

**SUMMARY OF UPDATES TO THE ADULT CORE SET MEASURES
TECHNICAL SPECIFICATIONS AND RESOURCE MANUAL
JUNE 2016**

Overall Changes

- Updated reporting year to FFY 2016, and data collection timeframe to 2015.
- Added information about coding systems used in each measure.
- Updated specifications, value set codes, copyright, and table source information to HEDIS 2016 for all HEDIS measures.
- Added two new measures:
 - Measure OHD-AD: Use of Opioids at High Dosage
 - Measure SSD-AD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

I. The Core Set of Adult Health Care Quality Measures

- Inserted information about updates to the 2016 Adult Core Set.

II. Data Collection and Reporting of the Adult Core Set

- Added guidance on using the Medicaid and CHIP Program (MACPro) system for quality measure reporting:
 - CMS has designated the Medicaid and CHIP Program (MACPro) system as the online tool that states should use when reporting Adult Core Set measures. More information on the use of MACPro for quality measure reporting is available at <https://www.medicaid.gov/state-resource-center/medicaid-and-chip-program-portal/medicaid-and-chip-program-portal.html>. Further information on technical assistance for MACPro is provided at the end of this chapter.
- Added guidance to the Data Collection Time Frames for Measures bullet that the look-back period should not be included in the measure start and end dates:
 - For each measure, the measurement period used to calculate the denominator should be reported in the “Start Date” and “End Date” fields in MACPro. For many measures, the denominator measurement period for FFY 2016 corresponds to calendar year 2015 (January 1, 2015 – December 31, 2015). Some measures, however, also require states to review utilization or enrollment prior to this period to identify the measure-eligible population. States should not include these review periods (sometimes referred to as “look-back” periods) in the Start and End date range. Further information regarding measurement periods is available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/ff-2016-adult-core-set-measurement-periods.pdf>.
- Added bullet on the Anchor Date with guidance on determining an individual’s eligibility for a measure:

- Some measures include an anchor date, which is the date that an individual must be enrolled 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 2016 measurement period (December 31, 2015). 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.
- Added bullet on Enrollees with Partial Benefits with guidance about when to include enrollees with partial benefits in the measure denominator.
 - For each measure, states should include only the Medicaid/CHIP enrollees who are eligible to receive the services assessed in the numerator. If an enrollee is not eligible to receive the services assessed in the measure, the enrollee 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 enrollees in their state.
- Updated the bullet on Reporting a Weighted Rate with guidance for how to enter measure information in MACPro:
 - 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 MACPro. 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?” If the state has the numerator and denominator that were used to calculate the state-level rate, they should be entered in the Numerator and Denominator fields. If this information is not available, a state can enter “0” in the Numerator and Denominator fields, report the state-level rate in the “Rate” field, and explain the missing information in the “Additional Notes/Comments on Measure” section. If possible, the state should also provide the numerators, denominators, measure-eligible population, and rates for each health plan, delivery system, or program in this section as well as a description of the method used to calculate the state-level rate (including the approach used for weighting).
- Added bullet with information about how to calculate measures affected by the conversion from ICD-9 to ICD-10 codes:
 - 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. The following Adult Core Set measures are affected by this conversion: ABA, AMM, BCS, CBP, CCS, CHL, FUH, HA1C, HPC, HVL, IET, OHD, PC01, PC03, PCR, PQI01, PQI05, PQI08, PQI15, PPC, SAA, and SSD.
 - For HEDIS measures, the ICD-10 codes are included in the value set directory. For non-HEDIS measures, the ICD-10 codes are available in the specification or at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2016-Adult-ICD10-Codes.zip>.

- Modified bullets on Reporting and Submission to include information about MACPro.

