MATHEMATICA Policy Research

Child and Adult Core Set Stakeholder Workgroup:

Measures Suggested for Addition to the 2020 Core Sets

Measure Information Sheets

May 2019

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Ambulatory Care Sensitive Emergency Department Visits for Dental Caries in Children
Description	Number of emergency department (ED) visits for caries-related reasons per 100,000 member months for all enrolled children. Rates are stratified by age and by ED visit disposition (visits resulting in an inpatient admission and those not resulting in an inpatient admission). A lower rates indicates better quality.
Measure steward	American Dental Association/Dental Quality Alliance (ADA/DQA)
NQF number (if endorsed)	2689
Core Set domain	Dental and Oral Health Services
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children ages 0 through 20 during the measurement year. Measure is stratified by age: <1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20.
Data collection method	Administrative.
Denominator	All member months for enrollees who satisfy age criteria.
Numerator	Number of ED visits with a caries-related diagnosis code among all enrolled children. (Include only paid claims.) Numerator is stratified by ED disposition (whether visit resulted in an inpatient admission or did not result in an inpatient admission).
Exclusions	None.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Program-level.
For more information	https://www.ada.org/~/media/ADA/DQA/2019AmbCareSensitiveEDVisitsforDentalCariesinChildren.pdf

Additional Information for Consideration	
Current level of reporting	Program-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted because dental caries is largely preventable and can be reduced and managed through outpatient care processes, caries-related ED visits represent "ambulatory care sensitive" visits that are potentially avoidable through timely and effective use of outpatient care. Moreover, ED care for caries-related problems is generally not definitive compared to that provided in primary care dental settings and often results in referral to primary care dental sites. This measure can be used to promote performance improvement by allowing programs to track and monitor ED use for caries-related reasons by children over time and to evaluate and inform strategies to promote greater use of outpatient preventive dental services including ED diversion programs.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	This measure represents an outcome that can be impacted through quality improvement strategies, such as increasing access to routine preventive dental care and timely identification and management of dental caries.
Use of measure in other programs	A few states are using this measure for quality improvement purposes as well as Pay-for-Quality (P4Q) programs, but this measure is not part of a federal program.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure is undergoing NQF endorsement maintenance; however, there are no changes to the measure specifications.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Follow-Up after Emergency Department Visits for Dental Caries in Children
Description	Percentage of caries-related emergency department (ED) visits among children 0 through 20 years in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit.
Measure steward	American Dental Association/Dental Quality Alliance (ADA/DQA)
NQF number (if endorsed)	2695
Core Set domain	Dental and Oral Health Services
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children ages 0 through 20 during the measurement year. Measure is stratified by age: <1; 1-2; 3-5; 6-7; 8-9; 10-11; 12-14; 15-18; 19-20.
Data collection method	Administrative.
Denominator	Number of caries-related ED visits in the measurement year.
Numerator	Number of caries-related ED visits in the measurement year for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit.
Exclusions	Visits that resulted in an inpatient admission.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Program-level.
For more information	https://www.ada.org/~/media/ADA/DQA/2019FUafterERVisitsforDentalCariesinChildren.pdf

Additional Information for Consideration	
Current level of reporting	Program-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted dental caries is preventable, and use of the ED for dental caries-related conditions results in substantial costs. Because dental caries can be reduced and managed through outpatient care processes, caries-related ED visits represent "ambulatory care sensitive" visits that are potentially avoidable through timely and effective use of outpatient care. Moreover, ED care for dental caries-related conditions is generally not definitive compared to that provided in primary care dental settings and often results in referral to primary care dental sites. This process of care measure can be used to assess if the patient had timely follow-up with a dentist for more definitive care.

How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	This measure allows states to identify, monitor, and improve the percentage of children who are receiving timely, definitive care for caries-related dental problems and, therefore, have a decreased likelihood of repeat ED visits.
Use of measure in other programs	A few states are using this measure for quality improvement purposes as well as Pay-for-Quality (P4Q) programs, but this measure is not part of a federal program.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure is undergoing NQF endorsement maintenance; however, there are no changes to the measure specifications.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Adults with Diabetes – Oral Evaluation
Description	Percentage of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the measurement year.
Measure steward	American Dental Association/Dental Quality Alliance (ADA/DQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Dental and Oral Health Services
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Adults age 18 or older as of the last day of the measurement year.
Data collection method	Administrative.
Denominator	Unduplicated number of all enrolled adults with diabetes.
Numerator	Unduplicated number of enrolled adults with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation.
Exclusions	• Medicare-Medicaid Dual Eligibles • Care received at a hospice facility • Individuals who do not have a diagnosis from the NCQA Diabetes Value Set (type I or type II Diabetes) and are in the NCQA Diabetes Exclusion Value Set (e.g., have gestational diabetes, steroid/ drug induced diabetes).
Continuous enrollment period	Continuously enrolled for the measurement year (12 months) with a single gap of no more than 45 days (one month gap for programs that determine eligibility on a monthly basis).
Level of reporting for which specifications were developed	Plan-level; Program-level.
For more information	https://www.ada.org/~/media/ADA/DQA/2019_AdultDiabetes.pdf

Additional Information for Consideration	
Current level of reporting	Measure is currently undergoing testing and is scheduled for approval in June 2019.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted the 2018 Standards of Medical Care in Diabetes call for initial care management to include a referral to a dentist. This recommendation recognizes the established bi-directional relationship between diabetes mellitus and periodontal disease. Specifically, diabetes is associated with increased prevalence and severity of periodontal disease, while severe periodontal disease is associated with poor glycemic control. Oral evaluations represent an important entry point into the dental care system. Diagnosis and treatment planning for the prevention and treatment of periodontal disease at these visits offer patients appropriate dental care with the potential to improve diabetes outcomes.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	The established bi-directional relationship between diabetes mellitus and periodontal disease emphasizes the need for states to target their improvement efforts toward linking this subset of the Medicaid population to outpatient dental care settings to manage the severity of their periodontal health. Diagnosis and treatment planning for the prevention and treatment of periodontal disease at these visits offer patients appropriate dental care with the potential to improve diabetes outcomes.
Use of measure in other programs	One state has included this measure as part of its 2020 incentive program.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure aligns with the denominator for the HEDIS Comprehensive Diabetes Care measures, which are included in the Adult Core Set.

PRIMARY CARE ACCESS AND PREVENTIVE CARE

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Flu Vaccinations for Adults Ages 65 and Older (FVO)
Description	The percentage of Medicare members 65 years of age and older who received a flu vaccination between July 1 of the measurement year and the date when the Medicare CAHPS survey was completed.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0039
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 65 and older as of January 1 of the measurement year.
Data collection method	Survey (This measure is derived from the Medicare CAHPS Survey.)
Denominator	Medicare CAHPS respondents age 65 and older.
Numerator	The number of members in the denominator who responded "Yes" to the question "Have you had a flu shot since July 1, YYYY?"
Exclusions	Not specified.
Continuous enrollment period	Six months prior to the sample draw in January.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.ncqa.org/hedis/measures/flu-vaccinations/ Refer to NCQA HEDIS specifications volume 3.

Additional Information for Consideration	
Current level of reporting	Program-level (Medicare), plan-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted as of 2017, there are 10.7 million dual eligibles that have both Medicare and Medicaid. The majority of them are over age 65. The Adult Core Set currently includes ages 18-64 as part of the CAHPS survey. Adding this higher age band fills the gap of assessing the frequency of influenza immunization in an age bracket that is more likely to die from influenza than the younger adult age band.

How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	The NCQA 2017 national average for Medicaid HMO influenza vaccination rate (ages 18-64) was only 39.6% while the Medicare HMO and PPO rates (ages 65 and above) were respectively 72% and 74%. We currently do not know what the rate is for dual eligible influenza vaccination. Even at Medicare HMO and PPO rates, there is room for improvement. Influenza immunization reduces hospitalization by 71%. More than 12,000 people over the age of 65 died from influenza in 2017.
Use of measure in other programs	• NCQA Health Plan Accreditation Medicare • CMS Star Ratings
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	No major changes to the specifications are expected at this time.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Influenza Immunization
Description	Percentage of patients age 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
Measure steward	Physician Consortium for Performance Improvement (PCPI) Foundation
NQF number (if endorsed)	0041/0041e
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)

Technical Specifications	
Ages	Beneficiaries age 6 months and older.
Data collection method	Administrative and EHR.
Denominator	All patients seen for a visit between October 1 and March 31.
Numerator	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization. Previous receipt is defined as receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied.
Exclusions	For eligible clinicians submitting a denominator exception for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (e.g., patient allergy), patient reason (e.g., patient declined), or system reason (e.g., vaccination not available). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Clinician-level (individual or group practice).
For more information	https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2018_Measure_110_Claims.pdf

Additional Information for Consideration	
Current level of reporting	Clinician-level (individual or group practice).
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure to replace the FVA-AD measure, which is derived from the CAHPS survey. The Workgroup member noted that the CAHPS survey has poor response rates, high cost, and scoring is not comparable for diverse populations as discussed in the following publication: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/about-cahps/research/survey-administration-literature-review.pdf CDC estimates that influenza has resulted in between 9.3 million – 49.0 million illnesses, between 140,000 – 960,000 hospitalizations and between 12,000 – 79,000 deaths annually since 2010. The first and most important step in preventing flu is for all persons ages 6 months and above to get a flu vaccine every year. Flu vaccination has been shown to significantly reduce a child's risk of dying from flu. In seasons when the vaccine viruses matched circulating strains, flu vaccine has been shown to reduce the risk of having to go to the doctor with flu by 40 percent to 60 percent. Vaccination has been associated with lower rates of some cardiac events among people with heart disease, especially among those who had a cardiac event in the past year. Despite these proven benefits, flu vaccination levels remain low in all age groups, with disparities by race-ethnicity and state.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	In some states, Medicaid managed care plans are required to meet minimum performance thresholds for a list of measures, and to conduct quality improvement activities based on these measures. Pay for performance is another way plans, health systems, and medical groups could use this measure to drive quality improvement.
Use of measure in other programs	• The Merit-Based Incentive Payment System (MIPS) Program (Quality ID 110). • Medicare Shared Savings Program (MSSP) (ACO-14) • Medicaid Promoting Interoperability Program
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	None.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

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

Technical Specifications	
Ages	19 years of age and older at the start of the measurement period.
Data collection method	HEDIS Electronic Clinical Data Systems (ECDS) (Note: ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.)
Denominator	This measure includes denominators for four individual vaccine rates and a composite rate: Initial population = Beneficiaries age 19 and older at the start of the measurement period. 1. Influenza rate: The initial population, minus exclusions. 2. Td/Tdap rate: The initial population, minus exclusions. 3. Zoster rate: The initial population, minus exclusions, 50 years of age and older at the start of the measurement period. 4. Pneumococcal rate: The initial population, minus exclusions, age 66 years of age and older at the start of the measurement period. 5. Composite rate: The sum of denominators for the four individual vaccine rates.
Numerator	This measure includes numerators for four individual vaccine rates and a composite rate: 1. Influenza rate: Members in the influenza rate denominator who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period; or prior anaphylaxis due to Haemophilus influenzae type b vaccine or its components any time during or before the measurement period. 2. Td/Tdap rate: a. Members in Td/Tdap rate denominator who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period. OR

	b. Members in Td/Tdap rate denominator with history of at least one of the following contraindications any time during or before the measurement period: i. Anaphylaxis due to Tdap vaccine, anaphylaxis due to Td vaccine or its components. OR ii. Encephalopathy due to Tdap or Td vaccination (post tetanus vaccination encephalitis, post diphtheria vaccination encephalitis or post pertussis vaccination encephalitis). 3. Zoster rate: Members in Zoster rate denominator who received at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the member's 50th birthday; or prior adverse reaction caused by zoster vaccine or its components any time during or before the measurement period. 4. Pneumococcal rate: Members in Pneumococcal rate denominator who were administered both the 13-valent pneumococcal conjugate vaccine and the 23-valent pneumococcal polysaccharide vaccine at least 12 months apart, with the first occurrence after the age of 60; or prior pneumococcal vaccine adverse reaction any time during or before the measurement period. 5. Composite rate: The sum of numerators for the four individual vaccine rates.
Exclusions	Exclude members with any of the following: • Active chemotherapy during the measurement period. • Bone marrow transplant during the measurement period. • History of immunocompromising conditions, cochlear implants, anatomic or functional asplenia, sickle cell anemia & HB-S disease or cerebrospinal fluid leaks any time during the member's history through the end of the measurement period. • In hospice or using hospice services during the measurement period.
Continuous enrollment period	The measurement period (January 1 – December 31).
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.ncqa.org/wp-content/uploads/2018/10/HEDIS-2019-Volume-2-Technical-Update.pdf

Additional Information for Consideration	
Current level of reporting	Plan-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	Two Workgroup members suggested this measure for addition. Response 1: • Receipt of recommended vaccinations is a critically important intervention to protect the health of adults and reduce illness and death from vaccine-preventable diseases. There are currently no measures of Td/Tdap, zoster, or pneumococcal vaccination in the Adult Core Set. This measure would help drive improvement of receipt of these critically important vaccines and prevent unnecessary illness. Response 2: • In addition to influenza, the Advisory Committee on Immunization Practices (ACIP) also recommended tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine, herpes zoster vaccine, the 13-valent pneumococcal conjugate vaccine (PCV13) and the 23-valent pneumococcal polysaccharide vaccine (PPSV23) at various ages for routine adult immunization. However, many adults have not been assessed nor offered ACIP-recommended vaccines, resulting in poor health outcome and low adult immunization coverage nationally. Currently, the only immunization-related measure in the Adult Core Set is Flu Vaccination for Adults Ages 18-64 (FVA-AD). Addition of the Adult Immunization Status (AIS) measure to the Adult Core Set would close a significant gap in states' ability to monitor uptake of all routinely-recommended adult vaccines in their beneficiary populations. In conjunction with the existing childhood and adolescent immunization measures in the Child Core Set, this measure can also ensure the availability of protection of Medicaid beneficiaries from vaccine-preventable diseases across the lifespan.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Response 1: • National surveillance data show coverage for recommended adult vaccines is generally lower for adults with public health insurance compared to privately insured adults. Use of this measure would help Medicaid programs increase vaccination in their adult beneficiary populations, many of whom are vulnerable and face many health-related disparities, and reduce the disparity in receipt of critically important vaccines. Response 2: • The availability of this measure in the Adult Core Set and potential incorporation into state-managed integrated care models would not only help states in enhancing monitoring of adult immunization coverage, but also reducing morbidity and mortality from vaccine-preventable diseases across the lifespan. As there are corresponding indicators of pneumococcal, influenza, and zoster vaccination in Healthy People 2020, states can utilize this measure as a benchmark when considering the development of state health plans in support of national targets for adult immunization uptake. For

	example, only 45 percent of adults 19 and older reported their receipt of influenza vaccine during the 2014–2015 flu season, which is 25 points lower than the Healthy People 2020 target of 70 percent.
Use of measure in other programs	Under consideration for Merit-based Incentive Payment System—Quality and Medicare Shared Savings Program.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	The AIS measure was a first year HEDIS measure for HEDIS 2019. No major changes are expected to the specifications at this time.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Prenatal Immunization Status (PRS)
Description	Percentage of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations. Three rates are reported: Influenza, Tdap, and a Combination rate.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Not specified.
Data collection method	HEDIS Electronic Clinical Data Systems (ECDS) (Note: ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.)
Denominator	Deliveries during the measurement period, minus exclusions.
Numerator	This measure includes numerators for two individual vaccine rates and a combination rate: 1. Influenza rate: Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date; or deliveries where members had a prior anaphylactic reaction to influenza vaccine or its components any time during or before the measurement period. 2. Tdap rate: Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date); or deliveries where member has a history of at least one of the following contraindications any time before or during the measurement period: a. Anaphylactic reaction to Tdap or Td vaccine or its components; b. Encephalopathy due to Td or Tdap vaccination (post tetanus vaccination encephalitis, post diphtheria vaccination encephalitis, or post pertussis vaccination encephalitis). 3. Combination rate: Deliveries that met criteria for both Influenza and Tdap numerators.
Exclusions	Exclude deliveries where members have any of the following: • Weeks of gestation less than 37 at time of delivery. • In hospice or using hospice services during the measurement period.
Continuous enrollment period	28 days prior to delivery date through the delivery date.

Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.ncqa.org/wp-content/uploads/2018/10/HEDIS-2019-Volume-2-Technical-Update.pdf

Additional Information for Consideration	
Current level of reporting	Plan-level (Note: According to one Workgroup member, several states are using modified PRS specifications for state-level analysis)
Gap area(s) ***(per workgroup member who suggested the measure)***	Four Workgroup members suggested this measure for addition. Response 1: Maternal and perinatal health has been identified by prior reviews as an area to strengthen in the Core Sets. A prenatal (maternal) immunization measure comprising influenza and Tdap vaccines illustrates the recognition of the importance of immunizations in the maintenance of health and the prevention of disease. Prenatal immunization coverage levels are not adequate, and the improved utilization will likely provide not only morbidity and mortality improvements in the population, but also cost benefits to the health care system. Presently, prenatal immunizations are not reflected in the Core Sets. Response 2: This measure is being recommended as one of two vaccine-related measures addressing immunization gap areas for all adults and for pregnant women and neonates. This measure would be a new measure and would not replace a retiring measure. Receipt of recommended vaccinations is a critical strategy to improve the health of pregnant women and their neonates, making this extremely relevant for a Medicaid population. There are currently no measures of vaccination in this population in either Core Set; this measure would fill that gap. Response 3: • Currently, there is no prenatal immunization measure in either the Adult or Child Core Sets. Prenatal immunization is critical for both pregnant women and newborns as prenatal immunization offers protection against influenza and pertussis via transplacental transfer of immunological protection from mothers to babies in utero. • Research shows that pregnant women have higher risks of hospital admission than non-pregnant women during the influenza season, and pregnant women are at elevated risk of death from influenza infection. Over 500,000 pregnant women die from influenza every year globally. In addition, influenza infection in pregnant women is associated with adverse birth outcomes like prematurity and low birthweight. Vaccinating women against influenza during pregnancy significantly reduces the risk of influenza infection for both mother and infant following birth. Compared to no vaccination, influenza vaccination during pregnancy can save $107,742,336 in medical costs and $111,593,174 in total societal costs. Prenatal influenza immunization levels are lower among Medicaid beneficiaries compared to those who are insured through commercial plans. Pertussis (also known as whooping cough) poses

	the highest risk of hospitalization or death to infants younger than 12 months. Nationwide in 2017, there were 1545 cases in infants under 6 months of age and 9 deaths in infants under 1 year of age. Family members, particularly mothers, are often the source of pertussis infection in young infants, underscoring the importance of maternal vaccination. In addition, studies have shown that Tdap vaccination during pregnancy is effective in protecting infants from pertussis. A recent study based on administrative claims of commercially insured in the U.S. revealed that the average health care cost during a 12-month follow-up period was $8271; such cost is substantially higher among 1- and 2-month old infants at $18,781 and $15,446, respectively. Studies in Brazil and Japan have both found pertussis vaccination of pregnant women to be cost-effective. • This measure serves as an important indicator of receipt of recommended preventative services for maternal and perinatal health. It will also improve health outcomes of both pregnant women and their children while reduce costs to state's Medicaid programs. Since half of all U.S. births are covered by Medicaid, improving prenatal vaccination offers significant opportunities to improve the health of Medicaid and CHIP beneficiaries. By adding this measure to both the Child and Adult Core Sets and in concert with the Childhood Immunization Status and Immunization for Adolescents measures, Medicaid and CHIP beneficiaries will be better protected from vaccine-preventable diseases across the lifespan. • Studies have found that about half of women do not receive the influenza vaccine and/or the Tdap vaccine during pregnancy. Survey data from the 2009–2010 influenza season in the Pregnancy Risk Assessment Monitoring System (PRAMS) revealed that influenza vaccination coverage among women with live births was 51% for non-Hispanic White women, compared with 30% for non-Hispanic Black women and 42% for Hispanic women. In 2011, the PRAMS survey for Tdap vaccination indicated that vaccination coverage was lower for non-Hispanic Black women, those with Medicaid insurance and those starting prenatal care after the first trimester of pregnancy; 53% of women who had a live birth also reported receiving the Tdap vaccine during pregnancy, although 20% of the women surveyed did not know their immunization status. A study from 2011–2013 using administrative claims data and statewide immunization registry data of Medicaid-enrolled pregnant women in Michigan found that only 8% of non-Hispanic Black women, 12% of Asian women, and 7% of Arab women received the Tdap immunization during pregnancy, compared with 18% of non-Hispanic White women. By adding the PRS measure to the Core Sets, it will not only strengthen the wellness of mothers and infants by protecting them from vaccine-preventable diseases, but will also support efforts toward eliminating health disparities in maternal and perinatal health with the uptake of recommended vaccines in pregnant women.

	Response 4: Prenatal immunization status is proposed as a new measure (not in place of an existing measure). Maternal and perinatal health has been identified by prior reviews as an area to strengthen in the Core Sets. There are significant performance gaps and disparities in prenatal immunization levels, which results in preventable disease and death in Medicaid members, as described below. • Pertussis. Young infants are at the greatest risk of serious pertussis disease, which can result in hospitalization or death. Nationwide in 2017, there were 1,545 cases in infants under 6 months of age and 9 deaths in infants under 1 year of age. Immunizing pregnant women passes protection to their babies, and is the best way to protect young infants from pertussis. Immunizing mothers during their third trimester protects 9 in 10 babies from pertussis infections serious enough to need treatment in a hospital. However, prenatal immunization levels are lower among Medicaid members compared to privately insured women. Correspondingly, infants born to women in one state's Medicaid program in 2013-14 were 2.5 times more likely (95% Cl 2.2-3.0) to develop pertussis than infants born to privately insured women. • Influenza. Getting a flu shot reduces a pregnant women's risk of hospitalization by 40%, and helps protect the newborn before he/she is old enough to be vaccinated. However, prenatal influenza immunization appears lower in pregnant women with Medicaid insurance compared to private insurance.
How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	Response 1: The measure will provide useful and actionable results for state Medicaid and CHIP programs, especially if they publicly post results and require reporting by Medicaid managed care plans. Performance assessment and feedback can drive quality improvement efforts to raise immunization levels. There are national evidence-based recommendations for how health care providers can increase prenatal immunization levels. Response 2: Overall, only half of pregnant women nationally receive influenza or Tdap vaccination, indicating substantial missed opportunities to protect pregnant women and their babies from the consequences of influenza and pertussis infections. Data from multiple sources indicate pregnant women with public health insurance/Medicaid are less likely than privately insured women to receive indicated vaccines during pregnancy. This difference in coverage likely results in a disproportionate burden of influenza and pertussis disease among Medicaid beneficiaries: for example, one state determined that infants born in 2013-14 to mothers on Medi-Cal were 2.5 times more likely that those born to privately insured mothers to develop pertussis. States could use this measure to drive improvement on the quality of care of both Medicaid and CHIP beneficiaries to monitor vaccine uptake among their pregnant beneficiaries, reducing the disparity in vaccination coverage by insurance status and reducing the risk of

	illness, negative pregnancy outcomes, and death among their Medicaid populations. This measure is very relevant to the Medicaid population and its use would contribute toward improving birth outcomes. Response 3: Some states have already incorporated a special focus on prenatal immunization as part of their Medicaid programs. In Wisconsin, prenatal immunization coverage is monitored on an annual basis. Minnesota's Integrated Care for High Risk Pregnancies (ICHRP) program strives to address disparities in birth outcomes and incorporated cultural sensitivity in its maternal care services. By leveraging existing integrated care models in various states and utilizing payment model flexibilities, states can use this measure to drive improvement in the quality of care for both pregnant mothers and infants. Response 4: This measure will provide useful and actionable results for state Medicaid and CHIP programs, especially if they publicly post results and require reporting by Medicaid managed care plans. Performance assessment and feedback can drive quality improvement efforts to raise immunization levels. There are national evidence-based recommendations for how health care providers can increase prenatal immunization levels. In one state, the Medicaid Agency requires Medi-Cal managed care plans to meet minimum performance thresholds for a list of measures, and to conduct quality improvement activities based on these measures. Pay for performance is another way plans, health systems, and medical groups could use this measure to drive quality improvement.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	• This measure was new for HEDIS 2019. • Several workgroup members note that the measure specifications may need to be modified for state-level reporting to be feasible, especially given state issues in accessing EHR data.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Colorectal Cancer Screening
Description	Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0034
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	51-75 years as of December 31 of the measurement year.
Data collection method	Administrative and Hybrid.
Denominator	Members 51-75 years as of December 31 of the measurement year.
Numerator	One or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (FOBT) during the measurement period. • Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period. • Colonoscopy during the measurement period or the nine years prior to the measurement period. • Computed tomography (CT) colonography during the measurement period or the four years prior to the measurement period. • Fecal immunochemical DNA test (FIT-DNA) during the measurement period or the two years prior to the measurement period.
Exclusions	• Members 66 years of age and older in Institutional Special Needs Plans (SNP) or living long-term in an institution any time during the measurement period. • Members in hospice. • Patients with a diagnosis or past history of total colectomy or colorectal cancer (Optional).
Continuous enrollment period	The measurement year and the year prior to the measurement year.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2018_Measure_113_Claims.pdf https://www.ncqa.org/hedis/measures/colorectal-cancer-screening/

Additional Information for Consideration	
Current level of reporting	Plan-level, state-level, provider-level
Gap area(s) ***(per workgroup member who suggested the measure)***	Two Workgroup members suggested this measure for addition. Response 1: This measure would fill a critical gap by tracking the uptake of colorectal cancer among a high need population. Colorectal cancer is the second leading cause of cancer deaths in the U.S.; those with population characteristics consistent with many Medicaid beneficiaries, who are often vulnerable, lower income, and nonwhite, have higher rates of colorectal cancer and die from colorectal cancer at higher rates. People who are uninsured, report not having a regular health care provider, identify as a racial or ethnic minority, have a low annual household income, or report a low level of educational attainment are less likely to be up-to-date with colorectal cancer screening. The epidemiology, described and illustrated at the link below, indicates the prevalence of colorectal cancer in the <65 year old population which, in light of lower rates of screening for this preventable cancer, seems to warrant adding this measure to the Adult Core Set. This would be a new measure, not replacing an existing measure. This measure will provide useful and actionable results for state Medicaid and CHIP programs by tracking those receiving screening for this preventable cancer, and helping lower the mortality rate from CRC. Background and epidemiology: Colorectal cancer is the second most common cause of cancer death among cancers that affect both men and women and the second leading cause of cancer mortality in the U.S. In 2015, the most recent year for which data are available, there were 140,788 people diagnosed with colorectal cancer, and 52,396 deaths from the disease. Of the total people diagnosed in 2015, 80,604 were age 50-75 (45,304 age 50-64 years; 35,300 age 65-75). Of the total deaths in 2015, 25,505 were among people age 25,505 (13,117 among people age 50-64; 12,388 among people age 65-75). There were an estimated 260,052 people age 0-70 years who were living with colorectal cancer as of January 1, 2015. (U.S. Cancer Statistics, available at https://gis.cdc.gov/Cancer/USCS/DataViz.html). Recent studies have noted an increasing incidence of colorectal cancer among adults ages 45-49, prompting the American Cancer Society to recommend that average risk adults initiate screening at age 45. There is strong evidence that screening for colorectal cancer reduces the incidence of and deaths from the disease. The USPSTF recommends that adults ages 50-75 at average risk be screened for colorectal cancer routinely (Grade A recommendation). Despite strong evidence for its use, only 67% of age-eligible adults are up-to-date with colorectal cancer screening, leaving ~22 million adults who have never been screened (2016 BRFSS).

	People who are uninsured, report not having a regular health care provider, identify as a racial or ethnic minority, have a low annual household income, or report a low level of educational attainment are less likely to be up-to-date with colorectal cancer screening. https://www.cdc.gov/cancer/colorectal/statistics/ Response 2: Screening for colorectal cancer in adults has an A recommendation from the USPSTF. CDC supports screening for breast, cervical, colorectal, and lung cancer (for smokers). Screening for depression is the only preventive screening measure in the Adult Core Set for males and females. There are currently three preventive screening measures for females.
How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	Response 1: States could use this measure to drive improvement in the quality of care for Medicaid and CHIP beneficiaries by improving CRC screening rates among this population facing disparities in CRC incidence, mortality, and screening. CRC screening is a very effective tool that detects pre-cancer or early cancers early enough to prevent or effectively treat the cancer. This is a costly cancer if left undetected, which means that colorectal cancer is both cost saving and lifesaving. Response 2: In some states, Medicaid managed care plans are required to meet minimum performance thresholds for a list of measures, and to conduct quality improvement activities based on these measures. Pay for performance is another way plans, health systems, and medical groups could use this measure to drive quality improvement.
Use of measure in other programs	• Medicare Shared Savings Program (MSSP) • Qualified Health Plan (QHP) Quality Rating System (QRS) • Merit-Based Incentive Payment System (MIPS), Quality ID # 113 • Medicare Part C Star Rating • Uniform Data System • Medicaid Promoting Interoperability • Core Quality Measures Collaborative (CQMC) Measure • IHA Align Measure Perform • NCQA Health Plan Accreditation (Commercial and Medicare) • 4 states included this measure in their Medicaid Managed Care External Quality Review (EQR) 2018 Reporting
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure has been tested and approved for Medicare and commercial health plan reporting.

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MATHEMATICA Policy Research

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Description	Percentage of patients age 18 years and older with a BMI documented during the current encounter or during the previous 12 months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥18.5 and < 25 kg/m2.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	0421/0421e
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	Adult Body Mass Assessment (ABA-AD)

Technical Specifications	
Ages	Adults age 18 and older on the date of the encounter.
Data collection method	Administrative (G-codes), EHR.
Denominator	All patients age 18 and older on the date of the encounter with at least one eligible encounter during the measurement period.
Numerator	Patients with a documented BMI during the encounter or during the previous 12 months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous 12 months of the current encounter.

Exclusions	• Not eligible for BMI Calculation or Follow-Up Plan. A patient is not eligible if one or more of the following reasons are documented:
	  ○ Patients receiving palliative care
	  ○ Patients who are pregnant
	  ○ Patients who refuse measurement of height and/or weight or refuse follow-up
	• Exceptions. Patients with a documented BMI outside normal limits and a documented reason for not completing BMI follow-up plan. The Medical Reason exception could include, but is not limited to, the following patients as deemed appropriate by the health care provider:
	  ○ Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as: illness or physical disability; mental illness, dementia, confusion; nutritional deficiency, such as Vitamin/mineral deficiency.
	  ○ Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status.

Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Provider-level.
For more information	https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2018_Measure_128_Claims.pdf

Additional Information for Consideration	
Current level of reporting	Provider-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted obesity is a cross-cutting health problem. While classified as primary care, it includes behavioral health and is linked to all co-morbid conditions. Screening is NOT enough; to achieve quality we need to make sure that there is appropriate, evidence-based follow up.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Closing the appropriate care follow-up loops is the only way to improve quality using this quality measure; underperforming states can learn from higher performing states and build resources and accountability.
Use of measure in other programs	• Merit-Based Incentive Payment System (MIPS) Program (Quality ID # 128) • HRSA Uniform Data System • Behavioral Health Clinic Quality Measure • Medicaid Promoting Interoperability Program • Core Quality Measures Collaborative (CQMC) Measure
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	• During 2017 annual update for the 2018 performance year, the frequency of BMI documentation was revised from six months to twelve months. • This measure was discussed but not ultimately recommended at the 2018 Core Set Review meeting.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Follow-up with Patient Family After Developmental Screening
Description	Percentage of patients aged 6 months to 36 months whose family received a follow-up discussion of developmental screening results on the same day of the screening visit.
Measure steward	Agency for Healthcare Research & Quality (AHRQ), Pediatric Measurement Center of Excellence (PMCoE)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 6 months to 36 months.
Data collection method	Electronic health records (EHR) or Medical Record Review.
Denominator	All patients ages 6 months to 36 months who received a developmental screen using a standardized developmental screening tool that was administered either by the primary care clinician or, if conducted elsewhere, appears in the patient's medical chart.
Numerator	Patients whose family received a discussion of the developmental screen by a primary care clinician on the same day of the screening visit.
Exclusions	None.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Rate aggregation specified for the following levels: State, geographic region, health plan, practice, provider, Medicaid/CHIP.
For more information	https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/preventive/chipra-202-tech-specs.pdf More information on the standardized tools that meet the criteria for the denominator is available in the technical specification.

Additional Information for Consideration	
Current level of reporting	Unknown.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member did not provide a gap area for this measure.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	An estimated 1 in 7 children have some sort of developmental delay but only half receive treatment before they enter school. Diagnosing and treating delays as early as possible is important to help children be ready for school.

Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Promote Effective Communication & Coordination of Care.
Other	This measure was developed under the Pediatric Quality Measures Program (PQMP). More information about the PQMP is available at https://www.ahrq.gov/pqmp/index.html.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	HIV Screening
Description	Percentage of patients ages 15-65 who have been tested for HIV within that age range.
Measure steward	Centers for Disease Control and Prevention (CDC)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Patients 15-65 years of age.
Data collection method	Electronic Health Record (EHR)
Denominator	Patients 15 to 65 years of age who had an outpatient visit during the measurement period.
Numerator	Patients with documentation of an HIV test between the ages of 15 and 65 before the end of the measurement period.
Exclusions	Patients diagnosed with HIV prior to the start of the measurement period.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Provider-level.
For more information	https://ecqi.healthit.gov/ecqm/measures/cms349v1

Additional Information for Consideration	
Current level of reporting	Provider-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member suggested this as a new, HIV-related measure to be added to both the Child and Adult Core Sets, while still retaining the existing Adult Core Set measure Viral Load Suppression (HVL-AD). The HIV screening measure will provide useful and actionable results for state Medicaid and CHIP programs by identifying those with undiagnosed HIV, getting them into effective treatment, and reducing the transmission of HIV. The current Core Set does not provide the ability to track HIV screening so this measure fills an important gap in the efforts to control HIV. It will also allow Medicaid and CHIP to track progress toward the "Ending the HIV Epidemic by 2030" initiative launched in February 2019. It is being used in MIPS.

	General rationale: Human immunodeficiency virus (HIV) is a communicable infection that leads to a progressive disease with a long asymptomatic period. An estimated 1.1 million people in the United States are living with HIV, including about 162,500 people (one in seven) who are unaware of their status. Approximately 40% of new HIV infections are transmitted by people living with undiagnosed HIV. There were an estimated 38,500 new HIV infections in the United States in 2015. Among persons newly diagnosed with HIV, ~21% had Stage 3 HIV (AIDS) at the time of diagnosis. For those living with undiagnosed HIV, testing is the first step in maintaining a healthy life and reducing the spread of HIV. HIV screening identifies infected persons previously unaware of their infection, enabling them to seek medical and social services that can improve their health and the quality and length of their lives. Persons living with HIV who use antiretroviral therapy (ART) and achieve viral suppression can have a nearly normal life expectancy. Additionally, appropriate and adherent use of ART has been shown to substantially reduce risk for HIV transmission. However, data from the National Health Interview Survey indicate fewer than half of persons 18 and older reported ever having been tested for HIV as of 2017. Data from a clinical trial sponsored by the National Institutes of Health shows a clear personal health advantage to being diagnosed with HIV early and starting therapy right away. This information further highlights the importance of routine HIV testing and its potential impact on better health outcomes. The centrality of HIV screening to national and state HIV prevention efforts is reflected in the "Ending the HIV Epidemic by 2030" initiative newly announced by DHHS in February 2019. Specifically, the initiative focuses on "four key strategies that together can end the HIV epidemic in the United States: Diagnose, Treat, Protect, and Respond." Effective execution of the "Diagnose" strategy requires broader implementation of HIV screening recommendations, including one time screening for all persons between the ages of 15 and 65 (inclusive). Inclusion of the HIV screening measure in the Core Sets will both incentivize and support state efforts to improve delivery to/receipt of HIV screening within low-income populations and communities that may be at particularly high risk for living with undiagnosed HIV infections.

