Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

Technical Specifications and Resource Manual for
Federal Fiscal Year 2024 Reporting

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Center for Medicaid and CHIP Services
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CONTENTS

I. THE CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES (CHILD CORE SET)

Background

Section 1139A of the Social Security Act (the Act) includes broad mandates to strengthen the quality of care for and health outcomes of children in Medicaid and the Children's Health Insurance Program (CHIP). The Act calls for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish a core set of children's health care quality measures (Child Core Set) for voluntary use by state programs administered under Titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP.

More specifically, the Act requires the Secretary of Health and Human Services (HHS) to identify measures applicable to the duration of enrollment and health care coverage, preventive and health promotion services, and the treatment and management of acute and chronic conditions in children. The Act also calls for measures that could be used to assess families' experiences with health care, the availability of services, and care in the most integrated health settings. Ultimately, the goals of the Child Core Set are to provide a national estimate of the quality of health care for children served by Medicaid or CHIP and support states to drive improvements in health care quality and health outcomes using Core Set data; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

Implementation of a standardized Child Core Set is helping the Centers for Medicare & Medicaid Services (CMS) and states move toward a national system for quality measurement, reporting, and improvement. The data collected from these measures help CMS to better understand the quality of health care children receive through Medicaid and CHIP programs. The Act requires the Secretary of HHS to make publicly available the information states report to CMS on the quality of health care furnished to children under Medicaid and CHIP.

Section 50102(b) of the Bipartisan Budget Act of 2018 made state reporting of the Child Core Set measures mandatory starting in FFY 2024. Mandatory reporting of the Child Core Set will further advance CMS's efforts to develop a national, data-driven system for measuring and improving the quality of care for beneficiaries in Medicaid and CHIP.[1]

Description of the Child Core Set

The initial core set was published in February 2011. The Act required the Secretary to publish annual changes to the Child Core Set beginning in January 2013. Information on initial core set and a list of annual updates is provided in the Historical Policy Guidance document.[2] In addition, the 2024 Core Set History table provides a history of the measures included in the Child Core Set.[3]

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[1] Legislation making reporting of the Child Core Set measures mandatory: Bipartisan Budget Act of 2018 available at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.xml.

[2] Historical Policy Guidance is available at https://www.medicaid.gov/sites/default/files/2023-02/list-of-core-set-cib_1.pdf

[3] The Core Set History table is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

Table 1 lists each measure in the 2024 Child Core Set, the CMS Measures Inventory Tool (CMIT) number , and the measure steward. The data collection methods include administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), survey, and electronic health record (EHR, also referred to as the electronic specification method). The technical specifications in Chapter III of this manual provide additional details for each measure.

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

Table 1. 2024 Child Core Set

CMIT #*	Measure Steward[a]	Measure Name	Data Collection Method(s)	Data Submission Location[b]
Primary Care Access and Preventive Care				
760	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR	QMR System
128	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR	QMR System
124	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR[c]	QMR System
761	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)	Administrative	QMR System
363	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid[c]	QMR System
1003	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid	QMR System
24	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)	Administrative	QMR System
1775	NCQA	Lead Screening in Children (LSC-CH)	Administrative or hybrid	QMR System
Maternal and Perinatal Health				
413	CDC/NCHS	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records	CDC WONDER
581	NCQA	Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)**	Administrative or hybrid	QMR System
166	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative	QMR System
1002	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative	QMR System

CMIT #*	Measure Steward[a]	Measure Name	Data Collection Method(s)	Data Submission Location[b]
508	CDC/NCHS	Low-Risk Cesarean Delivery (LRCD-CH)	State vital records	CDC WONDER
Care of Acute and Chronic Conditions				
84	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)	Administrative	QMR System
80	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative	QMR System
49	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative	QMR System
Behavioral Health Care				
271	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Administrative or EHR[c]	QMR System
672	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Administrative or EHR	QMR System
268	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Administrative	QMR System
448	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Administrative[c]	QMR System
743	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Administrative	QMR System
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	Administrative	QMR System
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	Administrative	QMR System
Dental and Oral Health Services				
897	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)	Administrative	QMR System
1672	DQA (ADA)	Prevention: Topical Fluoride for Children (TFL-CH)	Administrative	QMR System
830	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)	Administrative	QMR System

CMIT #*	Measure Steward[a]	Measure Name	Data Collection Method(s)	Data Submission Location[b]
Experience of Care				
151***	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)[d]	Survey	AHRQ CAHPS Database

AHRQ = Agency for Healthcare Research & Quality; CAHPS = Consumer Assessment of Healthcare Providers and Systems; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NCHS = National Center for Health Statistics; NCQA = National Committee for Quality Assurance; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; QMR = Quality Measure Reporting; WONDER = Wide-ranging Online Data for Epidemiologic Research.

* The CMS Measures Inventory Tool (CMIT) is the repository of record for information about the measures that CMS uses to promote health care quality and quality improvement. More information is available at https://cmit.cms.gov/cmit/. A public access quick start guide for CMIT is available at https://cmit.cms.gov/cmit/assets/CMIT-QuickStartPublicAccess.pdf.

** Starting with the 2024 Core Set, the Prenatal and Postpartum Care measure in the Child and Adult Core Sets includes both the prenatal and postpartum care rates. For the Child Core Set, the rates are reported for beneficiaries under age 21. For the Adult Core Set, the rates are reported for beneficiaries age 21 and older.

*** AHRQ is the measure steward for the survey instrument in the Child Core Set (CMIT #151) and NCQA is the developer of the survey administration protocol.

[a] The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

[b] The QMR system is available at https://mdctqmr.cms.gov/. CDC WONDER is available at https://wonder.cdc.gov/. The AHRQ CAHPS Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/index.html.

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

[d] CAHPS® is a registered trademark of the AHRQ.

II. DATA COLLECTION AND REPORTING OF THE CHILD CORE SET

Mandatory reporting of the 2024 Child Core Set requires that states adhere to reporting guidance issued by CMS.[1] Adherence to the reporting guidance is essential to provide effective comparisons across states on standardized quality measure performance and to derive national performance rates for the care provided to Medicaid and CHIP beneficiaries.

To support consistency in reporting the Child Core Set measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapter III and provide detailed information on how to calculate each measure. For technical assistance with calculating and reporting these measures, contact the TA mailbox at MACQualityTA@cms.hhs.gov.

Refer to Table 1 in Chapter 1 for a list of 2024 Child Core Set measures, measure acronyms, measure stewards, and data collection methods.

Data Collection and Preparation for Reporting

- **Version of specifications.** This manual includes the most applicable version of the measure specifications provided by the measure stewards to CMS as of December 2023. The 2024 Child Core Set generally covers services provided during calendar year 2023. For Healthcare Effectiveness Data and Information Set (HEDIS®)[2] measures, this manual follows HEDIS measurement year (MY) 2023 specifications. For non-HEDIS measures, the manual includes the most applicable version of the specifications available from the measure steward for reporting 2023 data.
- **Value sets.** Many of the Child Core Set measure specifications reference value sets that must be used for calculating the measures. A value set is the complete set of codes used to identify a service or condition included in a measure.
    - The HEDIS value sets are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-hedis-value-set-directory.zip. HEDIS value set references are underlined in the specifications (e.g., BMI Percentile Value Set). Refer to Appendix A for a HEDIS Value Set Directory User Manual.
    - Value sets for the CCP-CH, CCW-CH, and CDF-CH measures are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.
    - Value sets for electronic specifications are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC), located at https://vsac.nlm.nih.gov. Access to the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a free UMLS license at https://www.nlm.nih.gov/databases/umls.html. When searching for value sets for a measure, states should use the measure's associated electronic specification number. To report on the 2024 Child Core Set measures, use the version of the value sets associated with the May 2023 release. This applies to the following Child Core Set measures that have electronic specifications: ADD-CH, CDF-CH, CHL-CH, CIS-CH, and WCC-CH.

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[1] Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting final rule: https://www.federalregister.gov/d/2023-18669. Initial Core Set Mandatory Reporting Guidance: https://www.medicaid.gov/sites/default/files/2023-12/sho23005_0.pdf.

[2] For FFY 2024, all Child Core Set measures with NCQA as the measure steward are HEDIS measures.

- **Medication lists.** Several HEDIS measures in the Child Core Set reference medication lists, which are a list of codes and medications used to identify dispensed medications. The Medication List Directory is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). This applies to the following Child Core Set measures: AAB-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CHL-CH, and FUA-CH.
- **Data collection time frames for measures.** States must adhere to the measurement periods identified in the technical specifications for each measure. Some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a child's birthday or diagnosis. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2023 data should be reported for FFY 2024. For many measures, the denominator measurement period for FFY 2024 corresponds to calendar year 2023 (January 1, 2023–December 31, 2023).

  Some measures also require states to review utilization or enrollment prior to this period. Further information about measurement periods for the 2024 Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2024-child-core-set-measurement-periods.pdf.
- **Continuous enrollment.** Continuous enrollment specifies the minimum amount of time that a beneficiary must be enrolled in Medicaid or CHIP before becoming eligible for a measure. It ensures that the state has enough time to render services during the measurement period. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, a beneficiary must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap (see next bullet). For the purpose of Core Set reporting, states should combine data across programs (e.g., Medicaid and CHIP), delivery systems (e.g., managed care and fee-for-service), and managed care plans when analyzing continuous enrollment for a beneficiary. A beneficiary who switches between Medicaid and CHIP programs, delivery systems, or managed care plans should be included in a measure as long as they meet the continuous enrollment criteria at the state-level. For example, a beneficiary might switch between managed care plans; these beneficiaries should be included in the numerator and denominator for the measure as long as the beneficiary is continuously enrolled in Medicaid or CHIP for the period specified in the measure (even if they are not continuously enrolled in a single plan).
- **Allowable gap.** Some measures specify an allowable gap that can occur any time during continuous enrollment. For example, the WCV-CH measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in Medicaid and CHIP enrollment of up to 45 days. Thus, a beneficiary who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year, because this beneficiary has one 38-day gap (January 1–February 7). A beneficiary who switches between Medicaid and CHIP programs, delivery systems, or managed care plans should be included in a measure as long as there is no gap in Medicaid or CHIP coverage that exceeds the allowable gap specified in the measure.

- **Retroactive eligibility.** This refers to the elapsed time between the actual date when Medicaid or CHIP became financially responsible for a beneficiary and the date when it received notification of the new beneficiary's eligibility. For measures with a continuous enrollment requirement, beneficiaries may be excluded if the retroactive eligibility exceeds the allowable gap requirement. This guideline must be used consistently across all measures.
- **Anchor date.** Some measures include an anchor date, which is the date that an individual must be enrolled in Medicaid or CHIP and have the required benefit to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure's FFY 2024 measurement period (December 31, 2023). For other measures, the anchor date is based on a specific event, such as a birthdate or a delivery date. States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.
- **Date specificity.** A date must be specific enough to determine that an event occurred during the time frame specified in the measure. For example, in the CIS-CH measure, beneficiaries must receive three hepatitis B vaccines. Assume a beneficiary was born on February 5, 2021. Documentation in the medical record that the first hepatitis B vaccine was given "at birth" is specific enough to determine that it was given prior to the deadline for this measure (the child's second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2023, the immunization cannot be counted because the date is not specific enough to confirm that it occurred prior to the beneficiary's second birthday. There are instances when documentation of the year alone is adequate; for example, most exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable. For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the CIS-CH measure, undated documentation on an immunization chart stating "chicken pox at age 1" is specific enough to determine that it occurred prior to the child's second birthday.
- **Reporting unit.** CMS defines the reporting unit for each measure as each state's Medicaid and CHIP program. This means that states should collect data across all of the health care delivery systems used in their state Medicaid and CHIP programs (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care [MC]). If data are collected separately across a state's delivery systems or across a state's managed care plans, states should aggregate data from all these sources into a state-level Medicaid rate and a state-level separate CHIP rate (for states with separate CHIP) before reporting the data to CMS. As part of this process, the state should also assess the continuous eligibility of individuals that do not meet continuous eligibility for a single program, delivery system, or managed care plan, but meet continuous eligibility requirements for Medicaid or CHIP at the state-level. For more guidance about developing state-level rates, see the bullet on "aggregating information for state-level reporting" below.
- **Eligible population for measurement.** For all measures, denominators must include all Medicaid and CHIP beneficiaries who satisfy all specified eligibility criteria (including age, continuous enrollment, benefit, event, and anchor date enrollment requirements). The eligible Medicaid and CHIP population should include Title XIX and Title XXI populations, but not populations funded only by states (such as state-covered children that are above the Medicaid and CHIP eligibility levels). States should include any special populations (e.g.,

waiver enrollees) covered by Medicaid or CHIP in the state. In addition, states should include beneficiaries who moved in or out of a program (Medicaid or CHIP), who were enrolled in more than one managed care plan, or who changed delivery systems (fee-for-service, managed care, primary care case management) during the measurement period. For each reporting year, CMS will issue sub-regulatory guidance with any exceptions to reporting all populations. States may request a 1-year exemption from reporting a specific population for one or more Child Core Set measures following guidance included in the Initial Core Set Mandatory Reporting Guidance State Health Official (SHO) Letter.[3] States interested in an exemption from FFY 2024 reporting must submit a request letter to CMS by September 1, 2024.

- **Beneficiaries with partial benefits.** For each measure, states should include only the beneficiaries who are eligible to receive the services assessed in the numerator. If a beneficiary is not eligible to receive the services assessed in the measure, the beneficiary should not be included in the denominator for the measure. The technical specifications for some measures have guidance regarding which benefits an individual must be eligible for to be included, but each state should assess the specific benefit packages of the beneficiaries in their state.
- **Aggregating information for state-level reporting.** To obtain state-level Medicaid and CHIP rates for a measure that is developed from the rates of multiple reporting units (such as multiple managed care plans or across managed care and FFS delivery systems), the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual plans) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid and administrative data from different sources can be combined to develop a state/program-level rate as long as the specifications allow the use of both data sources to construct the measure. For additional guidance on developing state- or program-level rates, refer to the TA Brief titled "Calculating State-Level Rates Using Data from Multiple Reporting Units."[4]
    - For FFY 2024 reporting, states with a separate CHIP must report on Child Core Set rates separately for separate CHIP (Title XXI) and Medicaid inclusive of CHIP-funded Medicaid expansion (Titles XIX and XXI).
- **Reporting stratified data.** Reporting stratified results for Core Set measures is a priority for CMS as it supports CMS's goal of advancing health equity. For FFY 2024 Core Set reporting, states are encouraged to report stratified data for the following stratification categories: Race, Ethnicity, Sex, and Geography. CMS defines these categories as the following:
    - Race and ethnicity, using the disaggregation of the 1997 Office of Management and Budget (OMB) minimum race and ethnicity categories, as specified in the 2011 HHS standards;
    - Sex, defined as biologic sex, using the 2011 HHS standards; and

[3] Initial Mandatory Core Set Reporting Guidance SHO: https://www.medicaid.gov/sites/default/files/2023-12/sho23005_0.pdf

[4] The TA Brief, "Calculating State-Level Rates Using Data from Multiple Reporting Units," is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf.

  - Geography, using a minimum standard of core-based statistical area (CBSA) with recommendation to move toward Rural-Urban Commuting Area Codes.

  More information is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/QMR-stratification-resource.pdf.

- **Reporting a weighted rate.** When a state develops a weighted rate combining data across multiple reporting units, the state should report the rate for the combined data in the "Rate" field. In addition, the state should check "Yes" under "Did you Combine Rates from Multiple Reporting Units (e.g., health plans, delivery systems, programs) to Create a State-Level Rate?" and select an option on how the rates were weighted. The information entered in the numerator and denominator fields will vary depending on the method used to calculate a state-level rate:
  - If a state-level rate is calculated using only administrative method data, states should enter the numerator and denominator totals in the Numerator and Denominator fields.
  - If a state-level rate is calculated using only hybrid method data, states should enter the total size of the sample used to calculate the measure across reporting units in the Denominator field and sum the numerators for each reporting unit in the Numerator field. The state should also report the total measure-eligible population represented in the data because this information will be used by CMS to create a state-level rate that combines the Medicaid and separate CHIP rates.
  - If the state-level rate is calculated using a combination of administrative and hybrid method data, states should enter the total measure-eligible population in the Denominator field to denote that denominators are a mix of sample sizes and measure eligible populations and enter 0 in the Numerator field. In the "Data Sources" section, the state should identify the number of reporting units that used each method (administrative and hybrid). The state should also report the total measure-eligible population represented in the data because this information will be used by CMS to create a state-level rate that combines the Medicaid and separate CHIP rates.
- **Age criteria.** The age criteria vary by measure. If a denominator for a measure specifies an age range beyond that eligible for a state's Medicaid and CHIP programs, the state should include only the ages eligible for the program in the denominator.
- **Exclusions.** Some measure specifications contain required exclusions. A beneficiary who meets required exclusion criteria should be removed from the measure denominator.
- **Supplemental data.** Supplemental data are data other than claims and encounters and medical record data abstracted for hybrid reporting used by organizations to collect information about delivery of health services to beneficiaries. Examples of supplemental data include immunization registries or case management program data.
- **Hospice exclusion.** Selected HEDIS measures in the Child Core Set include a required hospice exclusion: AAB-CH, ADD-CH, AMB-CH, AMR-CH, APM-CH, APP-CH, CHL-CH, CIS-CH, FUA-CH, FUH-CH, FUM-CH, IMA-CH, LSC-CH, PPC2-CH, W30-CH, WCC-CH, and WCV-CH. For these measures, states should exclude beneficiaries who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These beneficiaries may be identified using various methods, which may include but are not limited to, enrollment data, medical record, or claims/encounter data (Hospice Encounter Value Set; Hospice Intervention Value Set), or supplemental data for this required exclusion.

States should remove these beneficiaries as they determine the measure's eligible population. For hybrid measures, states should remove beneficiaries prior to drawing the sample. If a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed as a valid data error from the sample and replaced by a beneficiary from the oversample. Documentation that a beneficiary is near the end of life (e.g., comfort care, Do Not Resuscitate [DNR], Do Not Intubate [DNI]), or is in palliative care does not meet criteria for the hospice exclusion.

Supplemental data can be used for the hospice exclusion for all applicable measures, including measures that say "supplemental data may not be used for the measure" (e.g., AMB-CH).

- **Deceased beneficiaries exclusion.** Selected HEDIS measures in the Child Core Set include a deceased beneficiary exclusion: AAB-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CHL-CH, CIS-CH, CPC-CH, FUA-CH, FUH-CH, FUM-CH, IMA-CH, LSC-CH, PPC2-CH, W30-CH, WCC-CH, and WCV-CH. For these measures, beneficiaries who die any time during the measurement year should be excluded consistently from the HEDIS measures listed above. These beneficiaries may be identified using various methods that include, but are not limited to, enrollment data, medical record review, claims/encounter data, or supplemental data for this required exclusion.

  States should attempt to remove these beneficiaries prior to determining a measure's eligible population and drawing the sample for hybrid measures. A deceased beneficiary found during medical record review is removed as a valid data error from the sample and replaced by a beneficiary from the oversample.

  Supplemental data can be used for excluding deceased beneficiaries for all applicable measures, including measures that say "supplemental data may not be used for the measure (e.g., AMB-CH)

  This is a beneficiary-level exclusion. For episode-based measures, remove all beneficiary events/episodes from the measure.

- **Telehealth.** HEDIS measures consider synchronous telehealth visits, telephone visits, and asynchronous telehealth (e-visits, virtual check-ins) as separate modalities.
  - Synchronous telehealth requires real-time interactive audio and video telecommunications. A HEDIS measure specification that is silent about telehealth includes synchronous telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A HEDIS measure specification will indicate when synchronous telehealth is not eligible for use and should be excluded.
  - A HEDIS measure specification will indicate when telephone visits are eligible for use by referencing the Telephone Visits Value Set.
  - Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the beneficiary and the provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email. A HEDIS measure specification will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments Value Set.

  - Non-HEDIS measures will specify whether telehealth is allowed and what type of telehealth is included, if applicable.

