2025 Primary Care Core Measure Set Workgroup Recommendation Summary

Introduction

Due to the COVID-19 pandemic, a formal review process to update the New York State primary care core measure set was not facilitated since 2019. The Department of Health (Department) asked United Hospital Fund (UHF) to convene a workgroup comprised of diverse stakeholders including consumer advocates, the Department, health plans, providers, and other organizations. The aim of convening this workgroup was to recommend an updated, refined measure set, with approximately 10 measures, that align with CMS priorities, grants, and initiatives. Based on guidance from the Department, UHF facilitated a series of convenings to outline project goals, solicited feedback from individuals and stakeholder groups, and developed recommendations.

Workgroup Recommendations

Below are the measures that are recommended for consideration in the 2025 Primary Care Core Measure Set based on workgroup participation. The Department will convene internally to discuss these recommendations and subsequently provide a finalized measure list.

Recommended 2025 Primary Care Core Measure Set

Domain	Measure	ID
Prevention	Colorectal Cancer Screening	eCQM 130
	Breast Cancer Screening	CMS 93
Chronic Disease	Controlling High Blood Pressure	CMS 167
	Diabetes HbA1C Poor Control (>9%)	eCQM 122
Behavioral Health	Screening for Depression and Follow-Up Plan	CMS 672
Children and Adolescents	Child and Adolescent Well-Care Visits (WCV)	CMS 123
	Childhood Immunization Status	CMS 124
	Immunizations for Adolescents	CMS 363
	Well-Child Visits in the First 30 Months of Life	CMS 761
Utilization	Emergency Department Utilization	n/a NCQA
Patient Reported	Consumer Assessment of Healthcare Providers and Systems overall rating measures (CAHPS)	CMS 158
Health Equity	Screening for Social Drivers of Health	Quality ID 487

Workgroup Recommendation Process

UHF facilitated three workgroup member convenings which led to group recommendation of 12 measures for inclusion in the NYS 2025 Primary Care Core Measure Set. The Department started with a review of the 2020 Primary Care Core Measure Set. Measures that were retired or not aligned with CMS measure sets (Making Care Primary Model, AHEAD Model, or Universal Foundations) were removed. UHF created a crosswalk to summarize measure alignment across the priority CMS measure sets (See Appendix A). The first workgroup convening reviewed the potential measures based on alignment with the priority CMS measure sets. During this convening, three additional measures were identified by the workgroup for potential consideration, including adult immunization status, chlamydia screening for women, and cervical cancer screening. A resulting list of 20 validated and endorsed measures spanning 8 unique domains were identified based on workgroup feedback and measure alignment with the priority CMS measure sets (See Appendix B). The domains included prevention, chronic disease, children and adolescents, appropriate use, patient-reported, behavioral health, health equity, and cost.

The Department wanted approximately 10 measures total. To further refine the measure list, UHF developed a survey for workgroup members to score and rank the 20 proposed measures for inclusion in the recommended 2025 primary care core measure set. The survey was designed to be completed by one representative per health plan or provider organization to allow for equal weighting of diverse plan and provider responses. The survey collected information about ability to report, plan and provider burden, and a ranking for each measure within a domain (See Appendix C). UHF and the Department developed a comprehensive scoring rubric for the survey results, which included relevant goals, essential criteria, and key considerations (See Appendix D). The Department pre-scored criteria such as relevance of each measure to New York State primary care goals, alignment with payer measure sets, measure type, notable performance gaps, opportunities for improvement, and the level of measure evaluation. The second convening discussed the measures being considered, the survey, and the scoring criteria for the survey results. After the second convening, a 13-item survey was sent to 93 workgroup members who represented 43 unique organizations. Detailed measure descriptions and relevant benchmarks were sent to workgroup members along with the survey (See Appendices B and C).

