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Medicaid Health Home Core Set Stakeholder Workgroup:

Measures Suggested for Addition to the 2022 Core Set

Measure Information Sheets
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Contents

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MEASURE INFORMATION SHEET

HEALTH HOME CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2022 CORE SET

Measure Information	
Measure name	**Follow-Up After Emergency Department Visit for Mental Illness**
Description	Percentage of emergency department (ED) visits for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days); • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	3489
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease
Measure type	Process
Recommended to replace current measure?	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)
Is the measure on the Child or Adult Core Set?	Yes – the Adult Core Set. The measure has also been recommended for addition to the Child Core Set by the 2022 Child and Adult Core Set Review Workgroup

Technical Specifications	
Ages	Age 6 and older as of the ED visit. The following age stratifications are reported: ages 6 to 17, ages 18 to 64, age 65 and older, and a total rate (all ages). • The Adult Core Set includes this measure for beneficiaries age 18 and older. Rates are reported for two age groups: ages 18 to 64 and age 65 and older. • This measure has been recommended for addition to the Child Core Set for beneficiaries ages 6 to 17.
Data collection method	Administrative (claims).
Denominator	The denominator for this measure is based on ED visits, not on beneficiaries. The denominator includes ED visits with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year where the beneficiary was 6 years or older on the date of the visit.

Numerator	• 30-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. • 7-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.
Exclusions	• Exclude beneficiaries in hospice from the eligible population. • Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission.
Continuous enrollment period	Date of the ED visit through 30 days after the ED visit (31 total days).
Level of reporting for which specifications were developed	Plan-level.
Health home focus area	Serious mental illness/serious emotional disturbance.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	The specifications for this measure are available at https://www.medicaid.gov/medicaid/quality-ofcare/downloads/medicaid-adult-core-set-manual.pdf.
Information on testing or use at state Medicaid/CHIP level	This measure is currently being reported as part of the Adult Core Set. For FFY 2019, 36 states reported the measure for the Adult Core Set.
Description of required data source and data elements, including any barriers, limitations, or variations that could affect consistency of calculations	Required data elements include enrollment data, date of service, mental illness and intentional self-harm diagnosis codes, place of service codes, ED visits, and treatment procedure codes. Beginning with the FFY 2023 Core Set, this measure may be reported using the Fast Healthcare Interoperability Resource (FHIR) data model.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality in Medicaid Health Home programs, including ability to perform comparative analyses based on race, ethnicity, or socioeconomic status	This measure was suggested for addition to the Health Home Core Set by three Workgroup members (WGMs). One WGM indicated that Medicaid is the single largest payer for mental health services in the United States[1] and that high numbers of ED visits are an issue for Medicaid beneficiaries.[2] Another WGM indicated that health homes may receive alerts of inpatient admissions or ED visits in order to schedule ambulatory follow-up visits. They also indicated that disparities can be measured against both the stratified age groups. Two WGMs suggested that the measure be stratified by race and ethnicity.
How measure addresses the unique and complex needs of Medicaid Health Home enrollees and promotes effective care delivery	One WGM indicated that since more states are including foster care populations with their SMI/SED members, the use of trauma-informed services for the foster care population is encouraged by intervening quickly following an ED visit for mental illness or self-harm. Additionally, they indicated that not only does follow-up care for mental illness encourage treatment and reduce the stigma around diagnosis, this measure can also act as a preventative measure against others measures in the Core Set such as FUH-HH and OUD-HH relative to the inclusion of self-harm and may reduce all-cause readmissions (PCR-HH). Another WGM indicated that this measure highlights whether care coordination is effective or not across delivery systems; and given that health home enrollees may have higher health care needs, this type of care coordination measure assists in a more holistic view of the care delivery environment. Another WGM indicated that this measure addresses the need to coordinate care for people who live with mental illness and is able to monitor whether people who live with mental illness receive follow-up care after visiting the emergency room for reasons related to mental illness.
Evidence that measure could lead to improvement in quality of health care for Medicaid Health Home enrollees	Two WGMs noted that there is evidence suggesting that follow-up care for people with mental illness is associated with fewer repeated ED visits.[3] Another WGM commented that this measure is better than the all-ED utilization measure (AMB-CH) that was recommended for removal from the Child Core Set. (Note that the AMB-HH measure has been suggested for removal from the Health Home Core Set.)