- **Representativeness of data.** States should use the most complete data available and ensure that the rates reported are representative of the entire population enrolled in their Medicaid and CHIP programs (including dual Medicare-Medicaid eligibles, where applicable). This includes beneficiaries enrolled in all Medicaid and CHIP delivery systems as well as services received in all applicable health care settings (such as hospitals, outpatient settings, federally qualified health centers, rural health centers, and Indian Health Services or Tribal or Urban Indian Health Program facility). For a measure based on administrative data, all beneficiaries who meet the eligible population requirements for the measure should be included in the denominator. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire eligible population for the measure.
- **Data collection methods.** The measures in the Child Core Set have four possible data collection methods: administrative, hybrid, survey, and electronic health record (EHR, also referred to as the electronic specification method). Each measure specifies the data collection method(s) that can be used. If a measure includes a choice of methods, any of the listed methods may be used.
  - The administrative method uses transaction data (such as claims and encounters) or other administrative data sources (such as vital records and registries) to calculate the measure. These data can be used in cases in which the data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population is included in the denominator.
  - The hybrid method uses both administrative data sources and electronic health record (EHR) data to determine numerator compliance. Administrative data are reviewed to determine if beneficiaries in the systematic sample received the service, and medical record data are reviewed for beneficiaries who do not meet the numerator criteria through administrative data. The denominator consists of a systematic sample of beneficiaries drawn from the measure's eligible population. The hybrid method, when available, should be used when administrative data and EHR data are incomplete or may be of poor quality, or the data elements for the measure are not captured in administrative data.
  - The survey method uses data collected through a survey to calculate the measure. This data collection method applies to the CPC-CH measure in the Child Core Set.
  - The electronic specification method uses EHR data to calculate the measure. A link to the electronic specifications is included in the following measure specifications: ADD-CH, CDF-CH, CHL-CH, CIS-CH, and WCC-CH. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system.
- **Sampling.** For measures that use the hybrid method, sampling guidance is included in the technical specification if available from the measure steward. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.
  - For HEDIS measures that use the hybrid method, the sample size should be 411 for each reported program (e.g., Medicaid and CHIP), unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited hybrid rate. Regardless of the selected

sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

- For the DEV-CH measure, the sample is 411 divided across three age strata, or 137 in each age group.
- For the CAHPS survey, refer to Appendix E for information on sampling.

- **Small numbers.** If a measure has a denominator that is less than 30 and the state chooses not to report the measure due to small numbers, please note this in the question that asks, "Why are you not reporting on this measure?" and specify the denominator size.
- **Risk adjustment.** No Child Core Set measure requires risk adjustment.
- **Inclusion of paid, suspended, pending, and denied claims.** A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided. For some measures, the Guidance for Reporting within each measure's technical specification indicates which claims (paid, suspended, pending, and/or denied) should be included. This applies to the following measures: AAB-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CCP-CH, CCW-CH, CHL-CH, CIS-CH, CDF-CH, DEV-CH, FUA-CH, FUH-CH, FUM-CH, IMA-CH, LSC-CH, OEV-CH, PPC2-CH, SFM-CH, TFL-CH, W30-CH, WCC-CH, and WCV-CH.
- **ICD-9/ICD-10 conversion.** In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, measures should be calculated using ICD-10 codes for claims with a date of service or date of discharge on or after October 1, 2015. ICD-10 codes are available in the specification or in the corresponding Value Set Directory (see above). ICD-9-CM and ICD-9-PCS codes are still included in measures where the lookback period plus one year prior includes services before October 1, 2015. ICD-9 codes are still relevant to the following measures: AAB-CH, ADD-CH, AMR-CH, CIS-CH, and CPC-CH.
- **Visits that result in an inpatient stay.** Some HEDIS measures in the Child Core Set require exclusion of visits that result in an inpatient stay or observation stay. A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). This applies to the following Child Core Set measures: AAB-CH, ADD-CH, AMB-CH, AMR-CH, CPC-CH, FUA-CH, FUH-CH, and FUM-CH.

Reporting and Submission

Procedures for reporting the Child Core Set measures are provided below.

- **Submission deadline.** The deadline for submitting final data on the Child Core Set measures for FFY 2024 is December 31, 2024. States can update data submitted after the submission deadline; however, updates made after the deadline are not guaranteed to be used in the development of reports by CMS and performance rates on https://data.medicaid.gov, in the Medicaid & CHIP Scorecard, or in the State Medicaid & CHIP Profiles. States should submit data that are as complete as possible by the submission deadline. In addition, states will submit CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Health Plan Survey Database during the 2024 Database submission period in June 2024 for all measures that use the CAHPS

survey. Data that are submitted after the submission deadline will not be included in Core Set public reporting for FFY 2024.[5]

- **Completing fields.** Specific fields are applicable to each measure. States should complete each applicable field for each measure submitted to ensure consistent and accurate reporting and comparability across states. States are encouraged to document the methods used to calculate the measures in order to improve CMS's understanding of variations across states.
- **Reasons for not reporting a measure.** Reporting all measures on the Child Core Set is mandatory for states beginning with the 2024 Core Set. CMS recognizes that there may be unique circumstances where a state is unable to report a measure. If a state is unable to report a measure, the state should note that in the QMR system in addition to sending an email to the TA mailbox (MACQualityTA@cms.hhs.gov) explaining why the state cannot report the measure. This information will help CMS to understand why a state may not be reporting on a specific measure and to design technical assistance to help them with reporting.
- **Noting variations from measure technical specifications.** As per the Core Set final rule, CMS expects states to report measures adhering to the methods provided in the specifications. However, there may be unique circumstances where this is not possible. In those circumstances, states should provide additional information and context about the rates reported. Examples of variations include eligible population definitions that differ from the specifications (age ranges, codes for identifying the population, or missing population segments); differences in data sources used; differences in codes used (added, excluded, or substituted codes); differences in the version used; issues encountered in calculating the measure; and caveats not specified elsewhere. States that have questions about the technical specifications (such as data sources, code sets, or methodologies for identifying numerators and denominators) should contact CMS through the TA mailbox at MACQualityTA@cms.hhs.gov.
- **Inclusion of all measure-eligible beneficiaries in state reporting.** In the Core Set final rule, CMS specified that mandatory reporting requirements for the Child Core Set require states to ensure that all measure-eligible Medicaid and CHIP beneficiaries are included in state reporting. This includes beneficiaries who moved in or out of a program (Medicaid or CHIP), who were enrolled in more than one managed care plan, or who changed delivery systems (fee-for-service, managed care, primary care case management) during the measurement period. States must ensure that each eligible beneficiary is included in the measure calculation and there is no duplication or double-counting. For each measure, states should assess enrollment and claims data (or other data sources) to determine measure eligibility for the denominator, and calculate numerator compliance. CMS will provide additional technical assistance to states on ensuring that all measure-eligible beneficiaries are included in state reporting. States can also contact the TA mailbox at MACQualityTA@cms.hhs.gov.
- **Reporting separate rates for Medicaid and CHIP populations.** For each Child Core Set measure reported to CMS, states should calculate and report separate rates for the Medicaid population (inclusive of CHIP-funded Medicaid expansion) and the separate

[5] More information about the AHRQ CAHPS Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/index.html.

CHIP population (for states with a separate CHIP).[6] States must ensure that each measure-eligible Medicaid and CHIP beneficiary is included in the measure calculation, and attributed to the appropriate program based on the measure eligibility criteria, and that there is no duplication or double-counting. These rates will be reported separately in the reporting system and used to create a combined state-level rate. Any populations excluded from the denominator should be noted in the "Definition of Population Included in Measure" section of the online reporting system. CMS will provide additional technical assistance to states on applying attribution guidance for calculation of separate rates for Medicaid and CHIP populations. States can also contact the TA mailbox at MACQualityTA@cms.hhs.gov.

- **Data auditing.** For FFY 2024, CMS will not require certification or auditing of HEDIS or other measures. However, states are encouraged to do so when possible. For example, if there are state mechanisms for accreditation, certification, and managed care external quality review, or if the state validates its Child Core Set rates through another process, states should describe these processes in the applicable fields in the state-level Core Set Questions in the online reporting system.

Technical Assistance

To help states collect, report, and use the Child Core Set measures, CMS offers technical assistance. Please submit technical assistance requests about the Child Core Set measures to MACQualityTA@cms.hhs.gov.[7]

For access instructions or technical questions regarding use of the Quality Measures Reporting (QMR) application, please reach out to MDCT_Help@cms.hhs.gov.

[6] Title XXI programs are required by CHIPRA to collect and separately sample CAHPS survey data beginning in December 2013. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf.

[7] States with technical assistance questions about the Adult Core Set or Health Home Core Set should also contact MACQualityTA@cms.hhs.gov.

III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for each measure in the Child Core Set. Each specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and any other relevant measure information.

These specifications represent the most applicable version available from the measure steward as of December 2023.

MEASURE AAB-CH: AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS: AGES 3 MONTHS TO 17 YEARS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of episodes for beneficiaries ages 3 months to 17 years with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 3 months to 17 years, ages 18 to 64, age 65 and older, and total (ages 3 months and older). The Child Core Set measure applies to beneficiaries ages 3 months to 17 years and the Adult Core Set measure applies to beneficiaries age 18 and older.
- Include all paid, suspended, pending, and denied claims. Denied claims should be used to identify the eligible population, but cannot be used to identify numerator events.
- Supplemental data may not be used for this measure.
- The measure is reported as an inverted rate (see Section E. Calculation below).
- NCQA's Medication List Directory (MLD) for AAB Antibiotic Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-9-CM, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	The 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. The intake period captures eligible episodes of treatment.
Episode date	The date of service for any outpatient, telephone, observation or ED visit, e-visit, or virtual check-in during the intake period with a diagnosis of acute bronchitis/bronchiolitis.

Negative medication history	To qualify for negative medication history, the following criteria must be met: • A period of 30 days prior to the episode date, when the beneficiary had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions were dispensed more than 30 days prior to the episode date and are active on the episode date. A prescription is considered active if the "days supply" indicated on the date when the beneficiary was dispensed the prescription is the number of days or more between the date and the relevant service date. The 30-day lookback period for pharmacy data includes the 30 days prior to the intake period.
Negative comorbid condition history	A period of 12 months prior to and including the episode date, when the beneficiary had no claims/encounters with any diagnosis for a comorbid condition.
Negative competing diagnosis	The episode date and 3 days following the episode date when the beneficiary had no claims/encounters with any competing diagnosis.

C. ELIGIBLE POPULATION

Age	Ages 3 months to 17 years as of the episode date.
Continuous enrollment	30 days prior to the episode date through three days after the episode date (34 total days).
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population: Step 1: Identify beneficiaries with a visit with a diagnosis of acute bronchitis/bronchiolitis. Identify all beneficiaries who had an outpatient visit, ED visit, observation visit, telephone visit, e-visit or virtual check-in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set). Step 2: Determine all acute bronchitis/bronchiolitis episode dates. For each beneficiary identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

Event/diagnosis (continued)	Step 3: Test for negative comorbid condition history. Remove episode dates when the beneficiary had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 12 months prior to or on the episode date. Step 4: Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) was dispensed 30 days prior to the episode date or was active on the episode date. Step 5: Test for negative competing diagnosis. Remove episode dates where the beneficiary had a claim/encounter with a competing diagnosis on or 3 days after the episode date. A code from either of the following meets criteria for a competing diagnosis: • Pharyngitis Value Set. • Competing Diagnosis Value Set. Step 6: Calculate continuous enrollment. The beneficiary must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through 3 days after the episode date (34 total days). Step 7: Deduplicate eligible episodes. If a beneficiary has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a beneficiary has an eligible episode on January 1, include the January 1 visits and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: The denominator for this measure is based on episodes, not on beneficiaries. All eligible episodes that were not removed or deduplicated remain in the denominator.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) on or three days after the episode date.

E. CALCULATION

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (e.g., the proportion for episodes that did not result in an antibiotic dispensing event).

MEASURE ADD-CH: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) MEDICATION

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

1. Initiation Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.
2. Continuation and Maintenance (C&M) Phase: Percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Data Collection Method: Administrative or EHR[1]

Guidance for Reporting:

- Many of the ADHD medications are also used in the treatment of narcolepsy. In order to have a precise ADHD measure, children with narcolepsy are removed from the denominator of both indicators.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) for ADHD Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2024 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2023/cms136v12. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system.
- Refer to Appendix C for the definition of a prescribing practitioner.

[1] The Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS reporting. ECDS specifications are not currently available for Child Core Set reporting.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
Negative medication history	A period of 120 days (4 months) prior to the IPSD when the beneficiary had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an ADHD medication where the date is in the intake period and there is a negative medication history.
Initiation phase	The 30 days following the IPSD.
C&M phase	The 300 days following the IPSD (10 months).
Continuous medication treatment	The number of medication treatment days during the 301-day period must be ≥ 210 days (e.g., 301 treatment days – 91 gap days).
Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 301-day period. Use the following steps to identify and calculate covered days. Step 1 Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day or dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events. Identify the start and end dates: The start date is the date of service of the earliest dispensing event and the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days. For example: • If there are three 7-days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21. • If there are two 7-days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14. • If there are three 7-days supply dispensing events for the same medication on January 1, a 7-days supply dispensing event on January 20 and 7-days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4.

Treatment days (continued) (covered days)	Note: This step assumes that the beneficiary will take one prescription at a time (and start taking the next prescription after exhausting the previous prescription). Step 2 For all other dispensing events (multiple prescriptions for the same medication on different days without overlap, multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days. Note: This step assumes the beneficiary will take the different medications concurrently. Step 3 Count the covered days. Consider each calendar day covered by one or more medications to be one covered day.
Identifying same or different drugs	To identify same or different drugs, use the medication lists specified for the measure in the ADHD Medications table. Drugs in different medication lists are considered different drugs. For example, a dispensing event from the Dexmethylphenidate Medications List is considered a different drug from a dispensing event from the Methylphenidate Medications List.

C. ELIGIBLE POPULATION

Eligible Population: Rate 1 – Initiation Phase

Age	Age 6 as of March 1 of the year prior to the measurement year to age 12 as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 1 – Initiation Phase (Section D) to identify the eligible population for the Initiation Phase.

Eligible Population: Rate 2 – Continuation and Maintenance Phase

Age	Age 6 as of March 1 of the year prior to the measurement year to age 12 as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the index prescription start date (IPSD) and 300 days (10 months) after the IPSD.
Allowable gap	One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (e.g., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 2 – Continuation and Maintenance (Section D) to identify the eligible population for the Continuation and Maintenance Phase.

D. ADMINISTRATIVE SPECIFICATION

Rate 1 – Initiation Phase

Denominator

The Rate 1 eligible population

Step 1

Identify all children in the specified age range who were dispensed an ADHD medication (ADHD Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the 12-month Intake Period.

Table ADD-A. ADHD Medications

Drug Class	Prescription	Medication Lists
CNS stimulants	• Dexmethylphenidate • Dextroamphetamine • Lisdexamfetamine • Methylphenidate • Methamphetamine	• Dexmethylphenidate Medications List • Dextroamphetamine Medications List • Lisdexamfetamine Medications List • Methylphenidate Medications List • Methamphetamine Medications List
Alpha-2 receptor agonists	• Clonidine • Guanfacine	• Clonidine Medications List • Guanfacine Medications List
Miscellaneous ADHD medications	• Atomoxetine	• Atomoxetine Medications List

Step 2

Test for negative medication history. For each child identified in step 1, test each ADHD prescription for a negative medication history. The IPSD is the dispensing date of the earliest ADHD prescription in the intake period with a negative medication history.

Step 3

Calculate continuous enrollment. Children must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4

Remove children who had an acute inpatient encounter for a mental, behavioral, or neurodevelopmental disorder during the 30 days after the IPSD. Either of the following meets criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral, or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set)
- An acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient admission:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  - Identify the admission date for the stay.

Required exclusions

Exclude beneficiaries who meet any of the following criteria:

- Beneficiaries with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year
- Beneficiaries in hospice or using hospice services any time during the measurement year. Refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

Numerator

A follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set)
- An outpatient visit (BH Outpatient Value Set)
- An observation visit (Observation Value Set)
- A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)
- A telephone visit (Telephone Visits Value Set)

Note: Do not count a visit on the IPSD as the Initiation Phase visit.

Rate 2 – Continuation and Maintenance Phase

Denominator

The Rate 2 eligible population

Step 1

Identify all children who meet the eligible population criteria for Rate 1 – Initiation Phase.

Step 2

Calculate continuous enrollment. Children must be continuously enrolled for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Step 3

Calculate treatment days (covered days) to determine continuous medication treatment. Using the children in Step 2, determine if the child was dispensed a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 301-day period beginning on the IPSD through 300 days after the IPSD. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 91 days during the 301-day (10-month) period.

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 91. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4

Remove children who had an acute inpatient encounter for a mental, behavioral, or neurodevelopmental disorder during the 300 days (10 months) after the IPSD. Either of the following meets criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral, or neurodevelopmental disorder (Mental, Behavioral, and Neurodevelopmental Disorders Value Set)
- An acute inpatient admission with a principal diagnosis of mental, behavioral, or neurodevelopmental disorder (Mental, Behavioral, and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient admission:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  - Identify the admission date for the stay.

Numerator

Identify all children who meet the following criteria:

- Numerator compliant for Rate 1 Initiation Phase, and
- At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD

Any of the following code combinations identify follow-up visits:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set)
- An outpatient visit (BH Outpatient Value Set)
- An observation visit (Observation Value Set)
- A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)
- A telephone visit (Telephone Visits Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set)

Only one of the two visits (during days 31–300 after the IPSD) may be an e-visit or virtual check-in (Online Assessments Value Set).

E. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).

MEASURE AMB-CH: AMBULATORY CARE: EMERGENCY DEPARTMENT (ED) VISITS

National Committee for Quality Assurance

A. DESCRIPTION

Rate of emergency department (ED) visits per 1,000 beneficiary months among children up to age 19.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure includes all ages. For the purpose of Child Core Set reporting, states should calculate and report this measure for three age groups and a total rate: less than age 1, ages 1 to 9, ages 10 to 19, and total (ages 0 to 19).
- For the purpose of Child Core Set reporting, states should report this measure as a rate per 1,000 beneficiary months.
- Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason. If a child is enrolled retroactively, count all services for which the state paid or expects to pay.
- When confirming that an ED visit does not result in an inpatient stay, all inpatient stays must be considered, regardless of payment status (paid, suspended, pending, denied). For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and should not be included in this measure numerator.
- Supplemental data may not be used for this measure. In addition, supplemental data may not be used for the mental health and chemical dependency required exclusion.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Beneficiary months	Beneficiary months are a beneficiary's "contribution" to the total yearly enrollment. Beneficiary months are calculated by summing the total number of months each beneficiary is enrolled in the program during the measurement year.

C. ELIGIBLE POPULATION

Age	Children up to age 19.
Continuous enrollment	None.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Apply the following required exclusions: • Exclude visits for mental health or chemical dependency. Any of the following meet criteria: - A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set). - Psychiatry (Psychiatry Value Set). - Electroconvulsive therapy (Electroconvulsive Therapy Value Set). • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of beneficiary months

Step 1

Determine beneficiary months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The day selected must be consistent from person to person, from month to month, and from year to year. For example, if the state tallies enrollment on the 15th of the month and a child is enrolled on January 15, the child contributes one beneficiary month in January.

Retroactive enrollment. The state may include any months in which children were enrolled retrospectively, including months in which the state pays for services.

Step 2

Use the beneficiary's age on the specified day of each month to determine to which age group the beneficiary months will be contributed. For example, if a state tallies enrollment on the 15th of each month and a child turns 10 on April 3 and is enrolled for the entire year, then he or she contributes three beneficiary months (January, February, and March) to the ages 1 to 9 category and nine beneficiary months to the ages 10 to 19 category.

Numerator

ED visits: Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set)
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set)

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set).

A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date).

Age of Beneficiary: Report age as of the date of service.

Matching Enrollment with Utilization: Run enrollment reports used for beneficiary month calculations to determine utilization rates (such as ED visits/1,000 beneficiary months) within 30 days of the claims reports and for the same time period. Include retroactive additions and terminations in these reports. States that report utilization services must also report benefit enrollment (medical beneficiary months).

Counting Multiple Services: If a child receives the same service two different times (e.g., ED visits six months apart), count them as two visits. Count services, not the frequency of procedure codes billed (e.g., if a physician and a hospital submit separate bills pertaining to the same ED visit with the same date of service, only one should be included). The state must develop its own systems to avoid double counting.

E. CALCULATION OF THE ED VISIT RATES

Calculate the ED visit rate by dividing the number of ED visits by the number of beneficiary months and multiply by 1,000, as follows:

ED Visit Rate = (Number of ED visits/number of beneficiary months) x 1,000

Table AMB-A. ED Visits per 1,000 Beneficiary Months, by Age

Age	ED Visits	Beneficiary Months	Visits per 1,000 Beneficiary Months
<1	.	.	.
1–9	.	.	.
10–19	.	.	.
Unknown	.	.	.
Total	.	.	.

Source: Refer to Table AMB-1: Data Elements for Ambulatory Care in HEDIS specifications (MY 2020 & MY 2021 version).

F. ADDITIONAL NOTES

This measure has been adapted from the NCQA HEDIS measure Ambulatory Care: Emergency Department (ED) Visits measure and includes additional language from the HEDIS section, “Guidelines for Utilization Measures”.

