementation of multigenerational measures • Incorporation of broader measures of treatment outcomes for chronic conditions that include beneficiaries who may not have access to care • Use of existing data sources to increase efficiency and reduce state administrative burden (such as Transformed Medicaid Statistical Information System [T-MSIS] data) • Alignment and standardization across reporting programs (such as HEDIS, Medicare) • Collaboration across agencies to align measures and better address gaps (such as HRSA Maternal and Child Health Bureau) • Use of newer technologies for survey-based measures to collect information in real time
Long-Term Services and Supports
• Adverse health and safety events, including hospitalizations • Focus on whole-person care, including integration of medical and HCBS for individuals in LTSS • Children's experience of care, community integration, and quality-of-life measures
Primary Care Access and Preventive Care
• Identification of and intervention for adverse childhood experiences and exposure to trauma and toxic stress • Integrated physical health and behavioral health
Maternal and Perinatal Health
• Prenatal screenings for depression and mental health • Contraceptive counseling • Maternal health outcomes
Care of Acute and Chronic Conditions
• Hepatitis C screening

Suggestions for Technical Assistance to Support State Reporting of the Child and Adult Core Sets

Workgroup members discussed opportunities for TA to support states in reporting the Child and Adult Core Sets measures. The Workgroup made the following suggestions:

- Identify best practices and ensure that state Medicaid agencies can take advantage of shared learning opportunities
- Offer learning opportunities around measures that use the ECDS reporting methodology
- Provide TA and guidance around the LTSS and HCBS populations, including TA focused on removing silos between community providers and state agencies around data sharing to facilitate integrative outcomes for health
- Create a data users group akin to the QTAG where states can share challenges and successes and engage in shared learning
- Provide TA to help states integrate data for beneficiaries who are dually eligible for Medicare and Medicaid into reporting
- Explore options for calculating administrative measures on behalf of states using Medicare and T-MSIS data.

Suggestions for Improving the Child and Adult Core Sets Annual Review Process

Workgroup members also suggested several enhancements to the Core Sets Annual Review process:

- To enhance opportunities for reducing disparities, a Workgroup member suggested expanding the stratification section in the measure information sheets, including the elements of stratification and any limitations. Additionally, the Workgroup member suggested considering opportunities for alignment with the priorities of the Health Resources and Services Administration's Maternal and Child Health Bureau and Title V programs at state and territorial levels, and engagement with the bureau.
- A Workgroup member suggested considering options for how the Core Sets can continue to remain an accelerator in the field and be reflective of new and emerging areas that may unfold between the time of the voting meeting and the time states will report on the Core Sets. The Workgroup member noted that this aim could be realized by (1) giving states the option to submit electronic measures; (2) allowing for a measure to be added to a Core Set that had already been released if the Workgroup identified it as an emerging measure that might fill a Core Set gap; and/or (3) allowing states to report measures in identified key

priority areas (for example, health-related social needs) on a voluntary basis while feasibility challenges are addressed.

- A Workgroup member suggested allowing additional time between the orientation meeting and the deadline for Workgroup members to suggest measures for addition or removal.
- A Workgroup member questioned whether the Annual Review process should be structured differently, whereby Workgroup members and others suggest measures for addition to the Core Sets that measure stewards would then develop through a call for measures. The Workgroup member described the current process as a bit of "the tail wagging the dog," that is, measure developers may be sunsetting measures this Workgroup and others consider important. The Workgroup member also suggested that, before Workgroup discussion on the measures, CMCS or Mathematica should conduct an assessment of Medicaid programs and health plans to better understand their capacity for reporting, as well as how the complexity of measures affects reporting. Finally, they suggested a new member orientation before Core Sets Annual Review meetings so new members can receive background on measure-related concepts, thereby helping the meetings run more efficiently.

Next Steps

The 2025 Child and Adult Core Sets Annual Review Workgroup recommended adding two of the four measures suggested for addition to the 2025 Child and Adult Core Sets and did not recommend removing any of the five measures suggested for removal. The two recommended measures reflect a milestone for the Workgroup—the first time that adult dental and oral health measures have been suggested for addition to the Core Sets. The Workgroup also reconsidered the three deferred ECDS measures and affirmed its support for adding the three measures focused on postpartum depression, prenatal immunization status, and adult immunization status. This step reflects the Workgroup's continued commitment to promoting digital quality measurement as an opportunity to improve data collection and reporting.

During the Annual Review meeting, the Workgroup highlighted the importance of stratification of the Core Sets measures to advance health equity and states described their efforts to use the Core Sets to drive improvements in care delivery and health outcomes for Medicaid and CHIP beneficiaries. The Workgroup also consistently underscored the value of inviting community and member voices to inform the collection and reporting of Core Sets data.

The 2025 Child and Adult Core Sets Annual Review took place against a backdrop of mandatory reporting of the Child Core Set and the behavioral health measures in the Adult Core Set beginning in FFY 2024. In the measures they championed, the Workgroup sought to balance the feasibility of reporting measures with the need to promote and address strategic priorities across Medicaid and CHIP. The Workgroup also advocated for TA to support states as they prepare for mandatory reporting, as well as opportunities to streamline and build capacity for state reporting of the Core Sets.

The draft report was available for public comment from June 30, 2023, through August 4, 2023. Fourteen public comments were submitted. These comments are included in Appendix D. CMCS will review the final report to inform decisions about updates to the 2025 Child and Adult Core Sets. In addition, CMCS will obtain input from federal agencies and from state Medicaid and CHIP quality leaders to ensure that the Core Set measures are evidence-based and promote measure alignment within CMS and across federal agencies.[39] CMCS expects to release the 2025 Child and Adult Core Sets in spring 2024.

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

Appendix A.
Child and Adult Core Sets Measures

Exhibit A.1. 2023 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR[a]
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)	Administrative
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid[a]
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)	Administrative
NA	NCQA	Lead Screening in Children (LSC-CH)**	Administrative or hybrid
Maternal and Perinatal Health			
1382	CDC/NCHS	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
2903/ 2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
NA	CDC/NCHS	Low-Risk Cesarean Delivery (LRCD-CH)	State vital records
Care of Acute and Chronic Conditions			
0058	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)**	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Administrative or EHR[a]

Exhibit A.1 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Administrative
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Administrative[a]
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	Administrative
Dental and Oral Health Services			
2517	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)	Administrative
2528/ 3700/ 3701	DQA (ADA)	Topical Fluoride for Children (TFL-CH)	Administrative
NA	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)	Administrative
Experience of Care			
0006***	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

Note: More information on Updates to the 2023 Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

It is important to note that these measures reflect high quality comprehensive care provided across health care settings. Domains are intended to categorize measure topic areas and are not intended to define the health care setting in which care is provided.

* This measure is no longer endorsed by NQF.

** This measure was added to the 2023 Child Core Set.

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

[a] The Childhood Immunization Status, Immunizations for Adolescents, Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, and Metabolic Monitoring for Children and Adolescents on Antipsychotics measures are also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Child Core Set reporting.

Exhibit A.1 *(continued)*

AHRQ = Agency for Healthcare Research & Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCHS = National Center for Health Statistics; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs.

Exhibit A.2. 2023 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
0034	NCQA	Colorectal Cancer Screening (COL-AD)	Administrative or EHR[a]
0039*	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR[a]
Maternal and Perinatal Health			
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/ 2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0058	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older (AAB-AD)	Administrative
0059/ 0575	NCQA	Hemoglobin A1c Control for Patients With Diabetes (HBD-AD)**	Administrative, hybrid, or EHR
0272*	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275*	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277*	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283*	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768*	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR

Exhibit A.2 *(continued)*

NQF #	Measure Steward	Measure Name	Data Collection Method
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Administrative
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Administrative or EHR
0027*	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)	Administrative or EHR
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Administrative or hybrid
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Administrative
NA***	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	Administrative
Experience of Care			
0006****	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)	Survey
Long-Term Services and Supports			
NA	NCQA	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD)*****	Case management record review
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)	Survey

Exhibit A.2 *(continued)*

Notes: More information on Updates to the 2023 Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

It is important to note that these measures reflect high quality comprehensive care provided across health care settings. Domains are intended to categorize measure topic areas and are not intended to define the health care setting in which care is provided.

* This measure is no longer endorsed by NQF.

** The Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) measure was modified by the measure steward into a combined measure that has two rates: HbA1C Control (<8%) and HbA1C Poor Control (>9%). The combined measure is called Hemoglobin A1c Control for Patients With Diabetes (HBD-AD).

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

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

***** This measure was added to the 2023 Adult Core Set.

[a] The Colorectal Cancer Screening and Breast Cancer Screening measures are also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Adult Core Set reporting.

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance.

Exhibit A.3. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), 2010–2023

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Primary Care Access and Preventive Care																
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)[a]	X	X	X	X	X	X	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
0038	NCQA	Childhood Immunization Status (CIS-CH)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1392	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)[b]	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1407	NCQA	Immunizations for Adolescents (IMA-CH)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1516	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)[c]	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1959*	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV-CH)[d]	--	--	--	X	X	X	X	--	--	--	--	--	--	--
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)[c]	X	X	X	X	X	X	X	X	X	X	X	--	--	--
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP-CH)[e]	X	X	X	X	X	X	X	X	X	X	--	--	--	--
NA	NCQA	Lead Screening in Children (LSC-CH)[f]	--	--	--	--	--	--	--	--	--	--	--	--	--	X

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Maternal and Perinatal Health																
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)[g]	X	X	X	X	X	X	X	X	X	X	--	--	--	--
0471	TJC	PC-02: Cesarean Birth (PC02-CH)[h]	X	X	X	X	X	X	X	X	X	X	X	--	--	--
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)[i]	--	--	--	--	--	--	X	X	X	X	X	X	--	--
1382	CDC/NCHS	Live Births Weighing Less Than 2,500 Grams (LBW-CH)[j]	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1391*	NCQA	Frequency of Ongoing Prenatal Care (FPC-CH)[k]	X	X	X	X	X	X	X	X	--	--	--	--	--	--
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)[l]	--	--	--	--	--	--	--	X	X	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)[m]	--	--	--	--	--	--	--	--	X	X	X	X	X	X
NA	No current measure steward	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA-CH)[n]	--	--	--	X	X	X	X	X	--	--	--	--	--	--
NA	CDC/NCHS	Low-Risk Cesarean Delivery (LRCD-CH)[h]	--	--	--	--	--	--	--	--	--	--	--	X	X	X
Care of Acute and Chronic Conditions																
0002*	NCQA	Appropriate Testing for Children with Pharyngitis (CWP-CH)[o]	X	X	X	X	--	--	--	--	--	--	--	--	--	--
0058	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)[p]	--	--	--	--	--	--	--	--	--	--	--	--	--	X

