

Core Set of Adult Health Care Quality Measures for Medicaid
(Adult Core Set)

Technical Specifications and Resource Manual for
Federal Fiscal Year 2016 Reporting

June 2016

Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services



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ACKNOWLEDGMENTS

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CONTENTS

ACKNOWLEDGMENTS.....	iii
I. THE CORE SET OF ADULT HEALTH CARE QUALITY MEASURES (ADULT CORE SET).....	1
Background	1
Description of the Adult Core Set.....	1
II. DATA COLLECTION AND REPORTING OF THE ADULT CORE SET.....	5
Data Collection and Preparation for Reporting	5
Reporting and Submission	8
Technical Assistance.....	10
III. TECHNICAL SPECIFICATIONS.....	11
Measure ABA-AD: Adult Body Mass Index Assessment	12
Measure AMM-AD: Antidepressant Medication Management.....	15
Measure BCS-AD: Breast Cancer Screening	19
Measure CBP-AD: Controlling High Blood Pressure	21
Measure CCS-AD: Cervical Cancer Screening.....	29
Measure CDF-AD: Screening for Clinical Depression and Follow-Up Plan.....	33
Measure CHL-AD: Chlamydia Screening in Women	36
Measure CPA-AD: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H, Adult Version (Medicaid)	39
Measure CTR-AD: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).....	41
Measure FUH-AD: Follow-Up After Hospitalization for Mental Illness	48
Measure FVA-AD: Flu Vaccinations for Adults Ages 18 to 64	52
Measure HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Testing.....	54
Measure HPC-AD: Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	59
Measure HVL-AD: HIV Viral Load Suppression.....	64
Measure IET-AD: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment....	67
Measure MPM-AD: Annual Monitoring for Patients on Persistent Medications.....	72
Measure MSC-AD: Medical Assistance With Smoking and Tobacco Use Cessation	77
Measure OHD-AD: Use of Opioids at High Dosage	81
Measure PC01-AD: PC 01: Elective Delivery	92
Measure PC03-AD: PC-03: Antenatal Steroids	109
Measure PCR-AD: Plan All-Cause Readmissions Rate	124
Measure PPC-AD: Postpartum Care Rate.....	129
Measure PQI01-AD: PQI 01: Diabetes Short-Term Complications Admission Rate.....	132
Measure PQI05-AD: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	135

Measure PQI08-AD: PQI 08: Heart Failure Admission Rate 139

Measure PQI15-AD: PQI 15: Asthma in Younger Adults Admission Rate 147

Measure SAA-AD: Adherence to Antipsychotics for Individuals with Schizophrenia..... 150

Measure SSD-AD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who
Are Using Antipsychotic Medications 155

APPENDIX A: ADULT CORE SET HEDIS® VALUE SET DIRECTORY USER MANUAL 161

APPENDIX B: GUIDANCE FOR SELECTING SAMPLE SIZES FOR HEDIS® HYBRID
MEASURES 169

APPENDIX C: GUIDANCE FOR CONDUCTING THE ADULT CONSUMER ASSESSMENT OF
HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) HEALTH PLAN SURVEY 5.0H
(MEDICAID) 173

APPENDIX D: DEFINITION OF MEDICAID/CHIP CORE SET PRACTITIONER TYPES 179

APPENDIX E: ADDITIONAL INFORMATION ON DATA ELEMENTS FOR MEASURE PC-01:
ELECTIVE DELIVERY AND MEASURE PC-03: ANTENATAL STEROIDS 183

APPENDIX F: CAHPS® HEALTH PLAN SURVEY 5.0H ADULT QUESTIONNAIRE (MEDICAID) 195

I. THE CORE SET OF ADULT HEALTH CARE QUALITY MEASURES (ADULT CORE SET)

Background

The Affordable Care Act (Public Law 111-148) required the Secretary of Health and Human Services (HHS) to identify and publish a core set of health care quality measures for Medicaid-enrolled adults (Adult Core Set). This legislation parallels the requirement under Title IV of the Children's Health Insurance Program Reauthorization Act (CHIPRA; Public Law 111-3) to identify and publish a core set of quality measures for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

Implementation of the Adult Core Set will help CMS and states move toward a national system for measurement, reporting, and quality improvement. The data collected from these measures will help states and CMS to better understand the quality of health care that adults enrolled in Medicaid receive. As required by the Affordable Care Act, a Secretary's annual report on the quality of care for adults enrolled in Medicaid will be released every September, summarizing state-specific and national information on the quality of health care furnished to adults enrolled in Medicaid. These reports are available on Medicaid.gov at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>.