How measure can be used to monitor improvement	One WGM indicated that NCQA benchmarks across all Medicaid managed care (all ages) show that 41 percent of ED visits had a follow-up within 7 days and 56 percent had a follow-up within 30 days.[4] Additionally, for the FFY 2019 Adult Core Set, 36 states reported a median 7-day follow-up rate of 38 percent and a median 30-day follow-up rate of 52 percent for beneficiaries age 18 and older.[1] These data suggest there is substantial room for improvement. Another WGM noted that monitoring ED follow-up care may be associated with fewer inpatient behavioral health visits when ambulatory follow-up is conducted in a timely manner. Another WGM member commented that this measure can be trended over time and health home providers can directly influence improvement.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid beneficiaries	One WGM noted that 11 percent of the 27 million children in the U.S. have been diagnosed with a mental illness and nearly half of the children who qualify for Medicaid because of a disability have a behavioral health diagnosis.[5] Another WGM indicated that the prevalence of mental illness in the Minnesota Medicaid program is over 9,000 adults. In addition, mental health conditions have been exacerbated during the COVID-19 pandemic.
Use of measure in other CMS programs	• Adult Core Set • Core Quality Measures Collaborative (CQMC) Behavioral Health Core Set • Certified Community Behavioral Health Clinic Demonstration
Potential barriers states could face in calculating measure and recommended technical assistance resources	One WGM indicated that they did not expect states to face any barriers in producing this measure unless NCQA transitions the measure to a digital measure only. Another WGM suggested that states may need help connecting behavioral health and ED visit data. The sample size could also be a barrier for some states, but the sample size for this measure is bigger than the FUH measure which most states are already reporting. Another WGM mentioned that health homes have access to the technology to track this measure since states can access the claims associated with the health home records.

Citations

[1] https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html.

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5564052/pdf/pop.2016.0075.pdf.

[3] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf.

[4] https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-mental-illness/.

[5] https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/.

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MEASURE INFORMATION SHEET

HEALTH HOME CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2022 CORE SET

Measure Information	
Measure name	**Asthma Medication Ratio**
Description	The percentage of beneficiaries ages 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	1800
Meaningful Measures area(s) of measure	Management of Chronic Conditions
Measure type	Process
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	Yes – both the Child and Adult Core Sets

Technical Specifications	
Ages	Ages 5 to 64 as of December 31 of the measurement year. The following age stratifications are reported: ages 5 to 11, age 12 to 18, ages 19 to 50, ages 51 to 64, and a total rate (all ages).
Data collection method	Administrative (claims).
Denominator	Beneficiaries ages 5 to 64 as of December 31 identified as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measure year: • At least one emergency department (ED) visit with a principal diagnosis of asthma. At least one acute inpatient encounter with a principal diagnosis of asthma without telehealth. • At least one acute inpatient discharge with a principal diagnosis of asthma on the discharge claim. • At least four outpatient visits, observation visits, telephone visits, or e-visits or virtual check-ins, on different dates of service, with any diagnosis of asthma and at least two asthma medication dispensing events for any controller or reliever medication. • At least four asthma medication dispensing events for any controller or reliever medication. • At least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year; must also have at least one

	diagnosis of asthma, in any setting, in the same year as the leukotriene modifier or antibody inhibitor.
Numerator	The number of beneficiaries who have a medication ratio of 0.50 or greater during the measurement year.
Exclusions	Exclude beneficiaries with any of the following: • Who were in hospice. • Who had no asthma medications (controller or reliever) dispensed during the measurement year. • Who had any diagnosis from any of the following value sets, any time during the beneficiary's history through December 31 of the measurement year: – Emphysema – Other Emphysema – Chronic obstructive pulmonary disease (COPD) – Obstructive Chronic Bronchitis – Chronic Respiratory Conditions Due to Fumes/Vapors – Cystic Fibrosis – Acute Respiratory
Continuous enrollment period	The measurement year and the year prior to the measurement year. No more than one gap in enrollment of up to 45 days during each year of the continuous enrollment period.
Level of reporting for which specifications were developed	Plan-level.
Health home focus area	Chronic conditions.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	• FFY 2021 Adult Core Set Resource Manual: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf • FFY 2021 Child Core Set Resource Manual: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf • Also see NCQA HEDIS MY 2020 and MY 2021 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	According to the Workgroup member (WGM) who suggested the measure for addition, 42 states reported this measure in the Child Core Set and 39 states reported this measure in the Adult Core Set for FFY 2019.

Description of required data source and data elements, including any barriers, limitations, or variations that could affect consistency of calculations	The WGM indicated the measure requires both administrative claims and encounters (medical and pharmacy claims).