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
0060*	NCQA	Annual Pediatric Hemoglobin A1C Testing (PA1C-CH)[q]	X	X	X	X	--	--	--	--	--	--	--	--	--	--
0657	AAOH-HNSF	Otitis Media with Effusion – Avoidance of Inappropriate Systemic Antimicrobials in Children: Ages 2 to 12 (OME-CH)[r]	X	X	X	--	--	--	--	--	--	--	--	--	--	--
1381*	Alabama Medicaid	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One of More Asthma-Related Emergency Room Visits (ASMER-CH)[s]	X	X	X	X	--	--	--	--	--	--	--	--	--	--
1799*	NCQA	Medication Management for People with Asthma (MMA-CH)[t]	--	--	--	X	X	X	X	X	--	--	--	--	--	--
1800	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)[t]	--	--	--	--	--	--	--	--	X	X	X	X	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Behavioral Health Care																
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	X	X	X	X	X	X	X	X	X	X	X	X	X	X
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)[u]	--	--	--	--	--	--	--	--	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)[v]	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1365*	PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-CH)[w]	--	--	--	--	--	X	X	X	--	--	--	--	--	--

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
2800	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)[x]	--	--	--	--	--	--	--	--	--	--	X	X	X	X
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)[y]	--	--	--	--	--	--	--	X	X	X	X	X	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)[z]	--	--	--	--	--	--	--	--	--	--	--	--	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)[z]	--	--	--	--	--	--	--	--	--	--	--	--	X	X
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)[x]	--	--	--	--	--	--	X	X	X	X	--	--	--	--
Dental and Oral Health Services																
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)[aa]	--	--	--	--	--	X	X	X	X	X	X	--	--	--
2517	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)[bb]	--	--	--	--	--	--	--	--	--	--	--	--	X	X
2528/ 3700/ 3701	DQA (ADA)	Topical Fluoride for Children (TFL-CH)[bb]	--	--	--	--	--	--	--	--	--	--	--	--	X	X
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)[bb]	X	X	X	X	X	X	X	X	X	X	X	X	--	--
NA	CMS	Percentage of Eligibles That Received Dental Treatment Services (TDENT-CH)[cc]	X	X	X	X	X	--	--	--	--	--	--	--	--	--
NA	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)[dd]	--	--	--	--	--	--	--	--	--	--	--	X	X	X

Exhibit A.3 *(continued)*

NQF #	Measure Steward	Measure Name	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Experience of Care																
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)[ee]	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Notes: More information on Updates to the 2023 Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

It is important to note that these measures reflect high quality comprehensive care provided across health care settings. Domains are intended to categorize measure topic areas and are not intended to define the health care setting in which care is provided.

* This measure is no longer endorsed by NQF.

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

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

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

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

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

[f] The Lead Screening in Children measure was added to the 2023 Child Core Set to improve the understanding of the health disparities experienced by Medicaid and CHIP beneficiaries as children who live in low-income households are at higher risk of lead exposure. It also complements efforts to improve blood lead screening rates for children in Medicaid.

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

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

[i] The Audiological Diagnosis No Later Than 3 Months of Age measure was added to the 2016 Child Core Set due to opportunities for quality improvement on the measure and its alignment with the electronic health record incentive program. The measure was retired from the 2022 Child Core Set due to state-reported challenges in reporting.

Exhibit A.3 *(continued)*

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

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

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

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

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

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

[p] The Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years measure was added to the 2023 Child Core Set to support efforts to promote antibiotic stewardship and create further alignment across the Core Sets.

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

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

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

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

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

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

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

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

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

[z] The Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Ages 13 to 17 and Follow-up After Emergency Department Visit for Mental Illness: Ages 6 to 17 measures were added to the 2022 Child Core Set to address a gap in quality of care for adolescents diagnosed with substance use disorder, allow for comparative analyses across various populations, and allow health systems to identify opportunities for care coordination. These measures are currently being reported as part of the Adult Core Set and the addition of these measures to the Child Core Sets creates further alignment across the Core Sets. For the 2023 Child Core Set, the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence measure was renamed as Follow-Up After Emergency Department Visit for Substance Use.

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

Exhibit A.3 *(continued)*

[bb] The Percentage of Eligibles Who Received Preventive Dental Services measure was retired from the 2022 Child Core Set. In recognition of the importance of oral health to overall health, CMS replaced it with two measures: Oral Evaluation, Dental Services and Topical Fluoride for Children. The Topical Fluoride for Children measure has three rates corresponding to topical fluoride applications provided as (1) dental OR oral health services, (2) dental services, or (3) oral health services.

[cc] The Percentage of Eligibles That Received Dental Treatment Services measure was retired from the 2015 Child Core Set because it is not an effective tool for quality improvement; it is unclear if an increase or a decrease in the rate is desirable, and therefore the results are not actionable.

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

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

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

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

Exhibit A.4. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), 2013–2023

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Primary Care Access and Preventive Care													
0032	NCQA	Cervical Cancer Screening (CCS-AD)	X	X	X	X	X	X	X	X	X	X	X
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	X	X	X	X	X	X	X	X	X	X	X
0034	NCQA	Colorectal Cancer Screening (COL-AD)[a]	--	--	--	--	--	--	--	--	--	X	X
0039*	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	X	X	X	X	X	X	X	X	X	X	X
2372	NCQA	Breast Cancer Screening (BCS-AD)	X	X	X	X	X	X	X	X	X	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-AD)[b]	X	X	X	X	X	X	X	X	--	--	--
Maternal and Perinatal Health													
0469/ 0469e	TJC	PC-01: Elective Delivery (PC01-AD)[c]	X	X	X	X	X	X	X	X	X	--	--
0476*	TJC	PC-03: Antenatal Steroids (PC03-AD)[d]	X	X	X	X	X	X	--	--	--	--	--
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	X	X	X	X	X	X	X	X	X	X	X
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)[e]	--	--	--	--	X	X	X	X	X	X	X
2903/ 2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)[f]	--	--	--	--	--	X	X	X	X	X	X
Care of Acute and Chronic Conditions													
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	X	X	X	X	X	X	X	X	X	X	X
0057*	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)[g]	X	X	X	X	X	X	X	--	--	--	--

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
0058	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older (AAB-AD)[h]	--	--	--	--	--	--	--	--	--	X	X
0059/ 0575	NCQA	Hemoglobin A1c Control for Patients With Diabetes (HBD-AD)[i]	--	--	X	X	X	X	X	X	X	X	X
0063*	NCQA	Comprehensive Diabetes Care: LDL-C Screening (LDL-AD)[j]	X	X	--	--	--	--	--	--	--	--	--
0272*	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	X	X	X	X	X	X	X	X	X	X	X
0275*	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	X	X	X	X	X	X	X	X	X	X	X
0277*	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	X	X	X	X	X	X	X	X	X	X	X
0283*	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	X	X	X	X	X	X	X	X	X	X	X
0403*	NCQA	Annual HIV/AIDS Medical Visit (HMV-AD)[k]	X	--	--	--	--	--	--	--	--	--	--
1768*	NCQA	Plan All-Cause Readmissions (PCR-AD)	X	X	X	X	X	X	X	X	X	X	X
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)[l]	--	--	--	--	--	X	X	X	X	X	X
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)[k]	--	X	X	X	X	X	X	X	X	X	X
2371*	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM-AD)[m]	X	X	X	X	X	X	X	--	--	--	--
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)[n]	--	--	--	X	X	X	X	X	X	X	X
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)[o]	--	--	--	--	--	X	X	X	X	X	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Behavioral Health Care													
0004	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)[p]	X	X	X	X	X	X	X	X	X	X	X
0027*	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	X	X	X	X	X	X	X	X	X	X	X
0105	NCQA	Antidepressant Medication Management (AMM-AD)	X	X	X	X	X	X	X	X	X	X	X
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	X	X	X	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)[q]	X	X	X	X	X	X	X	X	X	X	X
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)[n]	--	--	--	X	X	X	X	X	X	X	X
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[r]	--	--	--	--	X	X	X	X	X	X	X
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)[s]	--	--	--	--	--	--	--	X	X	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)[t]	--	--	--	--	X	X	X	X	X	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)[t]	--	--	--	--	X	X	X	X	X	X	X
NA	NCQA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)[u]	X	X	X	X	X	X	X	X	X	X	X

Exhibit A.4 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Care Coordination													
0648*	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR-AD)[v]	X	X	X	X	--	--	--	--	--	--	--
Experience of Care													
0006	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)[w]	X	X	X	X	X	X	X	X	X	X	X
Long-Term Services and Supports													
NA	NCQA	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD)[x]	--	--	--	--	--	--	--	--	--	--	X
NA	NASDDDS /HSRI	National Core Indicators Survey (NCIDDS-AD)[y]	--	--	--	--	--	--	--	X	X	X	X

Notes: More information on Updates to the 2023 Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

It is important to note that these measures reflect high quality comprehensive care provided across health care settings. Domains are intended to categorize measure topic areas and are not intended to define the health care setting in which care is provided.

* This measure is no longer endorsed by NQF.

[a] The Colorectal Cancer Screening measure was added to the 2022 Adult Core Set to assess appropriate receipt of colorectal cancer screenings.

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

[c] The PC-01: Elective Delivery measure was retired from the 2022 Adult Core Set due to state-reported challenges in reporting.

[d] The PC-03: Antenatal Steroids measure was retired from the 2019 Adult Core Set due to the low number of states reporting this measure and the challenges states have reported in collecting it.

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

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

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

[h] The Avoidance of Antibiotic Treatment With Acute Bronchitis/Bronchiolitis measure was added to the 2022 Adult Core Set to assess inappropriate use of antibiotics.

Exhibit A.4 *(continued)*

[i] For the 2023 Adult Core Set, the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) measure was modified by the measure steward into a combined measure that has two rates: HbA1C Control (<8%) and HbA1C Poor Control (>9%). The combined measure is called Hemoglobin A1c Control for Patients With Diabetes (HBD-AD).

[j] The Comprehensive Diabetes Care: LDL-C Screening measure was replaced by the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure beginning with the 2015 Adult Core Set. The Comprehensive Diabetes Care: LDL-C Screening measure was retired from the Adult Core Set because clinical guidelines underpinning this measure were in flux and because NCQA removed it from HEDIS 2015. The Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) measure addresses the prevalent condition of diabetes and facilitates state efforts to drive quality improvement on the risk factor of poor HbA1c control.

[k] The Annual HIV Medical Visit measure was replaced by the HIV Viral Load Suppression measure beginning with the 2014 Adult Core Set. The Annual HIV Medical Visit measure lost NQF endorsement after the 2013 Adult Core Set was published. The HIV Viral Load Suppression measure is a regularly collected clinical indicator that is predictive of overall outcomes.

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

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

[n] Two measures focused on quality of care for adults with substance use disorders and/or mental health disorders were added to the 2016 Adult Core Set: (1) Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications focuses on the identification of cardiovascular disease, a leading cause of morbidity and mortality in this population; and (2) Use of Use of Opioids at High Dosage in Persons Without Cancer is a measure of potential overuse that addresses the epidemic of narcotic morbidity and mortality.

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

[p] For the 2023 Adult Core Set, the Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) measure was renamed as Initiation and Engagement of Substance Use Disorder Treatment (IET-AD).

[q] The age group for the Follow-Up After Hospitalization for Mental Illness measure changed from age 21 and older to age 18 and older for the 2019 Adult Core Set.

[r] The Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure was added to the 2017 Adult Core Set because it addresses chronic disease management for people with serious mental illness and assesses integration of medical and behavioral services by reinforcing shared accountability and linkage of medical and behavioral healthcare services.