The survey yielded responses across 28 unique organizations, with 33 individual workgroup members submitting a complete response. Duplicate entries were removed and the most complete response among submissions from multiple individuals responding on behalf of one health plan or provider organization was included in the analysis. Survey results were filtered by perspective group (e.g., consumer, the Department, plan, provider, other) and scores from each cohort were averaged into a total score for each group. The resulting composite scores for each group were averaged to allow for equal weighting regardless of how many individuals comprised each perspective group. UHF input the scores into the scoring rubric, as noted above, the scoring rubric also contained other variables that were pre-scored by the Department. The scoring rubric yielded scores for each of the 20 measures. In addition to scores, rankings were averaged to determine a composite rank for each measure within a domain. Generally, the scores that were aligned with the most priority measure sets scored highest. However, this was not true for children or adolescents because the CMS priority measure sets focus on adults. As such, there was no alignment scoring bonus among the child and adolescent measures and four of those measures scored similarly.

The final convening served to discuss recommended measures for removal based on the lowest total scores and rank within each domain. Given the lack of distinction between scores in the child and adolescent domain, we had an open discussion of all the child and adolescent measures, followed by a poll of attendees. Most respondents (64%) recommended retaining 4 measures within this domain, both child and adolescent well-child visit measures as well as child and adolescent immunization measures. Based on the scoring, ranking, and the workgroup

discussion, 12 primary care core measures (see Table 1) are being recommended to the state for consideration for inclusion in the 2025 primary care core measure set.

Future Considerations

Below are some opportunities to improve a future stakeholder measure review process.

1. **Measure Utilization**: Participants noted that it was difficult to make informed decisions about measure selection because it was unclear how the measures recommended by the workgroup would be applied or used by the Department.

    a. **Recommendation**: For future processes, participants should receive clear guidance from the Department on how the measures will potentially be used, who will be required to report, and how the information about performance will be shared by the Department to the public.

2. **Consumer Perspective**: Feedback from the consumer advocate perspective was limited because the questions were posed to plans and providers.

    a. **Recommendation**: A consumer advocate directed question is recommended for inclusion in future review cycles. Also, inclusion of additional consumer advocates in the workgroup might better inform whether potential measures included at the provider level would impact consumer choice of a health provider, facility, or plan.

3. **Other Perspectives**: Many participants identified as "other" rather than a plan, provider, Department, or consumer advocate. The other participants included plan associations, provider associations, and other perspectives.

    a. **Recommendation**: The categories could be better clarified for stakeholders to include plan associations in the plan perspective, provider associations in the provider perspective, and local government with state government for scoring and ranking.

4. **Measure Scoring**: The scoring rubric prioritized alignment with the priority CMS measure sets. Measures suggested by the workgroup (chlamydia screening for women, cervical cancer screening, and adult immunization status), which were not aligned with the priority CMS measure sets, scored lower than aligned measures, regardless of their relevance to primary care or the score they received from the participants.

a. **Recommendation**: To have recommendations that better reflect participant perspectives, a scoring rubric that does not bias the results should be considered.

5. **Workgroup Participation**: Discussion between external stakeholders during workgroup convenings is valuable for addressing targeted questions. For example, workgroup discussion guided recommendations about measure selection within the child and adolescent health domain.

    a. **Recommendation**: Additional opportunities for workgroup members to provide targeted feedback during stakeholder convenings should be considered.

6. **Stakeholder convening**: The Department should reconsider the structure of the external stakeholder engagement process to clarify the role and weight of the Department's perspective in measure scoring.

    a. **Recommendation**: A possible option is to distinguish the Department's internal review process and scoring from the external stakeholder workgroup engagement. For example, workgroup convenings could be used to gather external stakeholder input and make stakeholder recommendations to the state. The state would then convene internally to review the recommendations from the external workgroup, in addition to considering perspectives, initiatives, and priorities from the Department, before finalizing the new measure set.