Actionability and Strategic Priority	
How measure contributes to measuring overall quality in Medicaid Health Home programs, including ability to perform comparative analyses based on race, ethnicity, or socioeconomic status	The WGM noted that this measure assesses quality of care across the age span. Asthma is a prevalent condition in Medicaid and for many Health Home programs, a qualifying chronic condition for enrollees. Coordinating care, ensuring recommended care for chronic conditions is received, and making sure prescriptions are filled are among the core services for Medicaid Health Home programs focused on asthma as a chronic condition. The WGM also noted this measure contributes to assessing overall quality in Medicaid Health Home programs.
How measure addresses the unique and complex needs of Medicaid Health Home enrollees and promotes effective care delivery	The WGM indicated the measure promotes effective care delivery and supports a goal of the Medicaid Health Home programs, which is to improve health outcomes for beneficiaries with chronic conditions through coordinated care provided by an interdisciplinary team linking primary, behavioral health, and long-term services and supports. The WGM noted Medicaid Health Homes focused on two or more chronic conditions may include enrollees diagnosed with asthma. These enrollees need help ensuring that their care needs are met, evidence-based care is achieved, prescriptions are managed and filled, and appropriate follow-up occurs.
Evidence that measure could lead to improvement in quality of health care for Medicaid Health Home enrollees	According to publicly available data from NCQA, the overall Asthma Medication Rate for Medicaid HMOs is 63 percent, compared to 79 percent for Commercial HMOs and PPOs.[1] These data suggest opportunities for improvement within Medicaid.
How measure can be used to monitor improvement	Data from the Child and Adult Core Sets for FFY 2019 indicated that a median of 69 percent of children ages 5 to 18 with persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater (40 states)2 and a median of 55 percent of adults ages 19 to 64 with persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater (39 states).[3] The WGM noted that both rates indicate an opportunity for improvement. The WGM noted that Medicaid Health Home programs and providers can directly influence improvement in this measure by scheduling follow-up asthma appointments, filling prescriptions, and encouraging enrollees to follow evidence-based guidelines.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid beneficiaries	According to the Centers for Disease Control (CDC), the Medicaid asthma prevalence was 7.8 percent.[4] In children (0-18 years), the prevalence in Medicaid was 7.0 percent.[3] In adults (18 and older), the prevalence in Medicaid was 8.0 percent.[3]
Use of measure in other CMS programs	This measure is used in the following CMS programs: • Medicaid Adult and Child Core Set (Active) • Marketplace Quality Rating System (QRS) (Active)
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM did not identify any barriers that states could face in calculating this measure for the Health Home Core Set.

Citations

[1] https://www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/.

[2] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-chart-pack.pdf.

[3] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf.

[4] https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm.

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HEALTH HOME CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2022 CORE SET

Measure Information	
Measure name	**Comprehensive Diabetes Care: Hemoglobin A1c Poor Control >9.0%**
Description	The percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%) during the measurement year.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0059
Meaningful Measures area(s) of measure	Management of Chronic Conditions
Measure type	Intermediate Outcome
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	Yes – the Adult Core Set

Technical Specifications	
Ages	Ages 18 to 75 as of December 31 of the measurement year. The following age stratifications are reported: ages 18 to 64 and ages 65 to 75.
Data collection method	Administrative, Hybrid, or Electronic health records (EHR).
Denominator	Beneficiaries ages 18 to 75 as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits with a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year before.
Numerator	Beneficiaries whose most recent HbA1c level is greater than 9.0 percent (poor control), is missing a result, or the HbA1c test was not done during the measurement year.
Exclusions	Exclude beneficiaries with any of the following: • In hospice. • Age 66 and older as of December 31 of the measurement year living long term in an institution for more than 90 consecutive days during the measurement year. • Age 66 and older as of December 31 of the measurement year with frailty and advanced illness (optional exclusion). • Who do not have a diagnosis of diabetes during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or the year prior to the measurement year (optional exclusion).

Continuous enrollment period	The measurement year and the year prior to the measurement year. No more than one gap in enrollment of up to 45 days during the measurement year.
Level of reporting for which specifications were developed	Plan-level.
Health home focus area	• Chronic conditions • Substance use disorder • Serious mental illness/serious emotional disturbance