How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	States can use this measure to drive improvement in the quality of care for Medicaid and CHIP beneficiaries by identifying those living with undiagnosed HIV, enabling them to seek medical and social services that can improve their health and the quality and length of their lives, and substantially reducing risk for HIV transmission. Persons living with HIV who use antiretroviral therapy (ART) and achieve viral suppression can have a nearly normal life expectancy. Data from a clinical trial sponsored by the National Institutes of Health shows a clear personal health advantage to being diagnosed with HIV early and starting therapy right away. This information further highlights the importance of routine HIV testing and its potential impact on better health outcomes. States can examine the results of this screening test at different levels of aggregation (e.g., overall and by managed care organization [MCO], health system, clinic, and even individual provider levels) and identify potential opportunities for targeted outreach and enhanced technical assistance to drive performance improvement. State-to-state comparison can also identify higher-performing states from whom other states may learn best practices for improving HIV screening implementation across their Medicaid-enrolled populations. States can also track performance over time, evaluate the effectiveness of specific performance/quality improvement activities and initiatives, and contribute to the national call to end the HIV epidemic by 2030. States can use the measure to track performance and adopt the measure as part of value-based payments (e.g., incentive payments, whether in the form of withholds or bonuses) for MCOs, ACOs, etc. The measure is an eCQM and has been validated at the provider/clinic level.
Use of measure in other programs	• Merit-Based Incentive Payment System (MIPS), Quality ID # 475 • Electronic Clinical Quality Measure (eCQM) CMS349v1
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	The Workgroup member noted that this measure is being submitted to NQF for consideration for endorsement in 2019.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Lead Screening in Children (LSC)
Description	Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Primary Care Access and Preventive Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children who turn 2 years old during the measurement year.
Data collection method	Administrative or Hybrid.
Denominator	Children enrolled in Medicaid who turn 2 years old during the measurement year.
Numerator	At least one lead capillary or venous blood test on or before the child's second birthday.
Exclusions	Members in hospice.
Continuous enrollment period	12 months prior to the child's second birthday.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.ncqa.org/hedis/measures/lead-screening-in-children/ See NCQA HEDIS 2019 volume 2.

Additional Information for Consideration	
Current level of reporting	Plan-level, State-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this is an important screening test that may detect elevated lead blood levels. Undetected elevated blood levels have long term metabolic and neurological consequences. The NCQA Medicaid national average for 2017 was only 68.9% so there is a huge gap to be filled. The rate in 2008 was 66.7% and only recently increased in the past 2 years from 66.5% in 2015 to 68.9% in 2017. In one state that has been focused on this topic for many years, the 2018 HEDIS statewide average was 80.3%, so the needle can be moved on this measure.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	See above on filling the quality gap.

Use of measure in other programs	13 states included this measure in their Medicaid Managed Care External Quality Review (EQR) 2018 Reporting.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	• The Form CMS-416 EPSDT Participation Report collects data from states on the total number of screening blood lead tests (line 14). More information is available at https://www.medicaid.gov/medicaid/benefits/epsdt/index.html. • No major changes expected to the specifications at this time.

EXPERIENCE OF CARE: PATIENT-REPORTED OUTCOME MEASURES

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Child Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey
Description	The Child HCAHPS Survey is a standardized survey instrument that asks parents and guardians of children under 18 years old to report on their and their child's experiences with inpatient hospital care. The performance measures of the Child HCAHPS survey consist of 39 items organized by overarching groups into 18 composite and single-item measures. The top-box scoring method is recommended for the Child HCAHPS composite and single-item measures. The top box score refers to the percentage of respondents who answered survey items using the best possible response option. The measure time frame is 12 months.
Measure steward	Agency for Healthcare Research and Quality (AHRQ)
NQF number (if endorsed)	2548
Core Set domain	Experience of Care
Measure type	Outcome: PRO-PM
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children under age 18.
Data collection method	Survey.
Denominator	The denominator for each single-item measure is the number of respondents with a completed survey who responded to the item. The denominator for each composite measure is the number of respondents with a completed survey who responded to at least one of the items within the measure. The target population for the survey is parents of children under 18 years old who have been discharged from the hospital during the target 12-month time frame.
Numerator	Using the top-box scoring method, the numerator of the top-box score for a measure consists of the number of respondents with a completed survey who gave the best possible answer for the item(s) in a measure. For example, the top-box numerator for the communication between you and your child's nurses composite is the number of respondents who answered "Always" to questions about how well nurses communicated well with them. Experience of care is measured in the following areas:

	Communication with Parent 1. Communication between you and your child's nurses (3 items) 2. Communication between you and your child's doctors (3 items) 3. Communication about your child's medicines (4 items) 4. Keeping you informed about your child's care (2 items) 5. Privacy when talking with doctors, nurses, and other providers (1 item) 6. Preparing you and your child to leave the hospital (5 items) 7. Keeping you informed about your child's care in the Emergency Room (1 item) **Communication with Child** 8. How well nurses communicate with your child (3 items) 9. How well doctors communicate with your child (3 items) 10. Involving teens in their care (3 items) **Attention to Safety and Comfort** 11. Preventing mistakes and helping you report concerns (2 items) 12. Responsiveness to the call button (1 item) 13. Helping your child feel comfortable (3 items) 14. Paying attention to your child's pain (1 item) **Hospital Environment** 15. Cleanliness of hospital room (1 item) 16. Quietness of hospital room (1 item) **Global Rating** 17. Overall rating (1 item) 18. Recommend hospital (1 item)
Exclusions	**SURVEY AND MEASURES 1-18** Exclude parents of certain patients from the measure (numerator and denominator) based on clinical and non-clinical criteria: 1. "No-publicity" patients 2. Court/law enforcement patients 3. Patients with a foreign home addresses 4. Patients discharged to hospice care 5. Patients who are excluded because of state regulations 6. Patients who are wards of the state 7. Healthy newborns 8. Maternity-stay patients 9. Patients admitted for observation 10. Patients discharged to skilled nursing facilities 11. Patients who are emancipated minors **MEASURES 1-18** Exclude respondents from the numerator and denominator of a measure if they have completed survey items in the measure using multiple marks (i.e., they gave multiple answers to an individual question).

	MEASURES 8-9 Exclude the following respondents from the numerator and denominator: 1. All those who answered "No" to screener question 6 (Is your child able to talk with nurses and doctors about his or her health care?) 2. All those whose child was under 3 years old at discharge as determined using administrative data. **MEASURE 10** Exclude the following respondents from the numerator and denominator: 1. All those who answered "No" in screener question 43 (During this hospital stay, was your child 13 years old or older?) 2. All those whose child was under 13 years old at discharge as determined using administrative data 3. All those who answered "No" in screener question 6 (Is your child able to talk with nurses and doctors about his or her health care?) **MEASURE 12** Exclude the following respondents from the numerator and denominator: 1. All those who answered "No" in screener question 25 (During this hospital stay, did you or your child ever press the call button?) **MEASURE 14** Exclude the following respondents from the numerator and denominator: 1. All those who answered "No" in screener question 30 (During this hospital stay, did your child have pain that needed medicine or other treatment?)
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Facility-level.
For more information	https://www.ahrq.gov/cahps/surveys-guidance/hospital/about/child_hp_survey.html

Additional Information for Consideration	
Current level of reporting	Facility-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted few acute care measures are currently in the Core Sets. This measure fills the gap of experience of care for hospital care for children.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Experience of care is critical to quality and value. Assessing the experience of acute care for children and families is critical.

Use of measure in other programs	This survey is being used by at least 350 hospitals but is not being used in a federal program.
Meaningful Measures area(s) of measure	Strengthen Person & Family Engagement as Partners in Their Care.
Other	• This measure was developed under the Pediatric Quality Measures Program (PQMP). More information about the PQMP is available at https://www.ahrq.gov/pqmp/index.html. • Measure is undergoing NQF endorsement maintenance; there are no anticipated changes to the survey. • This measure was recommended for addition to the Child Core Set in 2014 and 2018 to address the gap areas of inpatient care, patient experience, and care coordination. In 2015, CMCS agreed to pilot a reporting process to determine the feasibility of the measure for future Core Sets. According to the 2018 MAP report, the "measure was undergoing testing to determine the survey vendor's ability to send hospital data directly to state agencies. Many hospitals have already adopted this measure for use, but the information is not publicly available. Broad adoption of this CAHPS family survey will ultimately enhance comparability of patient experience-related data across hospitals and populations."

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Healthy Days Core Module - Health-Related Quality of Life (CDC HRQOL-4)
Description	The four Health-Related Quality of Life Healthy Days Core Module (HRQOL-4) measures ask about self-rated general health and the number of days when a person was physically unhealthy, mentally unhealthy, or limited in usual activities within the previous 30 days. A summary measure combines physically and mentally unhealthy days.
Measure steward	Centers for Disease Control and Prevention (CDC)
NQF number (if endorsed)	Not endorsed
Core Set domain	Experience of Care
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages vary by survey.
Data collection method	Survey
Denominator	Total number of survey respondents (eligibility varies by survey).
Numerator	Q1. Number of respondents indicating that their general health is Excellent [or Very Good]. Q2. Number of days during the past 30 days the respondent's physical health was not good. Q3. Number of days during the past 30 days the respondent's mental health was not good. Q4. Number of days during the past 30 days the respondent's poor physical or mental health kept them from doing their usual activities.
Exclusions	None
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	National and state surveillance surveys, including the state-based Behavioral Risk Factor Surveillance System (BRFSS), the National Health and Nutrition Examination Survey, and the Medicare Health Outcomes Survey.
For more information	https://www.cdc.gov/hrqol/measurement.htm https://www.cdc.gov/hrqol/hrqol14_measure.htm

Additional Information for Consideration	
Current level of reporting	National Surveillance Surveys; Medicare Health Outcomes Survey.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted growing evidence shows that if unmet health-related social needs, such as homelessness, hunger, and exposure to violence are addressed, we can help undo their harm to health and improve overall progress on improving health, health care, and wellbeing. While there is a robust dialogue on how best to measure and improve upon an individual or community's social determinants of health, there are a few measures that have been in use or are currently being tested by the Centers for Medicare and Medicaid Innovation that would allow state Medicaid programs to begin measuring and then addressing social needs and social determinants. This is one of two recommended measures (see Health-Related Social Needs Screening) that could be tested over a several-year period as a starting point, while alignment around measures related to social needs and social determinants is fully reached. While there are some measures on the Core Sets that reflect unmet social needs, such as low birth weight, these suggested measures would be new and would be an attempt to explicitly measure quality of life and the ability to have social needs met, as a critical component of well health.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	States could use this measure to monitor and drive improved perceived overall health and well-being of individuals and communities, as a key fundamental benchmark of health, in addition to tracking receipt of clinical services as a means to improving health outcomes. Healthy Days are a reflection of some of the underlying determinants of health and its use will highlight the importance of addressing the total needs of the patient beyond but not limited to what can be delivered in a clinical setting. More information is available at https://www.cdc.gov/hrqol/pdfs/mhd.pdf.
Use of measure in other programs	• The standard 4-item set of Healthy Days core questions (CDC HRQOL–4) has been in the state-based Behavioral Risk Factor Surveillance System (BRFSS) for persons age 18 and older since 1993. • From 2000 to 2012, the CDC HRQOL–4 has been in the National Health and Nutrition Examination Survey (NHANES) for persons age 12 and older. • Since 2003, the CDC HRQOL–4 has been in the Medicare Health Outcomes Survey (HOS) for persons age 18 and older as of December 31st of the measurement year—a measure in the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS). • The health plan Humana uses the CDC's Healthy Days population health management tool to benchmark community health and to measure progress.

Meaningful Measures area(s) of measure	Work with communities to promote best practices of healthy living.
Other	States have access to the measure since it has been included in BRFSS since the 1990s. To address social needs and social determinants, the measure would require linkages with EHRs.

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CARE OF ACUTE AND CHRONIC CONDITIONS

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
Description	Percentage of episodes for members age 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0058
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Members who were 3 months or older as of the Episode Date. Report three age stratifications and a total rate: • 3 months-17 years • 18-64 years • 65 years and older • Total
Data collection method	Administrative, EHR.
Denominator	All members who had an outpatient visit with or without a telehealth modifier, a telephone visit, an online assessment, an observation visit, or an ED visit during the Intake Period (January 1–December 28 of the measurement year), with a diagnosis of acute bronchitis. The date of this visit is referred to as the Episode Date.
Numerator	Dispensed prescription for an antibiotic medication on or 3 days after the Episode Date.
Exclusions	• Members in hospice. • ED visits or observation visits that result in an inpatient stay. • Episode Dates where the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. • Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date. • Episode Dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the Episode Date.
Continuous enrollment period	30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.ncqa.org/wp-content/uploads/2019/02/20190208_10_Antibiotics.pdf

Additional Information for Consideration	
Current level of reporting	Plan-level, state-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	This measure is being suggested by a Workgroup member as one of two new antibiotic prescribing measures but would not replace the current pediatric CLABSI measure, which should be retained. This and the other suggested antibiotic prescribing measure will provide useful and actionable results for state Medicaid and CHIP programs by tracking prescribing practices by providers and by helping to avoid continued antibiotic resistance. Antibiotics are life-saving medications that treat bacterial infections, and antibiotic resistance is a pressing global health threat. CDC estimates that 2 million illnesses and 23,000 deaths are caused by antibiotic-resistant infections each year in the United States. Antibiotic use (and sometimes overuse or inappropriate use) is a major driver of antibiotic resistance. Additionally, antibiotics can have adverse events that can harm patients. Antibiotic-associated adverse events range from minor side-effects to severe reactions, such as life-threatening allergic reactions and Clostridioides difficile infections. CDC estimates that every year 200,000 emergency department visits occur in the United States from antibiotic-associated adverse events. Improving antibiotic use so that antibiotics are used correctly and only when needed is a key strategy to combat antibiotic resistance and improve patient safety. The majority of human antibiotic use, an estimated 85-95% by volume, occurs among outpatients. CDC estimates that at least 30% of outpatient antibiotic use is unnecessary, meaning no antibiotic was needed at all. Respiratory infections, including acute bronchitis, upper respiratory infections, and pharyngitis, are key drivers of unnecessary antibiotic use. However, the existing Core Set measures do not address the appropriate use of antibiotics. This HEDIS measure will address this key gap by addressing one of the major drivers of unnecessary antibiotic use in the outpatient setting.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	States can use this measure to promote appropriate outpatient antibiotic prescribing by providing data to healthcare providers on their performance on this measure compared with the goal performance and their peer providers who are top performers on this measure. Audit-and-feedback on antibiotic prescribing is an evidence-based strategy to promote adherence to national guidelines and is recommended in CDC's Core Elements of Outpatient Antibiotic Stewardship. https://www.cdc.gov/mmwr/volumes/65/rr/rr6506a1.htm?s_cid=rr6506a1_e Additionally, state Medicaid programs can partner with state public health departments to deliver tools and interventions to improve antibiotic use to providers with opportunities to improve performance on this measure. CDC's 6|18 Initiative recommends the use of audit-and-feedback using this quality measure use as an intervention to improve antibiotic use. https://www.cdc.gov/sixeighteen/hai/index.htm Currently, state Medicaid agencies and state health departments in

	Kansas, Nebraska, Arkansas, and Alaska, and in the Commonwealth of the Northern Mariana Islands are working together on this effort, so they have immediate experience with gathering this information. Additionally, CDC provides Epidemiology and Laboratory Capacity (ELC) support through an Infectious Diseases Cooperative Agreement, supporting antibiotic resistance activities in every state, including state and local laboratory and epidemiological expertise. Learn more on CDC's ELC website. https://www.cdc.gov/ncezid/dpei/epidemiology-laboratory-capacity.html State and local public health partners fight antibiotic resistance in healthcare facilities, the community, and food. State programs implement tracking, prevention, and antibiotic stewardship activities, described by these Antibiotic Resistance Investments maps. https://wwwn.cdc.gov/arinvestments
Use of measure in other programs	The existing measure is used in the following programs: • CMS's Qualified Health Plan (QHP) Quality Rating System (QRS). • The Core Quality Measures Collaborative (CQMC), in the Accountable Care Organizations/Patient Centered Medical Homes/Primary Care Core Set. • The Merit-Based Incentive Payment System (MIPS) Program (Quality ID #116), under National Quality Strategy domain: efficiency and cost reduction. Included in the following specialty measure sets: emergency medicine, family medicine, internal medicine, preventive medicine, and urgent care. • The 2020 Clinical Quality, Customer Service and Resource Use (QCR) Measure Set, as detailed in the U.S. Office of Personnel Management Federal Employee Health Benefits (FEHB) Program Carrier Letter. (https://www.opm.gov/healthcare-insurance/healthcare/carriers/2018/cl2018-07a1.pdf) • CDC's Core Elements of Outpatient Antibiotic Stewardship provides a framework for antibiotic stewardship implementation in outpatient settings based upon evidence-based interventions. One of the 4 Core Elements of Outpatient Antibiotic Stewardship is tracking and reporting of antibiotic prescribing, also called audit-and-feedback, including reporting performance on HEDIS measures related to appropriate outpatient antibiotic prescribing. https://www.cdc.gov/antibiotic-use/community/improving-prescribing/core-elements/core-outpatient-stewardship.html • CDC's 6|18 Initiative recommends the use of audit-and-feedback using this quality measure as an intervention to improve antibiotic use (https://www.cdc.gov/sixeighteen/hai/index.htm). As part of their participation in CDC's 6|18 Initiative to improve antibiotic use, Aetna has been sending letters since 2017 to health care providers giving them feedback on their performance on this quality measure. • NCQA Health Plan Accreditation (Medicaid and Commercial).