III. Technical Specifications

Measure ABA: Adult Body Mass Index Assessment

- Modified age references from “19 years” to “20 years.”
- Revised numerator language for the administrative method:
 - For enrollees age 20 or older on the date of service, BMI (BMI Value Set) during the measurement year or the year prior to the measurement year.
 - For enrollees younger than age 20 on the date of service, BMI percentile (BMI Percentile Value Set) during the measurement year or the year prior to the measurement year.
- Revised medical record review language for the hybrid method:
 - For Medicaid enrollees age 20 and older on the date of service, documentation in the medical record must indicate the weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The weight and BMI must be from the same data source.
 - For Medicaid enrollees younger than age 20 on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The weight and BMI percentile must be from the same data source.

Measure AMM: Antidepressant Medication Management

- Added instructions and value sets to identify acute and nonacute inpatient discharges for required exclusions.
- Clarified that the discharge date from the last discharge should be used for direct transfers.
- Modified numerator 1 language:
 - At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 114 days after the IPSD (115 total days). Continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.
- Modified numerator 2 language:
 - At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) beginning on the IPSD through 231 days after the IPSD (232 total days). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.
- Updated Table AMM-C to reflect the current NDC list.

Measure BCS: Breast Cancer Screening

- Updated Guidance for Reporting to clarify age range for eligible population:
 - This measure should include all women 52 to 74 years of age who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
- Modified optional exclusions language:
 - Any combination of codes that indicate a mastectomy on both the left and right side on the same or different dates of service:

Left Mastectomy (any of the following)	Right Mastectomy (any of the following)
Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same date of service)	Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Right Modifier Value Set</u>) (same date of service)
Absence of the left breast (<u>Absence of Left Breast Value Set</u>)	Absence of the right breast (<u>Absence of Right Breast Value Set</u>)
Left unilateral mastectomy (<u>Unilateral Mastectomy Left Value Set</u>)	Right unilateral mastectomy (<u>Unilateral Mastectomy Right Value Set</u>)

- Added new value set to identify history of bilateral mastectomy (History of Bilateral Mastectomy Value Set).

Measure CBP: Controlling High Blood Pressure

- Updated Guidance for Reporting:
 - To identify the eligible population for this measure, states should use administrative data to select all enrollees who had an outpatient visit with a diagnosis of hypertension during the first six months of the measurement year (January 1, 2015 - June 30, 2015). To identify the denominator, states should then review the enrollee’s medical record to confirm the hypertension diagnosis, which can be recorded anytime during the enrollee’s history on or before June 30 of the measurement year. If the enrollee’s diagnosis cannot be confirmed then exclude the enrollee.
- Updated event/diagnosis section:
 - Added HCPCS codes to the value set to identify outpatient visits. The new value set name is Outpatient Without UBREV Value Set.
- Revised the diabetes flag for the numerator:
 - Updated how the diabetes flag is assigned. Removed the criteria for polycystic ovaries when assigning a flag of “not diabetic.”
 - Added that those who are not initially assigned a diabetes flag are classified as “not diabetic.”
- Updated Table CBP-A to reflect the current NDC list.
- Added language to the hybrid denominator section:

- If the diagnosis of hypertension cannot be confirmed, the enrollee is excluded and replaced by the next enrollee from the oversample.
- Updated the optional exclusions section to include instructions and value sets for identifying nonacute inpatient admissions.
- Clarified that a problem list found in an office visit note should be considered a dated problem list and the date of the visit must be used.
- Added a note to clarify when states may change a diabetes flag that was assigned based on administrative data.

Measure CCS: Cervical Cancer Screening

- Updated Guidance for Reporting to clarify age range for eligible population:
 - This measure should include (1) all women ages 21 to 64 who have had a cervical cytology (Pap test) during the measurement year or the two years prior to the measurement year, and (2) women ages 30 to 64 who have had a cervical cytology/HPV co-test during the measurement year or the four years prior to the measurement year. Both criteria must be evaluated for numerator compliance; however, enrollees only need to meet one criteria to be included in the numerator for the measure.
- Revised optional exclusions language:
 - Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy”
 - Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening
 - Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

Measure CDF: Screening for Clinical Depression and Follow-up Plan

- Updated CPT codes in Table CDF-A to align with Version 9.1 of the measure specifications.