Minimum Technical Feasibility Criteria	
Link to current technical specifications	• FFY 2021 Adult Core Set Resource Manual: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf • Also see NCQA HEDIS MY 2020 and MY 2021Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	Two Workgroup members (WGMs) suggested the measure for addition to the Health Home Core Set. They noted that it is included in the CMS Medicaid Adult Core Set and it was reported by 29 states for FFY 2019 using Core Set specifications. (Note that two other states reported the measure but did not use Core Set specifications.)[1]
Description of required data source and data elements, including any barriers, limitations, or variations that could affect consistency of calculations	One WGM acknowledged that this measure requires claims/encounter data and medical records/chart review. Records should be available for reporting purposes. The WGM believed there shouldn't be any issues with coding or covered benefits that would affect the consistency of calculations across health home programs.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality in Medicaid Health Home programs, including ability to perform comparative analyses based on race, ethnicity, or socioeconomic status	One WGM commented that receiving recommended diagnosis-specific care and treatment is important to positive outcomes for health home program enrollees. Because diabetes is a qualifying chronic condition in many health home programs, as well as being an area of concern for behavioral health/SUD health homes due to use of antipsychotics contributing to a diabetes diagnosis, ensuring coordination by health home providers and practitioners is key to improving quality of life among health home enrollees.[2] Poor control of diabetes is a risk factor for complications, including renal failure, blindness, and neurologic damage.[3,4] The WGM pointed out this measure data allow for analysis by demographic disparity categories such as age, race, ethnicity, gender, geography, etc.
How measure addresses the unique and complex needs of Medicaid Health	One WGM commented that the HbA1c poor control measure impacts the quality of life for enrollees with chronic conditions and many with behavioral health/SUD diagnosis. They noted that the health home team

Home enrollees and promotes effective care delivery	can coordinate, schedule, and ensure HbA1c testing and follow-up are completed in order to improve HbA1c results. The other WGM indicated that this measure focuses on tertiary prevention of diabetes complications, which can have significant social and daily life impacts.
Evidence that measure could lead to improvement in quality of health care for Medicaid Health Home enrollees	One WGM suggested improving HbA1c results (in control) provides an opportunity to improve outcomes by reducing vision issues, amputations, and need for dialysis.[5] The other WGM noted poor control of diabetes is also a risk factor for neurologic damage.[6]
How measure can be used to monitor improvement	According to the Centers for Disease Control (CDC), in FFY 2019, a median of 39 percent of adults had diabetes in poor control.[7] The WGM indicated that this statistic shows that health home providers have a huge opportunity to work with enrollees to encourage receipt of recommended care and services, schedule testing, and ensure receipt of services. State reporting of the measure in the Adult Core Set provides similar evidence of substantial room for improvement. Across the 29 states reporting the measure in the Medicaid Adult Core Set for FFY 2019, a median of 39 percent of adults with diabetes had HbA1c in poor control (>9.0%).[8] In addition, Adult Core Set data for FFY 2017 to FFY 2019 show that performance improved. Among the 24 states reporting the measure for all three years, the rate of HbA1c poor control decreased from 40.9 percent to 38.3 percent, indicating better performance because lower rates are better for this measure.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid beneficiaries	One WGM indicated that among nonelderly adults with incomes at or below 138% of the poverty level, Medicaid beneficiaries were nearly twice as likely as the uninsured to have diabetes (9% versus 5%).[9] The other WGM stated that the prevalence of diabetes varies by state, geography, race, ethnicity, gender, and age.
Use of measure in other CMS programs	This measure is used in the following CMS programs:[10] • Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals (Inactive) • Medicare Shared Savings Program (Active) • Merit-Based Incentive Payment System (MIPS) Program (Active) • Medicaid Adult Core Set (Active).
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGMs did not identify any barriers that states could face in calculating this measure for the Health Home Core Set.

Citations

[1] Medicaid & CHIP. (2020) "Quality of Care for Adult Medicaid: Findings from 2019 Adult Core Set." https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf.

[2] Medicaid. Health Homes. n.d. https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

[3] Centers for Disease Control (CDC). (2020) "National Diabetes Statistics Report 2020: Estimates of Diabetes and Its Burden In the United States." https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.

[4] Centers for Disease Control (CDC). (2021) Diabetes and Nerve Damage. https://www.cdc.gov/diabetes/library/features/diabetes-nerve-damage.html#:~:text=Nerve%20damage%20can%20affect%20your,and%20maintaining%20a%20healthy%20lifestyle.

[5] Centers for Disease Control (CDC). (2020) "National Diabetes Statistics Report 2020: Estimates of Diabetes and Its Burden In the United States." https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.

[6] Centers for Disease Control (CDC). (2021) Diabetes and Nerve Damage. https://www.cdc.gov/diabetes/library/features/diabetes-nerve-damage.html#:~:text=Nerve%20damage%20can%20affect%20your,and%20maintaining%20a%20healthy%20lifestyle.