	• 11 states included this measure in their Medicaid Managed Care External Quality Review (EQR) 2018 Reporting. • The Utah Department of Health, Office of Health Care Statistics uses its state All Payers Claims Database to publicly report performance by clinic, and has included Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis as a reported measure since 2016. https://opendata.utah.gov/Health/2016-2015-Clinic-Quality-Comparisons-for-Clinics-w/35s3-nmpm
Meaningful Measures area(s) of measure	Make Care Safer by Reducing Harm Caused in the Delivery of Care.
Other	The existing measure, which has been in use since 2006, is under re-evaluation and updates have been proposed for HEDIS 2020. The public comment period for the proposed changes to the existing measure closed March 11, 2019. The final revised measure will be published in July 2019 and be included in HEDIS 2020 reporting. The proposed changes include: (1) changing the name from Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis to Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB); (2) expanding the eligible age range from 18-64 years to 3 months of age and older; (3) including the Medicare product line; (4) changing the measure from a member-based denominator to an episode-based denominator; (5) changing the negative competing diagnosis time frame to "on the episode date through the three days after"; and (6) updating the continuous enrollment and allowable gap.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Appropriate Treatment for Upper Respiratory Infection (URI)
Description	Percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0069
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Members who were 3 months or older as of the Episode Date. Report rates for three age groups and a total rate: • 3 months-17 years • 18-64 years • 65 years and older • Total.
Data collection method	Administrative, EHR.
Denominator	All members who had an outpatient visit with or without a telehealth modifier, a telephone visit, an online assessment, an observation visit, or an ED visit during the Intake Period (a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year), with a diagnosis of URI. The date of this visit is referred to as the Episode Date.
Numerator	Dispensed prescription for an antibiotic medication on or 3 days after the Episode Date.
Exclusions	• Members in hospice. • ED visits or observation visits that result in an inpatient stay. • Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. • Episode Dates where a new or refill prescription for an antibiotic medication was filled 30 days prior to the Episode Date or was active on the Episode Date. • Episode Dates where the member had a claim/encounter with a competing diagnosis on or 3 days after the Episode Date.
Continuous enrollment period	30 days prior to the Episode Date through three days after the Episode Date (34 total days).
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.ncqa.org/wp-content/uploads/2019/02/20190208_10_Antibiotics.pdf

Additional Information for Consideration	
Current level of reporting	Plan-level, State-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	This measure is being suggested by one Workgroup member as one of two new antibiotic prescribing measures but would not replace the current pediatric CLABSI measure, which should be retained. This and the other suggested antibiotic prescribing measure will provide useful and actionable results for state Medicaid and CHIP programs by tracking prescribing practices by providers and by helping to avoid continued antibiotic resistance. Antibiotics are life-saving medications that treat bacterial infections, and antibiotic resistance is a pressing global health threat. CDC estimates that 2 million illnesses and 23,000 deaths are caused by antibiotic-resistant infections each year in the United States. Antibiotic use is a major driver of antibiotic resistance. Additionally, antibiotics can have adverse events that can harm patients. Antibiotic-associated adverse events range from minor side-effects to severe reactions, such as life-threatening allergic reactions and Clostridioides difficile infections. CDC estimates that every year 200,000 emergency department visits occur in the United States from antibiotic-associated adverse events. Improving antibiotic use so that antibiotics are used correctly and only when needed is a key strategy to combat antibiotic resistance and improve patient safety. The majority of human antibiotic use, an estimated 85-95% by volume, occurs among outpatients. CDC estimates that at least 30% of outpatient antibiotic use is unnecessary, meaning no antibiotic was needed at all. Respiratory infections, including acute bronchitis, upper respiratory infections, and pharyngitis, are key drivers of unnecessary antibiotic use. However, the existing Core Set measures do not address the appropriate use of antibiotics. This HEDIS measure will address this key gap by addressing one of the major drivers of unnecessary antibiotic use in the outpatient setting.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	States can use this measure to promote appropriate outpatient antibiotic prescribing by providing data to healthcare providers on their performance on this measure compared with the goal performance and their peer providers who are top performers on this measure. Audit-and-feedback on antibiotic prescribing is an evidence-based strategy to promote adherence to national guidelines and is recommended in CDC's Core Elements of Outpatient Antibiotic Stewardship. https://www.cdc.gov/mmwr/volumes/65/rr/rr6506a1.htm?s_cid=rr6506a1_e Additionally, state Medicaid programs can partner with state public health departments to deliver tools and interventions to improve antibiotic use to providers with opportunities to improve performance on this measure. CDC's 6|18 Initiative recommends the use of audit-and-feedback using this quality measure use as an intervention to improve antibiotic use. https://www.cdc.gov/sixeighteen/hai/index.htm

	Currently, state Medicaid agencies and state health departments in Kansas, Nebraska, Arkansas, and Alaska, and the Commonwealth of the Northern Mariana Islands are working together on this effort, so they have immediate experience with gathering this information. Additionally, CDC provides Epidemiology and Laboratory Capacity (ELC) support through an Infectious Diseases Cooperative Agreement, supporting antibiotic resistance activities in every state, including state and local laboratory and epidemiological expertise. Learn more on CDC's ELC website. https://www.cdc.gov/ncezid/dpei/epidemiology-laboratory-capacity.html State and local public health partners fight antibiotic resistance in health care facilities, the community, and food. State programs implement tracking, prevention, and antibiotic stewardship activities, described by these Antibiotic Resistance Investments maps. https://wwwn.cdc.gov/arinvestments
Use of measure in other programs	The existing measure is used in the following programs: • Medicaid Promoting Interoperability Program • Qualified Health Plan (QHP) Quality Rating System (QRS) • Core Quality Measures Collaborative (CQMC), in the Pediatric Measures Core Set • Merit-Based Incentive Payment System (MIPS) Program (Quality ID 065), under National Quality Strategy (NQS) domain: Efficiency and Cost Reduction. Included in the following specialty measure sets: family medicine, otolaryngology, pediatrics, and urgent care. • CDC's Core Elements of Outpatient Antibiotic Stewardship provides a framework for antibiotic stewardship implementation in outpatient settings based on evidence-based interventions. One of the 4 Core Elements of Outpatient Antibiotic Stewardship is tracking and reporting of antibiotic prescribing, also called audit-and-feedback, including reporting performance on HEDIS measures related to appropriate outpatient antibiotic prescribing. https://www.cdc.gov/antibiotic-use/community/improving-prescribing/core-elements/core-outpatient-stewardship.html • CDC's 6|18 Initiative recommends the use of audit-and-feedback using this quality measure as an intervention to improve antibiotic use. https://www.cdc.gov/sixeighteen/hai/index.htm • NCQA Health Plan Accreditation (Medicaid and Commercial) • 14 States included this measure in their Medicaid Managed Care External Quality Review (EQR) 2018 Reporting • Texas Health and Human Services Commission (HHSC) Medicaid program includes this measure in its Pay-for-Quality (P4Q) for managed care organizations as a STAR Program Measure and a CHIP measure. https://hhs.texas.gov/about-hhs/process-improvement/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-program

Meaningful Measures area(s) of measure	Make Care Safer by Reducing Harm Caused in the Delivery of Care.
Other	The existing measure, which has been in use since 2004, is under reevaluation and updates have been proposed for HEDIS 2020. The final revised measure will be published in July 2019 and be included in HEDIS 2020 reporting. The proposed changes include: (1) changing the name from Appropriate Treatment for Children with Upper Respiratory Infection (URI) to Appropriate Treatment for Upper Respiratory Infection (URI); (2) expanding the eligible age range from 3 months to 18 years to 3 months of age and older; (3) including the Medicare product line; (4) changing the measure from a member-based denominator to an episode-based denominator; (5) allowing telehealth visits; (6) excluding an episode if the member has a diagnosis of a comorbid condition during the 12 months prior to the Episode Date; and (7) removing the requirement to exclude Episode Dates where there was any diagnosis other than URI on the same date.

MATHEMATICA Policy Research

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Transcranial Doppler Ultrasonography Screening for Children with Sickle Cell Anemia
Description	Percentage of children ages 2 through 15 years old during the measurement year and identified as having Sickle Cell Anemia who received at least one Transcranial Doppler ultrasonography screening within a year.
Measure steward	Q-METRIC – University of Michigan
NQF number (if endorsed)	2797
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children ages 24 months or older on January 1 of the measurement year but younger than 16 years on December 31 of the measurement year.
Data collection method	Administrative.
Denominator	Number of children who had three or more sickle cell anemia related health care encounters during the measurement year. If using claims data with ICD-9 coding, children with sickle cell anemia are identified as those with sickle cell anemia-related ICD-9-CM diagnosis codes on three or more separate healthcare encounters within the measurement year. If using claims data with ICD-10 coding, children with sickle cell anemia are identified as those with at least one outpatient visit with a sickle cell anemia-related or D571 ICD-10-CM diagnosis code within the measurement year.
Numerator	Number of children ages 2 through 15 with sickle cell anemia who received at least one Transcranial Doppler (TCD) ultrasonography screening within the measurement year.
Exclusions	Children with evidence of other insurance (i.e., coordination of benefits) during the measurement year.
Continuous enrollment period	Continuous enrollment during the measurement year.
Level of reporting for which specifications were developed	State-level, plan-level.
For more information	http://chear.org/qmetric2; http://chear.org/sites/default/files/stories/pdfs/transcranialdopplerscreeningmeasurespecification.pdf

Additional Information for Consideration	
Current level of reporting	Not specified.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted sickle cell disease (SCD) affects nearly 100,000 individuals in the US and substantially increases the risk of severe infections and stroke among affected children. Preventive services, including antibiotic prophylaxis, influenza immunization, and transcranial Doppler (TCD) screening, could reduce SCD-related infectious and neurologic morbidity. TCD screening was the least reliably delivered preventive service, with only 25% of children receiving at least one TCD during the study period. As with antibiotic prophylaxis and influenza immunization, the children most likely to receive a TCD (42%) were those with 2 or more hematologist visits (aOR 2.03 [1.02–4.04]). Children with no well child care visits (19%), no non-WCC generalist visits (22%), and no hematologist visits (20%) were the least likely to receive a TCD in each of the 3 visit type groupings. More information is available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4842129/#S13title
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Ensure children with sickle cell disease and their families are aware of preventive care that reduces their child's risk of infections and stroke, ensure access to appropriate providers, and coverage of services.
Use of measure in other programs	• Michigan Medicaid program • Michigan health plans • TriCare
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	• This measure was developed under the Pediatric Quality Measures Program (PQMP). The measure was tested with data from two states and with national Medicaid Analytic eXtract (MAX) data. More information about the PQMP is available at https://www.ahrq.gov/pqmp/index.html. • This measure is undergoing NQF annual updates; no major changes are expected to the specifications at this time. • This measure was recommended for addition to the Child Core Set by the 2018 Core Set Annual Review Workgroup. Participants noted that this measure aligns with National Institutes of Health (NIH) National Heart, Lung, and Blood Institute (NHLBI) guidelines for annual TCD screening of children with sickle cell anemia and that this claims-based measure is feasible for states to report. The Workgroup also noted that this measure addresses disparities in care for a population at risk for stroke at an early age.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia
Description	Percentage of children ages 3 months to 5 years who were identified as having Sickle Cell Anemia who received appropriate antibiotic prophylaxis during the measurement year.
Measure steward	Q-METRIC – University of Michigan
NQF number (if endorsed)	3166
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children ≥ 90 days on January 1 of the measurement year but younger than five years on December 31 of the measurement year.
Data collection method	Administrative.
Denominator	Number of children who had three or more sickle cell anemia related health care encounters during the measurement year. If using claims data with ICD-9 coding, children with sickle cell anemia are identified as those with sickle cell anemia-related ICD-9-CM diagnosis codes on three or more separate healthcare encounters within the measurement year. If using claims data with ICD-10 coding, children with sickle cell anemia are identified as those with at least one outpatient visit with a sickle cell anemia-related or D571 ICD-10-CM diagnosis code within the measurement year.
Numerator	Eligible children who received antibiotic prophylaxis for at least 300 days as determined in administrative data.
Exclusions	Children with evidence of other insurance (i.e., coordination of benefits) during the measurement year.
Continuous enrollment period	Continuous enrollment during the measurement year.
Level of reporting for which specifications were developed	State-level, plan-level.
For more information	http://chear.org/qmetric2; http://chear.org/sites/default/files/stories/pdfs/antibioticprophylaxismeasurespecification.pdf

Additional Information for Consideration	
Current level of reporting	Not specified.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted persons with sickle cell disease (SCD) are particularly susceptible to infection. Infants and very young children are especially vulnerable. The 'Co-operative Study of Sickle Cell Disease' observed an incidence rate for pneumococcal septicaemia of 10 per 100 person years in children under the age of three years. Vaccines, including customary pneumococcal vaccines, may be of limited use in this age group. prophylactic penicillin regimens may be advisable for this population. More information is available at https://www.ncbi.nlm.nih.gov/pubmed/28994899 Children under age 5 who have sickle cell disease and are at increased risk of life-threatening pneumococcal infection. 2014 NHLBI Guidelines include "Oral penicillin to be given twice daily for all patients with HbSS until 5 years of age." More information is available at https://www.aap.org/en-us/Documents/soho_clinical_topic_sickle_cell.pdf Gap in care: Existing evidence suggests children with SCD receive preventive services inconsistently. Antibiotic prophylaxis, known for 30 years to substantially reduce the incidence of invasive pneumococcal disease in children with SCD, is received only half the time. Citation: Preventive Care Delivery to Young Children with Sickle Cell Disease, David G. Bundy, MD, MPH, John Muschelli, ScM, [...], and Marlene R. Miller, MD, MSc, Journal of pediatric hematology/oncology 2016 May; 38(4): 294-300.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Relatively easy care pathway—ensuring access and use of antibiotics—that is critical to the care and outcomes for this population that impacts the child and family/caregivers by avoiding hospitalizations due to infection. Avoiding complications from pneumonia and other infections has the potential to address avoidable costly services.
Use of measure in other programs	• Michigan Medicaid program • Michigan health plans • TriCare
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	• This measure was developed under the Pediatric Quality Measures Program (PQMP). The measure was tested with data from two states and with national Medicaid Analytic eXtract (MAX) data. More information about the PQMP is available at https://www.ahrq.gov/pqmp/index.html. • This measure is undergoing NQF annual updates; no major changes are expected to the specifications at this time. • This measure was recommended for addition to the Child Core Set by the 2018 Core Set Annual Review Workgroup. Participants ranked this measure as having the highest priority out of the six

	measures recommended by the Workgroup. Participants noted that the addition of this claims-based measure to the Child Core Set could potentially have a large impact on the treatment of children with sickle cell anemia as studies have shown the effectiveness of antibiotic prophylaxis, but rates of utilization remain low.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Proportion of Days Covered: Antiretroviral Medications
Description	Percentage of individuals 18 years and older who met the Proportion of Days Covered (PDC) threshold of 90% for ≥3 antiretroviral medications during the measurement year.
Measure steward	Pharmacy Quality Alliance (PQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Process
Recommended to replace current measure?	HIV Viral Load Suppression (HVL-AD, NQF #2082)

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Administrative.
Denominator	Individuals 18 years or older who filled a prescription for ≥3 distinct antiretroviral medications (as a single agent or as a combination) on 2 different dates of service during the measurement year. The treatment period must be ≥91 days during the measurement year.
Numerator	The number of individuals in the denominator who met the PDC threshold of 90 percent during the measurement year.
Exclusions	Exclude any individuals in hospice care at any time during the measurement year.
Continuous enrollment period	The treatment period. Exclude individuals who dis-enroll and re-enroll in the same plan more than one day later (i.e., >1 day gap in enrollment) after a valid treatment period, but prior to the end of the measurement year.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.pqaalliance.org/adherence-measures

Additional Information for Consideration	
Current level of reporting	Not specified.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure provides a way to look at the quality of care for those living with HIV and could replace the viral load measure. MCOs have access to this data and it is an administrative measure.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	This would give states a measure of the adherence to HIV medications that leads to viral load suppression if taken 90% of the time.

Use of measure in other programs	• Medicare Part D Patient Safety Reports • URAC Accreditation for: Disease Management, Drug Therapy Management, Mail Service Pharmacy, Pharmacy Benefit Management, and Specialty Pharmacy
Meaningful Measures area(s) of measure	• Making Care Safer by Reducing Harm Caused in the Delivery of Care. • Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure replaces the 2018 specifications that evaluated ≥2 ARV medications with a PDC threshold of 90%.

MATHEMATICA Policy Research

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Description	Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: 1. Adults age ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR 2. Adults age ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR 3. Adults ages 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Care of Acute and Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Adults age 21 years and older at the beginning of the measurement period.
Data collection method	Electronic Health Records, Registry
Denominator	All patients who meet one or more of the following criteria (considered at "high risk" for cardiovascular events, under ACC/AHA guidelines): 1. Patients age ≥ 21 years at the beginning of the measurement period with clinical ASCVD diagnosis. 2. Patients age ≥ 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C ≥ 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia. 3. Patients ages 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period.
Numerator	Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period.

Exclusions	Patients who have a diagnosis of pregnant, are breastfeeding, or who have a diagnosis of rhabdomyolysis. Denominator exceptions: • Patients with adverse effect, allergy, or intolerance to statin medication • Patients with active liver disease or hepatic disease or insufficiency • Patients with end-stage renal disease (ESRD) • Patients with diabetes who have the most recent fasting or direct LDL-C laboratory test result < 70 mg/dL and are not taking statin therapy
Continuous enrollment period	Not specified (must be enrolled in Medicare FFS at any time during the measurement period).
Level of reporting for which specifications were developed	Provider-level.
For more information	https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2019_Measure_PREV13_CMSWebInterface_UPDATED.pdf

Additional Information for Consideration	
Current level of reporting	Provider-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure is being suggested as a new CVD-related measure and is not intended to substitute for the existing NQF #0018 measure of Controlling High Blood Pressure (CBD-AD) in the Medicaid Adult Core Set. Cardiovascular disease (CVD) is the leading cause of death in the United States, causing approximately 1 of every 7 deaths in the United States in 2011. In 2011, stroke caused approximately 1 of every 20 deaths in the United States and the estimated annual costs for CVD and stroke were $320.1 billion, including $195.6 billion in direct costs (hospital services, physicians and other professionals, prescribed medications, home health care, and other medical durables) and $124.5 billion in indirect costs from lost future productivity (cardiovascular and stroke premature deaths). CVD costs more than any other diagnostic group (Mozaffarian et al., 2015). Data collected between 2009 and 2012 indicates that more than 100 million U.S. adults, 20 years or older, had total cholesterol levels equal to 200 mg/dL or more, while almost 31 million had levels 240 mg/dL or more (Mozaffarian et al., 2015). Elevated blood cholesterol is a major risk factor for CVD and statin therapy has been associated with a reduced risk of CVD. Numerous randomized trials have demonstrated that treatment with a statin reduces LDL-C, and reduces the risk of major cardiovascular events by approximately 20 percent (Ference, 2015).

	In 2013, guidelines on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults were published (see Stone et al., 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: a Report of the American College of Cardiology [ACC]/American Heart Association [AHA] Task Force on Practice Guidelines). This guideline was published by an Expert Panel, which synthesized evidence from randomized controlled trials to identify people most likely to benefit from cholesterol-lowering therapy. The ACC/AHA Guideline recommendations are intended to provide a strong evidence-based foundation for the treatment of blood cholesterol for the primary and secondary prevention and treatment of Atherosclerotic Cardiovascular Disease (ASCVD) in adult men and women (21 years of age or older). The document concludes the addition of statin therapy reduces the risk of ASCVD among high-risk individuals, defined as follows: individuals with clinical ASCVD, with LDL-C >= 190 mg/dL, or with diabetes and LDL-C 70-189 mg/dL (Stone et al., 2013). However, one study that surveyed U.S. cardiovascular practices participating in the PINNACLE registry, found that 32.4 percent of patients with an indication for statins under the 2013 ACC/AHA cholesterol guidelines were not currently receiving them (Maddox et al., 2014). Although, systematic evidence review found that statins are safe drugs with low incidence of conditions or diseases attributable to statin use (Law et al., 2006). Overall, the Statin Safety Expert Panel that participated in an NLA Statin Safety Task Force meeting in October 2013 reaffirms the general safety of statin therapy. The panel members concluded that for most patients requiring statin therapy, the potential benefits of statin therapy outweigh the potential risks. In general terms, the benefits of statins to prevent non-fatal myocardial infarction, revascularization, stroke, and CVD mortality, far outweighs any potential harm related to the drug (Jacobson, 2014). For more information, including citations, please see: https://ecqi.healthit.gov/system/files/ecqm/measures/CMS347v2.html.
How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	States that adopt this measure can use it to drive improvements in quality of care and beneficiary outcomes in a number of ways. At a minimum, states can examine the results at different levels of aggregation (e.g., overall and by managed care organization [MCO], health system, clinic and even individual provider levels) and use these to identify potential opportunities for targeted outreach and technical assistance to drive performance improvement. State to state comparisons could identify higher-performing peer states and highlight best practices for improving Statin therapy implementation across their Medicaid-enrolled populations. Finally, states can use changes in performance over time to evaluate the effectiveness of specific performance/quality improvement activities and initiatives.