MEASURE AMR-CH: ASTHMA MEDICATION RATIO: AGES 5 TO 18

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of children and adolescents ages 5 to 18 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.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has four reportable age groups and a total rate: ages 5 to 11, ages 12 to 18, ages 19 to 50, ages 51 to 64, and total (ages 5 to 64). The Child Core Set measure applies to beneficiaries ages 5 to 18 and the Adult Core Set measure applies to beneficiaries ages 19 to 64. For the purpose of Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate: ages 5 to 11, ages 12 to 18, and total (ages 5 to 18).
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) for Asthma Controller Medications and Asthma Reliever Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- RxNorm codes cannot be used to identify the numerator.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, Modifier, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Oral medication dispensing event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is dispensed. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30.

Oral medication dispensing event (continued)	Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if the drugs are the same or different. Drugs in different medication lists are considered different drugs. • Two prescriptions for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each). • Two prescriptions for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each). • Two prescriptions for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days). • Two prescriptions for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).
Inhaler dispensing event	When identifying the eligible population, use the definition below to count inhaler dispensing events. All inhalers (e.g., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a beneficiary received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was dispensed. Use the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.
Injection dispensing event	Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a beneficiary received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events. Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. Allocate the dispensing events to the appropriate year based on the date when the prescription was dispensed.

Units of medication	When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event. Use the package size and units columns in the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicates the dispensed amount is 30 g, three inhaler canisters were dispensed.

C. ELIGIBLE POPULATION

Age	Ages 5 to 18 as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not consider continuously enrolled) during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical during the measurement year and in the year prior to the measurement year. Pharmacy during the measurement year.
Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. • At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set). • At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Event/diagnosis (continued)	• At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge: - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). - Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). - Identify the discharge date for the stay. • At least four outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), or e-visits or virtual check-ins (Online Assessments Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) and at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all of the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to identify asthma controller and reliever medications. • At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to identify asthma controller and reliever medications. Step 2 A beneficiary identified as having persistent asthma because of 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 (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (e.g., the measurement year or the year prior to the measurement year).
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who met any of the following criteria: • Beneficiaries 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 Value Set. - Other Emphysema Value Set. - COPD Value Set. - Obstructive Chronic Bronchitis Value Set. - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set. - Cystic Fibrosis Value Set. - Acute Respiratory Failure Value Set.

Required exclusions (continued) (Supplemental and medical record data may be used for these exclusions)	• Beneficiaries who had no asthma controller or reliever medications dispensed during the measurement year. Use all the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to identify asthma controller and reliever medications. • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries who have a medication ratio of ≥ 0.50 during the measurement year. Follow the steps below to calculate the ratio.

Use all the medication lists in Table AMR-A. Asthma Controller Medications table below to identify asthma controller medications. Use all the medication lists in Table AMR-B. Asthma Reliever Medications table below to identify asthma reliever medications.

Step 1

For each beneficiary, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of Units of medications.

Step 2

For each beneficiary, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of Units of medications.

Step 3

For each beneficiary, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4

For each beneficiary, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

Units of Controller Medications (step 1) / Units of Total Asthma Medications (step 3)

Step 5

Sum the total number of beneficiaries who have a ratio of ≥ 0.50 in step 4.

Table AMR-A. Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Table AMR-B. Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Note

- Do not use RxNorm codes when assessing the numerator.
- When mapping NDC codes, medications described as “injection,” “prefilled syringe,” “subcutaneous,” “intramuscular,” or “auto-injector” are considered “injections” (route).
- When mapping NDC codes, medications described as “metered dose inhaler,” “dry powder inhaler,” or “inhalation powder” are considered “inhalation” (route) medications.
- Do not map medications described as “nasal spray” to “inhalation” medications.

MEASURE APM-CH: METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

- Percentage of children and adolescents on antipsychotics who received blood glucose testing
- Percentage of children and adolescents on antipsychotics who received cholesterol testing
- Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing

Data Collection Method: Administrative[2]

Guidance for Reporting:

- This measure applies to beneficiaries ages 1 to 17. For the purpose of Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate: ages 1 to 11, ages 12 to 17, and total (ages 1 to 17).
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) for APM Antipsychotic Medications are available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.

[1] Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503.

[2] The Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Child Core Set reporting.

Benefit	Medical and pharmacy.
Event/diagnosis	At least two antipsychotic medication dispensing events (APM Antipsychotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) of the same or different medications, on different dates of service during the measurement year.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Blood Glucose

Beneficiaries who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol

Beneficiaries who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.

Blood Glucose and Cholesterol

Beneficiaries who received both the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

MEASURE APP-CH: USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries ages 1 to 17. For the purpose of Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate: ages 1 to 11, ages 12 to 17, and total (ages 1 to 17).
- This measure intends to assess use of psychosocial care as a first-line treatment for conditions for which antipsychotic medications are not indicated. This measure's value set contains typical forms of psychological services, such as behavioral interventions, psychological therapies, and crisis intervention.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) for Antipsychotic Medications and Antipsychotic Combination Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	January 1 through December 1 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antipsychotic medication where the date is in the intake period and there is a negative medication history.
Negative medication history	A period of 120 days (4 months) prior to the IPSD when the beneficiary had no antipsychotic medications dispensed for either new or refill prescriptions.

[1] Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, from a measure developed by MedNet Medical Solutions.

C. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	IPSD.
Benefit	Medical, mental health, and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify all beneficiaries in the specified age range who were dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2 Test for negative medication history. For each beneficiary identified in step 1, test each antipsychotic prescription for a negative medication history. The IPSD is the dispensing date of the earliest antipsychotic prescription in the intake period with a negative medication history. Step 3 Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Beneficiaries for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year meet criteria: • At least one acute inpatient encounter with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Either of the following code combinations meet criteria: - BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set). - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set).

Required exclusions (continued) (Supplemental and medical record data may be used for these exclusions)	• At least two visits in an outpatient, intensive outpatient, or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set), meet criteria: - An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set). - An outpatient visit (BH Outpatient Value Set). - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set). - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set). - Electroconvulsive therapy (Electroconvulsive Therapy Value Set). - An observation visit (Observation Value Set). - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set). - A telephone visit (Telephone Visits Value Set). - An e-visit or virtual check-in (Online Assessments Value Set). Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Documentation of psychosocial care (Psychosocial Care Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.

MEASURE CCP-CH: CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 15 to 20 who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 days of delivery and within 90 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery and within 90 days of delivery.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 90 days of delivery is used to monitor the provision of contraception throughout the postpartum period. A 90-day period is used because the 2018 American College of Obstetricians and Gynecologists [ACOG] Committee Opinion No. 736 recommended a postpartum visit within the first 3 weeks postpartum, which should then be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth, and six additional days are allowed for women whose postpartum care visit is delayed.[1]

This measure is episode-based and uses live birth delivery as the start of the episode.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – Postpartum Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- In total, four rates will be reported for the Child Core Set measure:
  - Ages 15 to 20: Most or moderately effective contraception – within 3 days of delivery.
  - Ages 15 to 20: Most or moderately effective contraception – within 90 days of delivery.
  - Ages 15 to 20: LARC – within 3 days of delivery.
  - Ages 15 to 20: LARC – within 90 days of delivery.

[1] ACOG. "Optimizing Postpartum Care: Committee Opinion Number 736." *Obstetrics & Gynecology*, vol. 131, no. 5, 2018, pp. e140–e150. https://doi.org/10.1097/AOG.0000000000002633

- The measurement year is calendar year 2023. There is no lookback period for this measure.
- Include all paid, suspended, pending, and denied claims.
- Some women may have more than one delivery in the measurement year; this measure is designed to identify unique live births (defined as those that occur ≥180 days apart) rather than women who had a live birth. Each live birth delivery is evaluated separately to assess if most or moderately effective contraception is provided during the postpartum period.
- Women with a live birth occurring after September 30 are excluded from the denominator because there may not have been an opportunity to provide the woman with contraception in the postpartum period (defined as within 90 days of delivery).
- When calculating the number of days postpartum for the numerator, consider the date of delivery to be day 0. For instance, if a live birth occurred on September 27, 2023, review all claims through September 30, 2023 for the 3-day postpartum rates and review all claims through December 26, 2023 for the 90-day postpartum rates.
- The codes used to calculate this measure are available in Tables CCP-A through CCP-D at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.
- The code sets and SAS programs needed to calculate this measure are available at https://opa.hhs.gov/claims-data-sas-program-instructions.
- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system. However, contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.
- For more information on interpreting performance results on this measure, see Section E, “Additional Notes.”

This measure includes the following coding systems: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, or ring.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2023.

C. ELIGIBLE POPULATION

Age	Women ages 15 to 20 as of December 31 of the measurement year who had a live birth.
Continuous enrollment	Within the measurement year, women enrolled from the date of delivery to 90 days postpartum.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	Delivery of a live birth.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population includes women ages 15 to 20 who had a live birth in the measurement year.

Women with a live birth occurring after September 30 will be excluded from the denominator because they may not have an opportunity to receive contraception in the postpartum period (defined as within 90 days of delivery). Follow the steps below to identify the eligible population:

Step 1

Identify live births by using codes in Table CCP-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Step 2

Exclude deliveries that did not end in a live birth (e.g., miscarriage, ectopic, stillbirth, or pregnancy termination) by using the codes in Table CCP-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Exclude live births that occurred during the last 3 months of the measurement year. These deliveries should be excluded from the denominator because there may not have been an opportunity to provide contraception during the postpartum period. ACOG recommends having a comprehensive postpartum visit no later than 12 weeks after birth.

Figure CCP-A below provides a flowchart for implementing these exclusion and inclusion categories.

Numerator for Rate 1

The eligible population that was provided a most or moderately effective method of contraception.

Step 3a: Identify Rate 1 Numerator

Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD/IUS, implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCP-

C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Step 4a: Identify Rate 1 Date

Determine the date that the contraceptive method was provided to identify: (a) women that were provided contraception in the immediate postpartum period of 3 days after delivery; and (b) women that were provided contraception within 90 days of delivery. The second category will also include women who were provided contraception in the first 3 days postpartum.

Step 5a: Calculate Rate 1

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

Numerator for Rate 2

The eligible population that was provided a LARC method.

Step 3b: Identify Rate 2 Numerator

Define the numerator by identifying women in the denominator who were provided a LARC in the measurement year. To do this, use the codes in Table CCP-D, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Step 4b: Identify Rate 2 Date

Determine the date that the LARC method was provided to identify: (a) women that were provided LARC in the immediate postpartum period of 3 days after delivery; and (b) women that were provided LARC within 90 days of delivery. The second category will also include women who were provided LARC in the first 3 days postpartum.

Step 5b: Calculate Rate 2

Calculate the rates by dividing the number of women who were provided a LARC method of contraception by the number of women in the denominator.

Figure CCP-A below provides a flowchart to calculate Rate 1 and Rate 2.

E. ADDITIONAL NOTES

Racial and socioeconomic disparities in contraceptive access and use are substantial. Studies suggest that these disparities are driven by structural barriers such as the cost of contraceptives, health insurance access, racial bias, distrust in the medical system, and pharmacy-level barriers.[2] In particular, Black and Latina women are less likely to use any contraceptive methods compared to white women.[3,4] However, women of color are more frequently offered LARC methods.[5] Given the history of coercive and involuntary female

[2] Sutton, Madeline Y., Ngozi F. Anachebe, Regina Lee, and Heather Skanes. "Racial and Ethnic Disparities in Reproductive Health Services and Outcomes." *Obstetrics & Gynecology,* vol. 137, issue 2, February 2021, pp. 225–233. https://doi.org/10.1097/AOG.0000000000004224.

[3] Dehlendorf, C., Seo Young Park, Chetachi A. Emeremni, Diane Comer, Kathryn Vincett, and Sonya Borrero. "Racial/Ethnic Disparities in Contraceptive Use: Variation By Age and Women's Reproductive Experiences." *American Journal of Obstetrics and Gynecology*, vol. 210, issue 6, 2014, article 526.e1-526.e9.

[4] Sutton et al. (2021), Op. Cit.

[5] Kathawa, C.A., and K.S. Arora. "Implicit Bias in Counseling for Permanent Contraception: Historical Context and Recommendations for Counseling." *Health Equity*, vol. 4, 2020, pp. 326–329. https://doi.org/10.1089/heq.2020.0025.

sterilizations in the United States, which disproportionately impacted women of color, ACOG recommends that contraceptive counseling should focus on patient-centered shared decision making. Specifically, ACOG recommends that "obstetrician-gynecologists should intentionally incorporate the reproductive justice framework[6] by (1) acknowledging historical and ongoing reproductive mistreatment of people of color and other marginalized individuals, (2) recognizing that counselor bias, unconscious or otherwise, may affect care and working to minimize the effect, and (3) prioritizing patients' values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method."[7] Against this background, stratifying measure results by race and ethnicity can help illuminate disparities in contraceptive provision and help identify program improvement opportunities to reduce/close this gap.

Healthy People 2030[8] and the World Health Organization recommend an inter-pregnancy interval of at least 18 months; therefore, all postpartum women can be considered at risk of unintended pregnancy for that period of time.

The Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception that can be used in the postpartum period. If the infant is being fed only its mother's breast milk, and the woman has not experienced her first postpartum menses, then LAM provides 98 percent protection from pregnancy in the first 6 months postpartum.[9]

Despite the protection from LAM, many health care providers will want to provide contraceptive services to women at the postpartum visit because the effectiveness of breastfeeding for pregnancy prevention drops quickly when women stop exclusive breastfeeding. It may be difficult for many clients to receive contraceptive services at that time.

More information on how to interpret performance results on this measure is available at https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf.

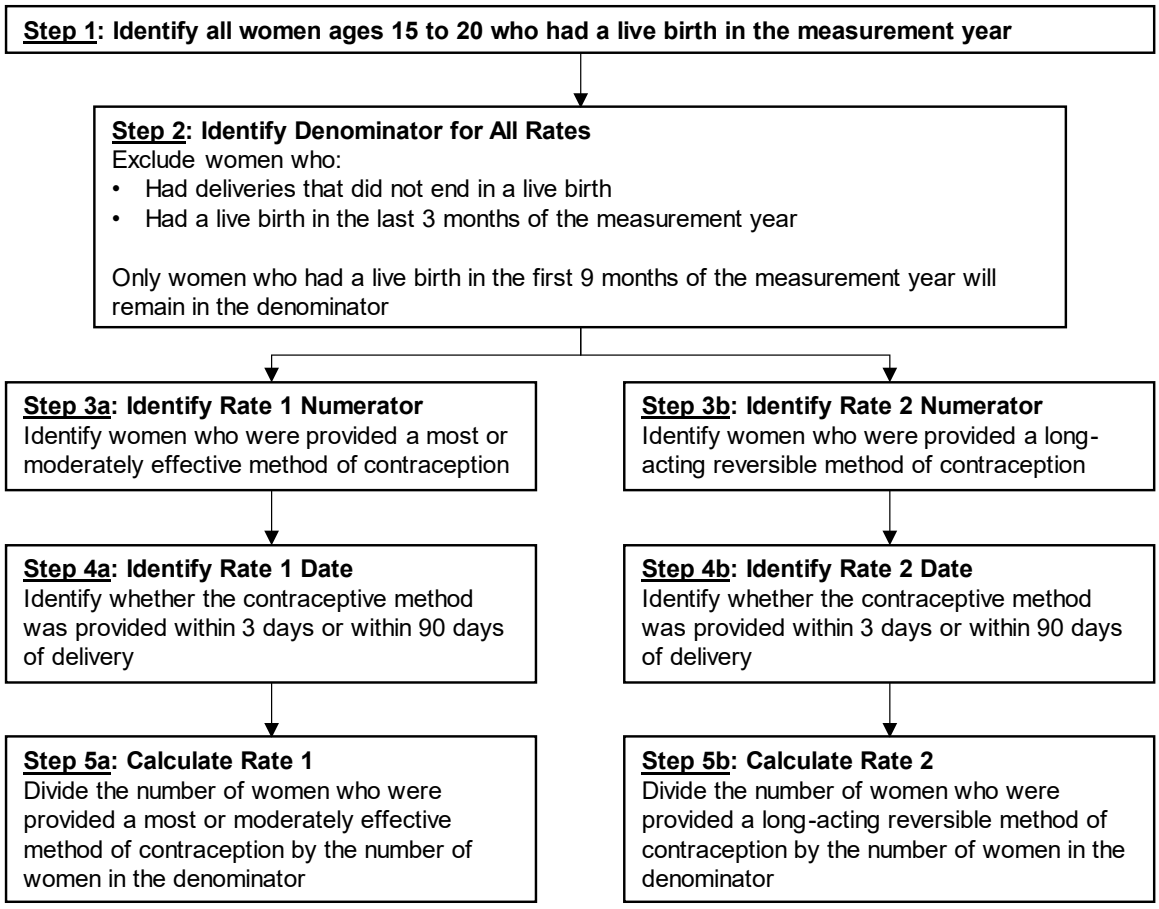
[6] Ross, L.J. "Understanding Reproductive Justice: Sister Song Women of Color Reproductive Health Collective." Feminist Press, 2017

[7] ACOG. "Patient-Centered Contraceptive Counseling: Committee Statement Number 1." *Obstetrics & Gynecology*, vol. 139, no. 2, 2022, pp. 350–353. https://doi.org/10.1097/AOG.0000000000004659.

[8] Office of Disease Prevention and Health Promotion. "Healthy People 2030. Family Planning." https://health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning.

[9] Trussell J., A.R.A. Aiken, E. Micks, and K.A. Guthrie. "Efficacy, Safety, and Personal Considerations." In Contraceptive Technology, 21st edition, edited by R.A. Hatcher, A.L. Nelson, J. Trussell, C. Cwiak, P. Cason, M.S. Policar, A. Edelman, A.R.A. Aiken, J. Marrazzo, and D. Kowal. Ayer Company Publishers, Inc., 2018.

Figure CCP-A. Measure Flowchart



MEASURE CCW-CH: CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 15 to 20 at risk of unintended pregnancy, the percentage that:

1. Were provided a most effective or moderately effective method of contraception.
2. Were provided a long-acting reversible method of contraception (LARC).

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods. A state should exercise caution in using this measure for payment purposes, because performance on this measure is a function of a woman's preferences. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state, and see where there is room for improvement. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods.

This measure is person-based and calculated so that every person in the measure is counted once.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – All Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- The measurement year is calendar year 2023. There is no lookback period for this measure to determine if there was a previous sterilization, LARC insertion, or other contraceptive method provided prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- A secondary data source, such as the National Survey of Family Growth (NSFG) can be used to interpret the results of this measure. For more information, see Section E, "Additional Notes."
- The codes used to calculate this measure are available in Tables CCW-A through CCW-F at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.
- The code sets and SAS programs needed to calculate this measure are available at https://opa.hhs.gov/claims-data-sas-program-instructions.
- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system. However, contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.
- For more information on interpreting performance results on this measure, see Section E, "Additional Notes."

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, or ring.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2023.

C. ELIGIBLE POPULATION

Age	Women ages 15 to 20 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Follow the steps below to define the denominator:

Step 1

Identify all women ages 15 to 20.

Step 2

Define the denominator by excluding women not at risk of unintended pregnancy because they:

- Were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table CCW-A.

- Had a live birth in the last 3 months of the measurement year because there may not have been an opportunity to provide them with contraception. A three-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a comprehensive postpartum visit by 12 weeks, and an additional 6 days was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table CCW-D.
- Were still pregnant at the end of the measurement year, as indicated by a pregnancy code (Table CCW-B) and an absence of a pregnancy outcome code indicating a non-live birth (Table CCW-C) or a live birth (Table CCW-D).

Once the exclusions are applied, the denominator includes women who were:

- Not pregnant at any point in the measurement year.
- Pregnant during the measurement year but whose pregnancy ended in the first 9 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.
- Pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

All code tables used in the calculation of the denominator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Figure CCW-A below provides a flowchart for implementing these exclusion and inclusion categories.

Numerator

Follow the steps below to define the numerator rates:

Step 3a: Identify Rate 1 Numerator

The eligible population that was provided a most or moderately effective method of contraception.

Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD/IUS, or implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCW-E.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Step 3b: Identify Rate 2 Numerator

The eligible population that was provided a LARC method.

Define the numerator by identifying women in the denominator who were provided a LARC in the measurement year. To do this, use the codes in Table CCW-F.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Measure calculation

Follow the steps below to calculate the measure performance rates:

Step 4a: Calculate Rate 1

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

Step 4b: Calculate Rate 2

Calculate the rates by dividing the number of women who were provided a LARC by the number of women in the denominator.

Figure CCW-A below provides a flowchart to calculate Rate 1 and Rate 2.

E. ADDITIONAL NOTES

Racial and socioeconomic disparities in contraceptive access and use are substantial. Studies suggest that these disparities are driven by structural barriers such as the cost of contraceptives, health insurance access, racial bias, distrust in the medical system, and pharmacy-level barriers.[1] In particular, Black and Latina women are less likely to use any contraceptive methods compared to white women.[2,3] However, women of color are more frequently offered LARC methods.[4] Given the history of coercive and involuntary female sterilizations in the United States, which disproportionately impacted women of color, ACOG recommends that contraceptive counseling should focus on patient-centered shared decision making. Specifically, ACOG recommends that "obstetrician-gynecologists should intentionally incorporate the reproductive justice framework[5] by (1) acknowledging historical and ongoing reproductive mistreatment of people of color and other marginalized individuals, (2) recognizing that counselor bias, unconscious or otherwise, may affect care and working to minimize the effect, and (3) prioritizing patients' values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method."[6] Against this background, stratifying measure results by race and ethnicity can help illuminate disparities in contraceptive provision and help identify program improvement opportunities to reduce/close this gap.