[7] Centers for Disease Control (CDC). (2020) "National Diabetes Statistics Report 2020: Estimates of Diabetes and Its Burden In the United States." https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf.

[8] Medicaid & CHIP. (2020) "Quality of Care for Adult Medicaid: Findings from 2019 Adult Core Set." https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-chart-pack.pdf.

[9] Kaiser Family Foundation (KFF). (2012) "The Role of Medicaid for People with Diabetes." https://www.kff.org/wp-content/uploads/2013/01/8383_d.pdf.

[10] CMS Measures Inventory Tool. (2021). "Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9/0%)." https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=1404#tab5.

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HEALTH HOME CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2022 CORE SET

Measure Information	
Measure name	**Colorectal Cancer Screening**
Description	The percentage of patients 50 to 75 years of age who had appropriate screening for colorectal cancer.
Measure steward	National Committee for Quality Assurance (NCQA)
NQF number (if endorsed)	0034
Meaningful Measures area(s) of measure	Promote Effective Prevention & Treatment of Chronic Disease
Measure type	Process
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	No. This measure has been recommended for addition to the Adult Core Set by the 2022 Child and Adult Core Set Review Workgroup

Technical Specifications	
Ages	Ages 51 to 75 as of December 31 of the measurement year.
Data collection method	Administrative (claims only), Hybrid (claims and medical record review), and 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. NCQA has proposed transitioning this measure to ECDS only reporting starting in measurement year [MY] 2024 and is currently assessing public comment related to this proposal.)
Denominator	Members ages 51 to 75 with a visit during the measurement period.
Numerator	Members with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (FOBT) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year. • Colonoscopy during the measurement year or the nine years prior to the measurement year. • Computed tomography (CT) colonography during the measurement year or the four years prior to the measurement year. • Fecal immunochemical DNA test (FIT-DNA) during the measurement year or the two years prior to the measurement year.

Exclusions	Exclude members who meet any of the following: • In hospice. • Receiving palliative care. • Age 66 and older with frailty and advanced illness. • Medicare member age 66 and older enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement year. • Medicare member age 66 and older living long-term in an institution any time during the measurement year. • Colorectal cancer at any time during the member's history (optional). • Total colectomy at any time during the member's history (optional).
Continuous enrollment period	The measurement year and the year prior to the measurement year. No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Level of reporting for which specifications were developed	Plan-level.
Health home focus area	• Chronic conditions • Serious mental illness/serious emotional disturbance • Substance use disorder • HIV/AIDS

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2020 and MY 2021 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The measure steward, NCQA, has specified and tested the measure for use with Medicare and commercial insurance plans. The measure is not currently specified for use in Medicaid. NCQA indicated they plan to specify and test the measure for the Medicaid population in the coming year. However, several states are using the measure in their Medicaid program. For example: • The measure is being used in California under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program as part of the state's Section 1115 Medicaid waiver. • New York has required Medicaid plans to report colorectal cancer (CRC) screening rates using the NCQA HEDIS measure since 2012. New York has developed CRC screening benchmarks for the 50th, 75th, and 90th percentile. • Oregon requires Medicaid Coordinated Care Organizations (CCOs) to report HEDIS CRC screening rates. Oregon saw a 10-percentage point increase in CRC screening rates among its CCOs after requiring reporting (from 2014 to 2019).