Description of the Adult Core Set

In January 2012, the Secretary selected and published an initial core set of 26 adult health care quality measures for voluntary use by states. The Affordable Care Act required the Secretary to issue updates to the Adult Core Set beginning in January 2014 and annually thereafter. The following resources describe the initial core set and recent updates.

- Initial Core Set: Background on the Initial Core Set can be found at: <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>.
- 2014 Adult Core Set Update: One measure was replaced in the Adult Core Set (Annual HIV Medical Visit was replaced by HIV Viral Load Suppression). Additional information on the 2014 Adult Core Set can be found at: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf>.
- 2015 Adult Core Set Update: One measure was replaced in the Adult Core Set (Comprehensive Diabetes Care: LDL Screening was replaced by Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)). Additional information on the 2015 Adult Core Set can be found at: <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf>.
- 2016 Adult Core Set Update: Two measures were added to the Adult Core Set (Use of Opioids at High Dosage and Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications). Additional information on the 2016 Adult Core Set is available in a December 2015 CMCS Informational Bulletin (<http://medicaid.gov/federal-policy-guidance/downloads/CIB-12-11-15.pdf>).

The following table lists each Adult Core Set measure, the National Quality Forum (NQF) number (when the measure is NQF-endorsed), 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), electronic health records, and

surveys. The technical specifications in Chapter III of this manual provide additional details for each measure.

NQF #	Measure Steward ^a	Measure Name	Data Collection Method(s)
Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS)	Administrative or hybrid
0033	NCQA	Chlamydia Screening in Women (CHL)	Administrative
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA)	Survey
0418	CMS	Screening for Clinical Depression and Follow-Up Plan (CDF)	Hybrid
2372	NCQA	Breast Cancer Screening (BCS)	Administrative
NA	NCQA	Adult Body Mass Index Assessment (ABA)	Administrative or hybrid
Maternal and Perinatal Health			
0469	TJC	PC-01: Elective Delivery (PC01)	Hybrid
0476	TJC	PC-03: Antenatal Steroids (PC03)	Hybrid
1517	NCQA	Postpartum Care Rate (PPC)	Administrative or hybrid
Behavioral Health and Substance Use			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Administrative
0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	Survey
0105	NCQA	Antidepressant Medication Management (AMM)	Administrative
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	Administrative
NA	NCQA	Adherence to Antipsychotics for Individuals with Schizophrenia (SAA)	Administrative
NA	PQA	Use of Opioids at High Dosage (OHD)*	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP)	Hybrid
0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Testing (HA1C)	Administrative or hybrid
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) (HPC)	Administrative or hybrid
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15)	Administrative
1768	NCQA	Plan All-Cause Readmissions Rate (PCR)	Administrative
2082	HRSA	HIV Viral Load Suppression (HVL)	Administrative

NQF #	Measure Steward ^a	Measure Name	Data Collection Method(s)
2371	NCQA	Annual Monitoring for Patients on Persistent Medications (MPM)	Administrative
Care Coordination			
0648	AMA-PCPI	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (CTR)	Hybrid
Experience of Care			
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid) (CPA)^b	Survey

AHRQ = Agency for Healthcare Research & Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CMS = Centers for Medicare & Medicaid Services; HRSA = Health Resources and Services Administration; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission.

* This measure was added to the 2016 Adult Core Set.

^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 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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II. DATA COLLECTION AND REPORTING OF THE ADULT CORE SET

To support consistency in reporting the Adult 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.

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.

Data Collection and Preparation for Reporting

- Version of specifications. This manual includes the most applicable version of the measure specifications available to CMS as of December 2015. For HEDIS measures, this manual follows HEDIS 2016 specifications (2015 measurement year). For non-HEDIS measures, the manual includes the most applicable version of the specifications available from the measure steward for reporting 2015 data.
- Value sets. HEDIS 2016 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 Value Set Directory (VSD) includes all value sets and codes needed to report all HEDIS measures included in the Adult Core Set. Value set references are underlined in the specifications (e.g., BMI Percentile Value Set). The Value Set Directory is available at <https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2016-adult-value-set-directory.zip>. Refer to Appendix A for a HEDIS Value Set Directory User Manual.
- Data collection time frames for measures. States should 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 hospital discharge for a mental health condition. 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 2015 data should be reported for FFY 2016. 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/quality-of-care/downloads/ffy-2016-adult-core-set-measurement-periods.pdf>.
- Continuous enrollment. This refers to the time frame during which an enrollee must be eligible for benefits to be included in the measure denominator. The technical specifications provide the continuous enrollment requirement for each measure, if applicable.
- Allowable gap. Some measures specify an allowable gap that can occur during continuous enrollment. For example, the Controlling High Blood Pressure measure requires

continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in enrollment of up to 45 days. Thus, an enrollee 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 enrollee has one 38-day gap (January 1–February 7).