In addition, stratification of measure results by category of Medicaid eligibility (e.g., family planning waiver vs. other Medicaid eligibility) is also recommended for interpretation. A secondary data source, such as the National Survey of Family Growth[7] (NSFG) or the

[1] Sutton, Madeline Y., Ngozi F. Anachebe, Regina Lee, and Heather Skanes. "Racial and Ethnic Disparities in Reproductive Health Services and Outcomes." *Obstetrics & Gynecology,* vol. 137, issue 2, February 2021, pp. 225–233. https://doi.org/10.1097/AOG.0000000000004224.

[2] Dehlendorf, C.,, Seo Young Park, Chetachi A. Emeremni, Diane Comer, Kathryn Vincett, and Sonya Borrero. "Racial/Ethnic Disparities in Contraceptive Use: Variation By Age and Women's Reproductive Experiences." *American Journal of Obstetrics and Gynecology*, vol. 210, issue 6, 2014, article 526.e1-526.e9.

[3] Sutton et al. (2021), Op. Cit.

[4] Kathawa, C.A., and K.S. Arora. "Implicit Bias in Counseling for Permanent Contraception: Historical Context and Recommendations for Counseling." *Health Equity,* vol. 4, 2020, pp. 326–329. https://doi.org/10.1089/heq.2020.0025.

[5] Ross, L.J. "Understanding Reproductive Justice: Sister Song Women of Color Reproductive Health Collective." Feminist Press, 2017.

[6] ACOG. "Patient-Centered Contraceptive Counseling: Committee Statement Number 1." *Obstetrics & Gynecology*, vol. 139, no. 2, 2022, pp. 350–353. https://doi.org/10.1097/AOG.0000000000004659.

[7] Centers for Disease Control and Prevention. "National Survey of Family Growth." November 2020. https://www.cdc.gov/nchs/nsfg/index.htm.

Behavioral Risk Factor Surveillance System[8] (BRFSS) could be used to interpret provision of most and moderately effective contraceptive methods. Secondary data sources may be used to interpret the results for the general Medicaid population. However, the results for the family planning waiver recipients do not need to be adjusted with secondary data as the vast majority of clients who receive services from these programs are seeking contraceptive services and should therefore be considered at risk of unintended pregnancy.

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy (e.g., who are fecund, are not pregnant or seeking pregnancy, and have ever had sex). However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention or history of sexual activity. Further, both sterilization and LARC are long-lasting but there is no systematic record of receipt of sterilization or LARC in the year(s) preceding the measurement year. These limitations can be offset by using estimates from secondary survey data to help interpret this measure's results and to better understand the limitations of claims data.

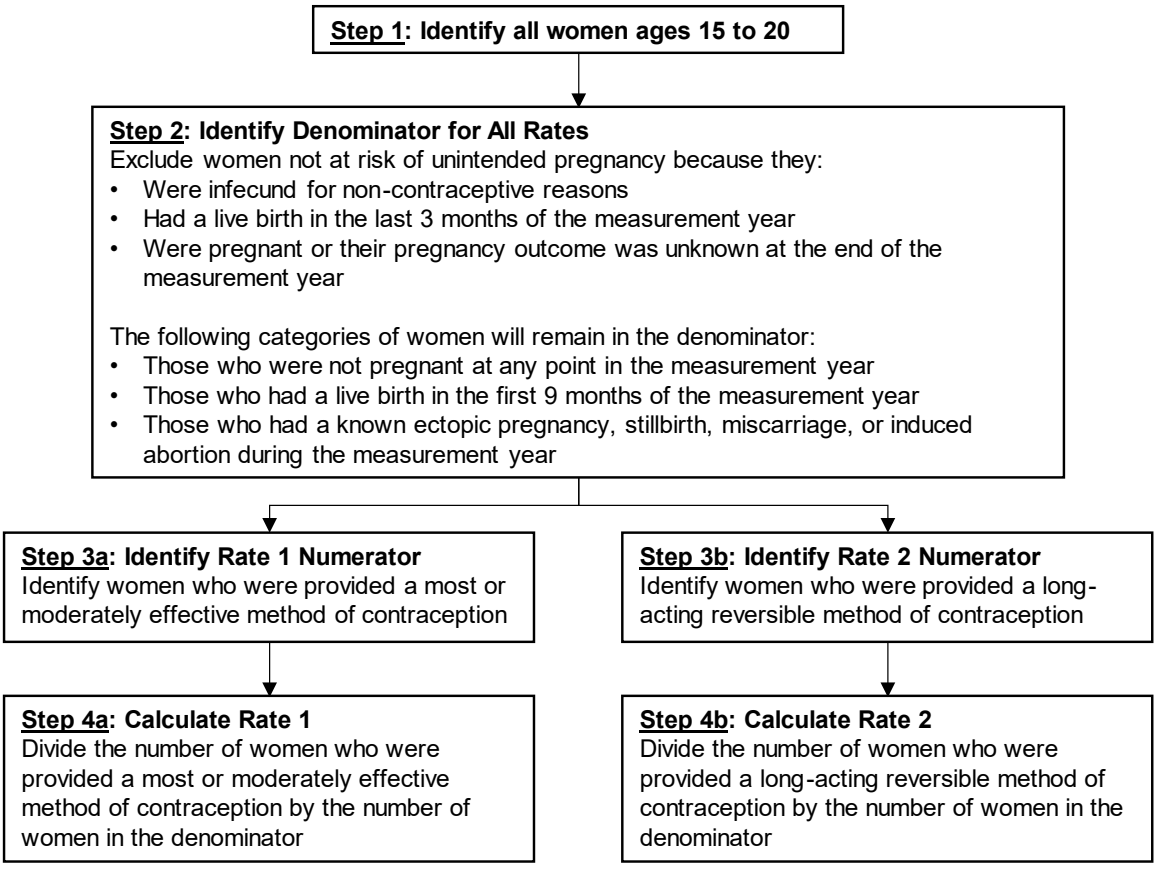
NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men ages 15 to 49. Approximately 5,000 individuals are interviewed each year, and updated data files are released every two years. This survey can be used to identify the portion of beneficiaries that are not at risk of unintended pregnancy because they never had sex, are infecund, or are trying to get pregnant. This information can then help determine the population at risk for unintended pregnancy to provide context for measure performance.

BRFSS is a national telephone survey that collects that data about health-related risk factors, chronic health conditions, and use of preventive services.

More information on how to interpret performance results on this measure is available at https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf.

[8] Centers for Disease Control and Prevention. "Behavioral Risk Factor Surveillance System." August 2020. https://www.cdc.gov/brfss/.

Figure CCW-A. Measure Flowchart



MEASURE CDF-CH: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure includes beneficiaries age 12 and older. The Child Core Set measure applies to beneficiaries ages 12 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older.
- The intent of the measure is to screen for depression in beneficiaries who have never had a diagnosis of depression or bipolar disorder prior to the qualifying encounter used to evaluate the numerator. Beneficiaries who have been diagnosed with depression or bipolar disorder will be excluded from the measure.
- The denominator for this measure includes beneficiaries ages 12 to 17 with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  1. Those beneficiaries with a positive screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool with a follow-up plan documented.
  2. Those beneficiaries with a negative screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool.
- The QPP claims/CQM specifications for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of Child Core Set reporting, there are two G codes included in the numerator to capture whether depression screening using an age-appropriate standardized tool was done on the date of the eligible encounter or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.
- An age-appropriate, standardized, and validated depression screening tool must be used and results documented as positive or negative for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. The screening should occur on the date of a qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter. The depression screening must be reviewed and addressed by the provider on the date of the encounter. Positive pre-screening results indicating a beneficiary is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.

- The measure assesses the most recent depression screening completed either during the qualifying encounter or within the 14 calendar days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a beneficiary screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which includes one or more of the following:
  - Referral to a provider for additional evaluation.
  - Pharmacological interventions.
  - Other interventions for the treatment of depression.
- For beneficiaries with multiple qualifying encounters, the beneficiary does not need to be screened at every encounter, only once during the performance year.
- A follow-up plan must be documented on the date of the qualifying encounter for a positive depression screen.
- Should a beneficiary screen positive for depression:
  - A clinician should only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
  - A clinician could opt to complete a suicide risk assessment when appropriate and based on individual beneficiary characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- This measure contains both exclusions and exceptions:
  - Denominator exclusion criteria are evaluated before checking if a beneficiary meets the numerator criteria; a beneficiary who qualifies for the denominator exclusion should be removed from the denominator.
  - Denominator exception criteria are only evaluated if the beneficiary does not meet the numerator criteria; beneficiaries who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.
- This measure can be calculated using administrative data only. Medical record review may be used to validate the state's administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report this measure.
- Include all paid, suspended, pending, and denied claims.
- Tables CDF-A through CDF-F are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.
- The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v12.html. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system.

This measure includes the following coding systems: CPT, HCPCS, ICD-9-CM, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the population in which it is being utilized. Examples of depression screening tools include but are not limited to: • Adolescent Screening Tools (12–17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2. • Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.
Follow-up plan	Documented follow-up for a positive depression screening *must* include one or more of the following: • Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen. • Pharmacological interventions. • Other interventions or follow-up for the diagnosis or treatment of depression. Examples of a follow-up plan include but are not limited to: • Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. • Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. The documented follow-up plan must be related to positive depression screening, for example: “Patient referred for psychiatric evaluation due to positive depression screening.”

C. ELIGIBLE POPULATION

Age	Ages 12 to 17 on date of encounter.
Event/diagnosis	Outpatient visit (Table CDF-A) during the measurement year.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population with an outpatient visit during the measurement year (Table CDF-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip).

Numerator

Beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the qualifying encounter using one of the codes in Table CDF-B available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip.

Exclusions

A beneficiary is not eligible if one or more of the following conditions are documented in the beneficiary medical record:

- Beneficiaries who have been diagnosed with depression or bipolar disorder

Use the codes in Table CDF-C, CDF-D, and CDF-E to identify exclusions (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip).

Exceptions

A beneficiary that does not meet the numerator criteria and meets the following exception criteria should be removed from the measure denominator. However, if the beneficiary meets the numerator criteria, the beneficiary would be included in the measure denominator.

- Beneficiary reason:
  - Beneficiary refuses to participate.
- Medical reason:
  - Beneficiary is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the beneficiary's health status.
  - Situations where the beneficiary's cognitive, functional, or motivational limitations may impact the accuracy of results.

Use the code in Table CDF-F (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-child-non-hedis-value-set-directory.zip) to identify exceptions.

MEASURE CHL-CH: CHLAMYDIA SCREENING IN WOMEN AGES 16 TO 20

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of women ages 16 to 20 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- For HEDIS, this measure has two reportable age groups and a total rate: ages 16 to 20, ages 21 to 24, and total (ages 16 to 24). The Child Core Set measure applies to beneficiaries ages 16 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 24.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) for Contraceptive Medications and Retinoid Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2024 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2023/cms153v11. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Women ages 16 to 20 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries who are sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The state must use both methods to identify the eligible population; however, a beneficiary only needs to be identified in one method to be eligible for the measure. Claim/encounter data. Beneficiaries who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria: • Pregnancy Value Set. • Sexual Activity Value Set. • Pregnancy Tests Value Set. Pharmacy data. Beneficiaries who were dispensed prescription contraceptives during the measurement year (Contraceptive Medications List, see link to the Medication List Directory in Guidance for Reporting above). Step 2 For the beneficiaries identified in Step 1 based on a pregnancy test alone, remove beneficiaries who meet either of the following: • A pregnancy test (Pregnancy Tests Value Set) during the measurement year and a prescription for isotretinoin (Retinoid Medications List, see link to the Medication List Directory in Guidance for Reporting above) on the date of the pregnancy test or 6 days after the pregnancy test. • A pregnancy test (Pregnancy Tests Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or 6 days after the pregnancy test.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

MEASURE CIS-CH: CHILDHOOD IMMUNIZATION STATUS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

Data Collection Method: Administrative, Hybrid, or EHR[1]

Guidance for Reporting:

- States should report a separate rate for each vaccine, as well as three separate combination rates.
- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all children who turned age 2 during the reporting year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, any immunizations missing from claims or registry data must be sought from medical records.
- If immunization registry data are used to calculate this measure, select “Immunization Registry” as an Administrative data source in the Data Source section of the web-based reporting system. States can select “Immunization Registry” in addition to other data sources used to calculate the measure. If use of immunization registry data varies by reporting unit, describe the data source used by each reporting unit in the “Additional Notes/Comments on Measures” section.
- The 14-Day Rule specifies that the vaccinations (with the exception of MMR) must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. This rule does not apply to the MMR vaccine. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Include all paid, suspended, pending, and denied claims.
- The electronic specification for FFY 2024 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2023/cms117v11. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system.

This measure’s Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CVX, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[1] The Childhood Immunization Status (CIS) measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Child Core Set reporting.

B. ELIGIBLE POPULATION

Age	Children who turn age 2 during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the beneficiary's second birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who had any of the following on or before their second birthday: - Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set). - Immunodeficiency (Disorders of the Immune System Value Set). - HIV (HIV Value Set; HIV Type 2 Value Set). - Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set). - Intussusception (Intussusception Value Set).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

DTaP

Any of the following on or before the child's second birthday meet criteria:

- At least four DTaP vaccinations (DTAP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).
- Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set).

IPV

Either of the following on or before the child's second birthday meets criteria:

- At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106).

MMR

Any of the following meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- All of the following any time on or before the child's second birthday (on the same or different date of service):
  - History of measles illness (Measles Value Set).
  - History of mumps illness (Mumps Value Set).
  - History of rubella illness (Rubella Value Set).
- Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the child's second birthday.

HiB

Either of the following on or before the child's second birthday meets criteria:

- At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

Hepatitis B

Any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the child's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis illness (Hepatitis B Value Set).
- Anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101).

VZV

Any of the following meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday.
- Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the child's second birthday.

Pneumococcal Conjugate

Either of the following on or before the child's second birthday meets criteria:

- At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal conjugate vaccine (SNOMED CT code 471141000124102).

Hepatitis A

Any of the following meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday.
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the child's second birthday.

Rotavirus

Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth:

- At least two doses of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service.
- At least one dose of the two-dose rotavirus vaccine (Rotavirus (2 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103).

Influenza

Either of the following meets criteria:

- At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.
  - An influenza vaccination recommended for children 2 years and older (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday meets criteria for one of the two required vaccinations.
- Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) on or before the child's second birthday.

Combination rates

Calculate the following rates for Combinations 3, 7, and 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 3	x	x	x	x	x	x	x			
Combination 7	x	x	x	x	x	x	x	x	x	
Combination 10	x	x	x	x	x	x	x	x	x	x

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

For DTaP, count any of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine
- Encephalitis due to the vaccine

For MMR, VZV, hepatitis A, and hepatitis B, count any of the following:

- Evidence of the antigen or combination vaccine
- Documented history of the illness
- Anaphylaxis due to the vaccine

For IPV, pneumococcal conjugate, influenza, HiB, and rotavirus, count either of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine

For combination vaccinations that require more than one antigen (DTaP and MMR), the state must find evidence of all the antigens.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

For immunization evidence obtained from the medical record, count children where there is evidence that the antigen was rendered from one of the following:

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered

For documented history of illness or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the child's second birthday.

Notes in the medical record indicating that the child received the immunization "at delivery" or "in the hospital" may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "child is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header or “DTaP/DTP/DT” can be counted as evidence of DTaP. The burden on states to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

Immunizations documented using a generic header (e.g., polio vaccine) or “IPV/OPV” can be counted as evidence of IPV. The burden on states to substantiate the IPV antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

MEASURE CPC-CH: CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) HEALTH PLAN SURVEY 5.1H – CHILD VERSION INCLUDING MEDICAID AND CHILDREN WITH CHRONIC CONDITIONS SUPPLEMENTAL ITEMS

Agency for Healthcare Research and Quality (survey instrument)

National Committee for Quality Assurance (survey administration protocol)

A. DESCRIPTION

A.1 – CAHPS Health Plan Survey 5.1H, Child Version

This measure provides information on parents' experiences with their child's health care. Results summarize children's experiences through ratings, composites, and individual question summary rates.

Four global rating questions reflect overall satisfaction:

- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

Four composite scores summarize responses in key areas:

- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Customer Service

A single question reflects experience of care in the following key area:

- Coordination of Care.

In addition, item-specific results ("question summary rates") are reported for select questions.

A.2 – Children with Chronic Conditions (CCC)

This measure provides information on parents' experience with their child's health care for the population of children with chronic conditions. Three composites 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. Question summary rates are also reported individually for two items summarizing the following concepts:

- Access to Prescription Medicines
- Family-Centered Care: Getting Needed Information

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to beneficiaries age 17 and younger as of December 31 of the measurement year.
- The version included in the Child Core Set is CAHPS 5.1H − Child Version Including Medicaid and Children with Chronic Conditions (CCC) Supplemental Items. Appendix D contains the CAHPS 5.1H instrument with CCC Supplemental Items.
- The survey should be conducted by a third-party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol. Appendix E contains additional guidance on conducting the CAHPS 5.1H Child Survey, including the sampling protocol.
- To reduce state burden and streamline reporting, CMS will calculate state-level performance results for this measure using data submitted to the AHRQ CAHPS Health Plan Survey Database. **States are not asked to report data for this measure for FFY 2024 in the online Core Set reporting system.**
- More information about the CAHPS Health Plan Survey Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html.
- CHIP requirements for CAHPS: The Core Set mandatory reporting final rule updated the requirements for CHIP reporting by amending 42 CFR 457 to align reporting requirements with those required for the Medicaid and CHIP Child Core Set. Therefore, CHIP programs are required to report on the version 5.1H- Child Version of the CAHPS measure included in the Medicaid and CHIP Child Core Set. The new requirements instruct states to sample Title XXI-funded Medicaid expansion CHIPs with Title XIX-funded Medicaid, and separate CHIPs are required to be sampled separately. Additionally, states are required to report CAHPS survey results for CHIP in the AHRQ CAHPS Health Plan Survey Database. Summary CAHPS survey results for CHIP will no longer be collected in the CHIP annual report beginning in FY 2024, except for verification.
- This measure includes a required exclusion for beneficiaries who die during the measurement year. For additional information, refer to the deceased beneficiary exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

B. ELIGIBLE POPULATION

Age	Age 17 and younger as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

C. IMPLEMENTING THE CAHPS SURVEY

Administration	Survey should be conducted by a third-party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol. See Appendix E for more information.
Collection mode	Survey data collection methodologies include Mail-Only and Mixed (mail and telephone) mode protocols. In addition, Internet enhancements are permitted.
Sample size	The sample needs to be large enough to achieve a goal of 411 completed surveys for both the GC and CCC populations per reporting unit (e.g., health plan, PCCM program, or state) and at least 100 valid responses on each question, a cost-effective method shown to produce statistically valid survey comparisons.

D. COMPLETION CRITERIA

The survey vendor assigns a beneficiary a disposition code of Complete and Eligible when the following conditions are met:

- Responses indicate that the beneficiary meets the eligible population criteria
- Three of the five questions listed in the table below are answered appropriately.

Survey Type	**Questions for Complete and Eligible Survey**				
Children With CCC	Q3	Q25	Q40	Q44	Q49

Note: See Appendix D for the Children with CCC questionnaire.

Note: The questions for the Complete and Eligible Survey represent the first question in each section of the CAHPS survey (except for the “About You” section) and the Rating of Health Plan question.

MEASURE DEV-CH: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE

Oregon Health and Sciences University

A. DESCRIPTION

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C).
  - The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts.
  - For example, a state may conduct a chart review on a sample of records where the CPT code was used to determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening.
- When calculating the numerator, modified claims can be included depending on the intent of the modifier:
  - States should include claims with a modifier that indicates a global developmental screening occurred. For example, Z13.42 can be used to indicate an “Encounter for screening for global developmental delays.”
  - States should exclude claims with a modifier indicating that only a domain-specific screening occurred.
  - Modifiers that indicate that a screening was performed at a certain type of visit can be included.
- To facilitate CMS’s understanding of the data reported for this measure, states should use the “Additional Notes/Comments on Measure” section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).
- Include all submitted claims (e.g., paid, suspended, pending, or denied) as the claims reflect services that were rendered.

