Frequently Asked Questions: Medicaid and CHIP Core Sets Mandatory Reporting

Annual reporting of the Medicaid and Children's Health Insurance (CHIP) Child Core Set and the behavioral health measures on the Medicaid Adult Core Set is mandatory beginning with Federal Fiscal Year (FFY) 2024 reporting in Fall of 2024.[1,2] The following frequently asked questions address mandatory reporting and will be updated as CMS receives additional questions. States and others are encouraged to visit the Performance Measurement page on Medicaid.gov for technical assistance (TA) resources on mandatory reporting. Please send questions to: MACQualityTA@cms.hhs.gov.

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[1] Core Set Final Rule: https://www.federalregister.gov/d/2023-18669

[2] Initial Core Set Mandatory Reporting Guidance State Health Official Letter: https://www.medicaid.gov/sites/default/files/2023-12/sho23005_0.pdf

General

Q1: Section 437.20 of the Mandatory Reporting final rule (final rule) requires states to submit a state plan amendment (SPA) attesting that the agency would report on the mandatory measures of the Child and Adult Core Sets in accordance with the requirements in § 437.15. Where can states find the SPA template and when is it due to CMS?

A1: CMS released the Child and Adult Core Sets Reporting SPA Reviewable Unit (RU) on April 19, 2024. The SPA is now available in the Medicaid & CHIP Program (MACPro) System and is due to CMS by December 31, 2024. Implementation guides with further information are available on Medicaid.gov: https://www.medicaid.gov/resources-for-states/medicaid-and-chip-program-portal/eligibility-administration-spa-implementation-guides/index.html.

State Quality Measure Reporting (QMR) system users should coordinate with state colleagues who work on SPAs to complete this important step in mandatory reporting.

Q2: What is the deadline for FFY 2024 state reporting? Also, what service delivery period does the data reflect?

A2: States are required to submit data to CMS for all measures on the FFY 2024 Child Core Set and the behavioral health measures on the Adult Core Set by December 31, 2024. States are also encouraged to report on the non-mandatory measures on the Adult Core Set by December 31, 2024. For Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey specific measures, please refer to the CAHPS Fact Sheet for information on the reporting deadline.[3]

Generally, FFY 2024 Core Set data will reflect service utilization in calendar year 2023, but there may be exceptions for specific measures.[4,5]

States will report these data using CMS' QMR System, which is the same system used in recent years. CMS expects the QMR will open to accept FFY 2024 Core Sets data beginning in September 2024, with all data required to be submitted by December 31, 2024.

For FFY 2024 reporting, CMS will report on the following quality measures for states using alternate data sources:

- Live Births Weighing Less Than 2,500 Grams (LBW-CH) measure – calculated using the Centers for Disease Control and Prevention's (CDC) data;
- Low-Risk Cesarean Delivery (LRCD-CH) measure – calculated using CDC data;
- Measures from the 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) – calculated in part using Agency for Healthcare Research and Quality's (AHRQ) CAHPS Database;

[3] CAHPS Fact Sheet: https://www.medicaid.gov/sites/default/files/2024-03/cahpsfactsheet.pdf

[4] Child Core Set Measurement Period Table: https://www.medicaid.gov/media/170291

[5] Adult Core Set Measurement Period Table: https://www.medicaid.gov/media/170266

- Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) – calculated in part using AHRQ's CAHPS Database;
- National Core Indicators Survey (NCIIDD-AD) measure – calculated using data submitted to the National Core Indicators (NCI) National Team; and
- Measures from the CAHPS® Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD) — calculated in part using AHRQ's CAHPS Database.

Q3: Do states have to report both fee-for-service and managed care populations? If a measure is not reported by a managed care plan, will the state have to report it?

A3: States are required to report all applicable delivery systems, including both fee-for-service (FFS) and managed care populations for every mandatory measure.

Q4: When will CMS implement the Office of Management and Budget (OMB)'s Statistical Policy Directive No. 15 which updates race and ethnicity stratification reporting categories?

A4: CMS currently intends to make updates to QMR for FFY 2025 Core Set reporting to reflect the 2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15 (Directive No. 15): Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity standards.[6] For FFY 2024 reporting, consistent with previous years, QMR will include the option for states to enter data stratified by the minimum race and ethnicity categories described in the 2011 HHS standards.[7] CMS will provide additional guidance to states ahead of FFY 2025 reporting.

Methodology

Q5: If a state reports on the population enrolled in managed care using the hybrid method, can the state report on the FFS population using the administrative method?

A5: Yes, states can use different methodologies for different populations. Please refer to the TA resource on combining data sources across multiple reporting units to create a state-level rate. States are encouraged to document this information in the QMR system if they used different methodologies for different reporting units.

Q6: Are states able to utilize an aggregated rate, composed of the state's individual managed care plan (MCP) rates, to meet mandatory reporting requirements?

A6: A state can aggregate data from its individual MCP rates but will need to consider if this excludes any measure-eligible Medicaid or CHIP beneficiaries from the denominator. If measure-eligible beneficiaries are excluded from the aggregated MCP rates (for example, FFS populations or individuals that switched plans during the year but were enrolled in Medicaid for

[6] Statistical Policy Directive No.15: https://www.federalregister.gov/d/2024-06469

[7] https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0

the continuous enrollment period), the state must calculate a rate for the excluded individuals and report a state-level rate that includes all populations.