Appendix A

Primary Care Core Measure Set

Cross Walk

Measure Name	Making Care Primary	AHEAD Primary Care Measures	CMS Universal Foundation
Colorectal Cancer Screening	x	x	x
Controlling High Blood Pressure	x	x	x
Diabetes HbA1C Poor Control (>9%)	x	x	x
Breast Cancer Screening		x	x
Screening for Depression and Follow-Up Plan	x	x	x
Child and Adolescent Well–Care Visits (WCV)			x
Childhood Immunization Status			x
Initiation and Engagement of Substance Use Disorder Treatment			x
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			x
Asthma Medication Ratio			x
Follow-Up After Hospitalization for Mental Illness			x
Emergency Department Utilization (EDU)	x	x	
Screening for Social Drivers of Health	x		x
Follow-Up After Emergency Department Visit for Substance Use			x
Immunizations for Adolescents			x
Oral Evaluation, Dental Services (OED)			x
Well-Child Visits in the First 30 Months of Life (W30)			x
Plan All-Cause Readmissions			x
Depression Remission at Twelve Months	x		
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			x
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics			x
Adult Immunization Status			x
Acute Hospital Utilization (AHU)		x	
All-Cause Hospital Readmissions			x
CAHPS Overall Rating			x
EDU Continuous Improvement (FQHCs and Indian Health Programs only)	x		
Person-Centered Primary Care Measure (PCPCM)	x		
Total Per Capita Cost (TPCC)	x		
TPCC Continuous Improvement (non- FQHCs and non- Indian Health Programs only)	x		

Reference Material - NYS Primary Care Core Measure Set: Populations Measured and Data Sources

Domain	Measure	ID	Population	Data Source
Prevention	Colorectal Cancer Screening	eCQM 130	Adults: 50-75 years	Claims/EHR
	Chlamydia Screening for Women	eCQM 153	Adults: 16-24 years	Claims-only possible
	Breast Cancer Screening	CMS 93	Adults: 50-75 years	Claims-only possible
	Cervical Cancer Screening	eCQM 124	Adults: 21-64 years	Claims-only possible
	Adult Immunization Status - Electronic (Influenza)(AIS-E)	CMS 26	Adults: 19 years +	Administrative/Claims/EHR
Chronic Disease	Controlling High Blood Pressure	CMS 167	Adults: 18-85 years	Claims/EHR
	Diabetes HbA1C Poor Control (>9%)	eCQM 122	Adults: 18-75 years	Claims/EHR
Behavioral Health	Initiation and Engagement of Substance Use Disorder Treatment	CMS 394	Adults: 18 years +	Administrative/Claims/EHR
	Screening for Depression and Follow-Up Plan	CMS 672	Adults: 18 years +	Claims/EHR
Utilization	Plan All-Cause Readmissions	CMS 561	Adults: 18-64 years	Claims
	Emergency Department Utilization (EDU)	n/a NCQA	Adults: 18 years +	Claims
Children and Adolescents	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	CMS 760	Child/Adolescents: 3 - 17 years	Claims/EHR
	Well-Child Visits in the First 30 Months of Life (W30)	CMS 761	Children: 15-30 months	Administrative/Claims
	Immunizations for Adolescents	CMS 363	Adolescents: 13 years+	Claims/EHR
	Child and Adolescent Well–Care Visits (WCV)	CMS 123	Child/Adolescents: 3-21 years	Claims
	Childhood Immunization Status	CMS 124	Children: 2 years	Administrative/Claims/EHR
Health Equity	Screening for Social Drivers of Health	Quality ID 487	Adults: 18 years +	Administrative/Claims/EHR
Patient Reported	Person-Centered Primary Care Measure (PCPCM)	CMS 1004	All	Survey
	CAHPS Overall Rating	CMS 158	All	Survey
Cost	Total Per Capita Cost (TPCC)	-	All	Claims