- The Bright Futures/American Academy of Pediatrics periodicity schedule includes more information about the recommendations for developmental screening and is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.[1]
  - As noted in the periodicity schedule, screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening" and is accessible at https://pediatrics.aappublications.org/content/145/1/e20193449.[2]
  - The article also includes more information about the developmental screening tools that meet the measure criteria and is available at https://aap2.silverchair-cdn.com/aap2/content_public/journal/pediatrics/145/1/10.1542_peds.2019-3449/7/peds_20193449supplementarydata.pdf.[2]
- During the development of this measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays.
- States should use the "Deviations from Measure Specifications" field to document any deviations from the specifications for this measure.

This measure includes the following coding system: CPT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children age 1, 2, or 3 between January 1 and December 31 of the measurement year.
Continuous enrollment	Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second, or third birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).
Anchor date	Enrolled on the child's first, second, or third birthday.
Benefit	Medical.
Event/diagnosis	None.

[1] Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.* 4th ed. American Academy of Pediatrics; 2017. https://www.aap.org/periodicityschedule.

[2] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." *Pediatrics*, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

C. GUIDANCE ON DEVELOPMENTAL SCREENING TOOLS

Criteria for developmental screening tools used in the measure, as well as example tools that do and do not meet criteria, are included below in Section E.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

The children in the eligible population who turned 1 during the measurement year.

Denominator 2

The children in the eligible population who turned 2 during the measurement year.

Denominator 3

The children in the eligible population who turned 3 during the measurement year.

Denominator 4

All children in the eligible population who turned 1, 2, or 3 during the measurement year, e.g., the sum of denominators 1, 2, and 3.

Numerators

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. This measure is based on three, age-specific indicators.

Numerator 1

Children in Denominator 1 who had a claim with CPT code 96110 before or on their first birthday.

Numerator 2

Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays.

Numerator 3

Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.

Numerator 4

Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data

CPT code 96110 (Developmental testing, with interpretation and report)

Important note about appropriate use of claims data

This measure is anchored to standardized tools that meet four criteria specified below in the paragraph beginning with “Tools must meet the following criteria.” States that have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

States should include claims with a modifier that indicates that a global developmental screening occurred. For example, Z13.42 can be used to indicate an “Encounter for screening for global developmental delays.”

Claims NOT included in this measure

It is important to note that modified 96110 claims should not be included IF the modifier is used to indicate that the screening is for a specific domain of development (for example, social emotional screening via the ASQ-SE or autism screening). This measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral, and social delays.

Exclusions

None.

E. MEDICAL RECORD SPECIFICATION

Denominator

A systematic sample of 411 drawn from the eligible population stratified by age.

Denominator 1

137 children from the sample who turned 1 during the measurement year.

Denominator 2

137 children from the sample who turned 2 during the measurement year.

Denominator 3

137 children from the sample who turned 3 during the measurement year.

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

Children in Denominator 1 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented before or on their first birthday.

Numerator 2

Children in Denominator 2 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their first and before or on their second birthday.

Numerator 3

Children in Denominator 3 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their second and before or on their third birthday.

Numerator 4

Children in Denominator 4 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented in the 12 months preceding or on their first, second or third birthday (the sum of numerators 1, 2 and 3).

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed, and
- The standardized tool used (see below), and
- Evidence of a screening result or screening score

Tools must meet the following criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Example developmental screening tools that meet criteria for the measure

The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)[3], which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement:[4]

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

Note: The 2020 AAP Statement describes the screening tool properties that may be useful for states to consider in designing their policies.

[3] Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.* 4th ed. American Academy of Pediatrics; 2017. https://www.aap.org/periodicityschedule.

[4] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." *Pediatrics*, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-child care) include the following:[5]

- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months

The tools listed above are not specific recommendations but are examples of tools cited in Bright Futures that meet the above criteria.

Tools that do NOT meet the criteria

It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

Exclusions

None.

F. CALCULATION ALGORITHM

Step 1

Determine the denominators.

From the total denominator, sort into three age cohorts: children who turned age one, two or three between January 1 and December 31 of the measurement year.

Step 2

Determine the numerators.

For each age cohort, and for the total, identify children who had a screening for developmental, behavioral, and social delays performed before or on their birthday as found through claims data or documented in the medical chart.

Administrative Data: Children for whom a claim of 96110 was submitted for services in the 12 months preceding or on their birthday.

Medical Record Review: Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding or on their birthday. Documentation must include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.

[5] Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening." *Pediatrics,* vol. 118, no.1, July 2006, pp. 405-420. https://pediatrics.aappublications.org/content/118/1/405.

Step 3

Calculate the age-specific indicators (ages 1 to 3) by dividing the age-specific numerator by the age-specific denominator and multiplying by 100 to get a percentage.

Step 4

Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

If administrative data are used, the entire eligible population is used for the denominator. If using the hybrid method (administrative plus medical record data sources), a systematic sample can be drawn of 411, with 137 in each age group.

G. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

A sample of 411 will provide sufficient statistical power for states reporting a statewide developmental screening rate for children ages 1 to 3. With the smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 may be insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

The eligible population, from which the original sample was drawn, should be stratified by age, and the age-specific sample drawn from within each stratum. To oversample for any age group, the state should return to the original listing of eligible children in that age group, and continue adding children to the sample until the larger sample is complete. However, to maintain consistency of reporting and avoid having to weight the age groups to calculate the total, the state should only include the first 137 children sampled in the age-specific and total rates reported to CMS.

MEASURE FUA-CH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE: AGES 13 TO 17

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries ages 13 to 17 years with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). The Child Core Set measure applies to beneficiaries ages 13 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older.
- The denominator should be the same for the 30-day rate and the 7-day rate within each age group.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Refer to Appendix C for the definition of a mental health provider. States must develop their own methods to identify mental health providers.
- NCQA's Medication List Directory (MLD) for Alcohol Use Disorder Treatment and Opioid Use Disorder Treatment medications are available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

[1] Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 13 to 17 as of the ED visit.
Continuous enrollment	The date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical, chemical dependency, and pharmacy. Note: Beneficiaries with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was between ages 13 and 17 on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay. Exclude 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, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.

ED visits followed by residential treatment	Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. A code from any of the following meets criteria for residential treatment: • Residential Behavioral Health Treatment Value Set. • Psychiatric Residential Treatment Center (POS code 56). • Residential Substance Abuse Treatment Facility (POS code 55). • Residential Program Detoxification Value Set. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (BH Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

- An outpatient visit (BH Outpatient Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health provider
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with a mental health provider
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with a mental health provider
- An observation visit (Observation Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An observation visit (Observation Value Set) with a mental health provider
- A peer support service (Peer Support Services Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider

- A telephone visit (Telephone Visits Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telephone visit (Telephone Visits Value Set), with a mental health provider
- An e-visit or virtual check-in (Online Assessments Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set), with a mental health provider
- A substance use disorder service (Substance Use Disorder Services Value Set)
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set)
- A substance use service (Substance Use Services Value Set)
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List, Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after the ED visit or within 7 days after the ED visit).

MEASURE FUH-CH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGES 6 TO 17

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for beneficiaries ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

- Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge
- Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The Child Core Set measure applies to beneficiaries ages 6 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older.
- Follow the detailed specifications to (1) include the appropriate discharge when the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than (or equal to) the 7-day follow-up rate.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or from the same visit.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of a mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 6 to 17 as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period). Identify the discharge date for the stay. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

Acute readmission or direct transfer (continued)	If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim), exclude both the original and the readmission/direct transfer discharge.
Nonacute readmission or direct transfer	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30 Day Follow-up

follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7 Day Follow-up

A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (BH Outpatient Value Set) with a mental health provider

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider
- An observation visit (Observation Value Set) with a mental health provider
- Transitional care management services (Transitional Care Management Services Value Set) with a mental health provider
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)
- A telephone visit (Telephone Visits Value Set) with a mental health provider
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

MEASURE FUM-CH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS: AGES 6 TO 17

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries ages 6 to 17 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 which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The Child Core Set measure applies to beneficiaries ages 6 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older.
- The denominator should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate within each age group.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[1] Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

B. ELIGIBLE POPULATION

Age	Ages 6 to 17 as of the date of the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness and Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was between ages 6 and 17 on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by 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. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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 a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period specified for the rate (within 30 days after the ED visit or within 7 days after the ED visit).

MEASURE IMA-CH: IMMUNIZATIONS FOR ADOLESCENTS

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Data Collection Method: Administrative or Hybrid[2]

Guidance for Reporting:

- When no sampling is involved, states may use claims or registry data together or alone to obtain immunization records for the entire eligible population (all adolescents who turned age 13 during the reporting year) and report using the administrative specification.
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, seek any immunizations missing from claims or registry data from medical records.
- If immunization registry data are used to calculate this measure, select "Immunization Registry" as an Administrative data source in the Data Source section of the web-based reporting system. States can select "Immunization Registry" in addition to other data sources used to calculate the measure. If use of immunization registry data varies by reporting unit, describe the data source used by each reporting unit in the "Additional Notes/Comments on Measure" section.
- This measure adheres to the HEDIS 14-Day Rule. The 14-Day Rule specifies that vaccinations must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Include all paid, suspended, pending, and denied claims.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CVX, HCPCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[1] Adapted with financial support from the Centers for Disease Control & Prevention (CDC).

[2] The Immunizations for Adolescents (IMA) Measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Child Core Set reporting.

B. ELIGIBLE POPULATION

Age	Adolescents who turn age 13 during the measurement year.
Continuous enrollment	12 months prior to the beneficiary's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months (60 days) is not continuously enrolled).
Anchor date	Enrolled on the beneficiary's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Meningococcal Serogroups A, C, W, Y

Either of the following meets criteria:

- At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set), with a date of service on or between the adolescent's 11th and 13th birthdays.
- Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the child's 13th birthday

Tdap

Any of the following meet criteria:

- At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine (Tdap Immunization Value Set; Tdap Vaccine Procedure Value Set), with a date of service on or between the adolescent's 10th and 13th birthdays.
- Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the child's 13th birthday
- Encephalitis due to the tetanus, diphtheria or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) on or before the child's 13th birthday

HPV

Any of the following meet criteria:

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), on or between the child's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.
- At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the adolescent's 9th and 13th birthdays
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the child's 13th birthday

Combination 1 (Meningococcal, Tdap)

Adolescents who are numerator compliant for both the meningococcal and Tdap indicators.

Combination 2 (Meningococcal, Tdap, HPV)

Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

For meningococcal and HPV, count either of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine

For Tdap, count any of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine
- Encephalitis due to the vaccine

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

For immunization information obtained from the medical record, count adolescents where there is evidence that the antigen was rendered from either of the following:

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered

For documented history of anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the child's 13th birthday.

For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

For meningococcal, do not count meningococcal recombinant (serogroup B) (MenB) vaccines. However, immunizations documented under a generic header of "meningococcal" and generic documentation that the "meningococcal vaccine", "meningococcal conjugate vaccine" or "meningococcal polysaccharide vaccine" were administered meet criteria.

Immunizations documented using a generic header or "Tdap/Td" can be counted as evidence of Tdap. The burden on states to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

E. ADDITIONAL NOTES

To align with Advisory Committee on Immunization Practices (ACIP) recommendations, only the quadrivalent meningococcal vaccine (serogroups A, C, W and Y) is included in the measure.

To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).

MEASURE LBW-CH: LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS

Centers for Disease Control and Prevention / National Center for Health Statistics

A. DESCRIPTION

Percentage of live births that weighed less than 2,500 grams at birth during the measurement year.

Note: A lower rate indicates better performance.

Data Collection Method: State Vital Records submitted to the National Center for Health Statistics (NCHS) National Vital Statistics System, Natality.

Guidance for Reporting:

- To reduce state burden and streamline reporting, CMS will calculate this measure for states using state natality data obtained through the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). **States are not asked to report data for this measure for FFY 2024 Core Set reporting.**
- The most recent NCHS natality data for each state are available at: http://wonder.cdc.gov/natality-expanded-current.html.
- The measurement period for this measure is the calendar year before the Child Core Set reporting year. For example, calendar year 2023 data should be used for the FFY 2024 reporting year.
- Eligibility for this measure is based on deliveries that have Medicaid as principal source of payment for delivery as indicated on the birth certificate. For more information on the principal source of payment field see "21. Principal source of payment" in NCHS's Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

B. ADMINISTRATIVE SPECIFICATION

Denominator

The number of resident live births in the state in the reporting period with Medicaid as the principal source of payment for the delivery.

The following four principal sources of payment for the delivery are available in all states' birth certificates: (1) Private insurance, (2) Medicaid (or a comparable state program), (3) Self-pay, or (4) Other. More detailed information for the "other" category is available for 34 states and the District of Columbia. In some states, deliveries covered by CHIP may be included in the "Medicaid" category. For more information on the principal source of payment field see "21. Principal source of payment" in NCHS's Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

Numerator

The number of resident live births in the state in the reporting period weighing less than 2,500 grams at birth with Medicaid as the principal source of payment for the delivery.

Units

Report as a percentage.

C. EXCLUSIONS

Exclude resident live births from both the denominator and numerator with a birth weight that is “Unknown or Not Stated.”

MEASURE LRCD-CH: LOW-RISK CESAREAN DELIVERY

Centers for Disease Control and Prevention /National Center for Health Statistics

A. DESCRIPTION

Percentage of nulliparous (first birth), term (37 or more completed weeks based on the obstetric estimate), singleton (one fetus), in a cephalic presentation (head-first) births delivered by cesarean during the measurement year.

Note: A lower rate indicates better performance.

Data Collection Method: State Vital Records submitted to the NCHS National Vital Statistics System, Natality.

Guidance for Reporting:

- To reduce state burden and streamline reporting, CMS will calculate this measure for states using state natality data obtained through the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). **States are not asked to report data for this measure for FFY 2024 Core Set reporting.**
- The most recent NCHS natality data for each state are available at: http://wonder.cdc.gov/natality-expanded-current.html.
- The measurement period for this measure is the calendar year before the Child Core Set reporting year. For example, calendar year 2023 data will be used for the FFY 2024 reporting year.
- Eligibility for this measure is based on deliveries that have Medicaid as the principal source of payment for the delivery as indicated on the birth certificate. For more information on the principal source of payment field see "21. Principal source of payment" in NCHS's Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

B. DEFINITIONS

Cephalic	Presenting part of the fetus listed as vertex, occiput anterior (OA), or occiput posterior (OP).
Cesarean delivery	Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.
Nulliparous	The birth is a first live birth (Live Birth Order is "1").
Principle source of payment for the delivery	The following four principal sources of payment are available in all states' birth certificates: (1) Private insurance, (2) Medicaid (or a comparable state program), (3) Self-pay, or (4) Other. More detailed information for the "other" category is available for 34 states and the District of Columbia. In some states, deliveries covered by CHIP may be included in the "Medicaid" category. For more information on the principal source of payment field see "21. Principal source of payment" in NCHS's Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

Singleton	Plurality is “Single.”
Term	Term is 37 or more completed weeks based on the obstetric estimate.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The number of resident live births in the state in the reporting period with Medicaid as the principal source of payment for the delivery. All of the following additional criteria must be met:

- The birth is a first live birth (Live Birth Order is “1”)
- Fetal Presentation is “Cephalic”
- The obstetric estimate of gestational age (OE Gestational Age Recode) is greater than or equal to 37 weeks
- Plurality is “Single”

The following four principal sources of payment for the delivery are available in all states’ birth certificates: (1) Private insurance, (2) Medicaid (or a comparable state program), (3) Self-pay, or (4) Other. More detailed information for the “other” category is available for 34 states and the District of Columbia. In some states, deliveries covered by CHIP may be included in the “Medicaid” category. For more information on the principal source of payment field see “21. Principal source of payment“ in NCHS’s Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

Numerator

The number of resident live births in the state in the reporting period with Medicaid as the principal source of payment for the delivery. All of the following additional criteria must be met:

- The birth is a first live birth (Live Birth Order is “1”)
- Fetal Presentation is “Cephalic”
- The obstetric estimate of gestational age (OE Gestational Age Recode) is greater than or equal to 37 weeks
- Plurality is “Single”
- Delivery Method of “Cesarean” on the birth certificate

Units

Report as a percentage.

D. EXCLUSIONS

Exclude resident live births from both the denominator and numerator that meet any of the following criteria:

- Births to women with previous live births or unknown parity (live birth order >1 or "Unknown or Not Stated")
- Delivery method is "Unknown or Not Stated"
- Multiple gestations (plurality equal to "Twin," "Triplet," "Quadruplet," or "Quintuplet or higher")
- Other or unknown presentations (fetal presentation equal to "Breech," "Other," "Unknown or Not Stated," or "Not Reported")
- Gestational age <37 weeks or "Unknown or Not Stated"

MEASURE LSC-CH: LEAD SCREENING IN CHILDREN

National Committee for Quality Assurance

A. 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.

Data Collection Method: Administrative, Hybrid

Guidance for Reporting:
• Include all paid, suspended, pending, and denied claims.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, LOINC, SNOMED, and UB.

B. ELIGIBLE POPULATION

Age	Children who turn 2 years old during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Enrolled on the child's second birthday.
Benefits	Medical.
Event/diagnosis	None.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

States that use the Hybrid Method to report the Childhood Immunization Status (CIS-CH) and Lead Screening and Children (LSC-CH) measures may use the same sample for both measures. Because required exclusions are applied to the CIS-CH measure, if the state uses the CIS-CH systematic sample, the same children will be excluded from the LSC-CH measure. Excluding these children will not create a statistically significant difference in the LSC-CH eligible population.

States may reduce the sample size based on the current year's administrative rate or prior year's rate for the lowest rate of all CIS-CH antigen, CIS-CH combinations, and LSC-CH rate.

If a separate sample from the CIS-CH measure is used for LSC-CH, states may reduce the sample based on the current measurement year's administrative rate or the prior year's rate for LSC-CH.

Numerator

At least one lead capillary or venous blood test on or before the child's second birthday as documented through either administrative data or medical record review.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Documentation in the medical record must include both of the following:

- A note indicating the date the test was performed
- The result or finding

MEASURE OEV-CH: ORAL EVALUATION, DENTAL SERVICES

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- Children enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for this measure.
- For FFY 2024 Child Core Set reporting, the following rate is required: Total ages <1 to 20.
- Include all paid, suspended, pending, and denied claims.

This measure includes the following coding systems: CDT and NUCC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children who are under age 21 as of December 31 of the measurement year. Report 9 age stratifications (optional for FFY 2024) and a total rate (required for FFY 2024): • Age <1. • Ages 1 to 2. • Ages 3 to 5. • Ages 6 to 7. • Ages 8 to 9. • Ages 10 to 11. • Ages 12 to 14. • Ages 15 to 18. • Ages 19 to 20. • Total ages <1 to 20.
Continuous enrollment	180 days during measurement year.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The unduplicated number of enrolled children who received a comprehensive or periodic oral evaluation as a dental service during the measurement year.

Check if beneficiary received an oral evaluation as a dental service.

- [CDT CODE] = D0120 or D0150 or D0145, AND
- [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table OEV-A below[1]

If both of these criteria are met, include in the numerator and continue to the next step.

Note: In this step, all claims with missing or invalid CDT Code, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table OEV-A will not be counted in the numerator.

Exclusions

None.