	Measuring and tracking performance can be a powerful tool for driving improved access to and delivery of Statin treatment among Medicaid beneficiaries. States could further incentivize efforts to translate measured performance into measured improvements by adopting the Statin measure as part of the quality measures they use to structure value-based payments (e.g., incentive payments, whether in the form of withholds or bonuses) for MCOs, ACOs, etc. In fact, because the measure is an eCQM and has been validated at the provider/clinic level, states have an opportunity to simultaneously roll it out at multiple (and ideally mutually reinforcing) levels, including provider, clinic, system, plan, and state. Currently, only 48% of people ages 35-64 are taking statins among those for whom it is recommended (ref Wall HK, et al. Vital Signs: Prevalence of Key Cardiovascular Disease Risk Factors for Million Hearts 2022 — 2011–2016. MMWR. 2018;67(35):983-991.). This equates to over 25 million people who are at elevated risk for having an atherosclerotic cardiovascular event, a number of whom are likely Medicaid beneficiaries. Because of their generic status, statins are relatively inexpensive and readily available making this highly effective cardiovascular risk reduction strategy accessible to many and an intervention that states should be tracking.
Use of measure in other programs	• The Million Hearts Clinical Quality Measures • Merit-Based Incentive Payment System Program (MIPS)
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	While this measure is not NQF endorsed, it is an Electronic Clinical Quality Measure (eCQM [347]) and, therefore, has undergone the requisite testing for a CMS measure to be e-specified.

MATERNAL AND PERINATAL HEALTH

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	PC-05: Exclusive Breast Milk Feeding
Description	The measure is reported as an overall rate which includes all newborns that were exclusively fed breast milk during the newborn's entire hospitalization. Exclusive breast milk feeding is defined as a newborn receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines.
Measure steward	The Joint Commission (TJC)
NQF number (if endorsed)	0480/0480e
Core Set domain	Maternal and Perinatal Health
Measure type	Process
Recommended to replace current measure?	PC-01: Elective Delivery

Technical Specifications	
Ages	Not applicable.
Data collection method	Hospital chart review or EHR Only acceptable data sources include: diet flow sheets, feeding flow sheets, and intake and output sheets. Sampling is permitted.
Denominator	Single term newborns discharged alive from the hospital
Numerator	Newborns that were fed breast milk only since birth Yes = There is documentation that the newborn was exclusively fed breast milk during the entire hospitalization. N = There is no documentation that the newborn was exclusively fed breast milk during the entire hospitalization OR unable to determine from medical record documentation. More information on notes for abstraction is available at https://manual.jointcommission.org/releases/TJC2019A/DataElem0273.html.
Exclusions	The following newborns are excluded from the denominator: • Admitted to the Neonatal Intensive Care Unit (NICU) at this hospital during the hospitalization • Diagnosis of galactosemia • Procedure code for parenteral nutrition • Experienced death • Length of stay >120 days • Patients transferred to another hospital • Patients who are not term or with <37 weeks gestation
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Hospital-level.
For more information	https://manual.jointcommission.org/releases/TJC2019A/MIF0170.html

Additional Information for Consideration	
Current level of reporting	Hospital-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted: • Unwarranted variations in the health system promulgates health disparity. Breast milk feeding improves life course health and decreases disparity. Understanding that the goal is not 100% and that women and families have the right to choose breast or formula- the measure does not limit choice or pressure families. The measure functions to hold systems accountable to minimize systems level, institutional, and provider-level variations in access to evidence based care. Lack of access to evidence-based lactation counseling, informed consent, and shared decision has impact on disparities. • "Exclusive Breastfeeding for the first 6 months of neonatal life" has long been the expressed goal of WHO, DHHS, APA, and ACOG. A Cochrane review substantiated the benefits. • Exclusive Breastfeeding Rate during birth hospital stay has been calculated by the California Department of Public Health for the last several years using newborn genetic disease testing data. Healthy People 2020 and the CDC have also been active in promoting this measure. • Holding prenatal and intrapartum providers accountable is an important way to incent greater efforts during the critical prenatal and immediate postpartum periods where breastfeeding attitudes are solidified. (NQF Perinatal Maintenance Report.)
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Gaps in evidence-based practice around the issue of infant feeding are substantial and have long-term impacts on life course health including the development of diabetes, obesity, and cancer. This metric is highly actionable, aligned with life course health and primary prevention metrics.
Use of measure in other programs	• Mandatory Joint Commission reporting measure. • Hospital Inpatient Quality Reporting, Medicare and Medicaid Electronic Health Record Incentive Program for Hospitals and Critical Access Hospitals, and Hospital Compare.
Meaningful Measures area(s) of measure	Promote effective prevention & treatment of chronic disease.
Other	The 2016 and 2017 Measure Applications Partnership discussed the Exclusive Breast Milk Feeding measure for addition to the Child Core Set. It was recommended for addition in 2016 and did not pass the consensus vote in 2017. The 2017 Child and Adult Core Sets included three other Joint Commission measures. None have been publicly reported due to state challenges with accessing hospital records for chart reviews. PC-03: Antenatal Steroids was retired from the 2018 Adult Core Set. There are no changes expected to the specifications at this time.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Prenatal Depression Screening and Follow-Up (PND)
Description	Percentage of deliveries in which women were screened for clinical depression while pregnant and if screened positive, received follow-up care. Two rates are reported. 1. Depression Screening: The percentage of deliveries in which women were screened for clinical depression using a standardized tool during pregnancy. 2. Follow-Up on Positive Screen: The percentage of deliveries in which pregnant women received follow-up care within 30 days of screening positive for depression.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Maternal and Perinatal Health
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 12 and older .
Data collection method	HEDIS Electronic Clinical Data Systems (ECDS) (Note: ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.)
Denominator	1. Depression Screening: Deliveries during the Measurement Period (January 1 – December 31). 2. Follow-Up on Positive Screen: All deliveries from the Depression Screening numerator with a positive finding for depression during pregnancy.
Numerator	1. Depression Screening: Deliveries in which women had documentation of depression screening performed using an age-appropriate standardized screening instrument (as defined in the measure specification) during pregnancy. 2. Follow-Up on Positive Screen: Deliveries in which women received follow-up care on or 30 days after the date of the first positive screen (31 days total), or documentation of additional depression screening on the same day and subsequent to the positive screen indicating either no depression or no symptoms that require follow-up.
Exclusions	• Deliveries in which women were in hospice or using hospice services during the measurement period. • Pregnancy <37 gestational weeks on delivery date.
Continuous enrollment period	28 days prior to delivery date through the delivery date.

Level of reporting for which specifications were developed	Plan-level.
For more information	The draft document is available at https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf
Additional Information for Consideration	
Current level of reporting	None.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted maternal depression screening and follow-up in the prenatal period measure will fill a gap in assessing the content of prenatal care.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	There is a current gap in our understanding of prenatal depression and the evidence is very clear that when identified early, perinatal depression can be treated successfully and improves outcomes for mothers and children. A recent report on child fatalities in Colorado identified behavioral health supports for parents as the priority strategy for reducing child maltreatment and deaths.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure is proposed for HEDIS 2020.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Postpartum Depression Screening and Follow-Up (PPD)
Description	Percentage of deliveries in which women were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. Two rates are reported. 1. Depression Screening: The percentage of deliveries in which women were screened for clinical depression using a standardized tool within 12 weeks (84 days) post-delivery. 2. Follow-Up on Positive Screen: The percentage of deliveries in which women received follow-up care within 30 days of screening positive for depression.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Maternal and Perinatal Health
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 12 and older.
Data collection method	HEDIS Electronic Clinical Data Systems (ECDS) (Note: ECDS includes data from administrative claims, electronic health records, case management systems and health information exchanges/clinical registries.)
Denominator	1. Depression Screening: Deliveries during September 8 of the year prior to the Measurement Period through September 7 of the Measurement Period. 2. Follow-Up on Positive Screen: All deliveries from the Depression Screening Numerator with a positive finding for depression during the 84-day period following the date of delivery.
Numerator	1. Depression Screening: Deliveries in which women had documentation of depression screening performed using an age-appropriate standardized instrument (as defined in the measure specification) during the 84-day period following the date of delivery. 2. Follow-Up on Positive Screen: Deliveries in which women received follow-up care on or 30 days after the date of the first positive screen (31 days total), or documentation of additional depression screening on the same day and subsequent to the positive screen indicating either no depression or no symptoms that require follow-up.
Exclusions	• Deliveries in which women were in hospice or using hospice services during the measurement period. • Depression Screening Numerator: Exclude depression screenings performed in an acute inpatient setting.

Continuous enrollment period	114 days following the date of delivery. (Note: This period includes 84 days for depression screening plus 30 days for follow-up on a positive screen. NCQA is seeking public comment on the participation period for this measure, recognizing that many Medicaid beneficiaries lose coverage 60 days post-delivery. The disadvantage to this approach is that women who lose Medicaid coverage at 60 days will not be captured in the measure's eligible population.)
Level of reporting for which specifications were developed	Plan-level.
For more information	The draft document is available at https://www.ncqa.org/wp-content/uploads/2019/02/20190208_08_Perinatal_Depression.pdf

Additional Information for Consideration	
Current level of reporting	None.
Gap area(s) ***(per workgroup member who suggested the measure)***	Three Workgroup members suggested this measure for addition. Response 1: • Current efforts to understand postpartum depression are insufficient. First, this is a disrupted time of care for women and new measures to help incent better access to care and care coordination during this period are needed. Second, current postpartum depression measures require charting in the baby's chart, which is difficult and carries significant challenges. A new measure is needed to fill this gap in measures for women in the postpartum period. Response 2: • This would be filling a gap in postnatal care for women. Research continually illustrates the negative impacts that postpartum depression can have on a mother's and child's long-term health and other critical outcomes. In addition, CMS now allows payment for maternal depression screens under the child's Medicaid ID number (if the mom herself is not eligible for Medicaid). These screenings can take place in the primary care setting (including pediatric care settings). Response 3: • There is currently no Core Set measure that addresses the health of the mother-child relationship.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Response 1: • Women who experience postpartum depression need supports to address their depression and recover. The data are very clear about the impacts of postpartum depression on maternal well-being and child development. Data also show that women of color and women with low-incomes experience higher rates of postpartum depression making it critical that Medicaid and CHIP programs address this condition.

	Response 2: • The measure would assess how frequently providers are conducting maternal depression screenings on women up to 12 weeks after birth and help determine how to promote increases in screening rates. It also will help identify how often women are referred to services within 30 days of a positive screen. The measure could speak to availability of resources and potential training for providers who do not know how to handle a positive depression screen. Response 3: • Managed care plans could be required to meet minimum performance thresholds and to conduct quality improvement activities based on these measures. Pay for performance is another way plans, health systems, and medical groups could use this measure to drive quality improvement.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure is proposed for HEDIS 2020.

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BEHAVIORAL HEALTH CARE

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Tobacco Use: Screening and Cessation Intervention.
Description	Percentage of patients age 18 and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user
Measure steward	Physician Consortium for Performance Improvement (PCPI) Foundation
NQF number (if endorsed)	0028/0028e
Core Set domain	Behavioral Health Care
Measure type	Process
Recommended to replace current measure?	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD, NQF #0027)

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Administrative, EHR.
Denominator	All patients age 18 and older seen for at least two visits OR at least one preventive visit during the measurement period.
Numerator	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
Exclusions	Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason).
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Clinician: Group/Practice, Clinician: Individual.
For more information	https://www.ncdr.com/WebNCDR/docs/default-source/pinnacle-public-documents/2018_measure_226_registry.pdf?sfvrsn=6

Additional Information for Consideration	
Current level of reporting	Provider-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	This measure was suggested by one Workgroup member as a replacement to the current tobacco cessation measure, which is taken from the CAHPS Health Plan 5.0H survey. The Workgroup member noted that the CAHPS survey has poor response rates, high cost, and scoring is not comparable for diverse populations as discussed in the following publication: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/about-cahps/research/survey-administration-literature-review.pdf

How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	In some states, managed care plans are required to meet minimum performance thresholds for a list of measures, and to conduct quality improvement activities based on these measures. Pay for performance is another way plans, health systems, and medical groups could use this measure to drive quality improvement.
Use of measure in other programs	• Merit-Based Incentive Payment System (MIPS). • The Million Hearts Clinical Quality Measures. • Health Resources and Services Administration Uniform Data System. • Comprehensive Primary Care Plus (CPC+).
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	The 2018 Core Set Review Workgroup conditionally supported this measure for addition to the Adult Core Set, pending the removal of NQF #0027 Medical Assistance with Smoking and Tobacco Use Cessation. The Workgroup agreed that NQF #0028 is a superior measure as the measure provides a variety of collection methods, including claims, registry, and electronic health records. In addition, this measure includes both screening rates and the percentage of individuals who received cessation intervention, whereas measure #0027 only addresses whether cessation assistance was offered.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
Description	Percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	2800
Core Set domain	Behavioral Health Care
Measure type	Process
Recommended to replace current measure?	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)

Technical Specifications	
Ages	Children and adolescents ages 1–17 as of December 31 of the measurement year. Rates are reported for the following age groups: ages 1–5 years, 6–11 years, and 12–17 years.
Data collection method	Administrative.
Denominator	Children and adolescents 1–17 years of age who had at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year.
Numerator	Children and adolescents who had the following during the measurement year on the same or different dates of service. • At least one test for blood glucose or HbA1c AND • At least one test for LDL-C or cholesterol
Exclusions	Members in hospice are excluded from the eligible population.
Continuous enrollment period	The measurement year.
Level of reporting for which specifications were developed	Plan-level.
For more information	http://www.qualityforum.org/QPS/QPSTool.aspx?m=2800%20#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22ItemsToCompare%22%3A%5B%5D,%22StandardID%22%3A2800,%22EntityTypeID%22%3A1%7D

Additional Information for Consideration	
Current level of reporting	Plan-level, state-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure looks at all children ages 1–17 on at least 2 prescriptions of antipsychotics to see if they had appropriate monitoring for the development of abnormal cholesterol and blood sugar levels. These are known side effects of these medications. In 2017, NCQA reported a Medicaid HEDIS national average of only 34% of children on these medications had appropriate

	monitoring. https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/ There is a large quality gap and this looks at a larger denominator than the (APC-CH) measure.
How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	States can work with their MCOs and providers to improve blood test monitoring from the currently low Medicaid HEDIS average of 34%. In one state that has been focused on this topic for many years, the statewide average for this measure is 63%.
Use of measure in other programs	• NCQA Health Plan Accreditation and Ratings Program (Medicaid and Commercial). • 8 states included this measure in their Medicaid Managed Care External Quality Review (EQR) 2018 Reporting.
Meaningful Measures area(s) of measure	Make Care Safer by Reducing Harm Caused in the Delivery of Care.
Other	• An updated version of the measures is under consideration. Changes include (1) combining the 1–5 and 6–11 years age groups and (2) adding separate rates for blood glucose and cholesterol testing. • This measure was recommended for addition to the Child Core Set by Workgroup members in 2017 and 2018. They noted that this measure could incentivize providers to ensure that children prescribed these medications also receive metabolic monitoring. They noted that the measure is feasible since it is prescription-based and can be extracted from claims.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
Description	Percentage of patients age 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.
Measure steward	Physician Consortium for Performance Improvement (PCPI) Foundation
NQF number (if endorsed)	2152
Core Set domain	Behavioral Health Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Electronic health record, Registry.
Denominator	All patients age 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.
Numerator	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user.
Exclusions	Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons).
Continuous enrollment period	None.
Level of reporting for which specifications were developed	Provider-level.
For more information	https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2018_Measure_431_Registry.pdf

Additional Information for Consideration	
Current level of reporting	Provider-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted that most people who drink too much (i.e., excessive drinkers) in the U.S. do not meet the diagnostic criteria for alcohol dependence, or what based on the current DSM-5 diagnostic criteria would be referred to as having a "severe alcohol use disorder." In fact, 9 in 10 excessive drinkers do not meet the diagnostic criteria for alcohol dependence. The same applies more specifically to binge drinkers (4+ drinks/occasion for women; 5+ drinks/occasion for men); approximately 90% of adult excessive drinkers in the U.S. are binge drinkers. While alcohol dependence is a serious public health problem, a comprehensive approach is recommended to preventing excessive alcohol use that includes effective community-based strategies for reducing excessive drinking, such as those recommended by the Community Guide (www.thecommunityguide.org/alcohol), as well as effective clinically-based prevention strategies, such as alcohol screening and brief intervention (ASBI), to address those who are and are not considered alcohol dependent. In as much as pregnant women may sometimes be among this group, this allows for intervention that improves fetal outcomes. This measure will fill a gap since the current Core Sets do not include this screening and brief intervention tool. This measure is being recommended as a new behavioral health measure and would not replace the current measures related to alcohol use.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	There are Medicaid billing codes available for alcohol screening and brief intervention although they are not turned on in every state. Having measure NQF #2152 included in the Medicaid Adult Core Set, given inclusion in MIPS and a new similar ASF HEDIS Measure, should help to fill a gap in the Adult Core Set in effectively addressing excessive alcohol use in the non-alcohol-dependent majority of adults who drink too much. Excessive alcohol use is a costly and significant preventable cause of morbidity and mortality in all states.
Use of measure in other programs	Merit-Based Incentive Payment System Program (MIPS).
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	• This measure was recommended for addition to the Adult Core Set in 2018 and 2016. ○ **2018**: Workgroup discussed several barriers associated with this measure, including reporting burden (i.e., states' inability to collect registry data) and broad screening tool specifications (i.e., current specifications include a systematic screening method rather than a validated screening tool). The decision to support this measure for inclusion was based on the importance of measuring alcohol screening and counseling rates, especially for vulnerable populations.