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

[t] The Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence (FUA/FUM-AD) measure was added to the 2017 Adult Core Set because it addresses priority areas of access and follow-up of care for adults with mental health or substance use disorders. In the 2017 and 2018 Adult Core Sets, this was included as a single measure (FUA/FUM-AD). For the 2019 Adult Core Set, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) and Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) are included as two separate measures. For the 2020 Adult Core Set, these two measures have separate NQF numbers (previously they were both endorsed under 2605). For the 2023 Adult Core Set, the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence measure was renamed as Follow-Up After Emergency Department Visit for Substance Use.

[u] The Adult Core Set includes the NCQA version of the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure, which is adapted from the CMS measure (NQF #1879).

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

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

[x] The Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD) measure was added to the 2023 Adult Core Set to fill a critical gap area in measuring the quality of care in long-term services and supports. It also promotes alignment with the Home and Community Based Services measure set.

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

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

Exhibit A.4 *(continued)*

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

Appendix B.
Measures Suggested for Review at the 2025 Child and Adult Core Sets Annual Review, by Domain

Exhibit B.1. Measures Suggested for Review at the 2025 Child and Adult Core Sets Annual Review, by Domain

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Primary Care Access and Preventive Care				
Removal Note: This measure will not be discussed because it is being retired by the measure steward for FFY 2024 and will be retired from the 2024 Adult Core Set.	Flu Vaccinations for Adults Ages 18-64 (FVA-AD)	NCQA	0039[a]	Survey
Addition Note: This measure will not be discussed because the measure was recommended by the Workgroup previously and CMCS deferred a decision.	Adult Immunization Status	NCQA	3620	ECDS[b]
Maternal and Perinatal Health				
Addition	Oral Evaluation During Pregnancy	DQA (ADA)	Not endorsed	Administrative
Care of Acute and Chronic Conditions				
Removal	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	PQA	2940	Administrative
Removal	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	PQA	3389	Administrative
Addition	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS	Not endorsed	EHR or clinical registry
Behavioral Health Care				
Removal	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) and Age 18 and Older (CDF-AD)	CMS	0418/0418e[a]	Administrative or EHR
Addition Note: This measure will not be discussed because it does not meet minimum technical feasibility criteria.	Tobacco Use and Help with Quitting Among Adolescents	NCQA	2803[a]	EHR or clinical registry
Dental and Oral Health Services				
Removal	Topical Fluoride for Children (TFL-CH)	DQA (ADA)	2528/3700/ 3701	Administrative
Addition	Topical Fluoride for Children	NCQA	Not endorsed	Administrative

Exhibit B.1 *(continued)*

Suggested for Removal or Addition	Domain and Measure Name	Measure Steward	NQF #	Data Collection Method
Addition	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	DQA (ADA)	Not endorsed	Administrative
Experience of Care				
Removal	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) and Adult Version (CPA-AD)	AHRQ[c]	0006	Survey

Note: Data collection methods are current as of March 2023. The methods may change as measures undergo specification updates and maintenance.

[a] Measure is no longer endorsed by the National Quality Forum (NQF).

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

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

AHRQ = Agency for Healthcare Research and Quality; ADA = American Dental Association; CMCS = Center for Medicaid and CHIP Services; CMS = Centers for Medicare & Medicaid Services; DQA = Dental Quality Alliance; ECDS = Electronic Clinical Data System; EHR = Electronic Health Record; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PQA = Pharmacy Quality Alliance.

Appendix C.
Summary of 2025 Child and Adult Core Sets Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

This appendix summarizes the discussion of measures considered by the Workgroup and not recommended for removal from or addition to the 2025 Child and Adult Core Sets. The discussion took place during the Workgroup meeting from April 25 to April 27, 2023. The summary is organized by domain. Exhibit C.1 at the end of this appendix includes the measure name, measure steward, National Quality Forum (NQF) number (if endorsed), measure description, data collection method, and key points of discussion about the measures discussed and not recommended for removal or addition.

Dental and Oral Health Services

Workgroup members discussed two "paired" dental and oral health measures. The Dental Quality Alliance (DQA) *Topical Fluoride for Children* (TFL-CH) measure was suggested for removal from the Child Core Set, and the National Committee for Quality Assurance (NCQA) version of the *Topical Fluoride for Children* measure was suggested to replace the DQA version.

The DQA *Topical Fluoride for Children* (TFL-CH) measure assesses the percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as (1) dental or oral health services, (2) dental services, and (3) oral health services during the measurement year. This measure was added to the 2022 Child Core Set, and reporting is still underway. The NCQA *Topical Fluoride for Children* measure assesses the percentage of members 1 to 4 years of age who received at least two fluoride varnish applications during the measurement year. It is a first-year Healthcare Effectiveness Data and Information Set (HEDIS®) measure for measurement year (MY) 2023 and an adaptation of the DQA measure.

The Workgroup member who suggested replacing TFL-CH with the NCQA measure noted that the NCQA measure focuses on a younger population of children who would benefit most from topical fluoride treatments, and it would also be easier to implement with providers and achieve meaningful impact. They also said their state has a contingent that is outspoken against fluoride varnish, and focusing on a more targeted population would allow the state to develop partnerships with health plans and better leverage resources to drive outcomes for younger children.

The Workgroup discussed these measures together and conveyed strong support for retaining TFL-CH as a reflection of evidence-based prevention. Two Workgroup members pointed to the evidence, noting the current measure recognizes that topical fluorides must be applied with frequency over multiple years to be maximally effective. Another Workgroup member added that children have a continued risk for dental caries, especially in Medicaid, and commented that replacing the current measure could send a misleading message that topical fluoride varnish is no longer recommended for children over age four.

Workgroup members also discussed the administrative impacts of replacing the TFL-CH measure in the Child Core Set. One Workgroup member noted that the current measure covers the entire range of the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) population, which allows for stratifications consistent with Form CMS-416 (the annual EPSDT

report). The Workgroup member added that TFL-CH can easily be calculated administratively using Transformed Medicaid Statistical Information (T-MSIS) data.

Another Workgroup member expressed concern about the state effort needed to report quality measures and the administrative costs that can accompany programming even administrative measures. They stated it would have been helpful if reporting on TFL-CH had been completed to understand how well states have been able to report the measure. They expressed that, given the similarities between the current measure and its suggested replacement, doing so would not justify the state resources needed to support reporting on a different topical fluoride measure unless there was strong evidence that the DQA TFL-CH measure was not reportable or if a change occurred in the clinical guidance around fluoride treatment. In response to the Workgroup's discussion about the feasibility of calculating the TFL-CH measure, Mathematica indicated that there is evidence the current measure is feasible based on state reporting experience during the current reporting cycle. Mathematica also noted that they have been exploring the use of data from the T-MSIS Analytic Files (TAF) to calculate the TFL-CH measure on behalf of states.

Another Workgroup member conveyed their state's intention to continue using the DQA measure, which is being implemented in their accountable care organizations (ACO) program. The Workgroup member discussed support for the current measure because of the importance of preventive care for children up to age 20 in addressing both disparities and the prevalence of caries and other dental issues for older as well as younger children.

During the public comment period, representatives from the American Academy of Pediatric Dentistry (AAPD) and the National Network for Oral Health Access (NNOHA), and the North Carolina Medicaid dental officer shared comments to support retaining the existing TFL-CH measure and urged against replacing it with the NCQA measure. The commenters echoed the Workgroup discussion about the feasibility, reliability, and validity of the existing TFL-CH measure. They shared that the broader age range of the DQA TFL-CH measure aligns with best practices for fluoride application throughout childhood, not just early childhood. The commenters from AAPD and NNOHA noted that the DQA TFL-CH measure includes all forms of topical fluoride, whereas the NCQA measure would be limited to just one form. The North Carolina dental officer further shared that the NCQA measure does not differentiate between provider types and appears to combine children receiving fluoride varnish from any provider type into one numerator. The dental officer noted that differentiating the provider type, as in the DQA TFL-CH measure, supports strategic planning for improvements in service delivery in North Carolina.

Behavioral Health Care

The Workgroup discussed but did not recommend removal of the Screening for Depression and Follow-Up Plan measures from the 2025 Child and Adult Core Sets. *Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)* and *Age 18 and Older (CDF-AD)* measure the

percentage of beneficiaries age 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression tool, and if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter. The measures use administrative or electronic health record (EHR) data collection methodology.

The Workgroup member who suggested these measures for removal from the Child and Adult Core Sets noted significant challenges in data collection, and that the results may not be reliable. The Workgroup member indicated that the use of administrative rates can lead to a state's performance being inaccurately represented, and that the availability of EHR data varies from state to state. The Workgroup member who proposed these measures for removal did not suggest any alternatives.

Workgroup members expressed mixed opinions on retaining CDF-CH and CDF-AD in the Core Sets, reflecting the tension between the feasibility and strategic priority of the measures. A few Workgroup members voiced serious concern about removing both measures without a replacement measure, pointing to a rise in the rates of suicide, depression, and other mental health issues, especially among adolescents. Another Workgroup member expressed support for retaining the measures, as well as interest in hearing more about data collection challenges.

Several Workgroup members discussed the challenges of reporting the measures. One Workgroup member indicated that administrative rates do not provide meaningful information due to gross underreporting of depression screenings. As a result, they emphasized the need for access to good EHR data. A few Workgroup members mentioned that the Healthcare Common Procedure Coding System (HCPCS) codes required for this measure are not commonly used and not billable, so providers would likely benefit from technical assistance and financial incentives to use these codes more consistently. A Workgroup member added that primary care providers have difficulty reporting the follow-up portion of the measures. Despite these noted feasibility concerns, Workgroup members overwhelmingly voted in support of retaining the measures in the Core Sets.

During the public comment period, two representatives from the National Association of Community Health Centers (NACHC) agreed that the benefits of the measures outweighed the feasibility concerns. Both public commenters shared challenges regarding difficulties in reporting and workflow but stated that the measures should not be removed from the Core Sets. One of the commenters said that removing these measures without replacements would be inappropriate and harmful to the mental health of the nation.[40]

[40] Public comments submitted on the *Screening for Depression and Follow-Up Plan* measures can be found in Appendix D.

Care of Acute and Chronic Conditions

The Workgroup discussed but did not recommend removing two measures and adding one measure related to the Care of Acute and Chronic Conditions domain.

The Workgroup considered removal of two opioid-related measures from this domain: *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD), which assesses the percentage of beneficiaries age 18 years and older who receive prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MMEs), over a period of 90 days or more; and *Concurrent Use of Opioids and Benzodiazepines* (COB-AD), which measures the percentage of beneficiaries age 18 years and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded from both measures.

Three Workgroup members suggested removal of the OHD-AD measure from the Adult Core Set. One Workgroup member indicated that states struggle with how to interpret the results of this measure and often question at what level the measure is actionable. Another Workgroup member noted that policy and practice changes following the 2016 Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain have reduced opioid prescriptions. The Workgroup member stated that the opioid epidemic is no longer driven by prescription opioids, but by heroin, illicitly manufactured fentanyl, and other drugs, and suggested that some actions providers may take to improve performance on OHD-AD may put patients at significant risk of harm or death. The third Workgroup member suggested this measure for removal from the Adult Core Set to support implementation of CDC's 2022 Clinical Practice Guideline for Prescribing Opioids for Pain and allow for maximum flexibility and care for the treatment of patients living with pain. The Workgroup member who suggested COB-AD for removal was concerned that the actions providers take to try to improve performance on the measure may put patients at risk, such as discontinuing or tapering medications, refusing to accept new patients on this combination of medications, or dismissing patients from their practice, all of which can lead to adverse patient outcomes.