Reference Material - Measure Descriptions for NYS Primary Care Core Measure Set

Measure	ID	Description
Colorectal Cancer Screening	eCQM 130	The percentage of adults, ages 50 to 75 years, who had appropriate screening for colorectal cancer*.
Chlamydia Screening for Women	eCQM 153	The percentage of sexually active young women, ages 16 to 24 years, who had at least one test for chlamydia during the measurement year.*
Breast Cancer Screening	CMS 93	The percentage of women, ages 50 to 74 years, who had a mammogram anytime on or between October 1 two years prior to the measurement year and December 31 of the measurement year.*
Cervical Cancer Screening	eCQM 124	Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21-64 who had cervical cytology performed within the last 3 years - Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years.†
Adult Immunization Status - Electronic (Influenza)(AIS-E)	CMS 26	Percentage of members 19 years of age and older who are up-to-date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.†
Controlling High Blood Pressure	CMS 167	Controlling High Blood Pressure: The percentage of members, ages 18-85 years, who had hypertension and whose blood pressure was adequately controlled (<140/9 0mm Hg) during the measurement year.*
Diabetes HbA1C Poor Control (>9%)	eCQM 122	The percentage of members 18-75 years of age with diabetes (types 1 and 2) whose most recent hemoglobin A1c (HbA1c) level indicated poor control (>9.0 percent).*
Initiation and Engagement of Substance Use Disorder Treatment	CMS 394	Percentage of beneficiaries age 18 and older with substance use disorder (SUD) that result in treatment initiation within 14 days and engagement within 34 days.†
Screening for Depression and Follow-Up Plan	CMS 672	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.†
Plan All-Cause Readmissions	CMS 561	Adults ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.†
Emergency Department Utilization (EDU)	n/a NCQA	For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.‡
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	CMS 760	The percentage of children and adolescents, ages 3 to 17 years, who had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, receiving the following three components of care during the measurement year: BMI percentile, Counseling for nutrition, Counseling for physical activity*
Well-Child Visits in the First 30 Months of Life (W30)	CMS 761	The percentage of members who turned 15 or 30 months old during the measurement year, who had the recommended number of well-child visits during the last 15 months.*

Immunizations for Adolescents	CMS 363	The percentage of members, age 13 years, who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine by their 13th birthday.*
Child and Adolescent Well–Care Visits (WCV)	CMS 123	The percentage of members, ages 3 to 21 years, who had at least one well-care visit during the measurement year.*
Childhood Immunization Status	CMS 124	Percentage of children 2 years of age 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 separate combination rates.†
Screening for Social Drivers of Health	Quality ID 487	Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.†
Person-Centered Primary Care Measure (PCPCM)	CMS 1004	PCPCM PROM (a comprehensive and parsimonious set of 11 patient-reported items) to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high value aspects of primary care based on a patient's relationship with the clinician or practice. Patients identify the PCPCM PROM as meaningful and able to communicate the quality of their care to their clinicians and/or care team.†
CAHPS Overall Rating	CMS 158	Survey is comprised of 10 Summary Survey Measures (SSMs) and measures patient experience of care within a group practice. The NQF endorsement status and endorsement id (if applicable) for each SSM utilized in this measure are as follows: Getting Timely Care, Appointments, and Information; (Not endorsed by NQF) How well Providers Communicate; (Not endorsed by NQF) Patient s Rating of Provider; (NQF endorsed # 0005) Access to Specialists; (Not endorsed by NQF) Health Promotion and Education; (Not endorsed by NQF) Shared Decision-Making; (Not endorsed by NQF) Health Status and Functional Status; (Not endorsed by NQF) Courteous and Helpful Office Staff; (NQF endorsed # 0005) Care Coordination; (Not endorsed by NQF) Stewardship of Patient Resources. (Not endorsed by NQF).†
Total Per Capita Cost (TPCC)	-	An average of per capita costs across all attributed patients and includes all Medicare Parts A and B costs for one year following the identification of a primary care relationship. †

Measure Description References

**Centers for Medicare & Medicaid Services Measure Inventory Tool*

† eQARR, New York State Department of Health

‡ HEDIS, NCQA

Practice Level Benchmarks

PCMH Domain	Measure	Commercial	Medicaid	Medicare	Overall
Prevention	Breast Cancer Screening	74	65	77	72
	Cervical Cancer Screening	75	64	56	70
	Childhood Immunization Status	69	64	NA	65
	Colorectal Cancer Screening	54	48	70	56
	Chlamydia Screening in Women (16-20)	57	72	SS	67
	Chlamydia Screening in Women (21-24)	65	73	39	70
	Immunizations for Adolescents	27	40	NA	36
	Child and Adolescent Well-Care Visits - 12-17 yrs	77	70	NA	71
	Child and Adolescent Well-Care Visits - 15 months 6+ visits	88	67	NA	71
	Child and Adolescent Well-Care Visits - 18-21 yrs	49	47	SS	48
	Child and Adolescent Well-Care Visits - 30 months 2 visits	92	78	NA	80
	Child and Adolescent Well-Care Visits - 3-11 yrs	82	76	NA	77
	WCC - BMI Percentile 12-17 yrs	55	60	NA	59
	WCC - BMI Percentile 3-11 yrs	55	59	NA	58
	WCC - Counseling for Nutrition 12-17 yrs	35	51	NA	47
	WCC - Counseling for Nutrition 3-11 yrs	39	51	NA	49
	WCC - Counseling for Physical Activity 12-17 yrs	32	45	NA	42
	WCC - Counseling for Physical Activity 3-11 yrs	34	44	NA	42
Chronic Disease	Controlling High Blood Pressure	36	42	53	44
	Hemoglobin A1c Control for Patients with Diabetes	55	56	40	50
Behavioral Health	Engagement of Alcohol and Other Drug Treatment- 18+	15	18	6	15
	Initiation of Alcohol and Other Drug Treatment- 18+	37	49	38	45