	○ **2016**: Workgroup recommended the inclusion of this measure as a way to capture data on those who receive treatment following screening for behavioral health issues. The measure addresses the behavioral health gap area. Additionally, the measure fosters the principles of care coordination. The Workgroup discussed the measure's ability to "cut across the broad swath" of the Medicaid population, and have an impact on care management for a lot of conditions. • HEDIS includes a similar measure, Unhealthy Alcohol Use Screening and Follow-Up, which is reported using Electronic Clinical Data Sources (ECDS), including EHRs, registries, and case management reports. More information is available at https://www.ncqa.org/hedis/reports-and-research/hedis-measure-unhealthy-alcohol-use-screening-and-follow-up/.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Use of Opioids from Multiple Providers in Persons Without Cancer
Description	Percentage of individuals age 18 and older without cancer who received prescriptions for opioids from 4 or more prescribers AND 4 or more pharmacies within less than or equal to 180 days. Lower rates are better for this measure.
Measure steward	Pharmacy Quality Alliance (PQA)
NQF number (if endorsed)	2950
Core Set domain	Behavioral Health Care
Measure type	Process
Recommended to replace current measure?	None

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Administrative.
Denominator	Individuals with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days supply is greater than or equal to 15 during the measurement year (January 1 – December 31) and who had an index prescription start date from January 1 – October 3 of the measurement year and an opioid episode of at least 90 days during the measurement year.
Numerator	Individuals in the denominator who received opioid prescription claims from 4 or more prescribers AND 4 or more pharmacies.
Exclusions	Individuals with a diagnosis of Cancer during the measurement year or in hospice care at any time during the measurement year.
Continuous enrollment period	The measurement year (January 1 – December 31) with no more than one gap in enrollment of up to 31 days during the measurement year.
Level of reporting for which specifications were developed	Plan-level.
For more information	The measure was updated by the measure steward in 2019 from a proportion (XX out of 1,000) to a percentage. A new version of the specification is under consideration by NQF. More information is available at http://www.qualityforum.org/QPS/QPSTool.aspx?m=2950&e=1#qpsPageState=%7B%22TabType%22%3A1,%22TabContentType%22%3A2,%22ItemsToCompare%22%3A%5B%5D,%22StandardID%22%3A2950,%22EntityTypeID%22%3A1%7D

Additional Information for Consideration	
Current level of reporting	Tested in the Medicare population, commercial health plan, and Medicaid population.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition, indicating that addressing opioid abuse issues is a gap area.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Demonstrating a lower score/proportion would evidence the effectiveness of multiple state/health programs.
Use of measure in other programs	• Medicaid 1115 Substance Use Disorder Demonstrations • Medicare Part D Patient Safety reports
Meaningful Measures area(s) of measure	Make Care Safer by Reducing Harm Caused in the Delivery of Care.
Other	• This measure was recommended for addition to the Adult Core Set in 2018 because it addresses the epidemic of opioid morbidity and mortality. This is a claims-based measure, which reduces the reporting burden for states. This recommendation was not adopted by CMS in its 2019 Core Set update. • A related measure, Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD), is included in the 2019 Adult Core Set.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Use of Pharmacotherapy for Opioid Use Disorder
Description	Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.
Measure steward	Centers for Medicare & Medicaid Services (CMS), Center for Medicaid & CHIP Services (CMCS)
NQF number (if endorsed)	3400
Core Set domain	Behavioral Health Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Ages 18-64.
Data collection method	Administrative.
Denominator	Number of Medicaid beneficiaries ages 18 to 64 with at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.
Numerator	Beneficiaries ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measure year.
Exclusions	None.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	State-level.
For more information	http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=3400&print=0&entityTypeID=1

Additional Information for Consideration	
Current level of reporting	Not specified.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure is being recommended as a new behavioral health opioid-related measure, and is not intended to replace the current two measures (opioid at high doses and concurrent opioid and benzodiazepine use), which should be retained. Currently the Adult Core Set does not include measures related to treatment of OUD so this measure would address a critical gap and allow Medicaid to track progress in curbing the opioid use disorder epidemic. Given the changing epidemic, it is critical to track provision of treatment for those persons in the Medicaid population who have OUD. The opioid treatment measure will provide useful and actionable results for state Medicaid and CHIP programs by tracking those receiving treatment for OUD.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Adoption of the measure has the potential to improve the quality of care for Medicaid beneficiaries who have an opioid use disorder by increasing appropriate treatment for OUD as a key action in curbing this national epidemic. Currently there is no measure in the Adult Core Set that allows states to monitor pharmacotherapy for OUD, a critical step in helping to curb the epidemic. Existing Medicaid measures allow states to track (1) use, and promote reduced use, of high dose opioids in non-cancer settings, and (2) use of concurrent opioids and benzodiazepines; this measure will also allow states to track and promote use of treatment for those with OUD. This would have cross-cutting use in Emergency Department and Services, Inpatient/Hospital, and Outpatient Services. It fits into the National Quality Strategy Priority of Patient Safety, and can be used for quality improvement and external and internal benchmarking. States can examine the results of this test at different levels of aggregation and identify potential opportunities for targeted outreach and enhanced technical assistance to drive performance improvement. State to state comparison can also identify higher-performing states from whom other states may learn best practices for improving OUD treatment across their Medicaid-enrolled populations. States can also track performance over time, evaluate the effectiveness of specific performance/quality improvement activities and initiatives, and contribute to the national call to end the OUD epidemic.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Make Care Safer by Reducing Harm Caused in the Delivery of Care.
Other	None.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information		
Two similar measures were suggested for addition; the measure under consideration for HEDIS 2020 was adapted from the existing University of Southern California measure.		
Measure name	Continuity of Pharmacotherapy for Opioid Use Disorder	Pharmacotherapy for Opioid Use Disorder (POD)
Description	Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.	Percentage of new pharmacotherapy treatment episodes that resulted in 180 or more covered treatment days among members 16 years of age and older with a diagnosis of OUD.
Measure steward	University of Southern California (USC)	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	3175	Not endorsed
Core Set domain	Behavioral Health Care	Behavioral Health Care
Measure type	Process	Process
Recommended to replace current measure?	No	No

Technical Specifications		
Measure name	Continuity of Pharmacotherapy for Opioid Use Disorder	Pharmacotherapy for Opioid Use Disorder (POD)
Ages	Ages 18 to 64 (Note: MIPS includes age 18 and older.)	Age 16 and older
Data collection method	Administrative or EHR	Administrative or EHR
Denominator	Individuals ages 18-64 years of age who had a diagnosis (primary or secondary) of OUD and at least one claim for an OUD medication.	Individuals 16 years of age and older as of December 31 of the measurement year with any diagnosis of opioid use disorder during the intake period and a new episode of OUD pharmacotherapy. Note: The denominator is based on episodes not on members; all episodes not excluded remain in the denominator.

Technical Specifications		
Measure name	Continuity of Pharmacotherapy for Opioid Use Disorder	Pharmacotherapy for Opioid Use Disorder (POD)
Numerator	Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than 7 days.	At least 173 days of treatment with OUD pharmacotherapy, beginning on the New Episode of OUD Pharmacotherapy date through 179 days after the New Episode of OUD Pharmacotherapy date (180 total days). This allows a gap in medication treatment up to a total of 7 days during the 180-day period.
Exclusions	Adults who are deliberately phased out of Medication Assisted Treatment (MAT) prior to 180 days of continuous treatment.	None.
Continuous enrollment period	Not specified.	15 days prior to the New Episode of OUD Pharmacotherapy through 179 days after the New Episode of OUD Pharmacotherapy (195 total days).
Level of reporting for which specifications were developed	Health Plan	Health Plan
For more information	https://www.entnet.org/sites/default/files/uploads/PracticeManagement/Resources/_files/2019_measure_468_mipscqm.pdf	https://www.ncqa.org/wp-content/uploads/2019/02/20190208_07_POD.pdf

Additional Information for Consideration		
Measure name	Continuity of Pharmacotherapy for Opioid Use Disorder	Pharmacotherapy for Opioid Use Disorder (POD)
Current level of reporting	Provider	None. Field tested at the Medicaid health plan level using Medicaid managed care claims data.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure assesses for retention in care/continuity of care among the population with diagnoses of OUD. It serves as a proxy for recovery outcomes, an area we have very little data on and limited ways to measure. Measuring continuity of care serves as a first step in getting at more meaningful recovery and health care outcome measures for this population at high risk for overdose and death.	One Workgroup member suggested this measure for addition, indicating behavioral health as the gap area.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Several states have already examined different cut-points for retention in care (90 days, 270 days, etc.); for purposes of tracking beneficiary recovery and long-term outcomes, this measure is extremely useful and provides key information when examined in the context of those who remain in care for 6 months versus those not retained in care. States could begin to learn more about those individuals lost to care in the first 180 days, what factors are needed to ensure care retention and thus more sustainable long-term recovery outcomes for their beneficiaries.	A national priority area is to reduce OUD. This measure is a quality of care, coordination of care, follow-up after care measure for the Medicaid population. Focusing on the measure would encourage states and their contracted MCOs to develop processes to ensure Medicaid beneficiaries with OUD were involved in treatment for 180 days increasing the ability to overcome the addiction. The measure steward cites evidence suggesting that pharmacotherapy can improve outcomes for individuals with OUD and that continuity of pharmacotherapy is critical to prevent relapse and overdose.
Use of measure in other programs	Merit-Based Incentive Payment System (MIPS) Program (Quality ID #468).	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Promote effective prevention & treatment of chronic disease.	Promote effective prevention & treatment of chronic disease.

Additional Information for Consideration		
Measure name	Continuity of Pharmacotherapy for Opioid Use Disorder	Pharmacotherapy for Opioid Use Disorder (POD)
Other	The USC version of the measure is undergoing annual update.	This measure is proposed for HEDIS 2020. The measure concept was adapted from an existing measure—Continuity of Pharmacotherapy for Opioid Use Opioid (NQF #3175)—developed by RAND and stewarded by the University of Southern California (USC). This measure focuses on new prescriptions and expands the age range covered by the measure.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Query of Prescription Drug Monitoring Program
Description	For at least one Schedule II opioid electronically prescribed using Certified Electronic Health Records Technology (CEHRT) during the performance period, the Merit-based Incentive Payment System (MIPS) eligible clinician uses data from CEHRT to conduct a query of a Prescription Drug Monitoring Program (PDMP) for prescription drug history, except where prohibited and in accordance with applicable law.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not Endorsed
Core Set domain	Behavioral Health Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	All ages.
Data collection method	Administrative, EHR.
Denominator	Number of Schedule II opioids electronically prescribed using CEHRT by the MIPS eligible clinician during the performance period.
Numerator	Number of Schedule II opioids prescriptions in the denominator for which data from CEHRT is used to conduct a query of a PDMP for prescription drug history except where prohibited and in accordance with applicable law.
Exclusions	None.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Provider-level.
For more information	Measure specifications: https://cmit.cms.gov/CMIT_public/ReportMeasure?measureRevisionId=2302

Additional Information for Consideration	
Current level of reporting	Not specified.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure is being recommended as a new behavioral health opioid-related measure and would not replace the current two measures (opioid use at high does and concurrent opioid and benzodiazepine use), which should be retained. Currently the Adult Core Set does not include a measure to track providers' use of a PDMP; therefore this measure would fill an important gap.

	PDMPs are a very important tool to help providers in efforts to improve antibiotic prescribing practices for controlled substances. The concurrent use of this measure in MIPS encourages interoperability and encourages provider review of patients' history of controlled substance prescriptions using PDMPs before issuing a new or renewing a prescription. The PDMP measure will provide useful and actionable results for state Medicaid and CHIP programs by increasing use of the PDMP which in turn will help improve controlled substance prescribing as a key step in controlling the OUD epidemic.
How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	States can use this measure to drive improvement in the quality of care for Medicaid and CHIP beneficiaries by improving controlled substance prescribing practices as a key step towards addressing the urgent OUD epidemic in the US. PDMPs are databases that collect patient-specific prescription information at the point of dispensing. PDMPs continue to be validated as an effective strategy affecting prescribing behavior and improving opioid-related outcomes. PDMPs can inform clinical practice and protect patients at heightened risk of opioid misuse, abuse, and overdose. Robust PDMP implementation is associated with decreased opioid-related overdose deaths. In addition, PDMPs can be utilized as a public health surveillance tool and provide public health authorities with timely information that rapidly identifies "hot spots" or geographic areas with disproportionately higher rates of opioid prescribing and allow for targeted interventions such as academic detailing, or clinical training and outreach. Prescribers can use PDMP data at the point of care. PDMPs can support providers with information on safer prescribing and pain management. For example, several of the risk factors associated with opioid overdose can be tracked in the PDMP—high daily doses (morphine milligram equivalent or MME), receiving prescriptions from multiple providers, and overlapping opioid and benzodiazepine prescriptions.
Use of measure in other programs	• Promoting Interoperability • Merit-Based Incentive Payment System [MIPS] Program
Meaningful Measures area(s) of measure	Make Care Safer by Reducing Harm Caused in the Delivery of Care.
Other	The measure was added to MIPS for the 2019 performance period.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Follow-Up after High-Intensity Care for Substance Use Disorder (FUI)
Description	Percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder that result in a follow-up visit or service for substance use disorder among individuals 13 years of age and older. Two rates are reported: 1. Percentage of visits or discharges for which the individual received follow-up for substance use disorder within the 30 days after the visit or discharge. 2. Percentage of visits or discharges for which the individual received follow-up for substance use disorder within the 7 days after the visit or discharge.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	Not endorsed
Core Set domain	Behavioral Health Care
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 13 and older.
Data collection method	Administrative.
Denominator	Individuals age 13 and older who had an acute inpatient hospitalization, residential treatment, or a detoxification visit for a diagnosis of substance use disorder.
Numerator	For the two reported rates: 30 Day Follow-Up Rate. A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder. 7-Day Follow-Up Rate. A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 7 days after an episode for substance use disorder.
Exclusions	Members in hospice are excluded from the eligible population.
Continuous enrollment period	Date of episode through 30 days after episode (31 total days).
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.ncqa.org/wp-content/uploads/2019/02/20190208_06_FUI.pdf

Additional Information for Consideration	
Current level of reporting	None; proposed new measure for HEDIS 2020.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted that there are new flexibility and innovation opportunities for state Medicaid programs, which are helping to create a full continuum of care for substance use disorder including creating access to inpatient and residential treatment. However, follow-up care is critical after such intensive services to ensure individuals are receiving the supports they need to successfully recover. And, the cost of these new more intense treatments is significant so we must work to maximize follow-up care to ensure the investment in treatment is fully realized.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	Substance use disorder creates a major impact on an individual and their overall life and health. Medicaid programs have the opportunity to support individuals with substance use disorders to recover and thrive. This will improve the health and well-being of our communities and may reduce Medicaid costs overall.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease.
Other	This measure is proposed for HEDIS 2020.

LONG-TERM SERVICES AND SUPPORTS

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Long-Term Services and Supports (LTSS) Successful Transition After Long-Term Institutional Stay
Description	Proportion of long-term institutional facility stays among Medicaid Managed Long-Term Services and Supports (MLTSS) plan members age 18 and older, which result in successful transitions to the community (community residence for 60 or more days). This measure is reported as an observed rate and a risk-adjusted rate. (Note: This description has been updated to reflect the specifications that will be posted in May.)
Measure steward	Centers for Medicare & Medicaid Service (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	18 years and older as of July 1 of year prior to the measurement year.
Data collection method	Administrative.
Denominator	A New Institutional Facility Admission (IFA, an admission to the institutional setting directly from the community) with a length of stay 101 days or more between July 1 of the year prior to the measurement year and June 30 of the measurement year. OR A Prior Institutional Facility Admission (PIFA, an admission for MLTSS plan members who resided in the institutional facility on July 1 of the year prior to the measurement year) where the length of stay was at least 101 days inclusive of July 1 of the year prior to the measurement year. For example, a PIFA for a member identified as residing in an institutional facility on July 1 of the year prior to the measurement year, who was admitted to the facility on June 1 of the year prior to the measurement year and remained in the facility through September 15 of the year prior to the measurement year is considered a stay of at least 101 days. The denominator for this measure is based on discharges, not members.
Numerator	The count of discharges from an institutional facility to the community between July 1 of the year prior to the measurement year and October 31 of the measurement year that result in successful transition to the community for 60 consecutive days. Discharges that result in death, hospitalization, or readmission to the institution within 60 days of discharge from the institution do not meet the numerator criteria.
Exclusions	None.

Continuous enrollment period	Member must be continuously enrolled in a Medicaid MLTSS plan for at least 365 days during the period between July 1 of the year prior to the measurement year and December 31 of the measurement year. If the enrollee dies after discharge to the community, the continuous enrollment period does not include the period after death.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf Note: The technical specifications for this measure are in the process of being updated.

Additional Information for Consideration	
Current level of reporting	Plan-level
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this fills a gap for LTSS measures and supports community-first services for individuals with disabilities.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	This would help states measure the movement of people out of institutions both for those that have been there for a long time but could live in the community and for those that may have been there for a few months, but also could return to supported community living.
Use of measure in other programs	Included by CMS in a list of eight quality measures for states to consider when using a managed care delivery system for providing long-term services and supports. https://www.medicaid.gov/medicaid/managed-care/ltss/index.html
Meaningful Measures area(s) of measure	• Work with Communities to Promote Best Practices of Healthy Living • Promote Effective Communication & Coordination of Care.
Other	None.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update
Description	Percentage of Medicaid Managed Long-Term Services and Supports (MLTSS) plan members 18 years of age and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements. The following rates are reported: 1. Assessment of Core Elements. MTLSS plan members who had a comprehensive LTSS assessment with 9 core elements documented within 90 days of enrollment (for new members) or annually. 2. Assessment of Supplemental Elements. MLTSS plan members who had a comprehensive LTSS assessment with 9 core elements and at least 12 supplemental elements documented within 90 days of enrollment (for new members) or annually. In addition, two rates of required exclusions should be reported: 1. Member could not be contacted for care planning. 2. Member refused to participate in care planning.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	18 years and older as of the first day of the measurement year.
Data collection method	Case Management Record Review.
Denominator	A systematic sample drawn from the eligible population of members receiving Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care).
Numerator	The measure reports two numerators: Rate 1: Assessment of Core Elements The number of MLTSS plan members who had either of the following: • *For new members:* A comprehensive LTSS assessment completed within 90 days of enrollment, with all 9 core elements documented OR • *For established members*: A comprehensive LTSS assessment completed at least once during the measurement year, with all 9 core elements documented. Assessment must be a face-to-face discussion with the member in the member's home. Assessment by phone or video conference, or in

	another location that is not the member's home, is not permitted except in the following circumstances: • The member was offered an in-home assessment and refused the in-home assessment, OR • The member is residing in an acute facility during the assessment time period, OR • The state policy, regulation, or other state guidance excludes the member from a requirement for in-home assessment. The member's assessment must include documentation of the following 9 core elements and the date of the assessment: 1. Documentation that Activities of Daily Living (ADL) were assessed, or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking. 2. Documentation of acute and chronic health conditions. 3. Documentation of current medications. 4. Assessment of cognitive function using a standardized tool. 5. Assessment of mental health status using a standardized tool. 6. Assessment of home safety risks. 7. Confirm living arrangements. 8. Confirm current and future family/friend caregiver availability. 9. Documentation of current providers. Rate 2: Assessment of Supplemental Elements The number of MLTSS plan members who had either of the following: • *For new members*: A comprehensive LTSS assessment completed within 90 days of enrollment with 9 core and at least 12 supplemental elements documented, OR • *For established members*: A comprehensive LTSS assessment completed during the measurement year with 9 core and at least 12 supplemental elements documented. Assessment must be a face-to-face discussion with the member in the member's home. Assessment by phone or video conference, or in another location that is not the member's home, is not permitted except in the circumstances noted for Rate 1. The member's assessment must document evidence of 9 core elements defined above and evidence of at least 12 supplemental elements, and the date of the assessment. Supplemental elements include the following: 1. Documentation that Instrumental ADL were assessed, or that at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances. 2. Documentation of the current use of assistive device or technology to maintain or improve mobility.