The Workgroup largely discussed OHD-AD and COB-AD together, with several Workgroup members stressing the strategic priority of the measures and the continued need for measurement related to the ongoing opioid epidemic. One Workgroup member described COB-AD as an important measure that differentiates between high- and low-quality prescription care, stressing that this measure is a very well-recognized marker of quality and is important from a treatment standpoint. Also reflecting on COB-AD, another Workgroup member noted that, given the potential for overdose and death due to concurrent prescribing, there is still much more progress to be made in this area.

Workgroup members discussed the feasibility of OHD-AD, given that the measure steward, Pharmacy Quality Alliance (PQA), is considering retiring the measure for 2025 following CDC's decision to discontinue updates to the Opioid National Drug Code and Oral MME Conversion

File, which is necessary to calculate the measure. Workgroup members also questioned CDC's decision to discontinue production of the file, highlighting state data showing the ongoing impact of the opioid epidemic on hospitalization and deaths, and noting that substance use disorders are one of the top causes of maternal morbidity and mortality within a year postpartum. Another Workgroup member suggested that removal of the measure would be premature without more information from CDC.

Workgroup discussion also focused on some comments made about the unintended consequences of the OHD-AD and COB-AD measures. One Workgroup member expressed concern that patients whose medications were blocked or restricted might seek to obtain them on the street or experience withdrawal symptoms. The Workgroup member also questioned the actionability of the data for Medicaid, stating that it is difficult to obtain the historical data showing whether a patient is being managed by a physician. A Workgroup member acknowledged that certain prescribers may respond to the measure in a way that maintains their performance on COB-AD but said they did not believe Medicaid beneficiaries typically were going to practices that would cherry-pick patients in this way. They added that they were more concerned about the risk of patients dying from being prescribed these medications concurrently without management. In response to a question from a Workgroup member about the availability of data to support anecdotal concerns about patient abandonment or avoidance related to COB-AD, a PQA representative said they have not seen comments along those lines.

One Workgroup member questioned whether the Core Set is the right place to monitor these measures and mentioned the potential redundancy of efforts, noting that drug utilization review (DUR) programs are already doing a lot of work in this space; also, Medicaid programs are required to use DUR programs to help monitor prescribing patterns. The Workgroup member also emphasized that reporting does not equal improvement, suggesting that there are no consistent trends in the data for the OHD-AD measure.

Another Workgroup member noted that their DUR board has discussed ensuring that safeguards are in place so patients are not abandoned if providers decide to discontinue or taper medications. They believe there are clear interventions that could be implemented to help reduce both high dosage and concomitant use, such as utilization review, prior authorization, and prescription drug monitoring programs.

In response, a PQA representative suggested that DUR and Core Set reporting are complementary and not duplicative. DUR emphasizes state monitoring, whereas the Core Set focuses on highlighting variability and making comparisons across states.

A few Workgroup members emphasized the concurrent prescribing of opioids and benzodiazepines among the older adult population as support for retaining the COB-AD measure. In response, one Workgroup member noted that because many older adults are dually eligible for Medicare and Medicaid, and because Medicaid does not have as much information

about patients receiving their primary care through Medicare, COB-AD could perhaps be a better measure for Medicare than Medicaid.

During the public comment period, a representative from Kaiser Permanente supported retention of COB-AD and OHD-AD in the Adult Core Set, noting that the opioid epidemic continues to be a problem in many states, and there is evidence to support continued focus on both concurrent use and high dosage.

Following the Workgroup vote on the measures, the federal liaison from CDC commented that the measures no longer align with CDC guidance. Mathematica noted that the Center for Medicaid and CHIP Services (CMCS) has a process in which they coordinate with federal liaisons and other interested parties about the Core Sets, so there may be additional engagement in the future about these measures.

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease was suggested but not recommended for addition to the Core Sets; it measures the percentage of patients at high risk of cardiovascular events who were prescribed or were on statin therapy during the measurement period. The measure looks at three populations: (1) all patients with an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or ever had an ASCVD procedure; (2) patients age 20 years and older who have ever had a low-density lipoprotein cholesterol level at or above 190 mg/dL, or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; or (3) patients aged 40 to 75 years with a diagnosis of diabetes. A Workgroup member suggested this measure for addition because heart disease and stroke are the first and fifth leading causes of death in the United States, respectively, and that for people at high risk of having an ASCVD event, taking a high- or moderate-intensity statin is a highly effective cardiovascular risk reduction strategy. Furthermore, they noted that several quality reporting initiatives, including the Merit-based Incentive Payment System (MIPS) and the Million Hearts Initiative, use the measure.

Several Workgroup members from state Medicaid agencies raised concerns about the feasibility of the statin therapy measure due to its data collection methodology. One Workgroup member described it as a "very difficult measure," stating that state Medicaid agencies do not have the infrastructure necessary to collect and report the measure now because they do not have access to the necessary EHR data. Another Workgroup member said that, although they agreed with the intent of the measure, they did not believe their state would be able to report on it by 2025. They added they could possibly consider the measure for 2026, in alignment with timelines for interoperability compliance. Another Workgroup member remarked that the measure is burdensome to collect and would require a significant resource lift. They expressed concern about the measure in the context of uncertainty about mandatory Core Set reporting, noting that if the measure is required, it might necessitate shifting resources away from other programmatic priorities, such as oversight or integrity. The Workgroup member also questioned the readiness of the measure for use nationally, asking whether state Medicaid programs other than Texas currently were using the measure.

The Workgroup also questioned adding the CMS *Statin Therapy for the Prevention and Treatment of Cardiovascular Disease* measure to the Core Sets, as opposed to a similar measure from NCQA that could be easier for states to collect. One Workgroup member from a state Medicaid program said their state currently is using the NCQA measure, which includes a statin adherence portion, suggesting it is easier to collect because it relies on claims. Another Workgroup member said they would not be in favor of adding the CMS statin therapy measure to the Core Sets because there are other measures that are less resource intensive to collect and can better drive improvements in care for Medicaid beneficiaries. In response, the federal liaison from CDC noted they suggested this measure for addition instead of the NCQA measure because it aligns with other quality reporting programs, such as the Million Hearts Initiative and the Health Resources and Services Administration (HRSA) Uniform Data System. They also noted that, together with the *Controlling High Blood Pressure* (CBP-AD) and *Medical Assistance with Smoking and Tobacco Use Cessation* (MSC-AD) measures already in the Adult Core Set, improving performance on this suite of measures would represent effective comprehensive cardiovascular disease prevention.

Workgroup members also reflected on the actionability and technical design of the measure. For example, one Workgroup member commented on the number of measure exclusions, which they believed made the measure difficult for providers to monitor. Another Workgroup member remarked that it is difficult to base quality on whether a patient received a particular medication. Another Workgroup member asked whether, in development of this measure, there was consideration of pairing it with other measures that examine aspects of care that should occur before a statin is prescribed, such as lifestyle changes, exercise, and diet.

A representative of the measure steward responded to questions and comments from Workgroup members. They indicated that the measure follows American College of Cardiology and American Heart Association guidelines for blood cholesterol management. They also noted that it allows for an exception for medical professionals not to order statins if they do not believe they are needed.

During the public comment period, a representative from NACHC provided support for adding the measure to the Core Sets, noting the significant disparities among the high-risk populations assessed through the measure, and that it could have an impact on reducing disparities. They noted they are currently using this measure in their health centers as part of the Million Hearts Initiative.

Experience of Care

The Workgroup discussed but did not recommend removal of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures from the Experience of Care domain. The *CAHPS Health Plan Survey 5.1H*, *Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items* (CPC-CH) provides information on parents' experiences with their child's health care. Results summarize children's experiences through ratings,

composites, and individual question summary rates. The Children with Chronic Conditions (CCC) items provide information on parents' experience with their child's health care for children with chronic conditions. The *CAHPS Health Plan Survey 5.1H*, *Adult Version (Medicaid)* (CPA-AD) provides information on the experiences of adult beneficiaries with their health care and gives a general indication of how well the health care meets the beneficiaries' expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates. The measures are calculated based on data collected through the CAHPS Health Plan Survey. The Agency for Healthcare Research and Quality (AHRQ) is the measure steward for the survey instrument in the Child and Adult Core Sets, and NCQA is the developer of the survey administration protocol.

The Workgroup member who suggested the measures for removal indicated concerns about the reliability and validity of the survey instrument, and whether it is appropriate for comparative analyses by demographics. They expressed uncertainty about the reliability of self-reported data for assessing state progress compared to claims data. They also questioned the financial viability of the CAHPS surveys, given the time, expense, staff expertise, and contractors they require. Another Workgroup member suggested retaining the CAHPS surveys in the Core Sets but changing their frequency, citing the increasing difficulty of gathering sufficient responses for statistically valid results. They indicated that it is increasingly challenging to use the results to drive improvement due to low response rates.

During the discussion, several Workgroup members identified beneficiary experience of care as a priority for the Core Sets. Workgroup members noted the benefits of the data obtained through the CAHPS survey because self-reported perspectives on beneficiary experience are not reflected in other data sources, such as claims; in addition, the survey asks questions for which individuals and families are the best sources of information. Another Workgroup member mentioned that these measures are useful for discovering opportunities for improvement that might not be identifiable through other means. Speaking from the consumer perspective, a Workgroup member said that consumers would like to see more measures in the Experience of Care domain and that the CAHPS measures are currently the only ones in the Core Sets that assess consumer experience.

Although some Workgroup members voiced support for removing the measures and focusing on alternative methods for obtaining similar information, others expressed concern over losing measures that represent the consumer voice without a replacement measure. One Workgroup member mentioned that consumer voice is vital to existing quality improvement efforts; another stated that beneficiary experience has significant implications around equity of access and outcomes. Several Workgroup members from state Medicaid agencies described how the CAHPS results add value to their quality improvement efforts. They noted the importance of making CAHPS data publicly available through online quality dashboards and consumer report cards to help support consumer choice, aid the state procurement process, inform corrective action with health plans, and guide improvement efforts.

In voicing support for retaining both measures, a Workgroup member emphasized the importance of stratification in understanding differences in experiences between subgroups, such as individuals with disabilities. In response to a Workgroup member question about whether the CAHPS survey assesses respectful care and implicit bias, particularly in maternity care settings, Mathematica confirmed that the survey contains questions around how well doctors communicate. A representative from AHRQ also noted they are in the process of developing a maternity-focused CAHPS survey and invited Workgroup members to provide feedback to a recent request for information.

Throughout the discussion, Workgroup members acknowledged the existing challenges associated with the CAHPS measures, including low response rates, survey fatigue, latency between a visit and survey receipt, lack of respondent engagement and follow-up, and the validity of results. A member of the CAHPS survey team confirmed there is ample evidence that the measures are both reliable and valid.