	• Minnesota uses the HEDIS CRC screening measure; the Medicaid screening rate increased from 47.4 percent in 2011 to 56.2 percent in 2017. • The Maryland Department of Health created a "homegrown" measure based on the HEDIS measure for the 50 to 64 age group.
Description of required data source and data elements, including any barriers, limitations, or variations that could affect consistency of calculations	The Workgroup member (WGM) who suggested the measure for addition commented that standardized use of claims data alone may result in consistent CRC screening calculations across plans and states. In addition, hybrid methodologies with chart audits are an option but are not required.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality in Medicaid Health Home programs, including ability to perform comparative analyses based on race, ethnicity, or socioeconomic status	The WGM suggested this measure for addition because it addresses specific prevention needs. Prevention services may be neglected in individuals with chronic illness, and the addition of this measure would address that gap. Additionally, the WGM noted there are disparities in screening, which can be assessed with administrative data.
How measure addresses the unique and complex needs of Medicaid Health Home enrollees and promotes effective care delivery	The WGM noted prevention may be neglected in individuals with chronic illness, so addition of this measure would address that gap.
Evidence that measure could lead to improvement in quality of health care for Medicaid Health Home enrollees	The WGM cited information provided by California's cancer registry about significant differences in CRC late-stage diagnosis by insurance status from 2012 to 2016. The data showed that the state Medicaid-insured population had a late-stage diagnosis rate of 71 percent, which was identical to the rate for the state's uninsured population. The state's Medicare-insured population had a late-stage diagnosis rate of 64 percent. There were minor differences between 2012 and 2016 in late-stage diagnosis by race or ethnicity, suggesting that disparities were specific to Medicaid-insured individuals.
How measure can be used to monitor improvement	The WGM noted that if the measure is calculated with claims data, the data can then be linked with eligibility data and stratified to perform comparative analyses of screening rates in the Medicaid population, especially around racial, ethnic, and socioeconomic disparities. Additionally, the WGM indicated that the California cancer registry estimates above show there is room for improvement in the measure.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid beneficiaries	Colorectal cancer represents the fourth leading cause of cancer cases and is the second leading cause of cancer deaths in the United States.[1,2] In 2021, it is estimated that there will be 149,500 new cases of CRC and an estimated 52,980 deaths attributed to it.[3] According to the National Cancer Institute, about 4.3 percent of men and 4.0 percent women will be diagnosed with CRC at some point during their lifetime.[4]
Use of measure in other CMS programs	This measure is used in the following programs:[5] • Required CMS Medicare HEDIS quality performance measure (and 5-star incentivized) • Core Quality Measure Collaborative (CQMC) Accountable Care • Organizations/Patient Centered Medical Homes Core Measure Set • Marketplace Quality Rating System (QRS) • Medicare and Medicaid Electronic Health Record Incentive Program for Eligible Professionals • Medicare Shared Savings Program • Merit-Based Incentive Payment System (MIPS) Program
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM noted that administrative data can be used to calculate the measure. The WGM also felt that minimal TA would be needed.
Additional considerations	Additional information considered by the 2022 Child and Adult Core Set Review Workgroup includes the following: • States would require assistance in implementing the new measure and with coding (for example, the administrative specification includes SNOMED and LOINC codes). The measure steward indicated that health plans that encounter coding challenges with the existing Medicare or commercial-specified measure can report using the hybrid method, which supplements administrative codes with medical record review. • Main technical difficulty in measuring CRC screening is the look back period for colonoscopy (10 years) and sigmoidoscopy (5 years). However, they noted that this is a problem for all health plans regardless of insurance type and that Medicaid health plans already report this measure for their Medicaid-Medicare dually eligible enrollees. They also noted that numerous states have been able to overcome the long look back period required. For example, in Oregon, CCOs and clinics have worked together to harmonize colonoscopy claims and EHR data. Finally, WGMs indicated that fecal testing programs are increasingly being offered (especially since COVID-19, since testing can be done by mail) and testing completion is easily captured from claims data with a shorter look back period (up to 3 years rather than 10).

Citations

[1] National Cancer Institute. Cancer Stat Facts: Colorectal Cancer. https://seer.cancer.gov/statfacts/html/colorect.html.

[2] Siegel R, Miller K, Goding Sauer A, et al. Colorectal cancer statistics, 2020. CA Cancer J Clin. 2020;70(3):145-164. doi:10.3322/caac.21601. Epub 2020 Mar 5. PMID: 32133645.

[3] American Cancer Society. Cancer Facts & Figures 2021. https://www.cancer.org/content/dam/cancerorg/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2021/cancer-facts-and-figures-2021.pdf.

[4] American Cancer Society. Key Statistics for Colorectal Cancer. https://www.cancer.org/cancer/colon-rectalcancer/about/key-statistics.html.

[5] Centers for Medicare & Medicaid Services. CMS Measures Inventory Tool. Colorectal Cancer Screening. https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=451#tab5.

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MEASURE INFORMATION SHEET

HEALTH HOME CORE SET STAKEHOLDER WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2022 CORE SET

Measure Information	
Measure name	**Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) and Child Version Including Medicaid and Children with Chronic Conditions and Coordination of Care Supplemental Items**
Description	The Core CAHPS Survey provides information on the experiences of beneficiaries with their health care – or parents' experiences with their child's health care – and gives a general indication of how well the health care system meets beneficiaries' needs and expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates. The Children with Chronic Conditions Supplemental Items include 24 questions that ask about the health care experiences of children with chronic conditions. The Coordination of Care Supplemental Items include 11 questions designed to assess how well patient care was coordinated.
Measure steward	Agency for Healthcare Research & Quality (AHRQ) Note that AHRQ is the measure steward for the CAHPS survey instrument. The National Committee for Quality Assurance (NCQA) is the developer of the survey administration protocol.
NQF number (if endorsed)	0006
Meaningful Measures area(s) of measure	Patient's Experience of Care
Measure type	Patient-Reported Outcome-Based Performance Measure (PRO-PM)
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	Yes – both the Child and Adult Core Sets

Technical Specifications	
Ages	• For Children: Age 17 and younger as of December 31 of the measurement year. • For Adults: Age 18 and older as of December 31 of the measurement year.
Data collection method	Survey. Collected as part of the CAHPS Health Plan Survey 5.1H, Child and Adult Medicaid Versions. Note that the survey questionnaires and administration protocols vary slightly for the Child and Adult Medicaid versions.