Table OEV-A. NUCC maintained Provider Taxonomy Codes classified as "Dental Service"*

122300000X	1223P0106X	1223X0008X	125Q00000X	126800000X
1223D0001X	1223P0221X	1223X0400X	261QF0400X	261QD0000X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X	204E00000X
1223E0200X	1223P0700X	125J00000X	1223X2210X	261QS0112X
1223G0001X	1223S0112X	125K00000X	122400000X	

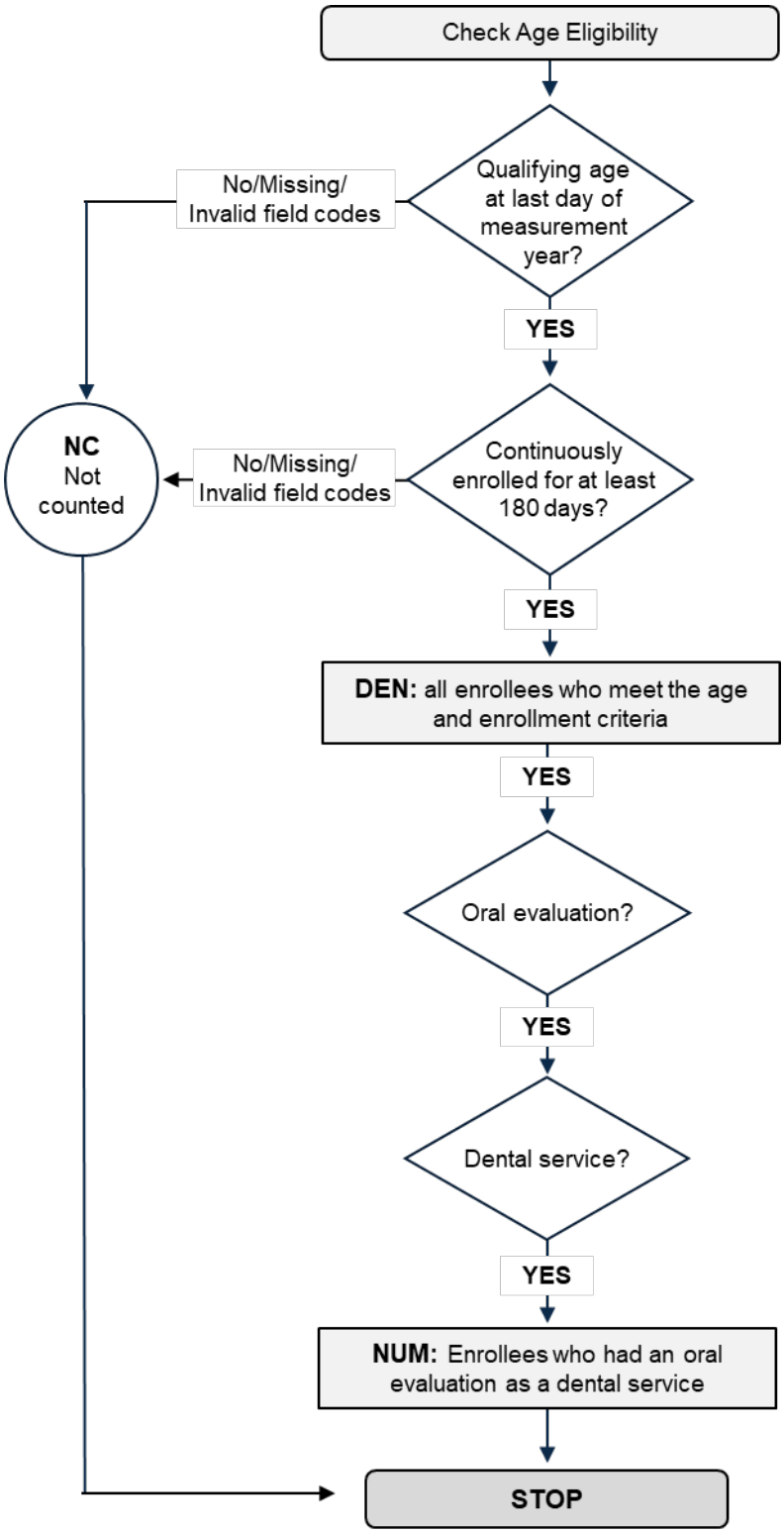
* Services provided by County Health Department dental clinics may also be included as "dental" services.

+ Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services. Services provided by independently practicing dental hygienists should be classified as "oral health" services and are not applicable for this measure.

[1] Identifying "dental" services: Programs and plans that do not use standard NUCC maintained provider taxonomy codes should use valid mapping to identify providers whose services will be categorized as "dental" services. In the case of stand-alone dental plans that reimburse ONLY for services rendered by or under the supervision of the dentist, states should consider all claims as "dental" services.

Figure OEV-A provides a flowchart for implementing these exclusion and inclusion criteria.

Figure OEV-A. Measure Flowchart



D. ADDITIONAL NOTES

More information on the rationale for and implementation of this measure is provided in the DQA Measures User Guide, available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024_dqa_pediatric_measures_user_guide.pdf?rev=6b5c35f29335439db82a245583400ca3&hash=8D43A8DE44A5E0555440407A6287DD9A.

Data quality considerations:

Reliability of the measure score depends on the quality of the data elements that are used to calculate the measure. The percentages of missing and invalid data for each data element used to calculate the measure must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, beneficiaries who have records with missing or invalid CDT CODE may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low-quality data set will result in a measure score that will not be reliable.

MEASURE PPC2-CH: PRENATAL AND POSTPARTUM CARE: UNDER AGE 21

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these beneficiaries, the measure assesses the following facets of prenatal and postpartum care.

- Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.
- Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- For the purpose of Child Core Set reporting, both the Timeliness of Prenatal Care and the Postpartum Care rates are reported for beneficiaries under age 21 as of the delivery date. The Adult Core Set measure is reported for beneficiaries age 21 and older as of the delivery date.
- States that use the hybrid methodology will need to draw separate samples by age, in order to submit results for the Child Core Set (under age 21) and Adult Core Set (age 21 and over).
- States may use vital records as an alternative data source for the prenatal care rate if they have confidence in the completeness and accuracy of these data. States can use Medicaid and CHIP administrative data to determine the measure-eligible population (including the requirement of continuous eligibility from 43 days before delivery through 56 days after delivery) and then link the Medicaid and CHIP records to vital records data to identify the information needed to calculate the numerator, including gestational age at delivery and the timing of these visits in relation to the gestational age. States using vital records should document this data source in the "Additional Notes/Comments on Measure" section. States should also provide information about the proportion of measure-eligible beneficiaries who were identified in Medicaid and CHIP administrative data but for whom a birth certificate could not be found in vital records data.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for definitions of a PCP, OB/GYN, and other prenatal care practitioners.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

First trimester	280–176 days prior to delivery (or estimated delivery date [EDD]).

C. ELIGIBLE POPULATION

Age	Under age 21 as of the date of delivery.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include beneficiaries who delivered in any setting. Multiple births. Beneficiaries who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Beneficiaries who had multiple live births during one pregnancy count once. Follow the steps below to identify the eligible population, which is the denominator for both rates. Step 1 Identify deliveries. Identify all beneficiaries with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge. Step 2 Remove non-live births (Non-live Births Value Set). Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Timeliness of Prenatal Care

A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance.

Step 1

Identify beneficiaries who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

These beneficiaries must have a prenatal visit during the first trimester.

Step 2

Identify beneficiaries who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery.

These beneficiaries must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after their enrollment start date.

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the beneficiary's enrollment start date during the pregnancy meet criteria.

Step 3

Identify prenatal visits that occurred during the required timeframe (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- A bundled service (Prenatal Bundled Services Value Set) where the state can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated)
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set)
- A prenatal visit (Prenatal Visits Value Set; Telephone Visits Value Set; Online Assessments Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set)

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria.

- A postpartum visit (Postpartum Visits Value Set)
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set)
- A bundled service (Postpartum Bundled Services Value Set) where the state can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered)

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Note: The practitioner requirement only applies to the Hybrid Specification. The state is not required to identify practitioner type in administrative data.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

Timeliness of Prenatal Care

A prenatal visit during the required timeframe. Refer to the Administrative Specification to identify the required timeframe for each beneficiary based on the date of enrollment and the gaps in enrollment during the pregnancy.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:

- Documentation indicating the beneficiary is pregnant or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, or
  - Documentation of last menstrual period (LMP), EDD, or gestational age, or
  - A positive pregnancy test result, or
  - Documentation of gravidity and parity, or
  - Documentation of complete obstetrical history, or
  - Documentation of prenatal risk assessment and counseling/education
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used)

- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or
  - TORCH antibody panel alone, or
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
  - Ultrasound of a pregnant uterus

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Postpartum visit to an OB/GYN or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following.

- Pelvic exam
- Evaluation of weight, BP, breasts and abdomen
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component
- Notation of postpartum care, including, but not limited to:
  - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check”
  - A preprinted “Postpartum Care” form in which information was documented during the visit
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
- Glucose screening for beneficiaries with gestational diabetes
- Documentation of any of the following topics:
  - Infant care or breastfeeding
  - Resumption of intercourse, birth spacing or family planning
  - Sleep/fatigue
  - Resumption of physical activity
  - Attainment of healthy weight

F. ADDITIONAL NOTES

- Criteria for identifying prenatal care for beneficiaries who were not enrolled during the first trimester allow more flexibility than criteria for beneficiaries who were enrolled.
  - For beneficiaries who were enrolled at least 219 days before delivery, the state has sufficient opportunity to provide prenatal care by the end of the first trimester.
  - For beneficiaries who were not enrolled at least 219 days before delivery, the state has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for the measure.
- For each beneficiary, the state must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the state must define a method to determine which EDD to use, and use that date consistently. If the state elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the beneficiary is removed as a valid data error and replaced by the next beneficiary of the oversample. The LMP may not be used to determine the first trimester.
- The state may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.
- A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.
- The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.
- The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.
- For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit, or virtual check-in are eligible for use in reporting.

MEASURE SFM-CH: SEALANT RECEIPT ON PERMANENT FIRST MOLARS

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled children who have ever received sealants on permanent first molar teeth: (1) at least one sealant and (2) all four molars sealed by the 10th birthdate.

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- States should use a 48-month look-back period when calculating the numerator. Enrollment in prior years is not required. States that do not have 48 months of lookback data should note this as a data limitation when reporting.
- Sealants received on the 10th birthdate are not included in the numerator.
- Sealants received prior to 48 months before the 10th birthday are not included in the numerator.
- Children enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for this measure.
- Include all paid, suspended, pending, and denied claims.

This measure includes the following coding system: CDT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children who turn age 10 in the measurement year.
Continuous enrollment	12 months prior to the child's 10th birthdate.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly the child may not have more than a 1-month gap in coverage.
Anchor date	Enrolled on the 10th birthdate.
Benefit	Dental.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator for Rate 1 (At Least One Sealant)

The unduplicated number of enrolled children who ever received a sealant on at least one permanent first molar tooth.

To calculate the number of beneficiaries who have ever received a sealant on at least one permanent first molar in the 48 months prior to the 10th birthdate, check for the following criteria:

- [CDT CODE] = D1351 in the 48 months prior to the 10th birthdate, AND
- [TOOTH-NUMBER] = 3 OR 14 OR 19 OR 30, using the Universal Numbering System.

If these criteria are met, include in numerator 1 and continue to the next step.

Numerator for Rate 2 (All Four Molars Sealed)

The unduplicated number of enrolled children who have received sealants on all four permanent first molars.

To calculate the number of beneficiaries who have received sealants on ALL FOUR permanent first molars in the 48 months prior to the 10th birthdate, check for the following criteria:

- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 3, using the Universal Numbering System, in the 48 months prior to the 10th birthdate, AND
- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 14, using the Universal Numbering System, in the 48 months prior to the 10th birthdate, AND
- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 19, using the Universal Numbering System, in the 48 months prior to the 10th birthdate, AND
- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 30, using the Universal Numbering System, in the 48 months prior to the 10th birthdate.

If these criteria are met, include in Numerator 2.

Exclusions

Exclude children from the denominator and numerator who have received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on all four permanent first molars in the 48 months prior to the 10th birthdate.

To determine exclusions, check if the beneficiary meets any of the following criteria for all four permanent molars (tooth numbers 14, 3, 19 and 30):

TOOTH NUMBER 14

On permanent first molar maxillary left [TOOTH NUMBER=14 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6793]

AND

TOOTH NUMBER 3

On permanent first molar maxillary right [TOOTH NUMBER=3 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6793]

AND

TOOTH NUMBER 19

On permanent first molar mandibular left [TOOTH NUMBER=19 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

[1] All surface combinations including the occlusal surface “O” should be included irrespective of the position of the “O.”

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6793]

AND

TOOTH NUMBER 30

On permanent first molar mandibular right [TOOTH NUMBER=30 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

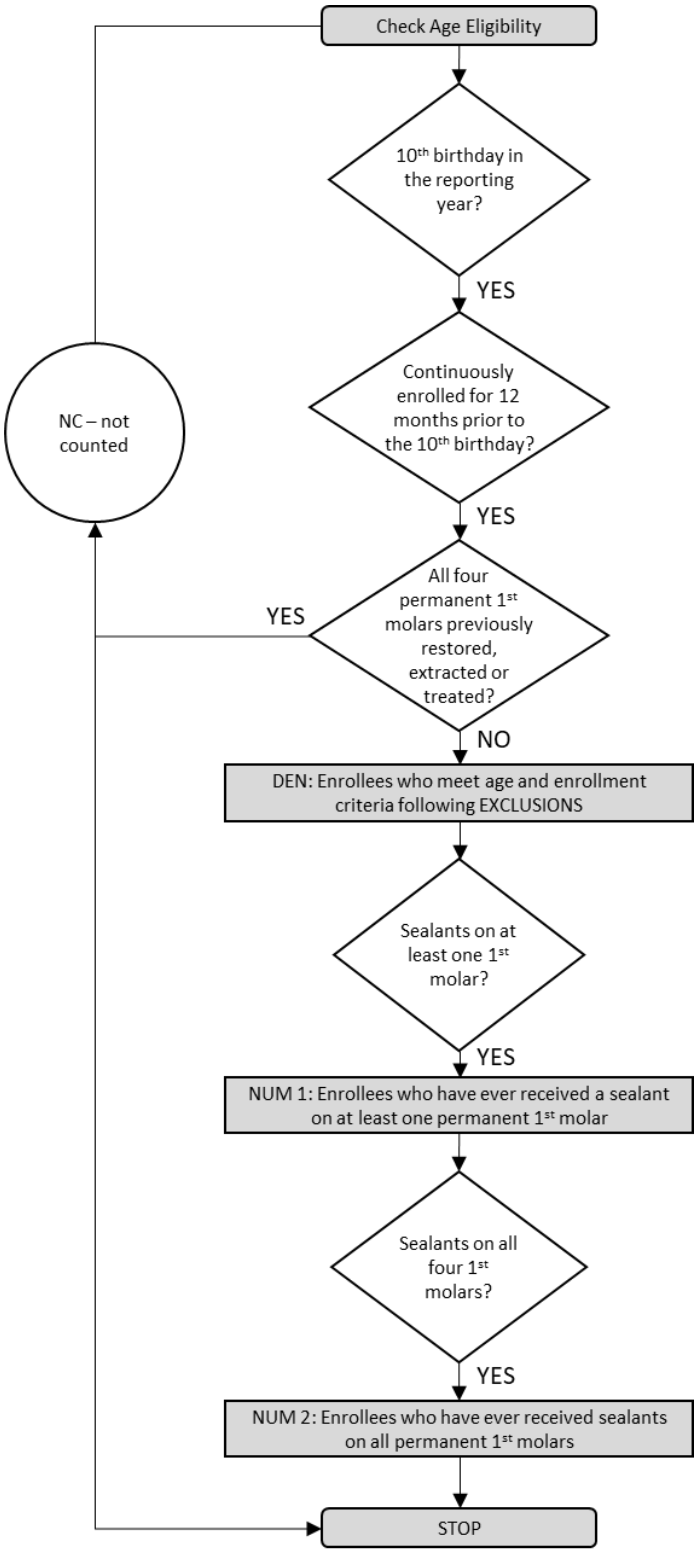
Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6793]

Figure SFM-A provides a flowchart for implementing these exclusion and inclusion criteria.

Figure SFM-A. Measure Flowchart



D. ADDITIONAL NOTES

More information on the rationale for and implementation of this measure is provided in the DQA Measures User Guide, available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024_dqa_pediatric_measures_user_guide.pdf?rev=6b5c35f29335439db82a245583400ca3&hash=8D43A8DE44A5E0555440407A6287DD9A.

Impact of exclusions on the measure rates:

Consideration should be given to evaluation of the impact of exclusions on the measure rates, particularly when using the measure to compare rates between reporting entities. Such consideration may assist in allowing users to understand the impact of access or other factors on the measure rates and the potential for measurement bias.

Stratifying by caries risk:

The dental sealant measure previously included in the Child Core Set assessed receipt of dental sealants among children at elevated caries risk. If programs are interested in understanding the rate of sealant application by risk status, the measure denominator may be stratified by elevated risk for dental caries:

- Elevated risk
- Not at elevated risk

For details on the elevated risk methodology, please refer to the DQA Measures User Guide available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024_dqa_pediatric_measures_user_guide.pdf?rev=6b5c35f29335439db82a245583400ca3&hash=8D43A8DE44A5E0555440407A6287DD9A.

Data quality considerations:

Reliability of the measure score depends on the quality of the data elements used to calculate the measure. The percentages of missing and invalid data for each data element must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, beneficiaries who have records with missing or invalid TOOTH-NUMBER CODE may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low-quality data set will result in a measure score that will not be reliable.

Measure Limitations Due to Limitations of Administrative Data:

1. Claims data cannot identify (a) teeth with active decay, (b) sealants not billed to the program/plan, or (c) treatment (e.g., restorations/extractions) not billed to the program/plan, thus impacting the precision of both the numerator and denominator.
2. Comparisons would be biased if programs being compared have significant differences in enrollment duration resulting in differences in the availability of complete treatment history for beneficiaries, which reduces the ability to consistently identify children to be included in the numerator or excluded from the denominator. However, this is not unique to dental measures.

3. The 12-month enrollment criterion, with the allowed single gap in coverage, may result in a significantly reduced population that is eligible for inclusion in the denominator in programs with shorter enrollment durations (greater “churn”) and, therefore, may be less representative of the population that is the focus of measurement.

MEASURE TFL-CH: PREVENTION: TOPICAL FLUORIDE FOR CHILDREN

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- Children enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for this measure.
- For FFY 2024 Child Core Set reporting, the following three rates are required: (1) Dental or oral health services: Total ages 1 through 20; (2) Dental services: Total ages 1 through 20; and (3) Oral health services: Total ages 1 through 20.
- Include all paid, suspended, pending, and denied claims.
- Numerator 1 is not the sum of numerators 2 and 3:
  - There could be instances where a child is eligible to be included in numerator 1 but not in numerator 2 or 3 (for example, if the child received two topical fluoride applications, one as a dental service and another as an oral health service).
  - There could also be instances where a child is eligible to be included in both numerators 2 and 3 (for example, if the child received two topical fluoride applications as a dental service and two topical fluoride applications as an oral health service).

This measure includes the following coding systems: CDT, CPT, and NUCC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children ages 1 through 20 as of December 31 of the measurement year. Report 8 age stratifications (optional for FFY 2024) and a total rate (required for FFY 2024): • Ages 1 to 2. • Ages 3 to 5. • Ages 6 to 7. • Ages 8 to 9. • Ages 10 to 11. • Ages 12 to 14. • Ages 15 to 18. • Ages 19 to 20. • Total ages 1 through 20.

Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 31 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly the child may not have more than a single 1-month gap in coverage.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator for Rate 1 (Dental or oral health services)

The unduplicated number of enrolled children who received at least two fluoride applications as dental or oral health services during the measurement year, where there were at least two unique dates of service when topical fluoride was provided. Services provided on each date should satisfy the following criteria:

- [SERVICE CODE] = CDT D1206 or CDT D1208 or CPT 99188

If these criteria are met, include in Numerator 1 and continue to the next step.

Note 1: No more than one fluoride application can be counted for the same beneficiary on the same date of service.

Note 2: In this step, all claims with missing or invalid SERVICE CODE should be excluded.

Numerator for Rate 2 (Dental services)

The unduplicated number of enrolled children who received at least two fluoride applications as dental services during the measurement year, where there were at least two unique dates of service when topical fluoride was provided. Service provided on each date should satisfy the following criteria:

- [SERVICE CODE] = CDT D1206 or D1208 AND
- [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table TFL-A below[1]

If these criteria are met, include in Numerator 2 and continue to the next step.

[1] Identifying “dental” services: Programs and plans that do not use standard NUCC maintained provider taxonomy codes should use valid mapping to identify providers whose services will be categorized as “dental” services. In the case of stand-alone dental plans that reimburse ONLY for services rendered by or under the supervision of the dentist, states should consider all claims as “dental” services.

Note 1: No more than one fluoride application can be counted for the same beneficiary on the same date of service.

Note 2: In this step, all claims with missing or invalid SERVICE CODE or with missing or invalid NUCC maintained Provider Taxonomy Codes should be excluded.

Numerator for Rate 3 (Oral health services)

The unduplicated number of enrolled children who received at least two fluoride applications as oral health services during the measurement year, where there were at least two unique dates of service when topical fluoride was provided. Services provided on each date should satisfy the following criteria:

- [SERVICE CODE] = CDT D1206 or CDT D1208 or CPT 99188 AND
- [RENDERING PROVIDER TAXONOMY] code is a valid NUCC maintained Provider Taxonomy code but NOT included in the NUCC maintained Provider Taxonomy Codes in Table TFL-A below

If these criteria are met, include in Numerator 3.

Note 1: No more than one fluoride application can be counted for the same member on the same date of service.

Note 2: In this step, all claims with missing or invalid SERVICE CODE or with missing or invalid NUCC maintained Provider Taxonomy Codes should be excluded.

Exclusions

None.