Measure CHL: Chlamydia Screening in Women

- Updated optional exclusion criteria:
 - Exclude women who qualified for the denominator based on a pregnancy test (Pregnancy Tests Value Set) alone and who meet either of the following:
 - A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and a prescription for isotretinoin (Table CHL-B) on the date of the pregnancy test or within the 6 days after the pregnancy test
 - A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or within the 6 days after the pregnancy test

Measure CTR: Timely Transmission of Transition Record

- Updated Guidance for Reporting:

- The measure includes transfers between hospitals, but excludes transfers within the same facility.
- The intent of the measure is to capture whether the inpatient facility sent a transition record including all required elements, as shown in Figure CTR-A. It is not necessary to confirm the transition record was received by the health care provider designated for follow-up care.
- Added language to the definition of “transmitted”:
 - The time and method of transmission should be documented to assess whether transmission was timely.
- Added language to the definition of “current medication list”:
 - The current medication list should include, at a minimum, medications in the following categories (including prescription, herbal products and over-the-counter medications):

Medications to be TAKEN by patient: Medications prescribed or recommended prior to inpatient stay to be continued after discharge, AND new medications started during the inpatient stay to be continued after discharge. Prescribed or recommended dosage, instructions, and intended duration must be included for each continued and new medication listed.

Medications NOT to be taken by patient: Medications (prescriptions, herbal products and over-the-counter medications) taken by patient before the inpatient stay that should be discontinued or held after discharge, AND medications administered during the inpatient stay that caused an allergic reaction, AND medications with which current prescriptions may react.
- Modified the definition of “contact information/plan for follow-up care”:
 - For enrollees discharged to an inpatient facility, the transition record may indicate that the four elements of 24-hour/7-day contact information are to be discussed between the discharging and the “receiving” facilities, including (1) physician for emergencies related to inpatient stay, (2) contact information for obtaining results of studies pending at discharge, (3) plan for follow-up care, and (4) primary physician, other healthcare professional, or site designated for follow-up care.
- Added a code for “discharged/transferred to court/law enforcement” to Table CTR-B to align with the current version of the measure specifications.
- Added a field for “principal diagnosis at discharge” to Figure CTR-A to align with the current version of the measure specifications.

Measure FUH: Follow-Up After Hospitalization for Mental Illness

- Updated Guidance for Reporting:
 - Follow the detailed specifications to (1) include the appropriate discharge when the patient 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 patient was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.

- Added instructions and value sets to identify acute inpatient discharges, readmissions, and transfers.
- Added language clarifying that states must use their own methods to identify “transfers.”
- Updated acute facility readmission or direct transfer language:
 - If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

Measure FVA: Flu Vaccinations for Adults Ages 18 to 64

- Added additional note regarding the small denominator threshold that requires at least 100 responses to be reportable.

Measure HA1C: Comprehensive Diabetes Care: Hemoglobin A1c Testing

- Clarified that the allowable gap language refers to the continuous enrollment period instead of the measurement year.
- Updated Table HA1C-A to reflect the current NDC list.
- Removed the optional exclusion for polycystic ovaries and added a note clarifying when the optional exclusions may apply.
- Updated optional exclusions to include enrollees who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Measure HPC: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)

- Updated Table HPC-A to reflect the current NDC list.
- Removed the optional exclusion for polycystic ovaries and added a note clarifying when the optional exclusions may apply.
- Updated optional exclusions to include enrollees who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Measure HVL: HIV Viral Load

- Updated Guidance for Reporting:
 - In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge or date of service on or after October 1, 2015. ICD-10 codes for this measure are available in Table HVL-B.
- Added language to the denominator section:

- Medical visits that occurred any time during the measurement year should be included in the denominator for the measure; there are no restrictions regarding the date of the visit relative to the date of HIV diagnosis.

Measure IET: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- Modified the “IESD” definition:
 - For direct transfers, the IESD is the discharge date from the last admission.
- Updated event/diagnosis section and numerator specification to include instructions and a value set for identifying acute and nonacute inpatient discharges.
- Clarified that the timeframe for initiation of AOD treatment (rate 1) is on the IESD or in the 13 days after the IESD (14 total days), if the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification, or ED visit.
- Clarified the timeframe for engagement of AOD treatment (rate 2):
 - For Medicaid enrollees who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.
 - The time frame for engagement, which includes the initiation event, is 30 total days.