- Anchor date. 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.
- Reporting unit. CMS defines the reporting unit for each measure as each state's Medicaid program. This means that states reporting any of the core measures should collect data across all of the health care delivery systems used in their adult Medicaid programs (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care [MC]). For maternity measures, states are asked to include CHIP-enrolled women in their calculations; see bullet directly below. If data are collected separately across Medicaid and CHIP or across a state's various health care delivery systems, states should aggregate data from all these sources into one state-level rate before reporting the data to CMS. For more guidance about developing a state-level rate, see the bullet on "aggregating information for state-level reporting" below.
- Eligible population for measurement. For all measures, the denominator includes Medicaid enrollees who satisfy measure-specific eligibility criteria. For the maternity measures only (Elective Delivery, Antenatal Steroids, and Postpartum Care Rate), the eligible population should also include CHIP-enrolled women who satisfy the measure-specific eligibility criteria.
- Enrollees with partial benefits. 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.
- Aggregating information for state-level reporting. To obtain a state-level rate for a measure that is developed from the rates of multiple units of measurement (such as multiple managed care organizations [MCOs] or across MC and FFS delivery systems), the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual MCOs) 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-level rates, refer to the TA Brief titled "Approaches to Developing State-level Rates Using Data from Multiple Sources."¹

¹ The TA Brief, "Approaches to Developing State-level Rates Using Data from Multiple Sources," is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.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 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).
- Age criteria. For the purpose of Adult Core Set reporting, states should calculate and report measures in two age groups (as applicable): Medicaid enrollees under age 65 and those age 65 and older. States should note any deviations from the specifications in the “Deviations from Measure Specifications” field in MACPro.
- Exclusions. Some measure specifications contain required or optional exclusions. A Medicaid or CHIP enrollee who meets required exclusion criteria should be removed from the measure denominator. Some exclusions are optional. States should note when reporting whether optional exclusions are applied.
- 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 program and, for maternity measures, CHIP-enrolled women who satisfy the measure-specific eligibility criteria. For a measure based on administrative data, all enrollees who meet the eligible population requirements for the measure should be included. 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 Adult Core Set have four possible data collection methods: administrative, hybrid, survey, and medical records, including electronic medical records (eMeasures).
 - The administrative method uses transaction data (for example, claims) or other administrative data sources 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 medical record data to determine numerator compliance. The denominator consists of a sample of the measure’s eligible population. The hybrid method, when possible, should be used when administrative data and electronic health record (EHR) data are incomplete or may be of poor quality or the data elements for the measure are not captured in administrative data (e.g., Controlling High Blood Pressure). More information on the use of the hybrid method for Adult Core Set Reporting is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf>.
 - The survey method uses data collected through a survey to calculate the measure. This data collection method applies to the Flu Vaccinations for Adults Ages 18 to 64, Medical Assistance with Smoking and Tobacco Use Cessation, and CAHPS 5.0H Health Plan Survey measures in the Adult Core Set.

- 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, 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 additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.
 - For the CAHPS survey, the sample size should be 1,350, plus an oversample based on the state's prior experience with survey response rates, to yield at least 411 completed surveys. Additional information on sampling for CAHPS is available in Appendix C.
 - States should use the "Additional Notes/Comments" field in MACPro to describe the sampling approach used for each measure. Additional guidance on sampling for hybrid measures is available in the following TA brief: Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets (October 2014).²
- 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 "Reason for Not Reporting" field in MACPro and specify the denominator size.
- Risk adjustment. One measure in the Adult Core Set, Plan All-Cause Readmissions, requires risk adjustment. However, this measure does not currently have a risk adjustor for the Medicaid population. CMS suggests that states report unadjusted rates for this measure until a standardized risk adjustor is made available.
- 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 such measures, the inclusion of claims, regardless of whether they were paid, denied, or voided would be appropriate. For HEDIS measures that rely on claims as a data source, the HEDIS Volume 2 manual provides guidance on which claims to include: <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx>.
- 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. 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, ICD-10 codes are included in the value set directory. For non-HEDIS measures, ICD-10 codes are available in the specification or at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.