Regardless of their perspectives on whether to remove or retain the CAHPS measures, a common suggestion from Workgroup members was to consider alternative methods and modalities for gaining meaningful insight about beneficiary experience. A few Workgroup members asked whether there were other means of gathering the data more efficiently and in real time—for example, electronically or through social media. Some Workgroup members suggested retaining the CAHPS measures but decreasing and staggering the frequency of survey administration, providing examples of states applying this approach to address low response rates. Mathematica reminded the Workgroup that the frequency with which surveys are collected will be determined by CMCS if the measures are retained in the Core Sets, and that the Workgroup will vote on whether to recommend removal of the measures. Another Workgroup member encouraged more inclusive hiring of those responsible for survey administration, arguing that having individuals representative of the community is a contributing factor to the quality of information collected. One Workgroup member also recommended greater transparency around the CAHPS reports.

During the public comment period, a CAHPS survey expert from Boston Children's Hospital expressed strong support for retaining both measures in the Core Sets, emphasizing the importance of measuring consumer experience among vulnerable pediatric populations.[41]

[41] Public comments submitted on the CAHPS measures can be found in Appendix D.

Exhibit C.1. Measures Discussed by the 2025 Child and Adult Core Sets Annual Review Workgroup and Not Recommended for Removal or Addition, by Domain

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Dental and Oral Health Services			
Measure Discussed and Not Recommended for Removal from the 2025 Child Core Set			
Topical Fluoride for Children (TFL-CH) Measure steward: Dental Quality Alliance/ American Dental Association (DQA/ADA)	2528 // 3700 // 3701	This measure assesses the percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as (1) dental or oral health services, (2) dental services, and (3) oral health services during the measurement year. Data collection method: Administrative	• Suggested for removal and replacement by the NCQA *Topical Fluoride for Children* measure • Support for retaining the measure, given that it reflects evidence-based prevention for children up to age 20, has utility for state quality improvement initiatives and addressing disparities, and allows for stratifications consistent with Form CMS-416; concern that removing the measure would decrease focus on oral health preventative care for children over age 4 • Differentiating by provider type can point to needed delivery system improvements • Switching to another measure would increase administrative costs to states for programming changes • Potential use of alternate data sources to calculate this measure with TAF data
Measure Discussed and Not Recommended for Addition to the 2025 Core Sets			
Topical Fluoride for Children Measure steward: NCQA	Not endorsed	This measure assesses the percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year. This is a first-year HEDIS measure for MY 2023 and is an adaptation of the DQA TFL-CH measure. Data collection method: Administrative	• Suggested to replace TFL-CH because the measure is focused on the youngest children who would benefit most from topical fluoride treatments and would be easier to implement with providers; states could also leverage limited resources and build a solid foundation for the younger population • Concern that use of this measure will decrease focus on preventative oral health care for children over age 4 • Concern about administrative burden and resources required to switch to a new measure

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Behavioral Health Care			
Measures Discussed and Not Recommended for Removal from the 2025 Child and Adult Core Sets			
Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH) and Age 18 and Older (CDF-AD) Measure steward: CMS	0418/0418e (no longer endorsed)	Percentage of beneficiaries age 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter. Data collection method: Administrative or EHR	• Suggested for removal because of significant challenges in data collection, including access to EHR data and underreporting of depression screenings in claims • Concerns about public reporting of the measure, given the poor quality of the data in some states • Hesitation to remove the measure, given the rise in the rates of suicide, depression, and other mental health issues in the United States, especially among adolescents • Concern about removing the measure without a replacement
Care of Acute and Chronic Conditions			
Measures Discussed and Not Recommended for Removal from the 2025 Adult Core Set			
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) Measure steward: PQA	2940	The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 MMEs over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. Data collection method: Administrative	• Suggested for removal because the measure may not be driving improvement in quality of care and outcomes, and is no longer aligned with CDC guidance around opioid prescribing • Discussion about the feasibility of the measure in light of CDC's decision to discontinue updates to the MME Conversion File needed to report the measure • Hesitation to remove the measure because of the need for measurement related to the ongoing opioid epidemic • Discussion about whether Core Set reporting is duplicative or complementary with other state monitoring efforts, such as DUR programs

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Concurrent Use of Opioids and Benzodiazepines (COB-AD) Measure steward: PQA	3389	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. Data collection method: Administrative	• Suggested for removal because of concerns around the actions providers may take to improve performance on the measure that may put patients at risk, such as discontinuing or tapering medications and hesitation to serve chronic opioid users • Hesitation to remove the measure because of the need for measurement related to the ongoing opioid epidemic • Discussion about whether Core Set reporting is duplicative or complementary with other state monitoring efforts, such as DUR programs • Comment that although there may be some instances of physicians unnecessarily tapering patients' medications to improve performance on the measure, there is greater concern about patient harms from concurrent prescribing
Measure Discussed and Not Recommended for Addition to the 2025 Core Sets			
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease Measure Steward: CMS	Not endorsed	Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period: 1. **Population 1**: All patients with an active diagnosis of clinical ASCVD, or ever had an ASCVD procedure; OR 2. **Population 2**: Patients age 20 years and older who have ever had a low-density lipoprotein cholesterol (LDL-C) level at or above 190 mg/dL, or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR 3. **Population 3**: Patients aged 40 to 75 years with a diagnosis of diabetes Data collection method: EHR or clinical registry	• Suggested for addition because statins are an effective and accessible strategy for reducing cardiovascular disease risk and this measure is already used in several federal quality reporting initiatives • Concerns about the feasibility of the measure and the resources required to report it, given the data sources are not currently available for most state Medicaid programs and lack of evidence of testing or use in Medicaid (beyond a single state program) • Concerns about the actionability of the measure, due to the large denominator size and the large number of measure exclusions

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Experience of Care			
Measures Discussed and Not Recommended for Removal from the 2025 Child and Adult Core Sets			
CAHPS Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) and Adult Version (Medicaid) (CPA-AD) Measure steward: AHRQ[a]	0006	CPC-CH: This measure provides information on parents' experiences with their child's health care. Results summarize children's experiences through ratings, composites, and individual question summary rates. The CCC items provide information on parents' experience with their child's health care for CCC. CPA-AD: This measure provides information on the experiences of adult beneficiaries with their health care and gives a general indication of how well the health care meets the beneficiaries' expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates Data collection method: Survey	• Suggested for removal because of concerns about the reliability and validity of CAHPS for comparative analyses; reliability of self-reported data compared to claims data; and the financial and staffing resources required to administer the CAHPS survey • Support for retaining the measure because of the importance of consumer and family voices in answering questions for which they are the best sources of information • Suggestion for continued consideration of alternative methods and modalities to gain meaningful insight into member experience and address survey fatigue and low response rates

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

Appendix D.
Public Comments on the Draft Report

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

The draft report was available for public review and comment from June 30, 2023 through August 4, 2023 at 8 p.m. Eastern Time, and comments were submitted to Mathematica via email. Mathematica received a total of 14 public comments. Commenters included state agencies, professional associations, academic institutions, research firms, health plans, other organizations, and individuals. Mathematica appreciates the time and effort taken by commenters to prepare and submit their comments on the draft report.

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

In summary, the majority of public comments were related to the two dental and oral health measures the Workgroup recommended for addition, as well as the three ECDS measures CMCS requested that the Workgroup reconsider. In addition, comments were received on two measures considered by the Workgroup but not recommended for removal from the 2025 Child and Adult Core Sets. Comments also addressed other topics discussed by the Workgroup, including health equity, stratification, and gap areas.

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

Topic	Commenter
General Comments	• Arizona Health Care Cost Containment System • Ashley C. Grill, MPH, RDH
ECDS Measures	• Arizona Health Care Cost Containment System • Association for Community Affiliated Health Plans • MassHealth • The Policy Center for Maternal Mental Health • University of Louisiana, Monroe • Virginia Department of Medical Assistance Services
Health Equity and Stratification	• Dental Quality Alliance • GEHA Connection Dental Federal® • Upstream USA
Gap Areas	• Ashley C. Grill, MPH, RDH • The Policy Center for Maternal Mental Health • Upstream USA

Exhibit D.1 *(continued)*

Topic	Commenter
Measures Recommended for Addition to the 2025 Core Sets	
Oral Evaluation During Pregnancy	• Academy of General Dentistry • Association for Community Affiliated Health Plans • Dental Quality Alliance • GEHA Connection Dental Federal® • MassHealth • North Carolina Department of Health and Human Services • Pennsylvania Department of Human Services • Virginia Department of Medical Assistance Services • Virginia Health Catalyst
Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults	• Academy of General Dentistry • Association for Community Affiliated Health Plans • Dental Quality Alliance • MassHealth • North Carolina Department of Health and Human Services • Pennsylvania Department of Human Services • Virginia Department of Medical Assistance Services • Virginia Health Catalyst
Measures Discussed and Not Recommended for Removal from the 2025 Child and Adult Core Sets	
CAHPS Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) and Adult Version (Medicaid) (CPA-AD)	• Association for Community Affiliated Health Plans
Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH) and Age 18 and Older (CDF-AD)	• The Policy Center for Maternal Mental Health

Academy of General Dentistry (Hans P. Guter)

The Academy of General Dentistry (AGD) is responding to the invitation to:

- Review the draft report *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Workgroup Review of the 2025 Child and Adult Core Sets* and
- Consider recommending the inclusion of the following two new DQA oral health measures in the 2025 Child and Adult Core Sets:
    - Oral Evaluation During Pregnancy
    - Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults

This request has been evaluated by AGD's Dental Practice Council, which maintains a liaison to the Dental Quality Alliance (DQA).

Based on the Council's input, the Academy of General Dentistry supports the recommendation that the two oral health measures referenced above be included in the 2025 Child and Adult Core Sets. Outlined below are a few of the key points supporting our position.

- Oral Evaluation During Pregnancy

  Recognition of the:
    - Relationship between overall health during pregnancy and oral health;
    - Increased risk of gingival inflammation and caries during pregnancy; and
    - Increased risk of adverse pregnancy outcomes – such as preterm birth, low birthweight, and preeclampsia – associated with periodontal disease during pregnancy.
- Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults

  Recognition that dental pain is a top diagnosis for opioid prescribing in emergency departments and that the ambulatory-care approach:
    - Has the potential to help bridge the medical-dental gap and
    - Take care of untreated disease that cannot be definitively addressed in emergency departments.

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

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

Arizona Health Care Cost Containment System (Ruben Soliz)

Thank you for the opportunity to review the *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP: Summary of a Workgroup Review of the 2025 Child and Adult Core Sets* draft report. On behalf of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's State Medicaid agency, I would like to share the following comments.