Includes both PCMH and non-PCMH practices.

Payer Benchmarks

Domain	Measure	QARR 2022 Commercial HMO Statewide	QARR 2022 Commercial PPO Statewide	QARR 2022 Medicaid Managed Care Statewide	QARR 2022 Essential Plan* Statewide
Adult Health	Controlling High Blood Pressure	69	58	67	66
	Hemoglobin A1c Control for Patients with Diabetes- Poor AbA1c Control	28	30	35	31
	Colorectal Cancer Screening (Ages 50-75)	70	62	53	55
	Flu Vaccination for Adults Ages 18-64	56	52	43	40
Behavioral Health	Pharmacotherapy for Opioid Use Disorder	37	26	33	30
Child and Adolescent Health	Adolescent Immunization	93	87	87	-
	Childhood Immunization Status (Combo 3)	86	78	69	-
	Well-Child Visits in the First 30 Months of life (15 Months - 30 Months)	93	92	78	-
	Child and Adolescent Well-Care Visits (Total)	75	72	68	-
	Weight Assessment- BMI Percentile	89	78	85	-
	Counseling for Nutrition	86	73	82	-
	Counseling for Physical Activity	84	69	78	-
Provider Network	Satisfaction with Provider Communication	95	95	92	93
	Satisfaction with Personal Doctor	85	82	81	84
	Satisfaction with Specialist	84	85	79	85
Satisfaction with Care	Getting Care Needed	85	83	79	78
	Getting Care Quickly	85	83	79	77
	Customer Service	90	86	86	88
	Shared Decision Making	-	-	79	-
	Care Coordination	84	81	79	82
	Wellness Discussion	-	-	73	-
	Getting Needed Counseling or Treatment	-	-	60	-
Women's Health	Breast Cancer Screening	79	73	66	67
	Cervical Cancer Screening	80	81	70	73
	Chlamydia Screening (Ages 16-20)	53	59	72	64
	Chlamydia Screening (Ages 21-24)	59	66	73	72

**Essential Plan (EP) is a health plan for low-income New Yorkers who don't qualify for Medicaid. EP has no premium for those who qualify and offers essential benefits, federally known as the Basic Health Plan.*

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Primary Care Core Measure Set 2024

Thank you for taking the time to complete this survey. Your participation will ensure that the recommendations regarding the updated primary care core measure set reflect your experience and the needs of your organization and colleagues.
[Reference Materials]

* 1. Please enter contact information below.

Final responses and scores will be deidentified before sharing with the New York State Department of Health. This information will only be used to contact you if we have questions about your survey response.

First and Last Name

Email

* 2. Which best describes your perspective?

- ◯ Provider
- ◯ Plan
- ◯ Community Based Organization
- ◯ Consumer
- ◯ New York State Department of Health
- ◯ Other (please specify)

Primary Care Core Measure Set 2024

Ability to Report

* 3. Can you or your organization report this measure?

Please answer from your perspective.

	No, we could not report	Yes, we could report	Yes, we are already reporting this or a similar measure	None of the above (does not apply to me or cannot answer)
Colorectal Cancer Screening *eCQM 130*	○	○	○	○
Chlamydia Screening for Women *eCQM 153*	○	○	○	○
Breast Cancer Screening *CMS 93*	○	○	○	○
Cervical Cancer Screening *eCQM 124*	○	○	○	○
Adult Immunization Status - Electronic (Influenza)(AIS-E) *CMS 26*	○	○	○	○
Controlling High Blood Pressure *CMS 167*	○	○	○	○
Diabetes HbA1C Poor Control (>9%) *eCQM 122*	○	○	○	○
Initiation and Engagement of Substance Use Disorder Treatment *CMS 394*	○	○	○	○
Screening for Depression and Follow-Up Plan *CMS 672*	○	○	○	○
Plan All-Cause Readmissions *CMS 561*	○	○	○	○
Emergency Department Utilization (EDU) *NCQA*	○	○	○	○
Weight Assessment and Counseling for Nutrition and	○	○	○	○