Table TFL-A. NUCC maintained Provider Taxonomy Codes classified as "Dental Service"*

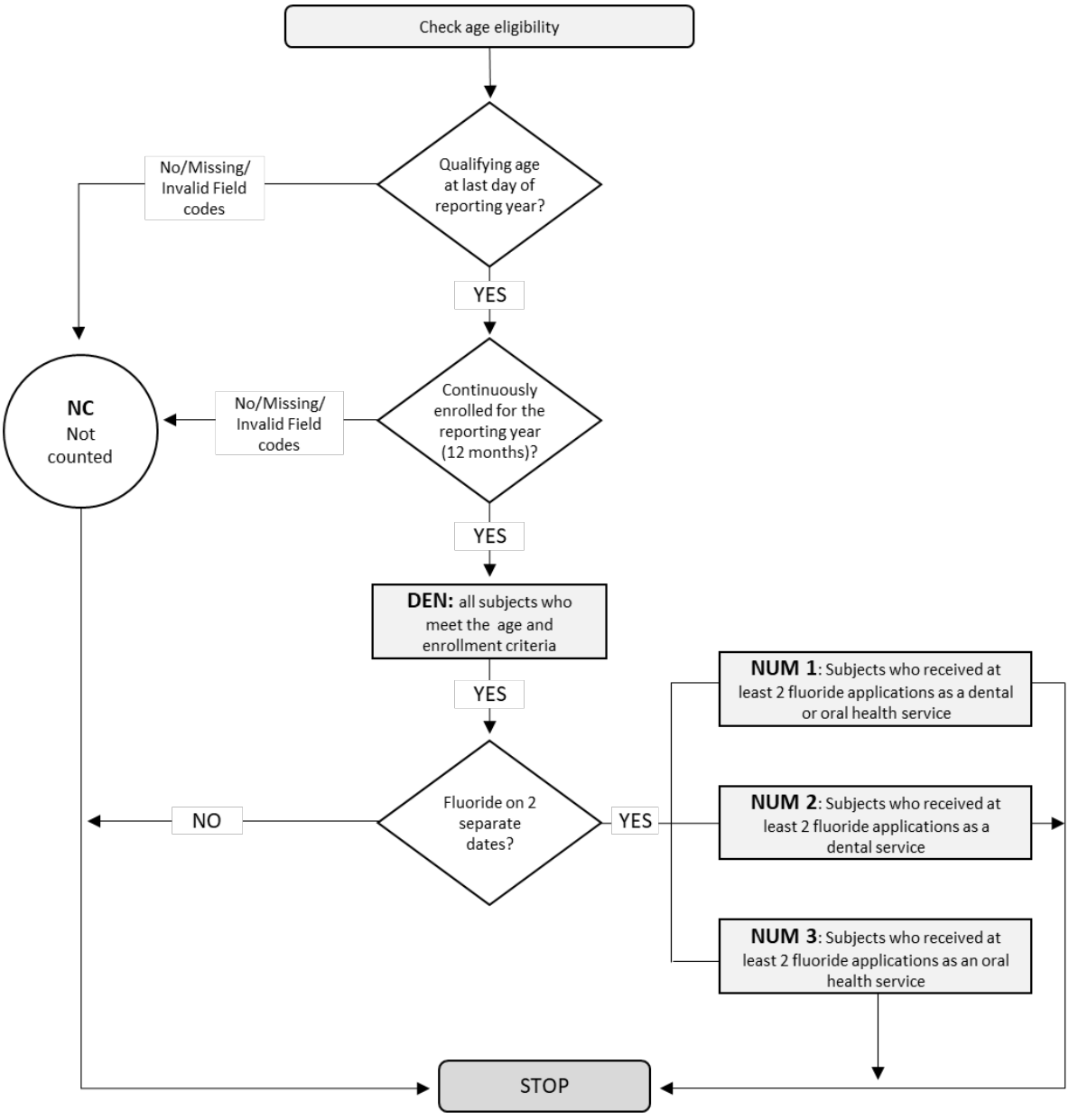
122300000X	1223P0106X	1223X0008X	125Q00000X	126800000X
1223D0001X	1223P0221X	1223X0400X	261QF0400X	261QD0000X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X	204E00000X
1223E0200X	1223P0700X	125J00000X	1223X2210X	261QS0112X
1223G0001X	1223S0112X	125K00000X	122400000X	

* Services provided by County Health Department dental clinics may also be included as "dental" services.

+ Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services. Services provided by independently practicing dental hygienists should be classified as "oral health" services and are not applicable for this measure.

Figure TFL-A provides a flowchart for implementing these exclusion and inclusion criteria.

Figure TFL-A. Measure Flowchart



D. ADDITIONAL NOTES

More information on the rationale for and implementation of this measure is provided in the DQA Measures User Guide, available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024_dqa_pediatric_measures_user_guide.pdf?rev=6b5c35f29335439db82a245583400ca3&hash=8D43A8DE44A5E0555440407A6287DD9A.

Data quality considerations:

Reliability of the measure score depends on the quality of the data elements that are used to calculate the measure. The percentages of missing and invalid data for each data element must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, beneficiaries who have records with missing or invalid SERVICE CODE to identify topical fluoride may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low-quality data set will result in a measure score that will not be reliable.

Measure Limitations:

This measure assumes that all modes of topical fluoride application are equally effective. This measure calls for the documentation of at least two instances (on different dates of service) of any combination of two fluoride specific CDT codes, D1206 and D1208 (or equivalent CPT codes when billed by non-dental providers). D1206 refers to professionally applied fluoride varnish and D1208 is any topical application of fluoride including fluoride gels or fluoride foams (excluding fluoride varnish).

This measure does not take into account alternate home-use fluoride products including supplements.

MEASURE W30-CH: WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children who had the following number of well-child visits with a primary care practitioner (PCP) during the last 15 months. The following rates are reported:

- Well-Child Visits in the First 15 Months. Children who turned age 15 months during the measurement year: Six or more well-child visits.
- Well-Child Visits for Age 15 Months–30 Months. Children who turned age 30 months during the measurement year: Two or more well-child visits.

Data Collection Method: Administrative

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- This measure adheres to the HEDIS 14-Day Rule. The 14-Day Rule specifies that well-child visits must occur 14 days apart to avoid double counting events when calculating the numerator. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Refer to Appendix C for the definition of a PCP.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Eligible Population: Rate 1 – Well-Child Visits in the First 15 Months

Ages	Children who turn age 15 months during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.
Continuous enrollment	31 days – age 15 months. Calculate 31 days of age by adding 31 days to the date of birth.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns age 15 months.
Benefit	Medical.
Event/diagnosis	None.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

Eligible Population: Rate 2 – Well-Child Visits for Age 15 Months–30 Months

Ages	Children who turn age 30 months during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	The date when the child turns age 30 months.
Benefit	Medical.
Event/diagnosis	None.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Rate 1 – Well-Child Visits in the First 15 Months

Denominator

The Rate 1 eligible population.

Numerator

Six or more well-child visits (Well-Care Value Set) on different dates of service on or before the 15-month birthday.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Rate 2 – Well-Child Visits for Age 15 Months–30 Months

Denominator

The Rate 2 eligible population.

Numerator

Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

D. ADDITIONAL NOTES

This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/).

MEASURE WCC-CH: WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year:

- Body mass index (BMI) Percentile documentation*
- Counseling for Nutrition
- Counseling for Physical Activity

* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- This measure applies to beneficiaries ages 3 to 17. For the purpose of Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate for each of the three indicators: ages 3 to 11, ages 12 to 17, and total (ages 3 to 17).
- The eligible population (denominator) for this measure includes children ages 3 to 17 who have an outpatient visit and meet the continuous enrollment criteria.
- A BMI percentile is included in the numerator count if the specified documentation is present, regardless of the primary intent of the visit. A BMI without a percentile is not acceptable for inclusion in the numerator count.
- The height, weight, and BMI must be from the same data source.
- The height and weight measurement should be taken during the measurement year.
- If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year.
- Include all paid, suspended, pending, and denied claims.
- The electronic specification for FFY 2024 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2023/cms155v11. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system.
- Refer to Appendix C for definitions of a PCP and OB/GYN and other prenatal care practitioner.

This measure’s Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, LOINC, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

BMI percentile	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

C. ELIGIBLE POPULATION

Ages	Ages 3 to 17 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Beneficiaries who have a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. • Beneficiaries in hospice or using hospice services any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

BMI Percentile

BMI percentile (BMI Percentile Value Set) during the measurement year.

Counseling for Nutrition

Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.

Counseling for Physical Activity

Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population for the Total age band (ages 3 to 17). The Total sample is stratified by age to report rates for the ages 3 to 11 and ages 12 to 17 age stratifications. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

BMI Percentile

BMI percentile during the measurement year as identified by administrative data or medical record review.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Documentation must include height, weight, and BMI percentile during the measurement year. The height, weight, and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile documented as a value (e.g., 85th percentile)
- BMI percentile plotted on age-growth chart

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

Beneficiary-reported services and biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner (refer to Appendix C for the definition of “PCP”) or specialist, if the specialist is providing a primary care service related to the condition being assessed, while taking a patient's history. The information must be recorded, dated, and maintained in the beneficiary's legal health record.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99 percent or <1 percent meets criteria because a distinct BMI percentile is evident (e.g., 100 percent or 0 percent).

Counseling for Nutrition

Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
- Checklist indicating nutrition was addressed
- Counseling or referral for nutrition education
- Beneficiary received education materials on nutrition during a face-to-face visit
- Anticipatory guidance for nutrition
- Weight or obesity counseling

Counseling for Physical Activity

Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating physical activity was addressed
- Counseling or referral for physical activity
- Beneficiary received educational materials on physical activity during a face-to-face visit
- Anticipatory guidance specific to the child's physical activity
- Weight or obesity counseling

F. ADDITIONAL NOTES

- The following notations or examples of documentation do not count as numerator compliant:
  - BMI Percentile
    - No BMI percentile documented in medical record or plotted on age-growth chart
    - Notation of BMI value only
    - Notation of height and weight only

  - Nutrition
    - No counseling/education on nutrition and diet
    - Counseling/education before or after the measurement year
    - Notation of “health education” or “anticipatory guidance” without specific mention of nutrition
    - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition
    - Documentation related to a beneficiary’s “appetite” does not meet criteria
  - Physical Activity
    - No counseling/education on physical activity
    - Notation of “cleared for gym class” alone without documentation of a discussion
    - Counseling/education before or after the measurement year
    - Notation of “health education” or “anticipatory guidance” without specific mention of physical activity
    - Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations
    - Notation solely related to screen time (computer or television) without specific mention of physical activity
- Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.

  For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:
  - Notation that a beneficiary with chronic knee pain is able to run without limping
  - Notation that a beneficiary has exercise-induced asthma
  - Notation that a beneficiary with diarrhea is following the BRAT diet
  - Notation that a beneficiary has decreased appetite as a result of an acute or chronic condition
- Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.
- Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.
- The BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity indicators do not require a specific setting. Therefore, services rendered during a telephone visit, e-visit, or virtual check-in meet criteria.

MEASURE WCV-CH: CHILD AND ADOLESCENT WELL-CARE VISITS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries ages 3 to 21. For the purpose of Child Core Set reporting, states should calculate and report rates for three age groups and a total rate: ages 3 to 11, 12 to 17, 18 to 21, and total (ages 3 to 21).
- This measure is calculated using administrative data only.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of a PCP and OB/GYN and other prenatal care practitioner.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 3 to 21 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

One or more well-care visits (Well-Care Value Set) during the measurement year. The well-care visit must occur with a PCP or an OB/GYN, but the practitioner does not have to be the practitioner assigned to the child.

D. ADDITIONAL NOTES

This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide).

Appendix A:
Child Core Set
HEDIS® Value Set Directory
User Manual

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A. What is the HEDIS Child Core Set Value Set Directory?

Measure specifications for HEDIS® measures in the Child Core Set reference value sets. A "value set" is the complete set of codes used to identify a service or condition included in a measure. The HEDIS Child Core Set Value Set Directory (VSD) includes all value sets and codes needed to report HEDIS measurement year 2023 measures included in the 2024 Child Core Set. This appendix describes how to use value sets in calculating HEDIS measures in the Child Core Set.

B. Structure of the Value Set Directory

The VSD (Excel workbook) contains the following spreadsheets:

- Copyright & Licensing
- Measures to Value Sets*
- Value Sets to Codes*
- Summary of Changes – Value Sets
- Summary of Changes – Codes
- Direct Reference Codes

* Elements are based on those included in the National Library of Medicine Value Set Authority Center (VSAC) standardized value set file. Not all elements are needed for Child Core Set reporting.

C. What's New in the Value Set Directory?

Direct Reference Codes (DRC) were added to the 2024 VSD. Also, refer to the Summary of Changes spreadsheets for changes to codes or value sets.

D. Child Measures to Value Sets

The Child Measures to Value Sets spreadsheet lists value sets by measure and includes the elements in Table A-1.

Table A-1. Child Measures to Value Sets

Element Name	Element Description
Measure ID	The measure abbreviation.
Measure Name	The measure name.
Value Set Name	The value set name.
Value Set OID	Unique identifier for the value set.

Use the Child Measures to Value Sets spreadsheet to identify all value sets used for a particular measure or to identify all measures that use a specific value set.

For example, setting the Measure ID filter to "WCC-CH" demonstrates that the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents measure uses the following value sets:

Measure ID	Measure Name	Value Set Name	Value Set OID
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	BMI Percentile	2.16.840.1.113883.3.464.1004.1038
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Nutrition Counseling	2.16.840.1.113883.3.464.1004.1190
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Outpatient	2.16.840.1.113883.3.464.1004.1202
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Physical Activity Counseling	2.16.840.1.113883.3.464.1004.1213
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Pregnancy	2.16.840.1.113883.3.464.1004.1219

Setting the Value Set Name filter to “Well-Care” identifies the two measures that use the value set:

Measure ID	Measure Name	Value Set Name	Value Set OID
W30-CH	Well-Child Visits in the First 30 Months of Life	Well Care	2.16.840.1.113883.3.464.1004.1262
WCV-CH	Child and Adolescent Well-Care Visits	Well Care	2.16.840.1.113883.3.464.1004.1262

E. Child Value Sets to Codes

The Child Value Sets to Codes spreadsheet lists the codes included in each value set and includes the elements in Table A-2.

Table A-2. Child Value Sets to Codes

Element Name	Element Description
Value Set Name	The value set name.
Value Set OID	Unique identifier for the value set.
Value Set Version	Version date for the value set (2023-10-27 for federal fiscal year 2024 reporting).
Code	The code.
Definition	The code definition. Note: The definition is not included for Uniform Bill, CPT, or the American Dental Association's Code on Dental Procedures and Nomenclature (CDT) codes due to licensing restrictions.
Code System	The code system for the code. Code systems are labeled as: • CPT: Current Procedural Terminology • CPT-CAT-II: Current Procedural Terminology Category II Codes • CVX: Vaccines Administered • HCPCS: Healthcare Common Procedure Coding System Level II • ICD10CM: International Classification of Diseases, 10th Revision, Clinical Modification (Diagnosis codes) • ICD10PCS: International Classification of Diseases, 10th Revision, Procedure Coding System (Procedure codes) • ICD9CM: International Classification of Diseases, 9th Revision, Clinical Modification (Diagnosis codes) • ICD9PCS: International Classification of Diseases, 9th Revision, Clinical Modification (Procedure codes) • LOINC: Logical Observation Identifiers Names and Codes • Modifier: Current Procedural Terminology and HCPCS Modifier Codes • POS: CMS Place of Service • SNOMED CT US Edition: Systematized Nomenclature of Medicine—Clinical Terms • UBREV: Uniform Bill (Revenue codes) • UBTOB: Uniform Bill (Type of Bill codes)
Code System OID	Unique identifier for the code system, if available.
Code System Version	Code system version tracking number, if available.

Use the Child Value Sets to Codes spreadsheet to identify all codes in a value set or to identify all value sets that use a particular code. For example, setting the Value Set Name filter to “Transitional Care Management Services” demonstrates that the following codes are included in the value set:

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Transitional Care Management Services	2.16.840.1.113883.3.464.1004.1462	2023-10-27	99495		CPT	2.16.840.1.113883.6.12	2023.1.22AA
Transitional Care Management Services	2.16.840.1.113883.3.464.1004.1462	2023-10-27	99496		CPT	2.16.840.1.113883.6.12	2023.1.22AA

Setting the Code filter to “O09.00” demonstrates that the code is included in the following value sets:

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Pregnancy	2.16.840.1.113883.3.464.1004.1219	2023-10-27	O09.00	[O09.00] Supervision of pregnancy with history of infertility, unspecified trimester	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA
Pregnancy Diagnosis	2.16.840.1.113883.3.464.1004.1220	2023-10-27	O09.00	[O09.00] Supervision of pregnancy with history of infertility, unspecified trimester	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA

F. Summary of Changes – Codes

The Summary of Changes – Codes spreadsheet lists code changes in FFY 2024 by value set and includes the elements in Table A-3.

Table A-3. Summary of Changes – Codes

Element Name	Element Description
Value Set	The name of the value set affected by the change.
Change	The change (Added; Deleted).
Code System	The code system for the code.
Code	The code.

Use the Summary of Changes – Codes spreadsheet to identify codes added to or deleted from a value set. For example, setting the Value Set Name filter to "Acute Inpatient" demonstrates added codes:

Value Set	Change	Code System	Code
Acute Inpatient	Added	CPT	99234
Acute Inpatient	Added	CPT	99235
Acute Inpatient	Added	CPT	99236

Codes for new value sets are not listed individually (as Added) in the Summary of Changes – Codes spreadsheet.

Codes for deleted value sets are not listed individually (as Deleted) in the Summary of Changes – Codes spreadsheet.

New and deleted value sets are listed in the Summary of Changes – Value Sets spreadsheet.

G. Summary of Changes – Value Sets

The Summary of Changes – Value Sets spreadsheet lists the FFY 2024 changes to value sets and includes the elements in Table A-4.

Use the Summary of Changes – Value Sets spreadsheet to identify revised, added, or deleted value sets

Table A-4. Summary of Changes – Value Sets

Element Name	Element Description
Value Set Name	The name of the affected value set.
Change	The change (Added; Deleted; Revised).
Description	Describes the affected measures or, for renamed value sets, the new value set name.

For example, the following shows an excerpt for the FUA-CH measure:

Value Set Name	Change	Description
Residential Behavioral Health Treatment	Added to	FUA-CH
Residential Program Detoxification	Added to	FUA-CH

H. Direct Reference Codes

A direct reference code is a single code that meets criteria for a service or condition. Direct reference codes are listed in the measure specification and are also included in the Direct Reference Codes spreadsheet of the VSD (as are direct reference codes used for measures reported using ECDS).

Table A-5. Direct Reference Codes

Element Name	Element Description
Measure ID	The measure abbreviation.
Measure Name	The measure name.
Code	The code.
Description	The description of the code.
Code System	The code system.

For example, the following shows an excerpt for the IMA-CH measure:

Measure ID	Measure Name	Code	Description	Code System
IMA-CH	Immunizations for Adolescents	428241000124101	Anaphylaxis due to human papillomavirus vaccine (disorder)	SNOMED CT US Edition
IMA-CH	Immunizations for Adolescents	428301000124106	Anaphylaxis due to meningococcal vaccine (disorder)	SNOMED CT US Edition

Appendix B: Guidance for Selecting Sample Sizes for HEDIS® Hybrid Measures

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This appendix provides additional information on when it may be feasible to use a sample size of less than 411 when the hybrid method is used. States may use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the sample size. The guidance in the table below is designed to minimize the burden of medical record review, while providing an adequate sample size for calculating the measure.

Table B.1. Sample Sizes for Hybrid Measures When Data Are Available from the Current Year's Administrative Rate or Prior Year's Reported Rate

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
≤ 51%	411
52%	410
53%	410
54%	409
55%	407
56%	405
57%	403
58%	401
59%	398
60%	395
61%	392
62%	388
63%	384
64%	380
65%	376
66%	371
67%	366
68%	360
69%	354
70%	348
71%	342
72%	335
73%	328
74%	321
75%	313
76%	305
77%	296

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
78%	288
79%	279
80%	270
81%	260
82%	250
83%	240
84%	229
85%	219
86%	207
87%	196
88%	184
89%	172
90%	159
91%	147
92%	134
93%	120
94%	106
≥ 95%	100

Notes: Table B-1 reflects the minimum required sample size. When reducing, a state's sample size may be between the allowed minimum sample size in Table B-1 and 411.

States that report using socioeconomic status (SES) categories must use the total rate for sample size reduction, not the cohort rates based on SES stratification.

Truncate the decimal portion of the rate to obtain a whole number.