Arizona supports the inclusion of measures in the Core Sets that aim to improve health outcomes and the quality of care delivery for Medicaid and CHIP beneficiaries. In addition to the feedback which Arizona provided during the workgroup review process, the State would like to offer the following feedback:

- For any measure changes considered within the Core Sets, particularly with measures considered for addition to the Core Sets, Arizona recommends:
    - Considering measures that measure performance for **existing** benefits and covered services and measures that allow for comparability across states.
    - Weighting technical feasibility requirements more heavily as a criterion for measure assessment, especially within the context of mandatory reporting requirements. While Arizona appreciates the inclusion of innovation as a factor in considering measures for addition to the Core Sets, the technical feasibility criterion is of particular importance to states who are ultimately responsible for calculating and reporting the measures.
    - Allowing states to report newly added measures or measures using the Electronic Clinical Data System (ECDS) calculation methodology on a voluntary basis while feasibility issues are addressed.

Thank you for providing the State with the opportunity to share this feedback. Please feel free to contact me directly with any questions related to this public comment.

Association for Community Affiliated Plans (Margaret A. Murray)

The Association for Community Affiliated Plans (ACAP) is grateful for the opportunity to submit comments on the proposed recommendations for changes to the 2025 Child and Adult Core Sets. ACAP is a national association of 80 not-for profit health plans. Collectively, ACAP health plans provide coverage to over 25 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicaid and CHIP as well as other publicly supported programs. Below are our responses to specific measure recommendations.

Proposed Measures for Addition

Oral Evaluation During Pregnancy

ACAP plans had varied opinions about the recommendation to add this measure to the Core Measure Set. While agreeing that dental health is crucial during pregnancy, some plans were fully supportive of the addition and others voiced some concerns including:

- In many states, dental benefits are carved out and the accuracy of the rate is dependent on data from the State—plans would not have a complete data set to report the measure accurately;
- Plan beneficiaries may have concerns about receiving certain dental services (e.g., x-rays) during pregnancy; and
- Concern about the potential prioritization of this measure over prenatal visits.

Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults

ACAP plans had varied opinions about the recommendation to add this measure to the Core Measure Set. Our plans echoed sentiments like the workgroup suggested on why this measure is a good addition to the Core Measure Sets. However, our plans highlighted concerns about the proposed addition similar to the *Oral Evaluation During Pregnancy* measure: concern around the accuracy and comparability of the data collected from state to state given the carve out of dental coverage in some states.

Plans also noted they would benefit from recommendations involving primary care providers who also often see non-traumatic dental conditions due to dental access challenges.

Deferred Decision on Adding Certain ECDS Measures

In general, ACAP plans noted it will be difficult to understand the real barriers and lack of resources to operationalize the deferred measures and improve data sources until reporting is required. They appreciated the suggested strategies discussed by the workgroup to support the state use of these measures and how to best support states in reporting including: 1) a recommendation for "*a third tier of reporting for interim, innovative measures that support movement in the direction CMCS and states want to go with measurement and reporting;" and 2) "the idea of promoting the use of the measures in a non-punitive way until states can better integrate them into reporting*."

More detailed comments on the specific measures are as follows:

(2020) Postpartum Depression Screening and Follow-Up

ACAP plans recognize the severity of the maternal mortality crisis and encourage efforts to develop measures that support improvement in the quality of care given to that population, including behavioral health care. While ACAP plans were generally supportive of this measure in the past, ongoing efforts have been underway to implement the ECDS depression measures and that additional level of experience has illuminated operational challenges that have now created more concern about the recommendation to add this measure.

One plan with substantial experience with trying to implement the ECDS depression measures found that, when reviewing medical records, the rate of screening in the post-partum period was very high, but that rate was not captured in the specifications required in the ECDS measure (i.e., a CPT code is not sufficient). They noted that extractions from the electronic health record are complex and EMR vendors have universally not cooperated with generating a report capable of meeting this measure. A reporting tool can be used, but the turnaround for ingesting such data is much shorter on the HEDIS Audit side (1 month after the close of the measurement year), such that primary source verification of such abstractions has had a low success rate (e.g., 10%). The plan recommended that the only scalable solution would be to have EMR vendors be required to generate a report for the 5 ECDS depression measures, but that is not yet required by ONC. Therefore, they recommend that the ECDS depression measures should not be added to the Core Measure Set until CMS and NCQA have formally submitted a request to ONC to require all EMR vendors to generate a standard report of these data.

Another plan with substantial experience noted that LOINC codes are used for depression screening, which currently cannot be submitted through claims—a portion of providers in the network still use the paper charts.

(2020) Prenatal Immunization Status

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

These concerns remain present after discussing the measure with our plans this year.

(2022) Adult Immunization Status

While ACAP plans support state-level reporting of adult immunizations, plans voiced the concern that solely using health plan data would be problematic. As noted in the Workgroup report, not all Medicaid programs cover adult immunizations and, even when they do, often adults will receive their immunizations through other sites of care that do not provide information back to the health plan's claims system. Medicaid managed care plans will face data collection challenges for any non-claims-based data.

On a more technical note, ACAP plans encourage the establishment and use of standard NDC codes with no proprietary codes allowed to ensure consistent reporting and assessment across entities. Additionally, we would encourage adding these adult immunizations to state-based immunization registries to support data completeness for the entire population.

These concerns remain present after discussing the measure with our plans this year.

Additional Comments on Workgroup Recommendations/Discussion

The draft report noted that the Workgroup discussed but did not recommend removal of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures from the Experience of Care domain: The CAHPS Health Plan Survey 5.1H, Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) and the CAHPS Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD). The Workgroup member who suggested the measures for removal indicated concerns about the reliability and validity of the survey instrument, and whether it is appropriate for comparative analyses by demographics. The Workgroup also discussed numerous other challenges with the use of CAHPS as well as some

members expressing support for the continued use of the CAHPS measures and identified beneficiary experience of care as a priority for the Core Sets.

ACAP plans confirmed the discussion of existing challenges associated with the CAHPS measures, including low response rates, survey fatigue, latency between a visit and survey receipt, lack of respondent engagement and follow-up, and the validity of results.

While some ACAP plans supported complete removal of the CAHPS measures based on the concerns raised by the Workgroup, in general, ACAP plans agreed with the suggestion from the Workgroup to test changes to CAHPS data collection methodology and to consider alternative methods and modalities for gaining meaningful insight about beneficiary experience.

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

Dental Quality Alliance (Ralph A. Cooley)

The Dental Quality Alliance (DQA) welcomes the opportunity to comment on the draft report of the *Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP Summary of a Workgroup Review of the 2025 Child and Adult Core Sets.*

The DQA appreciates and strongly supports the Workgroup recommendations to add two oral health measures, "Oral Evaluation During Pregnancy" and "Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults," to the Adult Core Set. Inclusion of these two measures would represent a milestone by incorporating oral health measures for the first time in the Adult Core Set. These measures also address two significant gaps identified during prior Adult Core Set workgroup reviews: 1) Access to/use of dental services for pregnant women and 2) Access to/use of dental services for adults and also promotes medical-dental integration.

The measure of oral evaluation during pregnancy is the only standardized, tested, and validated claims-based measure of dental care access during pregnancy and will support Medicaid and CHIP programs in their efforts to improve the overall health and well-being of both mothers and children.

The measure of ambulatory care sensitive ED visits provides a strong starting place for incorporating oral health considerations for the Medicaid adult population in general by providing a systems-level indicator of access to oral health care among Medicaid beneficiaries. This measure represents a first step towards the eventual promotion of appropriate dental care outside of the ED through increased preventive care, treatment of acute dental issues, and appropriate follow-up after ED use. It also highlights the extent to which there are adverse impacts associated with untreated dental disease in adults that impose significant costs in terms of both beneficiary health outcomes and actual program expenditures. These costs are incurred by all Medicaid programs, regardless of whether they provide adult dental benefits or not.

The DQA notes that the addition of these two measures builds on the foundation of state performance improvement from the existing dental/oral health measures in the Child Core Set: "Sealant Receipt on Permanent 1st Molars," "Oral Evaluation, Dental Services," and "Topical Fluoride for Children." The existing combination of measures for children promotes receipt of a robust age-appropriate preventive pediatric dental care bundle that encompasses a range of oral healthcare provider types and care settings.

The DQA also supports the Workgroup's efforts related to stratification of Core Set measures to advance health equity. In its implementation guidance, the DQA encourages stratification of all DQA measures by age, race, ethnicity, geography, and sex among other variables and provides guidance on how to do so.

Measuring performance is critical to improving quality of care – the DQA has created an oral healthcare quality dashboard for reporting dental quality measures using T-MSIS data and will be adding both of these measures to the dashboard by the end of the year. All dashboard measures are reported with stratifications where data are sufficiently complete.

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

GEHA Connection Dental Federal® (Ashley C. Grill)

From the FEDVIP plan view the use of demographic data is not yet available for plan development beyond age and zip code.

- "Core Sets data, including race, ethnicity, geography, and sex..."
  - Variables that may support members health equity plan feedback include:
    - Veteran status
    - Disability status
    - Pregnancy status
- Having a uniform age stratification would simplify the data management and query process.
  - Currently the proposed pregnancy age stratification is different from age stratification for other DQA measures.
    - HEDIS age stratification is different than DQA.
- Looking at pregnancy is excellent for the Oral Evaluation During Pregnancy.
  - For FEDVIP, we have data for dual enrolled members who may benefit from knowledge of plan performance looking back to prior to the pregnancy to see if prophylaxis was received prior to pregnancy.
    - Knowledge of the value of prevention long term may benefit public knowledge and understanding of the of oral health, dental prophylaxis, and improve the understanding of the plan design, and look at individuals with access to oral care services. When looking at the age stratified data.
    - (Total number of births within the plan – those who did not received prevention prior to pregnancy)/ total number of births within the plan = Plan prenatal dental wellness prevention score.
    - (Total number of births within the plan – those who did not receive prevention during the pregnancy)/total number of births within the plan = Plan pregnancy dental wellness prevention score.

Ashley C. Grill

Professionally, I had the opportunity to review the 2025 Child and Adult Core Set as a consultant for a FEDVIP plan. My formal plan-related comments will be sent separately. While listening to the report using the accessibility read-aloud feature, I reflected deeply on the topics.

On a personal level, I would like to respond to provide my feedback as a caregiver and person with lived experience in recovery. I'm actively involved in mental health advocacy, and oral health advocacy, and support oral health as a part of overall health. Thank you for the opportunity to review the Core Set and provide feedback.

- Upon reflection, there was a lack of the voice of the people who receive services in this process. Member voice, and representation throughout the process and the report would benefit from feedback from members served. Taking the time to explain these measures and the process to the individuals served and their caregivers and asking for what matters to people served. A whole-person wellness approach may improve the report and make it meaningful to the public.
  - Recommend sharing this report for public feedback with:
    - All state block grant review committees,
    - Recommend including organizational feedback from groups who advocate supporting people who receive services
      - National Council on Mental Wellness
      - State Oral Health Coalitions
      - American Dental Hygienists Association
      - Community mental health centers,
      - National Alliance on Mental Illness,
      - State Chapters of NAMI,
      - Other faith-based organizations,
      - Community organizations who are part of the community
      - Peer support organizations
        - Peer support is valuable for people to thrive living with disability, poverty, and other variables that qualify eligibility for public assistance programs like CHIP and Medicaid.