Denominator	• For Children: The survey sample includes parents and guardians of children ages 0 to 17 as of December 31 of the measurement year, who were continuously enrolled the last six months of the measurement year, and who were currently enrolled at the time the survey was completed. Note that the sample must yield at least 411 completed surveys. If the denominator is less than 100 children with chronic conditions, measures based on the Children with Chronic Conditions supplement are not calculated. • For Adults: The survey sample includes beneficiaries age 18 and older as of December 31 of the measurement year, who were continuously enrolled the last six months of the measurement year, and who were currently enrolled at the time the survey was completed. Note that the sample must yield at least 411 completed surveys.
Numerator	The **Core CAHPS Survey** includes four global rating questions reflecting overall experience: • Rating of All Health Care • Rating of Health Plan • Rating of Personal Doctor • Rating of Specialist Seen Most Often Four composite scores summarize responses in key areas: • Customer Service • Getting Care Quickly • Getting Needed Care • How Well Doctors Communicate Item-specific question summary rates are reported for the individual items included in each composite. The **Children with Chronic Conditions Supplemental Items** includes three additional composites that summarize satisfaction with basic components of care essential for successful treatment, management, and support of children with chronic conditions: • Access to Specialized Services • Family-Centered Care: Personal Doctor Who Knows the Child • Coordination of Care for Children with Chronic Conditions Item-specific question summary rates are reported for each composite. Question summary rates are also reported individually for two items summarizing the following concepts: • Access to Prescription Medicines • Family-Centered Care: Getting Needed Information The **Coordination of Care Supplemental Items** include questions about experience related to the following: • Doctor seemed informed and up to date about your/child's care from specialists

	• Doctor had your/child's medical records • Doctor followed up about blood test, x-ray results • Got blood text, x-ray results as soon as you/child needed them • Doctor talked about prescription drugs you/child are taking • Got help you/child needed from doctor's office to manage your/child's care among different providers and services
Exclusions	Exclude beneficiaries with any of the following: • Not currently enrolled at the time of the survey. • Member of their household already sampled. • Are institutionalized (put in the care of a specialized institution) or deceased.
Continuous enrollment period	The last six months of the measurement year. No more than one gap in enrollment of up to 45 days during the continuous enrollment period.
Level of reporting for which specifications were developed	Plan-level.
Health home focus area	• Chronic conditions • Serious mental illness/serious emotional disturbance • Substance use disorder • HIV/AIDS

Minimum Technical Feasibility Criteria	
Link to current technical specifications	• FFY 2021 Adult Core Set Resource Manual: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf • FFY 2021 Child Core Set Resource Manual: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf • Coordination of Care Supplemental Items: https://www.ahrq.gov/cahps/surveys-guidance/item-sets/search.html?f%5B0%5D=%3A14143&f%5B1%5D=supplemental_items_topics%3A14360&f%5B2%5D=survey%3A14143
Information on testing or use at state Medicaid/CHIP level	The Workgroup member (WGM) who suggested the measure for addition noted that Medicaid health plans are voluntarily reporting this measure to the AHRQ CAHPS Database. Benchmarking data are available at: https://cahpsdatabase.ahrq.gov/files/2020CAHPSHealthPlanChartbook.pdf The WGM noted that the CAHPS survey is currently included in the Child and Adult Core Sets. Many states also include CAHPS results in their health plan quality rating systems or report cards.
Description of required data source and data	The WGM acknowledged that fielding and analysis of the existing CAHPS survey without the inclusion of separate samples for certain

elements, including any barriers, limitations, or variations that could affect consistency of calculations	populations is very expensive and the return rates for these surveys are decreasing yearly. The WGM indicated that the inclusion of this set of measures and supplemental items for an additional sample of health home enrollees could potentially place an additional burden on states. The WGM also noted because CAHPS survey responses and completed surveys vary widely across cultures, age groups, and other demographics, the measure may not allow for consistent calculations across counties and states.