Reporting and Submission

Procedures for reporting the Adult Core Set measures into MACPro are provided below.

² Technical Assistance briefs can be found at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>.

- **Submission deadline.** CMS will announce the deadline for submitting and certifying final data on the Adult Core Set measures for FFY 2016 in the fall of 2016. States can update data submitted into MACPro after the submission deadline; however, updates made after the deadline are not guaranteed to be used in the development of reports by CMS and states are encouraged to submit data that are as complete as possible by the submission deadline.
- **Completing fields.** Specific fields are provided for each measure. States should complete every field for each measure submitted to ensure consistent reporting across states. Details on how to enter data on the Adult Core Set measures can be found in the MACPro Implementation Guides. A Consolidated Implementation Guide across all Adult Core Set measures is available under the “Actions” tab in MACPro. Measure-specific Implementation Guides are available in each measure screen.
- **Including attachments.** MACPro includes an attachment facility that allows states to upload supporting documents related to measures. More information about submitting attachments can be found in the Report Documents section of the MACPro Implementation Guides.
- **Reasons for not reporting a measure.** Although reporting the Adult Core Set is voluntary, states choosing not to report a measure are required to explain their reason for not reporting the measure. This information will assist CMS in understanding why each state or why all states as a group may not be reporting on specific measures.
- **Noting deviations from the measure technical specifications.** Although states are encouraged to report measures adhering to the methods provided in the specifications, this may not always be possible. It might also be necessary to provide additional information and context about the rates reported. Any deviations and clarifications should be recorded in the “Deviations from Measure Specifications” field in MACPro. Examples of deviations 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.
- **Reporting by Medicaid and CHIP programs.** For each Adult Core Set measure reported to CMS, states should specify the population included in the measure: Medicaid, CHIP, Medicare and Medicaid dual eligibles, and Other. Any populations excluded from the denominator should be noted in the “Deviations from Measure Specifications” field in MACPro.
- **Data auditing.** For FFY 2016, CMS will not require certification or auditing of HEDIS or other measures. However, states are encouraged to do so when possible. If there are current state mechanisms for accreditation, certification, and managed care external quality review reporting, or if the state validates its Adult Core Set rates, we ask that states describe these processes in MACPro.
- **Reporting electronic health record (EHR) Medicaid Incentive Program measures.** For states voluntarily reporting on a core measure that is also an EHR Medicaid incentive program measure (AMM, CBP, CCS, CDF, CHL, HPC, IET) we ask that states indicate whether any information was extracted from EHRs in the “Additional Notes/Comments on Measure” field in MACPro.

Technical Assistance

To help states collect, report, and use the Adult Core Set measures, CMS offers technical assistance. Please submit technical assistance requests specific to the Adult Core Set to: MACqualityTA@cms.hhs.gov.³

For questions about the use of MACPro, please contact the MACPro Help Desk at MACPro_HelpDesk@cms.hhs.gov or (301) 547-4688.

³ States with technical questions about the Child Core Set, the Health Homes Core Set, and Maternal and Infant Health measures should also contact MACqualityTA@cms.hhs.gov.

III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for each measure in the Adult 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 2015.

MEASURE ABA-AD: ADULT BODY MASS INDEX ASSESSMENT

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure applies to Medicaid enrollees ages 18 to 74. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 74.
- The height, weight, and BMI should be from the same data source.
- The height and weight measurement should be taken during the measurement year or the year prior to the measurement year.
- If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year or the year prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which indicate the relative position of a patient's BMI number among those of the same sex and age.

C. ELIGIBLE POPULATION

Age	Age 18 as of January 1 of the year prior to the measurement year to age 74 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 the continuous enrollment period. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee 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	Medicaid enrollees who had an outpatient visit (<u>Outpatient Value Set</u>) during the measurement year or the year prior to the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

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.

Exclusions (optional)

Enrollees who had a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, 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 additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

BMI value or percentile during the measurement year or the year prior to the measurement year 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

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.

For BMI percentile, the following documentation meets criteria:

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

Ranges and thresholds do not meet the criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

Exclusions (optional)

Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year or the year prior to the measurement year.