Additional guidance on calculating a state-level rate by combining rates from individual reporting units to a state-level rate can be found in this TA resource.

Q7: Some states do not have access to electronic health record (EHR) data and/or supplemental data (such as SNOMED, LOINC) or may use codes that are not found in claims data to calculate measures. Are states required to use a hybrid method and/or to make system, policy or data collection changes to report accurate data for measures which allow this data collection method? If so, what type of technical assistance is available to help states implement these changes?

A7: States are asked to collect data through one of the data collection methods that are specified in the measure's technical specifications. States are not required to prioritize hybrid or EHR as a data collection methodology if the measure is also specified for administrative data collection. However, states are strongly encouraged to utilize a data source and methodology that will provide the most accurate representation of the quality of care provided. Please email the technical assistance mailbox for assistance with reporting specific measures (MACQualityTA@cms.hhs.gov).

Q8: Are states required to adhere to the technical specifications issued by CMS for the Core Set measures, including reporting the Core Set age groups when Core Set age groups differ from Healthcare Effectiveness Data and Information Set (HEDIS) specifications?

A8: As finalized in § 437.15(a)(3) of the final rule, States are required to report on the mandatory measures in accordance with CMS Core Set Reporting Guidance. This includes reporting according to the specified age groups. Adherence to the reporting guidance is essential for providing effective comparisons across states on standardized quality measure performance and for deriving national performance rates for the care provided to Medicaid and CHIP beneficiaries. States are also encouraged to adhere to the specified age ranges for the non-mandatory measures on the Adult Core Set.

Q9: Should an MCP be excluded from the aggregate rate for any reason, including receiving a Do Not Report finding as part of its Performance Measure Validation?

A9: States are required to report all available data and include data for all Medicaid and CHIP beneficiaries that meet the measure-eligibility criteria for all mandatory measures. If an MCP receives a "Do Not Report" finding for a particular rate, the state should coordinate with CMS to provide additional context about the "Do Not Report" finding and determine whether the data should be included in state-level reporting.

Q10: Can states report rates from a similar National Committee for Quality Assurance (NCQA) HEDIS measure as a substitute for a measure on the Core Set?

A10: States should report the Core Set measures according to the Core Set specifications, without substitutions.

For example, states may not substitute the NCQA Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) measure for the Screening for Depression and Follow-Up Plan (CDF-CH, CDF-AD, or CDF-HH) measures that are on the Child and Adult Core Sets or the NCQA's Use of Opioids at High Dosage (HDO) measure for the Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) measure that is on the Adult Core Set.

States are encouraged to review the TA resources and/or contact CMS (MACQualityTA@cms.hhs.gov) for additional TA for assistance with reporting Core Set measures.

Sampling

Q11: For Adult Core Set measures that are broken out by age group (e.g., ages 18 to 64 and age 65 and older), are separate samples required to report the measure?

A11: When using the hybrid methodology to report a Core Set measure, a state must consider the size of the measure-eligible population in each age stratification. For example, if the Ages 65 to 85 population is very small in a state, it will be necessary to draw a separate sample to get sufficient representation to be able to report a separate rate for this age group. Information on reporting small numbers and cell suppression is provided in Q20.

Q12: For reporting of measures using the hybrid methodology, are states required to use two different samples for reporting Medicaid and CHIP rates separately?

A12: Yes, states should separately sample the Medicaid, inclusive of CHIP-funded Medicaid expansion, (Titles XIX and XXI) and separate CHIP (Title XXI) populations for Core Set reporting when using the hybrid methodology.

Q13: For the Prenatal and Postpartum Care (PPC2) measure, will CMS require separate samples for beneficiaries under age 21 and for those age 21 and older if utilizing the hybrid methodology for calculating and reporting? Or will one sample that is stratified by these age ranges meet CMS' requirements?

A13: CMS consulted with the measure steward who advised that if states use the hybrid methodology for the PPC2 measure, they will need to draw separate samples by age for the purpose of Core Set reporting, to submit results for the Child Core Set (under age 21) and Adult Core Set (age 21 and over).

Additionally, the final rule established that states with a separate CHIP program must report on Child Core Set measures in two categories: separate CHIP (Title XXI) and Medicaid inclusive of CHIP-funded Medicaid expansion (Titles XIX and XXI). Therefore, states with a separate CHIP program would need to draw separate samples for the Child Core Set for the Medicaid inclusive of CHIP-funded Medicaid expansion and separate CHIP populations.

Populations

Q14: Are states required to include CHIP populations when reporting on the mandatory

behavioral health measures in the Adult Core Set?

A14: For CHIP programs, reporting of the behavioral health measures in the Adult Core Set is voluntary but encouraged.

States must include CHIP populations for all Child Core Set measures. Through the final rule, CMS amended the quality reporting provisions in Part 457 to include requirements for reporting on health care quality measures, which only apply to state CHIP programs.