Physical Activity for Children/Adolescents *CMS 760*				
Well-Child Visits in the First 30 Months of Life (W30) *CMS 761*	○	○	○	○
Immunizations for Adolescents *CMS 363*	○	○	○	○
Child and Adolescent Well–Care Visits (WCV) *CMS 123*	○	○	○	○
Childhood Immunization Status *CMS 124*	○	○	○	○
Screening for Social Drivers of Health *Quality ID 487*	○	○	○	○
Person-Centered Primary Care Measure (PCPCM) *CMS 1004*	○	○	○	○
CAHPS Overall Rating *CMS 158*	○	○	○	○
Total Per Capita Cost (TPCC)	○	○	○	○

Primary Care Core Measure Set 2024

Provider Burden

* 4. Is reporting this measure a burden for providers?

Please answer from your perspective.

	No provider burden	Some provider burden	Yes, a lot of provider burden	None of the above (does not apply to me or cannot answer)
Colorectal Cancer Screening *eCQM 130*	○	○	○	○
Chlamydia Screening for Women *eCQM 153*	○	○	○	○
Breast Cancer Screening *CMS 93*	○	○	○	○
Cervical Cancer Screening *eCQM 124*	○	○	○	○
Adult Immunization Status - Electronic (Influenza)(AIS-E) *CMS 26*	○	○	○	○
Controlling High Blood Pressure *CMS 167*	○	○	○	○
Diabetes HbA1C Poor Control (>9%) *eCQM 122*	○	○	○	○
Initiation and Engagement of Substance Use Disorder Treatment *CMS 394*	○	○	○	○
Screening for Depression and Follow-Up Plan *CMS 672*	○	○	○	○
Plan All-Cause Readmissions *CMS 561*	○	○	○	○
Emergency Department Utilization (EDU) *NCQA*	○	○	○	○
Weight Assessment and Counseling for Nutrition and	○	○	○	○

Physical Activity for Children/Adolescents *CMS 760*				
Well-Child Visits in the First 30 Months of Life (W30) *CMS 761*	○	○	○	○
Immunizations for Adolescents *CMS 363*	○	○	○	○
Child and Adolescent Well–Care Visits (WCV) *CMS 123*	○	○	○	○
Childhood Immunization Status *CMS 124*	○	○	○	○
Screening for Social Drivers of Health *Quality ID 487*	○	○	○	○
Person-Centered Primary Care Measure (PCPCM) *CMS 1004*	○	○	○	○
CAHPS Overall Rating *CMS 158*	○	○	○	○
Total Per Capita Cost (TPCC)	○	○	○	○

Primary Care Core Measure Set 2024

Plan Burden

* 5. Is reporting this measure a burden for plans?

Please answer from your perspective.

	No plan burden	Some plan burden	Yes, a lot of plan burden	None of the above (does not apply to me or cannot answer)
Colorectal Cancer Screening *eCQM 130*	○	○	○	○
Chlamydia Screening for Women *eCQM 153*	○	○	○	○
Breast Cancer Screening *CMS 93*	○	○	○	○
Cervical Cancer Screening *eCQM 124*	○	○	○	○
Adult Immunization Status - Electronic (Influenza)(AIS-E) *CMS 26*	○	○	○	○
Controlling High Blood Pressure *CMS 167*	○	○	○	○
Diabetes HbA1C Poor Control (>9%) *eCQM 122*	○	○	○	○
Initiation and Engagement of Substance Use Disorder Treatment *CMS 394*	○	○	○	○
Screening for Depression and Follow-Up Plan *CMS 672*	○	○	○	○
Plan All-Cause Readmissions *CMS 561*	○	○	○	○
Emergency Department Utilization (EDU) *NCQA*	○	○	○	○
Weight Assessment and Counseling for Nutrition and	○	○	○	○