Appendix C: Definitions of Medicaid and CHIP Core Set Practitioner Types

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Practitioner Type	Definition
Mental Health Provider	A provider who delivers mental health services and meets any of the following criteria: • An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice • A Registered Nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC) • A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry • A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC)

Practitioner Type	Definition
Mental Health Provider (continued)	- Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria: o The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act). o The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or country in which it is located. - Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria: o Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a)(42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC o Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grants or funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC
Obstetrician/ Gynecologist (OB/GYN) and Other Prenatal Care Practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology • Certified nurse midwives, nurse practitioners, or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)
Primary Care Practitioner (PCP)	A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHCs) are considered PCPs

Practitioner Type	Definition
Primary Care Practitioner (PCP) (continued)	• To be certified as an FQHC, an entity must meet any one of the following criteria: - Is receiving a grant under Section 330 of the Public Health Service (PHS Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements - Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration - Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive federally-funded health center as of January 1, 1990 - Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991 • For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): - Provide comprehensive services and have an ongoing quality assurance program - Meet other health and safety requirements - Not be concurrently approved as a Rural Health Clinic (RHC) o Only certified RHCs are considered PCPs o To be certified as an RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner
Prescribing Practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications

Appendix D:
CAHPS® Health Plan Survey 5.1H
Child Questionnaire
(with CCC Supplemental Items)

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CAHPS® Health Plan Survey 5.1H Child Questionnaire (With CCC Supplemental Items)

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☑ Yes → **If Yes, Go to Question 1**

☐ No

{This box should be placed on the Cover Page}

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits your child receives. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call {SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. **Our records show that your child is now in {INSERT STATE MEDICAID PROGRAM NAME}. Is that right?**

   1☐ Yes → **If Yes, Go to Question 3**

   2☐ No

2. **What is the name of your child's health plan? (please print)**

   _____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care from a clinic, emergency room, or doctor's office. This includes care your child got in person, by phone, or by video. Do <u>not</u> include care your child got when he or she stayed overnight in a hospital. Do <u>not</u> include the times your child went for dental care visits.

3. **In the last 6 months, did your child have an illness, injury, or condition that <u>needed care right away</u>?**

   1☐ Yes

   2☐ No → **If No, Go to Question 5**

4. **In the last 6 months, when your child <u>needed care right away</u>, how often did your child get care as soon as he or she needed?**

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

5. **In the last 6 months, did you make any in person, phone, or video appointments for a <u>check-up or routine care</u> for your child?**

   1☐ Yes

   2☐ No → **If No, Go to Question 7**

6. In the last 6 months, how often did you get an appointment for a check-up or routine care for your child as soon as your child needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

7. In the last 6 months, not counting the times your child went to an emergency room, how many times did he or she get health care in person, by phone, or by video?

0☐ None → **If None, Go to Question 11**
1☐ 1 time
2☐ 2
3☐ 3
4☐ 4
5☐ 5 to 9
6☐ 10 or more times

8. In the last 6 months, how often did you have your questions answered by your child's doctor or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

9. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?

00☐ 0 Worst health care possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best health care possible

10. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

11. Is your child now enrolled in any kind of school or daycare?

1☐ Yes
2☐ No → **If No, Go to Question 14**

12. In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?

1☐ Yes

2☐ No → **If No, Go to Question 14**

13. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?

1☐ Yes

2☐ No

SPECIALIZED SERVICES

14. Special medical equipment or devices include a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment. In the last 6 months, did you get or try to get any special medical equipment or devices for your child?

1☐ Yes

2☐ No → **If No, Go to Question 17**

15. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

16. Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?

1☐ Yes

2☐ No

17. In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?

1☐ Yes

2☐ No → **If No, Go to Question 20**

18. In the last 6 months, how often was it easy to get this therapy for your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

19. Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?

1☐ Yes

2☐ No

20. In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?

1☐ Yes

2☐ No → **If No, Go to Question 23**

21. In the last 6 months, how often was it easy to get this treatment or counseling for your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

22. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?

1☐ Yes

2☐ No

23. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?

1☐ Yes

2☐ No → **If No, Go to Question 25**

24. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

1☐ Yes

2☐ No

YOUR CHILD'S PERSONAL DOCTOR

25. A personal doctor is the one your child would talk to if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

1☐ Yes

2☐ No → **If No, Go to Question 40**

26. In the last 6 months, how many times did your child have an in person, phone, or video visit with his or her personal doctor?

0☐ None → **If None, Go to Question 36**

1☐ 1 time

2☐ 2

3☐ 3

4☐ 4

5☐ 5 to 9

6☐ 10 or more times

27. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

28. In the last 6 months, how often did your child's personal doctor listen carefully to you?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

29. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

30. Is <u>your child</u> able to talk with doctors about his or her health care?

1☐ Yes

2☐ No → **If No, Go to Question 32**

31. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for <u>your child</u> to understand?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

32. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

33. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

1☐ Yes

2☐ No

34. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?

1☐ Yes

2☐ No → **If No, Go to Question 36**

35. In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

36. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?

00☐ 0 Worst personal doctor possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best personal doctor possible

37. Does your child have any medical, behavioral, or other health conditions that have lasted for more than 3 months?

1☐ Yes

2☐ No → **If No, Go to Question 40**

38. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

1☐ Yes

2☐ No

39. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

1☐ Yes

2☐ No

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, include the care your child got in person, by phone, or by video. Do not include dental visits or care your child got when he or she stayed overnight in a hospital.

40. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments for your child with a specialist?

1☐ Yes

2☐ No → **If No, Go to Question 44**

41. In the last 6 months, how often did you get appointments for your child with a specialist as soon as he or she needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

42. How many specialists has your child talked to in the last 6 months?

0☐ None → **If None, Go to Question 44**

1☐ 1 specialist

2☐ 2

3☐ 3

4☐ 4

5☐ 5 or more specialists

43. We want to know your rating of the specialist your child talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

00☐ 0 Worst specialist possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best specialist possible

YOUR CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

44. In the last 6 months, did you get information or help from customer service at your child's health plan?

1☐ Yes

2☐ No → **If No, Go to Question 47**

45. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

46. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

47. In the last 6 months, did your child's health plan give you any forms to fill out?

1☐ Yes

2☐ No → **If No, Go to Question 49**

48. In the last 6 months, how often were the forms from your child's health plan easy to fill out?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

49. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?

00☐ 0 Worst health plan possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best health plan possible

PRESCRIPTION MEDICINES

50. In the last 6 months, did you get or refill any prescription medicines for your child?

1☐ Yes

2☐ No → **If No, Go to Question 53**

51. In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

52. Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

1☐ Yes

2☐ No

ABOUT YOUR CHILD AND YOU

53. In general, how would you rate your child's overall health?

1☐ Excellent

2☐ Very Good

3☐ Good

4☐ Fair

5☐ Poor

54. In general, how would you rate your child's overall <u>mental or emotional</u> health?

1☐ Excellent

2☐ Very Good

3☐ Good

4☐ Fair

5☐ Poor

55. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?

1☐ Yes

2☐ No → **If No, Go to Question 58**

56. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 58**

57. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

58. Does your child need or use more medical care, more mental health services, or more educational services than is usual for most children of the same age?

1☐ Yes

2☐ No → **If No, Go to Question 61**

59. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 61**

60. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

61. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

1☐ Yes

2☐ No → **If No, Go to Question 64**

62. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 64**

63. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

64. Does your child need or get special therapy such as physical, occupational, or speech therapy?

1☐ Yes

2☐ No → **If No, Go to Question 67**

65. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 67**

66. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

67. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?

1☐ Yes

2☐ No → **If No, Go to Question 69**

68. Has this problem lasted or is it expected to last for at least 12 months?

1☐ Yes

2☐ No

69. What is <u>your child's</u> age?

00☐ Less than 1 year old

_____ YEARS OLD *(write in)*

70. Is your child male or female?

1☐ Male

2☐ Female

71. Is your child of Hispanic or Latino origin or descent?

1☐ Yes, Hispanic or Latino

2☐ No, not Hispanic or Latino

72. What is your child's race? Mark one or more.

a☐ White

b☐ Black or African American

c☐ Asian

d☐ Native Hawaiian or other Pacific Islander

e☐ American Indian or Alaska Native

f☐ Other

73. What is <u>your</u> age?

0☐ Under 18

1☐ 18 to 24

2☐ 25 to 34

3☐ 35 to 44

4☐ 45 to 54

5☐ 55 to 64

6☐ 65 to 74

7☐ 75 or older

74. Are you male or female?

1☐ Male

2☐ Female

75. What is the highest grade or level of school that you have completed?

1☐ 8th grade or less

2☐ Some high school, but did not graduate

3☐ High school graduate or GED

4☐ Some college or 2-year degree

5☐ 4-year college graduate

6☐ More than 4-year college degree

76. How are you related to the child?

1☐ Mother or father

2☐ Grandparent

3☐ Aunt or uncle

4☐ Older brother or sister

5☐ Other relative

6☐ Legal guardian

7☐ Someone else

THANK YOU

Please return the completed survey in the postage-paid envelope.

Appendix E: Guidance for Conducting the Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H

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Assessing patient experiences with health care is an important dimension of the quality of care. The Child Core Set includes a measure of experiences with health care based on the CAHPS® Survey.[1] This appendix provides additional guidance to states in carrying out CAHPS data collection, including information on the version of CAHPS used for FFY 2024 Child Core Set reporting, contracting with a survey vendor, generating a sample frame, identifying the supplemental sample of children with chronic conditions, drawing the sample, and conducting the survey using standard protocols.

A. Version of CAHPS for FFY 2024 Child Core Set Reporting

CAHPS is a family of surveys designed to assess consumer experiences with care. Different versions of the survey are available for use among various populations, payers, and settings. The version of the CAHPS Survey specified in the 2024 Child Core Set is the CAHPS Health Plan Survey 5.1H, Child Version Including Medicaid and Children With Chronic Conditions (CCC) Supplemental Items.[2] Appendix D contains the survey instrument for the Child Questionnaire with CCC Supplemental Items.

States will produce two separate sets of results: one for the general child population and one for the population of children with chronic conditions. For each population, results include the same ratings, composites, and individual question summary rates included in the core Child Questionnaire. In addition, five CCC-specific results are calculated for the CCC population: (1) Access to Specialized Services, (2) Family-Centered Care: Personal Doctor Who Knows Child, (3) Coordination of Care for Children With Chronic Conditions, (4) Access to Prescription Medicines, and (5) Family-Centered Care: Getting Needed Information.

B. Contracting with a Survey Vendor

To adhere to CAHPS 5.1H measure specifications, states must follow the HEDIS protocol which includes creating a sample frame and contracting with an NCQA-certified HEDIS measurement year (MY) 2023 survey vendor to administer the survey. The survey vendor draws the actual samples and fields the survey.

NCQA maintains a list of survey vendors that have been trained and certified to administer the CAHPS 5.1H survey. Each survey vendor is assigned a maximum capacity of samples. The capacity reflects the firm's and NCQA's projection of resources available to be dedicated to administer the survey. A current listing of NCQA-certified HEDIS MY 2023 survey vendors is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-1h-survey-certification/vendor-directory/.

C. Generating a Sample Frame

States are responsible for generating a complete, accurate, and valid sample frame data file that is representative of the entire eligible population (Table E-1). If states choose to have their sample frame validated, they should arrange for an auditor to verify the integrity of the sample frame before the survey vendor draws the sample and administers the survey.

[1] CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[2] AHRQ is the measure steward for the survey instrument and NCQA is the developer of the survey administration protocol.

Table E-1. Eligible Population for Child CAHPS 5.1H

Age	Age 17 and younger as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Source: HEDIS MY 2023 Volume 3: Specifications for Survey Measures (https://store.ncqa.org/hedis-my-2023-volume-3-epub.html).

To enable the survey vendor to generate the systematic sample, states must generate a sample frame data file for each survey to be fielded. States are strongly encouraged to generate sample frames after eliminating disenrolled and deceased beneficiaries and updating eligibility files with address and telephone number corrections. When sampling, keep the following in mind:

- If a state collects CAHPS data for both its Medicaid and CHIP programs, states must generate a separate sample frame for children in separate CHIP to meet CHIPRA requirements. Children in the Title XXI-funded Medicaid Expansion CHIP may be included in the Medicaid sample.[3]
- If each managed care plan carries out its own CAHPS survey, a separate sample frame must be generated for each plan.
- If a state has children enrolled in multiple delivery systems (managed care, primary care case management, and/or fee for service), the sample frame(s) should be representative of all children covered by the entire program. A state may generate one statewide sample frame that includes children in all delivery systems or separate sample frames for each delivery system. The sample frame(s) should represent all children that meet the eligibility criteria specified in Table E-1.

D. Identifying the Supplemental Sample of Children with Chronic Conditions

To identify the supplemental sample of children with chronic conditions, states use transaction data or other administrative databases to assign a prescreen status code to each child beneficiary in the CAHPS child survey sample frame data file. The prescreen status code identifies children who are more likely to have a chronic condition.

[3] CHIP requirements for CAHPS: Section 2108(e) of the Social Security Act (the Act), as implemented through CHIPRA section 402, requires Title XXI programs to submit to CMS "data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality of care and consumer satisfaction measures included in the CAHPS survey." CHIPRA requires States to submit data that are representative of all children covered by their entire Title XXI program (CHIP Medicaid Expansion, Separate CHIP Program, or Combination CHIP Program). If a state chooses to collect CAHPS data for children in both Medicaid and CHIP, the state must separately sample and submit data for children enrolled in its separate CHIP program to fulfill the CHIPRA requirement. Children in the Title XXI-funded Medicaid Expansion CHIP may be included in the Medicaid sample.

States search claims and encounters for the measurement year and the year prior to the measurement year and assign codes as follows:

1 = No claims or encounters during the measurement year or the year prior to the measurement year that meet the criteria listed for prescreen status code 2.

2 = The child has claims or encounters during the measurement year or the year prior to the measurement year that indicate the child is likely to have a chronic condition. To identify a sample of children with chronic conditions, refer to the CCC-CH value sets in the FFY 2024 Child Core Set HEDIS Value Set Directory. Any of the following meet criteria.

- At least one outpatient visit (Outpatient Value Set), telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set), acute inpatient encounter (Acute Inpatient Value Set; Newborn/Pediatric Acute Inpatient Value Set) or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year with a diagnosis code from the Chronic Conditions Value Set. The diagnosis does not have to be the principal diagnosis.
- At least one acute or nonacute inpatient discharge during the measurement year or the year prior to the measurement year with a diagnosis code from the Chronic Conditions Value Set. The diagnosis does not have to be the principal diagnosis. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- At least one psychiatry visit (Psychiatry Value Set) with a diagnosis code from the Chronic Conditions Value Set and a place of service code from one of the following:
  - Acute Inpatient POS Value Set
  - Nonacute Inpatient POS Value Set
  - ED POS Value Set
  - Outpatient POS Value Set
  - Telehealth POS Value Set
  - Partial Hospitalization POS Value Set
  - Community Mental Health Center POS Value Set
- At least two outpatient visits (Outpatient Value Set), telephone visits (Telephone Visits Value Set) or e-visits or virtual check-ins (Online Assessments Value Set) on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis. The visit codes need not be from the same value set (for example, one visit with a code from the Outpatient Value Set and another visit with a code from the Telephone Visits Value Set qualifies).
  - Conduct Disorder Value Set
  - Emotional Disturbance Value Set
  - Hyperkinetic Syndrome Value Set

  - Asthma Value Set
  - Failure To Thrive Value Set

- At least two psychiatry visits (Psychiatry Value Set) on different dates of service during the measurement year or the year prior to the measurement year with a place of service code (Outpatient POS Value Set; Telehealth POS Value Set; Partial Hospitalization POS Value Set; Community Mental Health Center POS Value Set) and a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis.
  - Conduct Disorder Value Set
  - Emotional Disturbance Value Set
  - Hyperkinetic Syndrome Value Set
  - Asthma Value Set
  - Failure To Thrive Value Set
- At least one acute inpatient encounter (Acute Inpatient Value Set; Newborn/Pediatric Acute Inpatient Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set) or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year with a diagnosis code from any of the value sets listed below. The diagnosis does not have to be the principal diagnosis.
  - Conduct Disorder Value Set
  - Emotional Disturbance Value Set
  - Hyperkinetic Syndrome Value Set
  - Asthma Value Set
  - Failure To Thrive Value Set
- At least one acute or nonacute inpatient discharge during the measurement year or the year prior to the measurement year with a diagnosis code from any of the following value sets: Conduct Disorder Value Set; Emotional Disturbance Value Set; Hyperkinetic Syndrome Value Set; Asthma Value Set; Failure To Thrive Value Set. The diagnosis does not have to be the principal diagnosis. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- At least one psychiatry visit (Psychiatry Value Set) with a diagnosis code (the diagnosis does not have to be the principal diagnosis) and a place of service code from the lists below:

Diagnosis Code Value Sets	Place of Service Code Value Sets
• Conduct Disorder Value Set • Emotional Disturbance Value Set • Hyperkinetic Syndrome Value Set • Asthma Value Set • Failure To Thrive Value Set	• Acute Inpatient POS Value Set • Nonacute Inpatient POS Value Set • ED POS Value Set

E. Drawing the Sample

The survey vendor is responsible for drawing the survey samples from the sample frame generated by the state. For each survey administered, the survey vendor draws a systematic sample of 1,650 children from the general child population and then draws the CCC supplemental sample. The survey vendor selects 1,840 children for the CCC supplemental sample from the set of beneficiaries with a prescreen status code of 2 who were not already selected for the general child population sample. The survey vendor combines the general child population sample (n=1,650) and the CCC supplemental sample (n=1,840) for survey administration and submission of survey results.

Deduplication

To reduce respondent burden, the survey vendor should deduplicate samples so that only one child per household is included in the sample. The survey vendor must use the deduplication method included in HEDIS MY 2023 Volume 3 before pulling the systematic sample.

Oversampling

A state should instruct its survey vendor to oversample if it has a prior history of low survey response rates, if it anticipates that a significant number of addresses or telephone numbers in the enrollment files are inaccurate, if it cannot eliminate disenrolled children from eligibility files, or if it does not expect to achieve a denominator of 100 for most survey calculations. The required sample sizes are based on the average number of complete and eligible surveys obtained by health plans during prior years; therefore, using the required sample size for a given survey does not guarantee that a state will achieve the goal of 411 completed surveys or the required denominator of 100 complete responses for each survey result. The state should work with its survey vendor to determine the number of complete and eligible surveys it can expect to obtain without oversampling based on prior experience.

If its prior response rates or the number of completed surveys is expected to fall below the goal of 411 completed surveys, the survey vendor should oversample. For example, if the vendor increases the general child population sample by 5 percent, the final sample size would be 1,733. If the vendor increases the general child population sample by 20 percent, the final sample size would be 1,980. The survey vendor will work with the state to determine an appropriate sampling strategy. For a detailed discussion of oversampling, see “HEDIS MY 2023 Volume 3: Specifications for Survey Measures,” Appendix 7, “General Recommendations for Oversampling Survey Measures.”

F. Survey Administration

The sampling and data collection procedures that the survey vendors have been trained and certified to carry out promote both the standardized administration of the survey instruments by different survey vendors and the comparability of resulting data. For results to comply with CAHPS 5.1H survey specifications, the state’s survey vendor must follow one of the standard CAHPS 5.1H survey protocols. The state will have to work with its survey vendor to select one of two standard options for administering HEDIS CAHPS surveys:

1. The mail-only methodology, a five-wave mail protocol with three questionnaire mailings and two reminder postcards
2. The mixed methodology, a four-wave mail protocol (two questionnaires and two reminder postcards) with telephone follow-up of a minimum of three and a maximum of six telephone attempts

The basic tasks and time frames for the two protocol options are detailed in Tables E-2 and E-3. Regardless of the approach selected, the survey vendor is expected to maximize the final survey response rate and to pursue contacts with potential respondents until the selected data collection protocol is exhausted. Achieving the targeted number of completed surveys does not justify ceasing the survey protocol.

Neither the state nor the survey vendor may use incentives of any kind for completion of the survey. Either a parent or caretaker who is familiar with the child's health care may complete the child survey.

The vendor is expected to maintain the confidentiality of sampled children. The health plan does not have access to the names of children selected for the survey.

Table E-2. Mail-Only Methodology

Survey Vendor Tasks	Time Frame
Send first questionnaire and cover letter to the surveyed child's family.	0 days
Send a postcard reminder to non-respondents 4–10 days after mailing the first questionnaire.	4–10 days
Send a second questionnaire and second cover letter to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents 4–10 days after mailing the second questionnaire.	39–45 days
Send a third questionnaire and third cover letter to non-respondents approximately 25 days after mailing the second questionnaire.	60 days
Allow at least 21 days for the third questionnaire to be returned by the respondent.	81 days

Source: HEDIS MY 2023 Volume 3: Specifications for Survey Measures.

Table E-3. Mixed Methodology

Survey Vendor Tasks	Time Frame
Send first questionnaire and cover letter to the surveyed child's family.	0 days
Send a postcard reminder to non-respondents 4–10 days after mailing the first questionnaire.	4–10 days
Send a second questionnaire and second cover letter to non-respondents approximately 35 days after mailing the first questionnaire.	35 days
Send a second postcard reminder to non-respondents 4–10 days after mailing the second questionnaire.	39–45 days
Initiate telephone interviews for non-respondents approximately 21 days after mailing the second questionnaire.	56 days
Initiate systematic contact for all non-respondents so that at least 3 telephone calls (and no more than 6 telephone calls) are attempted at different times of the day, on different days of the week, and in different weeks.	56–70 days
Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation.	70 days

Source: HEDIS MY 2023 Volume 3: Specifications for Survey Measures.

G. For Further Information

Information about the CAHPS Health Plan Survey is available at https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html.

Information about participating in the CAHPS Health Plan Survey Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html.