	3. Assessment of the member's self-reported health status using a standardized tool or question. 4. Assessment of behavior abnormalities that can result from a cognitive or psychological condition. 5. Assessment of the member's self-reported activation or self-efficacy using a standardized tool. 6. Documentation of vision needs, including whether the member has impaired vision and uses a device to address that need. 7. Documentation of hearing needs, including whether the member has impaired hearing and uses a device to address that need. 8. Documentation of speech needs, including whether the member has a speech impairment and uses a device to address that need. 9. Documentation of physical/occupational therapy needs, including whether the member needs physical or occupational therapy. 10. Screening for history of falls and/or problems with balance or gait. 11. Assessment of the member's alcohol or other drug use using a standardized tool. 12. Documentation of smoking status, including whether the member is a current smoker. 13. Documentation of the current or planned use of community, public or plan resources to address social risk factors. 14. Assessment of the member's social support in community. 15. Assessment of member's self-reported social isolation or loneliness. 16. Documentation of cultural and linguistic preferences. 17. Documentation of the existence of an advance care plan. 18. Documentation of current participation or preference for participating in work or volunteer activities. 19. Documentation of recent use of medical services, which can include the ED, hospitalization, home health, skilled nursing facility, paid home health care.
Exclusions	Required exclusions are reported with the performance measure rates. 1. Could Not Be Contacted for Assessment: New plan members who could not be contacted for LTSS comprehensive assessment within 90 days of enrollment and established plan members who could not be contacted for LTSS comprehensive assessment during the measurement year. MLTSS plans use their own process for identifying members who cannot be contacted for assessment, and document that at least three attempts were made to contact the member. 2. Refusal of Assessment: Plan members who refused a comprehensive assessment. Document that the member was contacted and refused to participate in an assessment.
Continuous enrollment period	Member must be enrolled in a Medicaid MLTSS plan for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For individuals with multiple

	distinct continuous enrollment periods during the measurement year, look at the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

Additional Information for Consideration	
Current level of reporting	Plan-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	Two Workgroup members suggested this measure for addition. **Response 1:** This is a relevant measure to address the LTSS gap, and one of the few nationally-recognized measures available for LTSS. Of the nationally-recognized measures for LTSS, this one is the most feasible to implement. While states are not yet reporting according to these specifications, many states already have some type of similar measure in place to look at assessment completion rates. **Response 2:** LTSS measure regarding comprehensive assessment, which is an important part of care for members with LTSS needs.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	**Response 1:** States would be able to monitor members' access to timely care management support to ensure there is no disruption in essential LTSS services for members and that any services to be provided are based on completion of a comprehensive assessment covering core elements (inclusive of evidence-based tools such as for cognitive function and mental status). States could compare rates across MLTSS plans or care management entities to identify any issues or delays in provision of care management. **Response 2:** Assuring that assessments have the required elements and are completed in a timely fashion is an element of quality LTSS services.
Use of measure in other programs	• Included by CMS in a list of eight quality measures for states to consider when using a managed care delivery system for providing long-term services and supports. https://www.medicaid.gov/medicaid/managed-care/ltss/index.html • This measure has been adopted as a first-year HEDIS measure for HEDIS 2019: LTSS Comprehensive Assessment and Update (LTSS-CAU).
Meaningful Measures area(s) of measure	• Strengthen Person & Family Engagement as Partners in their Care. • Promote Effective Communication & Coordination of Care.
Other	None.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update
Description	Percentage of Medicaid Managed Long-Term Services and Supports (MLTSS) plan members 18 years of age and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes documentation of core elements. The following rates are reported: 1. Care Plan with Core Elements Documented. MLTSS plan members who had a comprehensive LTSS care plan with nine core elements documented within 120 days of enrollment (for new members) or annually. 2. Care Plan with Supplemental Elements Documented. MLTSS plan members who had a comprehensive LTSS care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new members) or annually.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	18 years and older as of the first day of the measurement year.
Data collection method	Case Management Record Review.
Denominator	A systematic sample drawn from the eligible population of members receiving Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care).
Numerator	The measure reports two numerators. Rate 1: Care Plan with Core Elements Documented The number of MLTSS plan members who had either of the following: • *For new members:* A comprehensive LTSS care plan completed within 120 days of enrollment, with all 9 core elements documented, OR • *For established members*: A comprehensive LTSS care plan completed at least once during the measurement year, with all 9 core elements documented. Care plans must be discussed during a face-to-face encounter between the care manager and the member, unless exceptions apply. The care plan is not required to be created in the member's home. Video conferencing is allowable as evidence of a face-to-face discussion.

	Discussion of the care plan may not be done by phone except in the following circumstances: • The member was offered a face-to-face discussion and refused, OR • The state policy, regulation, or other state guidance excludes the member from a requirement for face-to-face discussion of a care plan. Assessment of the member and development of the care plan may be done during the same encounter or during different encounters. The initial care plan or care plan update must include documentation of following 9 core elements and the date of the care plan: 1. At least one individualized member goal (medical or non-medical outcome important to the member). 2. A plan of care to meet the member's medical needs. 3. A plan of care to meet the member's functional needs. 4. A plan of care to meet the member's needs due to cognitive impairment. 5. A list of all LTSS services and supports the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings, including the amount and frequency. 6. A plan for the care manager to follow up and communicate with the member. 7. A plan to ensure that the member's needs are met in an emergency. 8. Documentation of the family/friend caregivers who were involved in development of the care plan, and their contact information. 9. Documentation that the member or the member's representative (i.e., power of attorney) agrees to the completed care plan, or appeals the care plan. Rate 2: Care Plan with Supplemental Elements Documented The number of MLTSS plan members who had either of the following: • For new members: A comprehensive LTSS care plan completed within 120 days of enrollment with 9 core elements and at least 4 supplemental elements documented, or • For established members: A comprehensive LTSS care plan created during the measurement year with 9 core elements and at least 4 supplemental elements documented. The care plan must be completed within 120 days of enrollment and updated annually thereafter. Care plans must be discussed during a face-to-face encounter between the care manager and the member, unless exceptions apply. The care plan is not required to be created in the member's home. Video conferencing is allowable as evidence of a face-to-face discussion. The care plan may be discussed during the same encounter as the assessment. Discussion of the care plan may not be done by phone except in the following circumstances: • The member was offered a face-to-face discussion and refused, OR

	• The state policy, regulation, or other state guidance excludes the member from a requirement for face-to-face discussion of a care plan. The member's care plan must document evidence of 9 core elements defined above and evidence of at least 4 supplemental elements, and the date of the care plan. Supplemental elements include the following: 1. A plan of care to meet the member's mental health needs. 2. A plan of care to meet the member's social or community integration needs. 3. The duration of all LTSS the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings, or the time (date) when services will be reassessed. 4. Contact information for the member's LTSS providers. 5. A plan to assess the member's progress toward meeting established goals, including a time frame for reassessment and follow-up. 6. Documentation of barriers to the member meeting defined goals. 7. The member's first point of contact. 8. Contact information for member's primary care practitioner (PCP), or a plan for connecting the member to a PCP if the member does not currently have one.
Exclusions	Required exclusions are reported with the performance measure rates. 1. Could Not Be Contacted for Care Planning: New plan members who could not be contacted to create an LTSS comprehensive care plan within 120 days of enrollment, or established plan members who could not be contacted to create an LTSS comprehensive care plan during the measurement year. MLTSS plans use their own process for identifying members who cannot be contacted for care planning, and document that at least three attempts were made to contact the member. 2. Refusal of Care Planning: Plan members who refused a comprehensive care plan. Document that the member was contacted and refused to participate in a care plan.
Continuous enrollment period	Member must be enrolled in a Medicaid MLTSS plan for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For individuals with multiple distinct continuous enrollment periods during the measurement year, look at the assessment completed in the last continuous enrollment period of 150 days or more during the measurement year.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

Additional Information for Consideration	
Current level of reporting	Plan-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	Two Workgroup members suggested this measure for addition. **Response 1:** This measure would address the gap for LTSS. It is one of the few nationally-recognized measures available for LTSS and while many states are not yet reporting according to these new HEDIS specifications, most states do already track some type of similar measure around care plan completion for LTSS. **Response 2:** A plan that is aligned with the assessed needs is a staple of quality LTSS services.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	**Response 1:** It is essential that LTSS-eligible beneficiaries have a care plan in place as soon as possible (following completion of a comprehensive assessment) so that the services they need have been identified and can be initiated. Delays in care plan development could lead to gaps in care resulting in beneficiaries being admitted to hospitals or nursing facilities and/or limiting the beneficiaries' independence and quality of life. States could use this measure to compare performance across MLTSS plans or care management organizations to ensure expectations for care management quality are being met. **Response 2:** This would assure that planning and plan development for individuals with LTSS needs would include certain minimal elements as well as that the planning included a face-to-face component.
Use of measure in other programs	• Included by CMS in a list of eight quality measures for states to consider when using a managed care delivery system for providing long-term services and supports. https://www.medicaid.gov/medicaid/managed-care/ltss/index.html • This measure has been adopted as a first-year HEDIS measure for HEDIS 2019: LTSS Comprehensive Care Plan and Update (LTSS-CPU).
Meaningful Measures area(s) of measure	• Strengthen Person & Family Engagement as Partners in their Care. • Promote Effective Communication & Coordination of Care.
Other	None.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Long-Term Services and Supports (LTSS) Reassessment/ Care Plan Update After Inpatient Discharge
Description	Percentage of discharges from inpatient facilities for Medicaid Managed Long-Term Services and Supports (MLTSS) plan members 18 years of age and older for whom a reassessment and care plan update occurred within 30 days of discharge. Two performance rates are reported: 1. Reassessment after Inpatient Discharge. The percentage of discharges from inpatient facilities resulting in a LTSS reassessment within 30 days of discharge. 2. Reassessment and Care Plan Update after Inpatient Discharge. The percentage of discharges from inpatient facilities resulting in a LTSS reassessment and care plan update within 30 days of discharge. In addition, two rates of required exclusions should be reported: 1. Member could not be contacted for assessment and/or care planning. 2. Member refused to participate in assessment and/or care planning.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Process
Recommended to replace current measure?	No

Technical Specifications	
Ages	18 years and older as of the first day of the measurement year.
Data collection method	Case Management Record Review.
Denominator	A systematic sample of inpatient discharges drawn from the eligible population of members receiving Long-Term Services and Supports (Home and Community Based Services and/or Institutional Facility Care) and medical benefits through the MLTSS plan. The denominator for this measure is based on discharges, not on members. Members may appear more than once in the sample.
Numerator	The measure reports two numerators. Rate 1: Reassessment after Inpatient Discharge LTSS reassessment on the date of discharge or within 30 days after discharge. Reassessment must be a face-to-face discussion between the member and care manager. Reassessment may not be conducted over the telephone unless there is documentation that the member refused a face-to-face encounter. Reassessment in the inpatient facility on the day of discharge meets the requirement. The member's reassessment must

	include documentation of the following nine core elements and the date of the reassessment: 1. Documentation that Activities of Daily Living (ADL) were assessed, or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking. 2. Documentation of acute and chronic health conditions. 3. Documentation of current medications. 4. Assessment of cognitive function using a standardized tool. 5. Assessment of mental health status using a standardized tool. 6. Assessment of home safety risks. 7. Confirm living arrangements. 8. Confirm current and future family/friend caregiver availability. 9. Documentation of current providers. Documentation of "no change" does not meet numerator criteria. Rate 2: Reassessment and Care Plan Update after Inpatient Discharge LTSS reassessment and care plan update on the date of discharge or within 30 days after discharge. Reassessment must document evidence of the nine core elements described above and the reassessment date. The care plan must be conducted during a face-to-face encounter between the care manager and the member unless there is documentation that the member refused a face-to-face encounter. A care plan developed in the inpatient facility on the day of discharge meets the requirement. The care plan update must include documentation of the following nine core elements and the date of the care plan: 1. At least one individualized member goal (medical or non-medical outcome important to the member). 2. A plan of care to meet the member's medical needs. 3. A plan of care to meet the member's functional needs. 4. A plan of care to meet the member's needs due to cognitive impairment. 5. A list of all LTSS services and supports the member receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings, including the amount and frequency. 6. A plan for the care manager to follow up and communicate with the member. 7. A plan to ensure that the member's needs are met in an emergency. 8. Documentation of the family/friend caregivers who were involved in development of the care plan, and their contact information. 9. Documentation that the member or the member's representative (i.e., power of attorney) agrees to the completed care plan, or appeals the care plan. Documentation of "no change" does not meet numerator criteria.

Exclusions	1. Discharges for Planned Admissions: Exclude planned hospital admissions from the measure denominator. A hospital stay is considered planned if it meets any of the following criteria: • Hospital stays with a principal diagnosis of pregnancy or a condition originating in the perinatal period. • A principal diagnosis of maintenance chemotherapy. • A principal diagnosis of rehabilitation. • An organ transplant. • A potentially planned procedure without a principal acute diagnosis. The exclusion for planned admissions is not reported with the measure performance rates. 2. Could not be Contacted for Assessment and/or Care Plan Update: Members who could not be reached for assessment and care plan update following inpatient discharge. Organizations use their own process for identifying members who cannot be contacted for assessment, and document that at least three attempts were made to contact the member. To calculate the rate of individuals who could not be reached divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria. The exclusion for could not be reached is reported with the measure performance rates. 3. Refusal of assessment and/or care planning: Members who refused to participate in an assessment or development of a comprehensive LTSS care plan following inpatient discharge. To calculate the rate of individuals who refused, divide the number of individuals meeting this exclusion criterion by the number of people meeting the continuous enrollment criteria. The exclusion for refusal of assessment and/or care planning is reported with the measure performance rates.
Continuous enrollment period	Enrollment in the Medicaid MLTSS plan on the date of discharge through 30 days after the date of discharge.
Level of reporting for which specifications were developed	Plan-level.
For more information	https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

Additional Information for Consideration	
Current level of reporting	Plan-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this would assure that individuals with disabilities and LTSS needs had their needs assessed and their plan changed as needed in relation to a hospitalization.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	This would assure that people are evaluated for changes in their plan including medication post hospital discharge and that their new needs were met in a timely manner.
Use of measure in other programs	• Included by CMS in a list of eight quality measures for states to consider when using a managed care delivery system for providing long-term services and supports. https://www.medicaid.gov/medicaid/managed-care/ltss/index.html • This measure has been adopted as a first-year HEDIS measure for HEDIS 2019: LTSS Reassessment/Care Plan Update After Inpatient Discharge (LTSS-RAC).
Meaningful Measures area(s) of measure	Promote Effective Communication & Coordination of Care.
Other	None.