Possible future objectives

- Recommend: Developing new measures for SBIRT (alcohol, tobacco, and other drug screening) in mental illness especially during pregnancy, and to support caregivers' recovery through caregiver and parent support programs and projects.
- Recommend: Developing measures for access to telehealth prevention programs.
    - Oral health and topical fluoride application delivered via telehealth services
    - Behavioral health programs – mental health first aid classes and other programming as delivered via telehealth programming.
- Recommend: Developing measures to assess the prevalence of community-based resiliency training.
- Recommend: Focus on the solution – not just screening for the problems.
- Recommend: Developing measures that assess the availability of prevention programs in schools for behavioral, dental, primary care, and basic prevention programs.

MassHealth (Mike Levine)

Thank you for the opportunity to comment on the 2025 Child and Adult Core Sets (Core Measure Sets) Annual Review Process. Comments from MassHealth (Massachusetts Medicaid and CHIP combined program) are below.

Electronic Clinical Data Systems (ECDS) Measures

MassHealth has significant concerns regarding the feasibility of and timeline for implementing measures that rely on ECDS methodology for calculation (i.e., postpartum depression screening and follow up, prenatal and adult immunization status). While MassHealth generally agrees with the Workgroup's support of this set of enumerated measures and acknowledges the value of expanding the domains for depression screening measurement and immunization, its three primary concerns are described below.

First, MassHealth is concerned that these proposed measures do not align with NCQA's accreditation requirements. Because MassHealth managed care plans are contractually obligated to obtain NCQA accreditation, introducing measures that are not aligned with NCQA's requirements will impede consistent adoption and measure reporting across plans, resulting in aggregated, statewide measure rates that do not represent the full MassHealth managed care population. MassHealth therefore requests that HEDIS ECDS measures not be added to the Core Sets until NCQA incorporates such measures into their accreditation requirements.

Second, it is not feasible for MassHealth to implement these measures for its entire population. More specifically, MassHealth's Medicaid Management Information System (i.e., its claims adjudication engine) does not support the use of ECDS measurement for members who receive services on a fee-for-service basis. This includes members enrolled in our PCCM program (i.e., our Primary Care Clinician Plan), our PCCM Entity programs (i.e., our Primary Care ACOs), and members not enrolled in any managed care programs. To the extent CMS adopts the proposed measures as mandatory, MassHealth requests adequate transition time to support this update to its internal systems and adopt new mandatory reporting requirements.

Third, the timeline for introducing and implementing new measures is not clear. MassHealth therefore requests additional clarity regarding the timing and sequencing for implementing any mandatory measures and/or reporting requirements. Furthermore, MassHealth proposes that CMS delay any mandatory reporting for at least one year following the introduction of any new measure.

Dental Care Measures

MassHealth supports adding dental care measures to the Adult Core Set. The two proposed dental care measures (Oral Evaluation During Pregnancy and Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults) address important aspects of dental care as it relates to overall health. However, because wide variation exists among state Medicaid programs in terms of providing dental benefits to Medicaid members, measure rates between states may not be comparable.

Thank you for your consideration of MassHealth's comments.

North Carolina Department of Health and Human Services (Madison Joyce Shaffer)

Comment

The Evaluation Team at NC Medicaid appreciates the opportunity to submit comments to the Center for Medicare and Medicaid Services (CMS) on the core sets recommendation. The comments have been divided into sections based on feedback areas.

Summary

NC Medicaid appreciates the importance of dental care as part of a wholistic approach to health and acknowledges the current gap in measuring adult oral health within the Medicaid space. However, we caution the addition of two dental measures (*Oral Evaluation During Pregnancy* & *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* (EDV-A)) to the core set as the coverage of dental benefits, beyond emergency services, is inconsistent for adults across states. All states are required to provide dental benefits to children covered by Medicaid and the Children's Health Insurance Program (CHIP) however, states have discretion over providing dental benefits for adults.[i] In addition to inconsistent coverage across states, there are substantial barriers to accessing dental services (e.g., shortage in dental providers) that impact the actionability and viability of these quality measures.

Feasibility

If the workgroup is looking for consistent calculations between states and over time, dental measures are not ideal. Despite recent policy shift toward coverage for pregnant beneficiaries, not all states have implemented this change (e.g., Texas, Arizona, and Florida still have only emergency coverage for dental services). We want to echo the concerns brought up in the workgroup comments relating to potential issues with data consistency, data sources, and the level of feasibility. While both measures (*Oral Evaluation During Pregnancy & Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults* (EDV-A)) have the potential to quantify the need for action and positively impact vulnerable populations, NC Medicaid cautions against rushing into adding them both to the adult core set. *Oral Evaluation During Pregnancy* is a brand-new measure that just finished testing in only five states (Alaska, Idaho, North Carolina, Michigan, and Washington). These states were selected because they have extensive dental benefits for pregnancy and good TAF data quality for the critical data elements used to calculate the measure. Because of this, these states aren't a good representation of technical feasibility for other states. One example of a potential technical feasibility issue is properly identifying the eligible beneficiary population for the measure. Pregnancy related measures require analysts to consider different pregnancy period lengths and time frames for determining whether women received the service.

NC DHHS currently calculates the child version of (EDV-CH-A). However, we rarely utilize it as the rates are very low and they have continued to trend down. Adult dental services are also billed under fee-for-service, so it is less in line with our state's push for managed care.

Financial and Operational Viability

With recent efforts from CMS leaders to streamline quality measures across CMS quality programs, it seems counterproductive to add two new adult core set measures without retiring any. Adding two new measures to the adult core set will test state's financial and operational viability. In addition, the *Oral Evaluation During Pregnancy* measure is a process measure, and CMS is moving toward more meaningful outcome measures.

Desirability of Measures

Due to the inconsistent coverage of dental services and barriers to these services across the country, it is important to question the actionability of these measures at this time. Research has found that those with private dental insurance are more likely to see a dentist than those with Medicaid.[ii] Medicaid beneficiaries were twice as likely to report barriers to visiting a dentist, most commonly reporting cost and availability of providers. Here in North Carolina, four counties do not have regularly practicing dentists, and only about 40% of dentists in the state participate in Medicaid or CHIP.[iii] In addition, in 2022, only about 18% of the adult Medicaid recipients in North Carolina even used the dental care option.

These trends are not unique to North Carolina and limit the actionability of any dental related quality measure. Dentists nationwide have cited burdensome administrative requirements, missed appointments, lengthy payment wait times, and low reimbursement rates as barriers to their participation in Medicaid.

To help account for these barriers, the *Oral Evaluation During Pregnancy* measure should include a distinction between oral health and dental services. For example, the DQA *Oral Evaluation, Dental Services* (OEV) measure tracks services provided under the supervision of a dentist (dental services) and services provided by other professionals such as primary care providers (oral health services).

In addition to struggling with increasing the number of dentists enrolled in Medicaid, states have difficulty distributing the overall volume of Medicaid participants across dental providers. This has been referred to as "wide but shallow" pools of dental providers, and it is contributing to barriers in access to dental services for Medicaid beneficiaries.[iv]

Citations

[i] Medicaid.gov Dental Services. Accessed July 26, 2023. https://www.medicaid.gov/medicaid/benefits/dental-care/index.html.

[ii] Poll Shows Americans Open to Receiving Medical and Dental Care from a Range of Providers. Pew Research. (2019) https://www.pewtrusts.org/en/research-and-analysis/articles/2019/06/28/poll-shows-americans-open-to-receiving-medical-and-dental-care-from-range-of-providers.

[iii] North Carolina Health Professions Data System, Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Created August 01, 2023 at https://nchealthworkforce.unc.edu/interactive/supply/.

[iv] Vukicic, Marko Ph.D, Kamyar Nasseh, Ph.D, Chelsea Fosse, MPH. (2021) Dentist Participation in Medicaid: How should it be measured? Does it matter? Health Policy Institute (HPI) American Dental Association (ADA) https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief_1021_1.pdf.

Pennsylvania Department of Human Services (Bridget Gill-Gibson)

Thank you for the opportunity to review and provide comment on the 2025 Child and Adult Core Sets Annual Review Draft Report. I am commenting on behalf of an organization, PA DHS, to express our support of the two adult dental measures recommended for addition, Oral Evaluation During Pregnancy and Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults.

Policy Center for Maternal Mental Health (Sarah Johanek)

The undersigned organizations are grateful for the opportunity to provide feedback on the draft report of the 2025 Child and Adult Core Set Review Workgroup ("the Workgroup"). Joy Burkhard, the Policy Center for Maternal Mental Health's Executive Director, is a member of the Workgroup, and on behalf of the undersigned organizations, we would like to provide feedback on the recommendations regarding maternal mental health.

As noted in the report, "the Workgroup identified domain-specific gap discussions during the 2025 Child and Adult Core Sets Annual Reviews in the maternal and perinatal health field as prenatal screenings for depression and mental health, contraceptive counseling, and maternal health outcomes."

The undersigned organizations agree that each of these measures should be prioritized and that prenatal depression screening is as important if not more important, than depression screening during the postpartum period. This is because research has demonstrated up to 25% of women will suffer from prenatal depression.[i] Women with untreated depression during pregnancy are at risk of developing severe postpartum depression and suicidality and of delivering premature or low birth weight babies.[ii]

Depression during pregnancy can result in alterations to the DNA of the developing fetus. In this case, the mother transmits the trauma and stress of the psychological condition that she is experiencing into the biology of her offspring. Therefore, decreasing the rates of fetal exposure to prenatal depression or anxiety is essential in protecting the next generation.[iii,iv]

Workgroup Recommendation: The workgroup reconsidered the *Postpartum Depression Screening and Follow-Up*, which *"*measures the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care. Two rates are reported: a depression screening rate and a follow-up on positive screen rate." This measure was specified for the HEDIS Electronic Clinical Data System Measure (ECDS) reporting measure that was recommended by prior Workgroups to add to the Core Set. ECDS is a standardized reporting method, created by NCQA, to report electronic clinical data for HEDIS. The Workgroup confirmed their support for adding the *Postpartum Depression Screening and Follow-Up* ECDS measure to the Child and Adult Core Set.

Feedback: The undersigned organizations commend the workgroup and highly encourage CMS to adopt this measure. We recommend that the behavioral health measures of 1) prenatal depression screening and follow-up and 2) postpartum depression screening and follow-up be added to the adult core set. Since these are behavioral measures, they will be mandatory for state reporting in 2024.

Workgroup Discussion: The Workgroup discussed the removal of the measure *Screening for Depression and Follow-Up Plan: Ages 12-17 and Age 18 and Older*, but ultimately decided to

keep it in the 2025 Child and Adult Core Sets. They suggested the removal because there have been significant challenges to data collection, such as accessing EHR data and underreporting of depression screenings in claims. Additionally, there are concerns about public reporting of the measure because of the poor data quality in some states. The workgroup decided not to remove the measure because of the rise in rates of suicide, depression, and other mental health conditions in the U.S. They also agreed not to remove the measure without a replacement measure.

Feedback: The undersigned organizations commend the workgroup for this decision and strongly encourage CMS to follow this recommendation.

The undersigned organizations are grateful for this opportunity to provide feedback and are appreciative of the Workgroup's dedication to improving health data measurement.

Sincerely,

Association of Maternal and Child Health Programs

Postpartum Support International

Maternal Mental Health Leadership Alliance

The Policy Center for Maternal Mental Health

Mental Health America

Citations

[i] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2687389.