F. ADDITIONAL NOTES

The following notations or examples of documentation are considered “negative findings” and do not count as numerator compliant:

- No BMI or BMI percentile documented in medical record or plotted on age-growth chart
- Notation of weight only

MEASURE AMM-AD: ANTIDEPRESSANT MEDICATION MANAGEMENT

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees age 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

- **Effective Acute Phase Treatment.** Percentage of Medicaid enrollees who remained on an antidepressant medication for at least 84 days (12 weeks).
- **Effective Continuation Phase Treatment.** Percentage of Medicaid enrollees who remained on an antidepressant medication for at least 180 days (6 months).

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, and denied claims.
- NCQA's list of NDC codes for antidepressant medications can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the Intake Period.
Negative medication history	A period of 105 days prior to the IPSD when the enrollee had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of April 30 of the measurement year.
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Continuous enrollment	105 days (3 months) prior to the IPSD through 231 days after the IPSD.
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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IPSD.
Benefits	Medical and pharmacy.
Event/diagnosis	<p>Follow the steps below to identify the eligible population that should be used for both rates.</p> <p>Step 1: Determine the IPSD Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period.</p> <p>Step 2: Required exclusion Exclude enrollees who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient, or partial hospitalization setting during the 121 day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Enrollees who meet any of the following criteria remain in the eligible population:</p> <ul style="list-style-type: none"> • An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria: <ul style="list-style-type: none"> • <u>AMM Stand Alone Visits Value Set</u> with <u>Major Depression Value Set</u> • <u>AMM Visits Value Set</u> with <u>AMM POS Value Set</u> and <u>Major Depression Value Set</u> • An ED visit (<u>ED Value Set</u>) with any diagnosis of major depression (<u>Major Depression Value Set</u>) • An acute or nonacute inpatient discharge with any diagnosis of major depression (<u>Major Depression Value Set</u>). To identify acute and nonacute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Identify the discharge date for the stay to determine whether it falls during the 121 day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. <p>For a direct transfer, use the discharge date from the last discharge.</p> <p>Step 3: Test for Negative Medication History Exclude enrollees who filled a prescription for an antidepressant medication 105 days prior to the IPSD.</p> <p>Step 4: Calculate continuous enrollment Enrollees must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.</p>

D. ADMINISTRATIVE SPECIFICATION**Denominator**

The eligible population.

Numerator

Numerator 1: Effective Acute Phase Treatment

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.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Table AMM-C. Antidepressant Medications

Description	Prescription
Miscellaneous antidepressants	Bupropion Vilazodone Vortioxetine
Monoamine oxidase inhibitors	Isocarboxazid Phenelzine Selegiline Tranylcypromine
Phenylpiperazine antidepressants	Nefazodone Trazodone
Psychotherapeutic combinations	Amitriptyline-chlordiazepoxide Amitriptyline-perphenazine Fluoxetine-olanzapine
SSNRI antidepressants	Desvenlafaxine Duloxetine Levomilnacipran Venlafaxine
SSRI antidepressants	Citalopram Escitalopram Fluoxetine Fluvoxamine Paroxetine Sertraline
Tetracyclic antidepressants	Maprotiline Mirtazapine

Description	Prescription
Tricyclic antidepressants	Amitriptyline Amoxapine Clomipramine Desipramine Doxepin (>6mg) Imipramine Nortriptyline Protriptyline Trimipramine

Numerator 2: Effective Continuation Phase Treatment

At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) beginning on the IPSP through 231 days after the IPSP (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.

Regardless of the number of gaps, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps, each of 25 days, or two washout gaps of 10 days each and one treatment gap of 10 days).

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 specified.

MEASURE BCS-AD: BREAST CANCER SCREENING

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid-enrolled women ages 50 to 74 who had a mammogram to screen for breast cancer.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid-enrolled women 52 to 74 years of age to account for the 2-year, 3-month look-back period. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 50 to 64 and ages 65 to 74.
- 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.
- This measure requires a continuous enrollment period of 2 years and 3 months. Allowable gaps in enrollment may be one month or up to 45 days per full calendar year. No gap in enrollment is allowed during the first 3 months of the continuous enrollment period.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Women ages 52 to 74 as of December 31 of the measurement year.
Continuous enrollment	October 1 two years prior to the measurement year through December 31 of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year). To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). No gaps in enrollment are allowed from October 1 two years prior to the measurement year through December 31 two years prior to the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusions (optional)