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Home and Community Based Services (HCBS) Survey
Description	The CAHPS Home and Community-Based Services Survey (HCBS CAHPS) is the first cross-disability survey of the experience of home and community-based service (HCBS) beneficiaries receiving long-term services and supports (LTSS). It is designed to facilitate comparisons across the hundreds of state Medicaid HCBS programs throughout the country that target adults with disabilities, including frail elderly, individuals with physical disabilities, persons with developmental or intellectual disabilities, those with acquired brain injury, and persons with severe mental illness. The HCBS CAHPS Survey is available for voluntary use in HCBS programs as part of quality assurance and improvement activities and public reporting.
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	2967 (Note: 19 CAHPS HCBS measures are NQF endorsed.)
Core Set domain	Long-Term Services and Supports
Measure type	Outcome: PRO-PM
Recommended to replace current measure?	No

Technical Specifications	
Ages	Beneficiaries at least 18 years of age in the sample period.
Data collection method	Survey.
Denominator	Individuals eligible for the CAHPS HCBS survey include Medicaid beneficiaries who are at least 18 years of age in the sample period, and who have received HCBS services for 3 months or longer and their proxies. Eligibility is further determined using three cognitive screening items administered during the interview: Q1. Does someone come into your home to help you? (Yes, No) Q2. How do they help you? Q3. What do you call them? Individuals who are unable to answer these cognitive screening items are excluded from the survey. The denominator for all measures is the number of survey respondents. Some measures also have topic-specific screening items.
Numerator	The CAHPS HCBS measures are created using top-box scoring. This refers to the percentage of respondents that give the most positive response. HCBS experience is measured in the following areas. **Scale Measures** 1. Staff are reliable and helpful – average proportion of respondents that gave the most positive response on 6 survey items

	2. Staff listen and communicate well – average proportion of respondents that gave the most positive response on 11 survey items 3. Case manager is helpful - average proportion of respondents that gave the most positive response on 3 survey items 4. Choosing the services that matter to you - average proportion of respondents that gave the most positive response on 2 survey items 5. Transportation to medical appointments - average proportion of respondents that gave the most positive response on 3 survey items 6. Personal safety and respect - average proportion of respondents that gave the most positive response on 3 survey items 7. Planning your time and activities - average proportion of respondents that gave the most positive response on 6 survey items **Global Rating Measures** 8. Global rating of personal assistance and behavioral health staff - average proportion of respondents that gave the most positive response of 9 or 10 on a 0-10 scale 9. Global rating of homemaker - average proportion of respondents that gave the most positive response of 9 or 10 on a 0-10 scale 10. Global rating of case manager - average proportion of respondents that gave the most positive response of 9 or 10 on a 0-10 scale **Recommendation Measures** 11. Would recommend personal assistance/behavioral health staff to family and friends - average proportion of respondents that gave the most positive response of "Definitely Yes" on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 12. Would recommend homemaker to family and friends - average proportion of respondents that gave the most positive response of "Definitely Yes" on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) 13. Would recommend case manager to family and friends - average proportion of respondents that gave the most positive response of "Definitely Yes" on a 1-4 scale (Definitely no, Probably no, Probably yes, Definitely yes) **Unmet Needs Measures** 14. Unmet need in dressing/bathing due to lack of help - average proportion of respondents that gave the most positive response of "No" on a 1-2 scale (Yes, No) 15. Unmet need in meal preparation/eating due to lack of help - average proportion of respondents that gave the most positive response of "No" on a 1-2 scale (Yes, No) 16. Unmet need in medication administration due to lack of help - average proportion of respondents that gave the most positive response of "No" on a 1-2 scale (Yes, No)

	17. Unmet need in toileting due to lack of help - average proportion of respondents that gave the most positive response of "Yes" on a 1-2 scale (Yes, No) 18. Unmet need with household tasks due to lack of help - average proportion of respondents that gave the most positive response of "No" on a 1-2 scale (Yes, No) **Physical Safety Measure** 19. Hit or hurt by staff - average proportion of respondents that gave the most positive response of "No" on a 1-2 scale (Yes, No)
Exclusions	Individuals less than 18 years of age and individuals that have not received HCBS services for at least 3 months are excluded. During survey administration, individuals that failed any of the cognitive screening items mentioned in the denominator statement above are excluded.
Continuous enrollment period	Individuals continuously enrolled in an HCBS program for at least the last 3 months.
Level of reporting for which specifications were developed	Program-level.
For more information	https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbscahps-admin-ta-guide.pdf

Additional Information for Consideration	
Current level of reporting	Program-level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure would fill a gap of having no measure for HCBS.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	The measure is designed to facilitate comparisons across state Medicaid HCBS programs throughout the country that target adults with disabilities and seniors.
Use of measure in other programs	Available for voluntary use in HCBS programs.
Meaningful Measures area(s) of measure	Promote effective communication & coordination of care.
Other	During the annual review of the Adult Core Set for 2018, the NQF Measure Applications Partnership (MAP) conditionally supported the measure pending confirmation from CMS on the feasibility of implementation at the state level. The NQF MAP also recommended it for addition to the Adult Core Set for 2019. The MAP noted the need for home and community-based metrics to measure quality across the spectrum of settings where care is delivered. A comparison of the National Core Indicators-Aging and Disabilities (NCI-AD) and the HCBS CAHPS is available at https://nci-ad.org/images/uploads/NCI-AD_and_HCBS_CAHPS_Comparison.pdf.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	National Core Indicators (NCI™)
Description	The purpose of NCI is to gather a standard set of performance and outcome measures that can be used to track agencies' performance. NCI surveys include an in-person survey, family surveys, and staff stability survey. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals with intellectual and developmental disabilities and their families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety.
Measure steward	Human Services Research Institute (HSRI) and National Association of State Directors of Developmental Disabilities Services (NASDDDS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Outcome: Patient-Reported Outcomes
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Survey.
Denominator	Individuals who respond to the survey question or questions from which the indicator is drawn. The sampling frame varies by survey and by state; samples are usually limited to individuals who are age 18 or older and who receive at least one service besides case management.
Numerator	The numerator varies based on indicator. The current set of performance indicators includes approximately 150 outcomes within five domains: individual outcomes; health, welfare, and rights; system performance; staff stability; and family outcomes.
Exclusions	Varies based on indicator.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	State-level.
For more information	https://www.nationalcoreindicators.org/indicators/

Additional Information for Consideration	
Current level of reporting	State-level. 46 states plus DC participate in the NCI program.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted there are currently no measures for long terms services and supports (LTSS) for people with intellectual and developmental disabilities. This measure would go a long way in ensuring that LTSS is measured in the Core Sets.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	This measure can be used by states to trend inside the state quality of care for people with intellectual and developmental disabilities as well as to trend how the state as a whole is doing compared to other states or nationally.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	• Promote Effective Communication & Coordination of Care. • Strengthen Person and Family Engagement as Partners in Their Care. • Work with Communities to Promote Best Practices of Healthy Living.
Other	Information on using National Core Indicators Data for Quality Improvement Initiatives is available at https://www.nationalcoreindicators.org/upload/core-indicators/using_data_cleanedDLH_%28003%29_3_22_18.pdf A comparison of NCI and NCI-AD is available at https://www.nationalcoreindicators.org/upload/aidd/NCI_and_NCI-AD_overview_for_states_10-8-18.pdf

MATHEMATICA Policy Research

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	National Core Indicators for Aging and Disabilities (NCI-AD™) Adult Consumer Survey
Description	NCI-AD is a voluntary effort by State Medicaid, aging, and disability agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals with physical disabilities and their families. Indicators address key areas of concern including service planning, rights, community inclusion, choice, health and care coordination, safety and relationships.
Measure steward	Human Services Research Institute (HSRI) and National Association of States United for Aging and Disabilities (NASUAD)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Outcome: Patient-Reported Outcomes
Recommended to replace current measure?	No

Technical Specifications	
Ages	Age 18 and older.
Data collection method	Survey.
Denominator	Individuals who respond to the survey question or questions from which the indicator is drawn. The sampling frame includes seniors or adults 18 years and older with a physical disability (including acquired or traumatic brain injury (ABI/TBI)) who receive publicly funded long-term services and supports (LTSS) at least 2-3 times a week. Intellectual and development disability (IDD)-specific and mental illness (MI)-specific programs (like IDD or MI-specific waivers) are excluded from the sampling frame. People with IDD and/or MI (including severe MI) who are receiving LTSS through some other, non-IDD or MI-specific program can be sampled as part of those programs.
Numerator	Varies based on indicator
Exclusions	Varies based on indicator
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	State-level.
For more information	https://nci-ad.org/resources/the-survey/

Additional Information for Consideration	
Current level of reporting	State-level. 17 states collected NCI-AD data in 2018-2019.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted there are currently no measurements for Long Term Services and Supports (LTSS) for people using HCBS and other services. This measure is an excellent tool currently used by 17 states. Other states are moving forward in using it. The measurements are valid and reliable. It provides the ability for states to look at LTSS and is different than other measurement tools.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	This measure can be used by states to trend inside the state quality of care as well as to trend how the state as a whole is doing compared to specific other states or nationally.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	• Promote Effective Communication & Coordination of Care. • Strengthen Person and Family Engagement as Partners in Their Care. • Work with Communities to Promote Best Practices of Healthy Living.
Other	A comparison of NCI-AD and NCI is available at https://www.nationalcoreindicators.org/upload/aidd/NCI_and_NCI-AD_overview_for_states_10-8-18.pdf A comparison of NCI-AD and HCBS CAHPS is available at https://nci-ad.org/images/uploads/NCI-AD_and_HCBS_CAHPS_Comparison.pdf

MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Personal Outcome Measures
Description	Personal Outcome Measures are a tool to ensure services and supports are person-centered. In a Personal Outcome Measures interview, 21 indicators are used to understand the presence, importance and achievement of outcomes, involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment and more. Measures are organized into 5 topic areas: Human Security, Community, Relationships, Choices, and Goals.
Measure steward	Council on Quality and Leadership (CQL)
NQF number (if endorsed)	Not endorsed
Core Set domain	Long-Term Services and Supports
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Not specified. The 2017 validation study for this tool was conducted with participants age 18 and older.
Data collection method	In-depth interview.
Denominator	Individuals receiving services and supports who participate in an in-depth interview using the Personal Outcome Measures tool. Some service agencies use the tool with everyone they serve, while others interview a selection of their clients. If the latter, a representative sample should be selected. The target population for the tool is not explicitly defined, but the 2017 validation study was done with people with disabilities receiving services from organizations that provide: service coordination; case management; family and individual supports; behavioral health care; employment and other work services; residential services; non-traditional supports (micro-boards and co-ops); and human service systems.
Numerator	Individuals with the outcome and/or supports of interest present, based on the interviewers' assessment of the individual's responses to interview questions and probes, follow-up meetings with others who know the person best, observations, and documentation checks.
Exclusions	None.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Organizations providing services and supports.
For more information	Manual: https://www.c-q-l.org/files/2018Documents/2017-CQL-POMs-Manual-Adults.pdf

Additional Information for Consideration	
Current level of reporting	Not specified.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted this measure can be used for people with intellectual and developmental disabilities to explore quality of life outcomes for people receiving services, surrounding issues involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment, and more. It also looks at the supports in a person's life, to better understand what effect particular services are having on the presence of those outcomes.
How measure can be used to improve quality of care ***(per workgroup member who suggested the measure)***	This measure can be used to look at social determinants of health for people with intellectual and developmental disabilities. This, along with other measures being put forward for LTSS, will strengthen person and family engagement as partners in their care.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	• Strengthen Person and Family Engagement as Partners in Their Care. • Promote Effective Communication & Coordination of Care.
Other	• This measure is used by New York State's Office for People With Developmental Disabilities for person-centered planning. More information is available at https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning. • This measure was presented and discussed at the 2017 and 2018 Adult Core Set annual reviews. The Workgroup discussions focused on the importance of capturing data for Medicaid beneficiaries with disabilities, specifically, community integration, beneficiary experience, and quality of life data. The surveys address priority gap areas for intellectually, developmentally, and physically disabled populations, such as beneficiary reported outcomes, long-term services and supports, and home and community-based services. The survey instruments have been validated but do not include validated measures. The MAP agreed that actionable measures addressing quality of life would be useful and encouraged future development of such measures.

OTHER MEASURES

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Continuity of Insurance: Informed Participation
Description	Informed Participation assesses the continuity of enrollment of children in publicly financed insurance programs (Medicaid and CHIP), as defined by the ratio of enrolled months to eligible months over an 18-month period (called an "observation window"). The measure uses a natural experiment based on the random event of appendicitis to "inform" the estimate of coverage in a given state. The three assumptions consist of Coverage Presumed Eligible (PE), Coverage Presumed Ineligible (PI), or the average of the two (although it is not a separate metric, for clarity's sake this average is called "Mixed Coverage," or Coverage PM). Whichever rate falls closest to the rate of existing enrollment among appendicitis patients is then applied to all children in a state for a given year. The measure was developed using Medicaid Analytic eXtract (MAX) data and was designed to overcome a limitation of MAX data to determine the reason for disenrollment, including loss of eligibility (such as due to parental income increase or the acquisition of employer-sponsored insurance, a "good" reason) or failure to appropriately reenroll (a "bad" reason).
Measure steward	The Children's Hospital of Philadelphia (CHOP)
NQF number (if endorsed)	3154
Core Set domain	Other Measures
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Children ages 0 to 18 at the beginning of the 18-month observation window.
Data collection method	Administrative.
Denominator	The sum (within a state) of months eligible for Medicaid or CHIP for all children (ages 0 to 18) over an 18-month observation window. The definition of "eligible months" for Informed Participation depends on whether the natural experiment estimate most closely reflects Coverage Presumed Eligible, Presumed Ineligible, or the average of the two. The eligibility assumptions of Coverage PE and PI create upper and lower bounds on the "true" measure of continuity. Since Coverage is a ratio of insured to eligible months, Coverage PE will tend to underestimate true coverage due to the people who drop out of Medicaid and CHIP for good reasons. Similarly, Coverage PI may overestimate coverage, as some children may have been truly eligible prior to their first evidence of enrollment.

	Although Coverage PE and PI are highly correlated with each other and either metric can be used to track State performance over time, States may want to know which metric will give them a more accurate picture of their patterns of enrollment. For this reason, a measure of "Informed Participation" was developed based on rates of pre-hospitalization enrollment among pediatric appendectomy patients. Informed Participation's stronger correlation with the American Community Survey (ACS)—which can identify eligible unenrolled children—relative to PE and PI indicates that by examining the random event of appendicitis, some inherent limitations of administrative data are circumvented. But Informed Participation is also limited by variable and incomplete reporting of managed care claims in some States, and not all States may have sufficiently complete claims data to effectively implement the metric. More information about the definitions for the denominator are available at https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/duration/chipra-153-insurance-informed-coverage-report.pdf.
Numerator	The sum (within a state) of months enrolled in Medicaid or CHIP for all children over an 18-month window. A month is considered "covered" if a child has greater than 14 enrolled days in that month.
Exclusions	The denominator is the sum of eligible months for all children and assumes the following: • For children born within the 18-month window of observation, the total months of eligibility begins from the date of birth. • For children who reach the age of 18 before the end of the 18-month window of observation, total months of eligibility ends with their 18th birthday. For the appendicitis calculation, the population is limited to children between the ages of 2 and 16 years old.
Continuous enrollment period	None.
Level of reporting for which specifications were developed	State-level: Medicaid and CHIP programs (either separately or jointly administered).
For more information	Detailed specifications and results of testing for reliability, validity, and feasiliby are available at https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/duration/chipra-153-insurance-informed-coverage-report.pdf

Additional Information for Consideration	
Current level of reporting	The measure was developed to support meaningful comparison at the state-level. The measure is not currently being used at this level.
Gap area(s) ***(per workgroup member who suggested the measure)***	One Workgroup member suggested this measure for addition. The Workgroup member noted continuity of coverage impacts the completeness of other measures. Previous gap analysis conducted on the Child Core Set points to duration of coverage as a known gap.
How measure can be used to improve quality of care ***(per workgroup***	Understanding churn in Medicaid and CHIP can help drive states toward policies that promote continuous eligibility so that all quality measures incorporate the experience of all beneficiaries.

member who suggested the measure)	This measures can be used to help develop strategies to retain children eligible for coverage and minimize gaps that can occur during the renewal process.
Use of measure in other programs	No other programs listed in CMS's Measure Inventory Tool.
Meaningful Measures area(s) of measure	Make Care Affordable.
Other	This measure was developed under the Pediatric Quality Measures Program (PQMP). More information about the PQMP is available at https://www.ahrq.gov/pqmp/index.html. This measure is part of the Insurance Continuity Metric Suite, which contains five measures. SAS code for replicating the measure is available at https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/duration/chipra-153-section1-sas-code.pdf.

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MEASURE INFORMATION SHEET

CHILD AND ADULT CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2020 CORE SET

Measure Information	
Measure name	Health-Related Social Needs (HRSN) Screening
Description	A 10-item screening tool designed to identify patient needs in 5 domains that can be addressed through community services (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety).
Measure steward	Centers for Medicare & Medicaid Services (CMS)
NQF number (if endorsed)	Not endorsed
Core Set domain	Other Measures
Measure type	Outcome
Recommended to replace current measure?	No

Technical Specifications	
Ages	Not specified.
Data collection method	Survey.
Denominator	Total number of survey respondents.
Numerator	Housing Instability Q1. Number of respondents indicating they do not have housing today [I do not have housing; I have housing today, but I am worried about losing housing in the future; I have housing] Q2. Number of respondents indicating they have problems with: [Bug infestation; Mold; Lead paint or pipes; Inadequate heat; Oven or stove not working; No or not working smoke detectors; Water leaks; None of the above]. Food Insecurity Q3. Number of respondents indicating that within the past 12 months, they worried that their food would run out before they got money to buy more [Often true; Sometimes true; Never true]. Q4. Number of respondents indicating that within the past 12 months, the food they bought just didn't last and they didn't have money to get more [Often true; Sometimes true; Never true]. Transportation Needs Q5. Number of respondents indicating that lack of transportation has kept them from medical appointments, meetings, work or from getting things needed for daily living [Yes, it has kept me from medical appointments or getting medications; Yes, it has kept me from non-medical meetings, appointments, work, or getting things I need; No].

	Utility Needs Q6. Number of respondents indicating that in the past 12 months, the electric, gas, oil, or water company has threatened to shut off services in their home [Yes; No; Already Shut Off]. Interpersonal Safety Q7. Number of respondents indicating that anyone, including family, physically hurts them [Never; Rarely; Sometimes; Fairly often; or Frequently]. Q8. Number of respondents indicating that anyone, including family, insults or talks down to them [Never; Rarely; Sometimes; Fairly often; or Frequently]. Q9. Number of respondents indicating that anyone, including family, threatens them with harm [Never; Rarely; Sometimes; Fairly often; or Frequently]. Q10. Number of respondents indicating that anyone, including family, screams or curses at them [Never; Rarely; Sometimes; Fairly often; or Frequently].
Exclusions	Not specified.
Continuous enrollment period	Not specified.
Level of reporting for which specifications were developed	Not specified.
For more information	https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

Additional Information for Consideration	
Current level of reporting	None; testing by the Accountable Health Communities model in process.
Gap area(s) *(per workgroup member who suggested the measure)*	One Workgroup member suggested this measure for addition. The Workgroup member noted growing evidence shows that if we address unmet health-related social needs like homelessness, hunger, and exposure to violence, we can help undo their harm to health and improve overall progress on improving health, healthcare, and wellbeing. While there is a robust dialogue on how best to measure and improve upon an individual or community's social determinants of health, there are a few measures that have been in use or are currently being tested by Center for Medicare & Medicaid Innovation (CMMI) that would allow state Medicaid programs to begin to measure and then address social needs and social determinants of Medicaid beneficiaries. This measure could be tested over a several year period as a starting point, while alignment around measures related to social determinants and social needs is fully reached. While there are some measures on the Medicaid Core Sets that reflect unmet social needs, such as low

	birth weight, these recommended measures would be new and would be an attempt to begin to explicitly measure quality of life and the ability to have social needs met, as a critical component of well health. This measure is currently being tested by CMMI; perhaps consideration could be given to testing it in a Medicaid setting while further work is done to improve upon the current ability to address social needs and social determinants of health of individuals and populations.
How measure can be used to improve quality of care *(per workgroup member who suggested the measure)*	States could use this measure to monitor and drive improved perceived overall health and well-being of individuals and communities to monitor and subsequently address critical factors that fundamentally influence health and well-being such as food insecurity, housing instability, and safety. This would drive improvement in the quality of life for Medicaid and CHIP beneficiaries.
Use of measure in other programs	CMMI Accountable Health Communities Model (testing in process).
Meaningful Measures area(s) of measure	Work with Communities to Promote Best Practices of Healthy Living.
Other	The 2-item Children's HealthWatch Hunger Vital Sign screening tool was incorporated in the AHC HRSN tool: http://childrenshealthwatch.org/public-policy/hunger-vital-sign/

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