[ii] https://www.sciencedirect.com/science/article/abs/pii/S0149763416307345.

[iii] https://www.sciencedirect.com/science/article/abs/pii/S0149763416307345.

[iv] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2933409/.

University of Louisiana Monroe (Eddy Myers)

From Louisiana, we have a comment that measures that require ECDS/EHR data would be a challenge for states that do not receive electronic health record data from their providers.

Upstream USA (Emily Eckert)

Upstream USA appreciates the opportunity to comment on the 2025 Child and Adult Core Sets Annual Review draft report (hereinafter referred to as the "draft report"). Upstream is a nonprofit organization working to expand access to contraception and address disparities and biases in contraceptive care by providing high-quality, patient-centered training and technical assistance to health care organizations. Our transformative approach empowers patients to decide if and when they want to become pregnant, a critical step towards improving maternal health as well as positive health and social outcomes for parents, children, and their families.

The ability to decide if and when to become pregnant is foundational to people's lives. This premise has been reflected in Medicaid policy for decades. Indeed, family planning has been a required benefit in the Medicaid program since 1972, and in 2021, Medicaid and the Children's Health Insurance Program (CHIP) provided coverage to more than 23.7 million female patients of reproductive age.[i] While the Medicaid program provides broad coverage of contraceptives and represents the largest source of public funding for family planning services and supplies, today, more than 19 million women of reproductive age live in a contraceptive desert.[ii]

Through our more than 100 partnerships with health care organizations – including federally qualified health centers (FQHCs), local departments of health, and others – Upstream has extensive experience working to integrate contraceptive care quality measures into provider practices and helping these same practices use quality measurement data for continuous quality improvement. Specifically, we have experience working with National Quality Forum (NQF)-endorsed measures #2902, #2903, and #2904, various screening measures for reproductive health needs, and patient-reported outcome measures.

We believe that, in order to improve access to care for individuals enrolled in Medicaid and CHIP and to best ensure that the care being provided to program enrollees is patient-centered and free from bias and coercion, the Child and Adult Core Sets (Core Sets) should expand their suite of measures focused on contraception. Importantly, any quality measures that examine contraceptive care should be designed to promote patient-centered care and mitigate the risk of reproductive coercion.

Contraceptive Measures Currently Included in the Core Sets

Upstream supports the continued inclusion of National Quality Forum (NQF)-endorsed #2902, #2903, and #2904 in the draft report.[iii,iv] These measures are intended to increase access to the most and moderately effective methods of contraception.[v] Importantly, no benchmarks have been established for any of these measures, as benchmarks around method provision may unintentionally urge providers to "push" patients towards a specific method, or any method at all, at the cost of disregarding patient preferences. Still, including NQF #2902, #2903, and #2904 in the Core Sets can provide helpful insights to patients, providers, and other stakeholders, as very

low results (e.g., 1–2%) from these measures could suggest that barriers to most and moderately effective methods may exist in those settings.

Additional Contraceptive Measures for Consideration

Upstream commends the Workgroup for suggesting in the draft report that gaps in contraceptive measurement should be prioritized for future measure development, testing, and refinement. Upstream encourages the Workgroup to consider the need for and utility of measures related to reproductive need screening.

Reproductive need screening creates the space in a health care encounter for broad conversations around reproductive life planning. By asking a screening question, the health care provider can steer the conversation in the direction the patient themselves indicates is the right one (whether that is towards contraception, preconception health, prenatal care, or some other need). Two specific measures of reproductive need screening that the Workgroup could consider for inclusion in the Core Sets include the Self-Identified Need for Contraception (SINC) and the Pregnancy Intention Screening Question (PISQ).

The SINC-Based Contraceptive Care, Postpartum (#3682e) and SINC-Based Contraceptive Care, Non-Postpartum (#3699e) measures were endorsed for trial use by NQF during the spring 2022 review cycle.[vi] SINC is intended to assess whether a patient would like to receive education or counseling about their contraceptive options during a particular health care encounter. The SINC screening tool has value on its own, since the number of patients who are asked a SINC screening question, and who receive contraceptive counseling if they respond in the affirmative, could be a measure of the prevalence of reproductive needs screening and contraceptive counseling. It can also be used to refine the method-use measures by excluding from the denominator patients who are not interested in talking about their contraceptive option. PISQ is similar to SINC, but focuses narrowly on pregnancy intention. Versions of PISQ have been in use for over 10 years – the most notable being One Key Question®.[vii] Multiple positive pilot studies of One Key Question® have taken place across the country demonstrating the utility of the screening tool.

It should be noted that Upstream does not endorse the use of one screening tool over another, and SINC and PISQ are two tools among many. Rather, we work with our health center partners to implement the screening tool(s) that is best for their practice.

Both of these measures – SINC and PISQ – are included as part of the federal reporting requirements of the HHS Office of Population Affairs' Family Planning Annual Report 2.0 for Title X Family Planning Program grantees.[viii] In addition, both SINC and PISQ have existing Logical Observation Identifiers Names and Codes (LOINC) and Systematically Organized Computer-Processable Collection of Medical Terms (SNOMED) codes, and both are included in the United States Core Data for Interoperability (USCDI) at Comment Level.[ix,x]

In the draft report, the Workgroup specifically notes a need for measures around contraceptive counseling. Upstream agrees that contraceptive counseling is a critical component of sexual and reproductive health care, and that the Core Sets would benefit from a measure of the number of patients who are offered contraceptive options, rather than or in addition to patients who end up using contraceptive methods. We believe that any quality measures that examine rates of contraceptive counseling should avoid incentivizing counseling for patients who do not want it. To do so, Upstream recommends connecting any contraceptive counseling measure to the screening measures above, such that providers are incentivized for screening patients and offering counseling only when indicated.

Upstream also commends the Workgroup for its desire to explore the inclusion of measures oriented toward more person-centered experiences of care. Incorporating the patient voice into measurement systems alongside the NQF method-use measures is considered the gold standard of contraceptive quality measurement. A central component of Upstream's work with our health center partners is a patient survey that contains a suite of questions to understand patient experience with contraceptive care. Upstream leverages the Person-Centered Contraceptive Care (PCCC) patient-reported outcome measure within this patient survey, and we recently explored the reliability and validity of the PCCC in a large, diverse sample of patients who received care at our partner health centers.[xi] Our findings demonstrate a clear association between self-reported bias/coercion experienced by patients and lower likelihood of reporting high PCCC scores. The findings from our work support those from the initial validation study of the PCCC.[xii]

While the field of contraceptive care quality measurement is moving towards broader adoption of the PCCC, it may not yet meet the measure specifications outlined in the draft report. For example, while the PCCC has received NQF endorsement (#3543), it is not yet widely used nor is it validated at the health plan level. Despite these current limitations, Upstream encourages the Workgroup to add the PCCC to its list of measures under consideration and to revisit the status of this measure over time, as adoption continues to grow across the country. Concurrently, Upstream will continue to deploy the PCCC in our programmatic work and to advocate for its use in other venues (e.g., health plan, Medicaid, and other statewide patient surveys). Additionally, Upstream will continue to collaborate with other reproductive health organizations on interpreting and contextualizing PCCC results.[xiii] These insights may be helpful to the Workgroup should you consider recommending that the PCCC be added to the Core Sets in the future.

Stratification of Measures by Race, Ethnicity, and Other Demographic Factors

Upstream appreciates the attention that the draft report gives to the need to stratify the Core Set measures in order to advance health equity. In addition to considering factors such as race, ethnicity, language, and disability status, Upstream encourages the Workgroup to consider recommendations for stratifying the Core Set measures by sex. In doing so, the Workgroup should recommend a broad definition of sex to include sexual orientation and gender identity (SOGI).

Recommending that data be stratified by sex – including SOGI – is aligned with other data improvement work that is being undertaken by the Department of Health and Human Services and other federal agencies. For example, in 2016, CMS and the Office of the National Coordinator added a requirement that electronic health records (EHR) certified under Stage 3 of the Meaningful Use program allow users to record SOGI data in the demographics certification criteria. Also in 2016, the Health Resources and Services Administration (HRSA) began requiring that SOGI data be included as part of standard demographics reporting through the Uniform Data System.[xiv] As part of their rationale for the change, HRSA noted that "sexual orientation and gender identity can play a significant role in determining health outcomes," and that "gaining a better understanding of populations served by health centers, including sexual orientation and gender identity, promotes culturally competent care delivery and contributes to reducing health disparities overall."

This recommendation also aligns with a January 2021 Executive Order to advance equity for communities that have been historically underserved and a March 2021 Executive Order establishing a White House Gender Policy Council.[xv,xvi] Among other priorities, the White House Gender Policy Council has been directed to propose improvements in the collection of data related to gender and gender identity. Stratification by SOGI also aligns with the CMS framework for health equity.[xvii]

Upstream recognizes that there are some unresolved methodological and conceptual issues that persist with public reporting of SOGI data. We also recognize the inherent risk to patient privacy for individuals in small states as well as the importance of minimizing data reporting burdens for state Medicaid agencies who are required to report certain data elements via the Core Sets. However, to truly advance health equity for individuals enrolled in Medicaid and CHIP, Upstream believes the Core Set data should be stratified by SOGI, and we encourage the Workgroup to move in that direction.

Thank you for your consideration of our comments.

Citations

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

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Virginia Department of Medical Assistance Services (LaToya LaSmith)

The Department of Medical Assistance Services (DMAS) fully supports adding the two recommended measures to the Core Set; including Oral Evaluation during Pregnancy and Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults.

Pertaining to the Reconsideration of Deferred Electronic Clinical Data System Measures; including Postpartum depression, prenatal immunization status and adult immunization status. DMAS supports adding the ECDS measures to a Core Set Domain that would not be subject to mandatory reporting in 2025. There are concerns with the readiness to report Electronic Clinical Data System Measures for 2025 reporting.

Virginia Health Catalyst (Sarah Bedard Holland)

I am pleased to comment on behalf of Virginia Health Catalyst in response to the draft Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP.

Virginia Health Catalyst (Catalyst) is a public health nonprofit organization that ensures all Virginians have equitable access to comprehensive health care, including oral health. Catalyst meets this mission through advocacy and programmatic initiatives anchored by our four pillars: policy, public awareness, community and clinical care, and public health.

We applaud the 2025 Child and Adult Core Sets Annual Review Workgroup's recommendation to add the Oral Evaluation During Pregnancy measure to the 2025 Child and Adult Core Sets. Oral health is essential to overall health, especially so during pregnancy. Pregnant people are more likely to develop gingivitis, an early stage of periodontal disease.[i] This measure will send a clear message that addressing oral health is essential to promoting maternal and childhood health.

We also applaud the Workgroup's recommendation to add the Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adult measure to the Core Sets. The Workgroup correctly pointed out that this measure "serves as an indicator of systemic failures to provide routine preventive dental care." Tracking this data will help providers and policymakers promote prevention, reduce unnecessary emergency department utilization, and support better health.

Thank you for the opportunity to comment on this important work.

Citation

[i] National Maternal and Child Oral Health Resource Center, "Making the Case to HRSA for Retaining the Oral Health National Performance Measure," 2023.

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