Actionability and Strategic Priority	
How measure contributes to measuring overall quality in Medicaid Health Home programs, including ability to perform comparative analyses based on race, ethnicity, or socioeconomic status	The WGM indicated that this measure would address a significant gap in the Health Home Core Set as there are currently no measures related to beneficiaries' experience of care. In particular, the WGM cited the lack of measures related to provider communication and care coordination. For example: • Sixty percent of Medicaid beneficiaries have basic or below basic health literacy.[1] Effective oral communication is key to the provision of quality health care. If providers do not always explain things in a way that is easy to understand, they risk patients failing to follow-through on treatment plans and self-care, resulting in their health deteriorating or other patient safety issues like non-adherence to medications. • Medicaid Health Homes were established to coordinate care for people with who have chronic conditions. The WGM felt a measure of care coordination is a critical component to assess the performance of a Medicaid Health Home. The WGM noted this measure is especially relevant to beneficiaries that have complex conditions and may see multiple providers. Health Homes are specifically designed to coordinate care, and this is a measure of care coordination as experienced by the patient. The WGM indicated that this measure is cross-cutting, applying to all conditions and populations. The WGM pointed out this measure can be used to conduct disparities analyses.
How measure addresses the unique and complex needs of Medicaid health home enrollees and promotes effective care delivery	The WGM emphasized that positive beneficiary experiences, including good communication and care coordination, are a prerequisite to patient engagement, which is vital for good health outcomes. The WGM noted that performance on CAHPS communication measures has been the basis for quality improvement efforts.[2] The WGM suggested this measure would promote communication between primary care providers and specialists and improve patient safety around polypharmacy.[3,4] The WGM also highlighted that with increased complexity of their care needs, patients are required to understand a greater volume of information and be able to perform multiple self-care tasks. The WGM noted this measure would promote patient engagement with the timely communication of test results and provision of care management support. In addition, as Medicaid Health Home enrollees

	may see multiple providers, failure of those providers to communicate with each other can create patient safety risks, as well as inefficient or duplicative care.
Evidence that measure could lead to improvement in quality of health care for Medicaid health home enrollees	The WGM noted that given training and a supportive environment, providers can improve their communication skills. They also noted many trainings and tools exist for improving provider-patient communication. These training and tools are available at https://www.ahrq.gov/cahps/quality-improvement/index.html.
How measure can be used to monitor improvement	The WGM commented there is room for improvement across all of the CAHPS ratings and composites, including provider communication. For example, the WGM noted that 77 percent of adult Medicaid respondents reported that their providers always explained things in a way that was easy to understand.[5] Note that these rates are for the general Medicaid population and rates for the Health Home population are not available. They also noted that the existing trends of this measure can be assessed over time, allowing providers to directly influence improvement of this measure.

Additional Information for Consideration	
Prevalence of condition being measured among Medicaid beneficiaries	According to the WGM, this measure is relevant to the entire Medicaid population and applicable to all conditions.
Use of measure in other CMS programs	Medicaid and CHIP Child and Adult Core Sets
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM noted that there are no barriers to calculating measures based on the CAHPS survey. The CAHPS Analysis Program—often referred to as the CAHPS macro—is a free program, updated regularly, and works with all CAHPS surveys, enabling the user to conduct the analyses needed to produce valid comparisons of performance across similar health care organizations.[6]

Citations

[1] U.S. Department of Education, Institute of Education Sciences, 2003 National Assessment of Adult Literacy.

[2] The CAHPS Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience. "Section 4: Ways to Approach the Quality Improvement Process." May 2017.

[3] Agency for Healthcare Research & Quality (AHRQ). February 2020. "Patient Safety in Primary Care". https://psnet.ahrq.gov/perspective/patient-safety-primary-care#_edn6.

[4] Coronado-Vazquez V, Gomez-Salgado J, Cerezo-Espinosa de Los Monteros J, Ayuso-Murillo D, Ruiz-Frutos C. Shared decision-making in chronic patients with polypharmacy: An interventional study for assessing medication appropriateness. *J Clin Med*. 2019;8(6). doi: 10.3390/jcm8060904.

[5] Consumer Assessment of Healthcare Providers and Systems (CAHPS®). "CAHPS Health Plan Survey Database 2020 Chartbook: What Consumers Say About Their Experiences With Their Health Plans and Medical Care." https://cahpsdatabase.ahrq.gov/files/2020CAHPSHealthPlanChartbook.pdf.

[6] Analyzing CAHPS Survey Data. April 2021. https://www.ahrq.gov/cahps/surveys-guidance/helpful-resources/analysis/index.html.