Measure MPM: Annual Monitoring for Patients on Persistent Medications

- Added instructions and value sets to the optional exclusions section to identify acute and nonacute inpatient encounters.

Measure MSC: Medical Assistance with Smoking and Tobacco Use Cessation

- Updated Guidance for Reporting:
 - This measure uses a rolling two-year average to achieve a sufficient number of respondents for reporting. First-year data collection will generally not yield enough responses to be reportable. If the denominator is less than 100, the measure is not reported.
- Clarified that the allowable gap language refers to the continuous enrollment period instead of the measurement year.
- Added information to the calculation of measure section:
 - If the state did not report results for the current year (Year 2), the measure is not reported.

Measure PC01: PC-01 Elective Delivery

- Updated Guidance for Reporting:
 - Medical record review or use of vital records is required to determine both the numerator and denominator for this measure. The Hybrid Specification section includes a link to The Joint Commission sampling guidelines that can ease the burden of the medical record review process.

- In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2016-Adult-ICD10-Codes.zip>.
- In the numerator section, replaced “not experiencing spontaneous rupture of membranes” with “no history of a prior uterine surgery.”
- Added exclusion for those with unknown gestational age.

Measure PC03: PC-03 Antenatal Steroids

- Updated Guidance for Reporting:
 - Medical record review or use of vital records is required to determine both the numerator and denominator for this measure. The Hybrid Specification section includes a link to The Joint Commission sampling guidelines that can ease the burden of the medical record review process.
 - In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2016-Adult-ICD10-Codes.zip>.
- Added exclusion for those with unknown gestational age.

Measure PCR: Plan All-Cause Readmission Rate

- Added instructions and value sets to identify acute inpatient admissions and discharges.
- Added language clarifying which stay should be used to identify exclusions in cases of acute-to-acute transfers.
- Added language clarifying that states must use their own methods to identify “transfers.”

Measure PPC: Postpartum Care Rate

- Modified event/diagnosis criteria for identifying the eligible population:
 - Removed the identification of deliveries through infant claims.
 - Revised language to “Include women who delivered in any setting.”

Measure PQI01: PQI 01 Diabetes Short-term Complications Admission Rate

- Updated Guidance for Reporting:
 - Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the “Deviations from Measurement Specifications” section in MACPro.
 - In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims

with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2016-Adult-ICD10-Codes.zip>.

- Include paid claims only.

Measure PQI05: PQI 05 Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate

- Updated Guidance for Reporting:
 - Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the “Deviations from Measurement Specifications” section in MACPro.
 - In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2016-Adult-ICD10-Codes.zip>.
 - Include paid claims only.
- Added ICD-9-CM codes to Table PQI 05-A to align with Version 5.0 of the measure specifications.

Measure PQI08: PQI 08 Heart Failure Admission Rate

- Updated Guidance for Reporting:
 - Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the “Deviations from Measurement Specifications” section in MACPro.
 - In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2016-Adult-ICD10-Codes.zip>.
 - Include paid claims only.
- Added ICD-9-CM codes to Table PQI 08-A to align with Version 5.0 of the measure specifications.

Measure PQI15: PQI 15 Asthma in Younger Adults Admission Rate

- Updated Guidance for Reporting:
 - Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the “Deviations from Measurement Specifications” section in MACPro.

- In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/2016-Adult-ICD10-Codes.zip>.
- Include paid claims only.

Measure SAA: Adherence to Antipsychotics for Individuals with Schizophrenia

- Modified the “index prescription start date” definition:
 - The earliest prescription dispensing date for any antipsychotic medication during the measurement year.
- Modified the required exclusion language in step 2. Removed the requirement that one of the dispensing events had to be on or between January 1 and September 30 due to the revised IPSD time frame.
- Updated Table SAA-A to reflect the current NDC list.