Q15: Can states be granted an exemption from reporting CHIP separately for Child Core Set measures calculated using the hybrid data collection method for FFY 2024?

A15: There are no measures on the Core Sets for which hybrid (a combination of administrative data and medical records) is the only data collection method, though CMS recognizes that the hybrid method may be the preferred and more accurate method of data collection for calculating selected measures. A state could choose to use the hybrid methodology to calculate the measure for the CHIP population or calculate the measure for the CHIP population using another data collection method allowed in the technical specifications for that measure.

Q16: What is the expected timeframe for requiring reporting on the dually eligible Medicare and Medicaid population and the third-party coverage population?

A16: In the December 2023 State Health Official (SHO) letter, CMS indicated it will exempt states from FFY 2024 Core Set reporting on: (1) beneficiaries who have other insurance coverage as a primary payer before Medicaid or CHIP, including individuals dually eligible for Medicare and Medicaid; and (2) individuals whose Medicaid or CHIP coverage is limited to payment of third-party coverage premiums and/or cost sharing. At this time, CMS has not determined the timeline for requiring reporting on these populations but will continue to provide technical assistance to states and assess state readiness to report.

CMS will annually issue sub regulatory guidance that details the requirements and expectations for compliance with mandatory reporting for the upcoming year of Core Set reporting. This guidance will include any exemptions from the mandatory populations.

Q17: Would not having timely access to Medicare FFS data be a reason to request a 1-year exemption on reporting for duals? How would this work operationally? Alternatively, is it possible to report results for Duals without access to Medicare FFS claims?

A17: Yes, not having access to data would be a reason for a state to request an exemption from including the population of individuals dually eligible for Medicare and Medicaid in Core Set reporting. Please note: The December 2023 SHO letter exempts states from reporting on individuals dually eligible for Medicare and Medicaid for FFY 2024 reporting. Therefore, it is not necessary to request an exemption for this population for FFY 2024 reporting.

Q18: Beginning with 2024 reporting, do states have to report on all populations for all quality measures or just measures that are reported using the administrative methodology?

A18: The requirement to include all populations applies to all mandatory measures, regardless of the data collection method. However, states can use different methodologies for different populations. Please refer to the TA resource on combining data sources across multiple reporting units to create a state-level rate. States are encouraged to document in the QMR system if they used different methodologies for different reporting units.

Q19: Is there a minimum denominator size for data reported to CMS?

A19: CMS encourages states to report data in the QMR system for measures and rates with small cell sizes. These data will be suppressed for state-level public reporting in accordance with the CMS cell-size suppression policy, which prohibits the direct reporting of beneficiary and record counts of 1 to 10 and values from which users can derive values of 1 to 10.[8] Furthermore, CMS will suppress rates with a denominator less than 30 due to reliability concerns. That being said, CMS recognizes that some states prohibit the reporting of small cell sizes due to privacy concerns. Therefore, for FFY 2024 reporting, CMS advises these states to provide an explanation in the QMR system noting that these rates are not reported due to the state's small cell size policy.

Audit/ Validation of Data

Q20: Are states permitted to report draft measure rates in cases where measure rates have not been fully validated?

A20: States should use the most complete data available at the time of reporting to calculate measure rates. Any measure rates or other data that is submitted after the reporting deadline may not be incorporated into Core Set public reporting. At this time, states are not required to conduct validation of Core Set measure rates.

Q21: For measures with HEDIS-based specifications, are states required to have NCQA HEDIS certification to calculate and report the measures?

A21: States do not need to have NCQA HEDIS certification for Core Set reporting.

Exemption Requests

Q22: Is there a template for the one-year population exemption request?

A22: There is no template for exemption requests. States should submit a letter to CMS identifying the exemption(s) that they are requesting, and their plans to address this in future years.

State exemption requests must be submitted by September 1, 2024 to MACQualityTA@cms.hhs.gov. Each exemption request must:

- identify the specific population for which the state cannot report and for which measure(s) the exemption is being requested;

[8] CMS Cell Suppression Policy: https://www.hhs.gov/guidance/document/cms-cell-suppression-policy

- include details on why the exemption(s) is/are necessary;
- demonstrate that the state has made a reasonable effort to obtain the required data by the reporting deadline;
- provide a reasonable timeline of the actions underway to resolve the issue so that the population can be included in state reporting in future years; and
- be submitted only for the current reporting year.

Before submitting an exemption, states should review Core Set specifications to determine whether the population in question is eligible for measure reporting. Most measures require a beneficiary to receive full benefits, so beneficiaries who receive partial benefits (such as a transportation or emergency services only) would not be included in Core Set reporting. Each measure identifies the eligible population in the Core Set specifications, and states should not submit an exemption request for populations that are not measure-eligible.

The exemption request should be sent by the state Medicaid director to the following mailbox: MACQualityTA@cms.hhs.gov. CMS is happy to review and provide comments on draft requests prior to formal submission.

Q23: Does a state need to submit a separate one-year exemption request for each population?

A23: No, states can include requests to exempt more than one population in the single official exemption request letter. While states may submit more than one exemption request per reporting year, we encourage states to make each request as comprehensive as possible.