Physical Activity for Children/Adolescents *CMS 760*				
Well-Child Visits in the First 30 Months of Life (W30) *CMS 761*				
Immunizations for Adolescents *CMS 363*				
Child and Adolescent Well–Care Visits (WCV) *CMS 123*				
Childhood Immunization Status *CMS 124*				
Screening for Social Drivers of Health *Quality ID 487*				
Person-Centered Primary Care Measure (PCPCM) *CMS 1004*				
CAHPS Overall Rating *CMS 158*				
Total Per Capita Cost (TPCC)				

Primary Care Core Measure Set 2024

Relevance to Primary Care

* 6. Can this measure be impacted by a primary care provider?

Please answer from your perspective.

	No	Maybe	Yes	None of the above (does not apply to me or cannot answer)
Colorectal Cancer Screening *eCQM 130*	○	○	○	○
Chlamydia Screening for Women *eCQM 153*	○	○	○	○
Breast Cancer Screening *CMS 93*	○	○	○	○
Cervical Cancer Screening *eCQM 124*	○	○	○	○
Adult Immunization Status - Electronic (Influenza)(AIS-E) *CMS 26*	○	○	○	○
Controlling High Blood Pressure *CMS 167*	○	○	○	○
Diabetes HbA1C Poor Control (>9%) *eCQM 122*	○	○	○	○
Initiation and Engagement of Substance Use Disorder Treatment *CMS 394*	○	○	○	○
Screening for Depression and Follow-Up Plan *CMS 672*	○	○	○	○
Plan All-Cause Readmissions *CMS 561*	○	○	○	○
Emergency Department Utilization (EDU) *NCQA*	○	○	○	○
Weight Assessment and Counseling for Nutrition and	○	○	○	○

Physical Activity for Children/Adolescents *CMS 760*				
Well-Child Visits in the First 30 Months of Life (W30) *CMS 761*				
Immunizations for Adolescents *CMS 363*				
Child and Adolescent Well–Care Visits (WCV) *CMS 123*				
Childhood Immunization Status *CMS 124*				
Screening for Social Drivers of Health *Quality ID 487*				
Person-Centered Primary Care Measure (PCPCM) *CMS 1004*				
CAHPS Overall Rating *CMS 158*				
Total Per Capita Cost (TPCC)				

Primary Care Core Measure Set 2024

Rank by Domain

Please rank these measures from your perspective in order of priority for inclusion in the scorecard, with 1 being the highest priority for inclusion.

Not all measures will be included in the final recommendation. Please think of each domain individually when ranking which measures are the most important for inclusion.

* 7. Prevention

- ☐ Colorectal Cancer Screening
  eCQM 130
- ☐ Chlamydia Screening for Women
  eCQM 153
- ☐ Breast Cancer Screening
  CMS 93
- ☐ Cervical Cancer Screening
  eCQM 124
- ☐ Adult Immunization Status - Electronic (Influenza)(AIS-E)
  CMS 26

* 8. Children and Adolescents

- ☐ Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  CMS 760
- ☐ Well-Child Visits in the First 30 Months of Life (W30)
  CMS 761
- ☐ Immunizations for Adolescents
  CMS 363
- ☐ Child and Adolescent Well–Care Visits (WCV)
  CMS 123
- ☐ Childhood Immunization Status
  CMS 124

* 9. Chronic Disease

- [ ] Controlling High Blood Pressure
  CMS 167
- [ ] Diabetes HbA1C Poor Control (>9%)
  eCQM 122

* 10. Behavioral Health

- [ ] Initiation and Engagement of Substance Use Disorder Treatment
  CMS 394
- [ ] Screening for Depression and Follow-Up Plan
  CMS 672

* 11. Patient Reported

- [ ] Person-Centered Primary Care Measure (PCPCM)
  CMS 1004
- [ ] CAHPS Overall Rating
  CMS 158

* 12. Utilization

- [ ] Plan All-Cause Readmissions
  CMS 561
- [ ] Emergency Department Utilization (EDU)
  NCQA

Rate by Domain

Single measure domains will be prioritized below through rating.

* 13. Rate the following measures based on level of priority for inclusion in the scorecard, with 1 being the highest priority for inclusion, and 5 being the lowest priority.

	1 *high priority*	2	3	4	5 *low priority*
Domain: Health Equity Screening for Social Drivers of Health Quality ID 487	○	○	○	○	○
Domain: Cost Total Per Capita Cost (TPCC)	○	○	○	○	○

Appendix D

Primary Care Core Measure Set Pre-Scored
Measure Scoring Matrix 2024

MEASURE PRINCIPLES, CRITERIA, CONSIDERATIONS		Score	Controlling High Blood Pressure	Colorectal Cancer Screening - Electronic	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Comprehensive Diabetes Care (CDC): A1C Poor Control	Well-Child Visits in the First 30 Months of Life	Immunizations for Adolescents	Chlamydia Screening	Breast Cancer Screening	Cervical Cancer Screening	Childhood Immunization Status	Screening for Social Drivers of Health	Total Per Capita Cost (TPCC)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Plan All-Cause Readmissions	Screening for Clinical Depression and Follow-up Plan	Adult Immunization Status - Electronic (Influenza)(AIS-E)	Person-Centered Primary Care Measure (PCPCM)	CAHPS Overall Rating	Emergency Department Utilization (EDU)
Relevant to special populations			Adults 18 - 85	Adults: 50 - 75 Years	Child/Adolescents: 3-17 years	Adults 18 - 85			Adolescents/Adults: 16 - 24 Years	Adults: 50 -74	Adults: 21 - 64	Children: 2 Years Old			Adolescents/Adults: 13+	Adults: 18-64	Adolescents/Adults: 12 years +	Adults: 19+			
PRINCIPLES	**Relevant to NYS primary care goals***	P/F	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
	Addresses the Quadruple Aim* (Population Health, Experience/Quality of Care, Per Capita Cost, or Clinician Wellness)	P/F	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
	Standardized * (Measure exhibits desirable statistical properties e.g., room to improve, meaningful variation, consistently scoreable)	P/F	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P	P
	Subtotal Pass		**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**	**P**
ESSENTIAL CRITERIA	**Ability to Report/Burden**	0 - 3																			
	Relevance to Primary Care	0 - 3																			
	Aligned with payer measure sets*																				
	CMMI Medicare PC Demonstration- AHEAD	0-1	1	1	0	1	0	0	0	1	0	0	0	1	0	0	1	0	0	0	0
	CMMI Medicare PC Demonstration- MCP	0-1	1	1	0	1	0	0	0	0	0	0	1	0	0	0	1	0	1	0	1
	CMS Universal Foundation Measure	0-1	1	1	1	1	1	1	0	1	0	1	0	0	1	1	1	1	0	1	0
	Sum of 3 lines above		3	3	1	3	1	1	0	2	0	1	1	1	1	1	3	1	1	1	1
	Type of Measure*	0 - 3	3	1	1	3	1	1	1	1	1	1	1	1	1	3	1	1	3	3	1
KEY CONSIDERATIONS	**Measure can be evaluated at the level of analysis for intended use**** (e.g. Health Plan, Integrated Health System, Group/Practice, Clinician)	0 - 3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	0	3	3
	Notable performance gap or opportunity for improvement in NYS‡	0 - 3	3	3	3	3	3	3	3	3	3	3	3	3	3	0	3	3	3	3	3
	Subtotal Key Considerations		**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**3**	**6**	**6**	**3**	**6**	**6**
TOTAL SCORE: ESSENTIAL CRITERIA + KEY CONSIDERATIONS																					

Notes:
We recognize that the scoring process involves providing opinions and making subjective judgements and we encourage you to do so.

The scale for scoring the essential criteria and key considerations is 0-3, 0=no, 1=low, 2=medium, 3=high.
The scale for scoring the type of measure is 0=utilization, 1=process, 2=interim outcome, 3=outcome, 3=patient reported outcome-performance measure. This field has been prepopulated.
*Scores are prepopulated.
** Populated as 3 if measure is included in Health plans or use in any of the following programs: CPC+, eCQMs, Part C & D Star Ratings Measures, MSSP, and MIPS.
‡Appendix B provides additional data about measure performance (when available) to guide scoring. Aligned with NCQA defintion of "room for improvement" as an average performance of less than 90% equals 3 or 0 if performance >=90%.