Bilateral mastectomy any time during the enrollee's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:

- Bilateral mastectomy (Bilateral Mastectomy Value Set)
- Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (Bilateral Modifier Value Set)
- Two unilateral mastectomies (Unilateral Mastectomy Value Set) with service dates 14 days or more apart. For example, if the service date for the first unilateral mastectomy was February 1 of the measurement year, the service date for the second unilateral mastectomy must be on or after February 15.
- 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)
<ul style="list-style-type: none"> • Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a left-side modifier (<u>Left Modifier Value Set</u>) (same date of service) 	<ul style="list-style-type: none"> • Unilateral mastectomy (<u>Unilateral Mastectomy Value Set</u>) with a right-side modifier (<u>Right Modifier Value Set</u>) (same date of service)
<ul style="list-style-type: none"> • Absence of the left breast (<u>Absence of Left Breast Value Set</u>) 	<ul style="list-style-type: none"> • Absence of the right breast (<u>Absence of Right Breast Value Set</u>)
<ul style="list-style-type: none"> • Left unilateral mastectomy (<u>Unilateral Mastectomy Left Value Set</u>) 	<ul style="list-style-type: none"> • Right unilateral mastectomy (<u>Unilateral Mastectomy Right Value Set</u>)

- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set)

D. ADDITIONAL NOTES

This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

MEASURE CBP-AD: CONTROLLING HIGH BLOOD PRESSURE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:

- Enrollees ages 18 to 59 whose BP was <140/90 mm Hg
- Enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Enrollees ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg

A single rate is reported and is the sum of all three groups.

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure applies to Medicaid enrollees ages 18 to 85. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 85. The numerator for enrollees ages 18 to 64 will include enrollees ages 18 to 59 who meet the first criterion added to enrollees ages 60 to 64 who meet the second or third criteria. The rate for enrollees ages 65 to 85 will include all enrollees in that age group who meet the second or third criteria: diagnosis of diabetes with BP < 140/90 mm Hg or no diagnosis of diabetes with BP of <150/90 mm Hg.
- 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.
- This measure requires use of the hybrid method.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Adequate control	<p>Adequate control is defined as meeting any of the following criteria:</p> <ul style="list-style-type: none"> • Enrollees ages 18 to 59 whose BP was <140/90 mm Hg • Enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg • Enrollees ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg
Representative BP	<p>The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the enrollee is “not controlled.”</p>

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	<p>No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).</p>
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	<p>Medicaid enrollees are identified as hypertensive if there is at least one outpatient visit (<u>Outpatient Without UBREV Value Set</u>) with a diagnosis of hypertension (<u>Essential Hypertension Value Set</u>) during the first six months of the measurement year.</p>
Diabetes flag for the numerator	<p>After the Eligible Population is identified, assign each enrollee a diabetic or not diabetic flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for enrollees with diabetes is different than the threshold for enrollees without diabetes).</p> <p>Step 1</p> <p>Assign a flag of diabetic to enrollees who were identified as diabetic using claims/encounter data or pharmacy data. The state must use both methods to assign the diabetes flag, but an enrollee only needs to be identified by one method. Enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p>

<p>Diabetes flag for the numerator (continued)</p>	<p>Claims/encounter data. Enrollees who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> • At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED Value Set</u>), or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>). <p>Pharmacy data. Enrollees who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CBP-A).</p> <p>Step 2</p> <p>From enrollees identified in Step 1, assign a flag of “not diabetic” to enrollees who do not have a diagnosis of diabetes (<u>Diabetes Value Set</u>), in any setting, during the measurement year or year prior to the measurement year AND who had a diagnosis of gestational diabetes or steroid-induced diabetes (<u>Diabetes Exclusions Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year.</p> <p>Note: Enrollees classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as not diabetic in this step.</p> <p>Step 3</p> <p>For enrollees who were not assigned a flag in step 1 or step 2, assign a flag of “not diabetic.”</p>
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Table CBP-A: Prescriptions to Identify Enrollees With Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canaglifozin-metformin Empaglifozin-linagliptin Empaglifozin/metformin Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin

Description	Prescription
Antidiabetic combinations (continued)	Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Sitagliptin-simvastatin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin human inhaled Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human
Meglitinides	Nateglinide Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Dulaglutide Exenatide Liraglutide Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitagliptin

Note: Table CBP-A corresponds to NDC Code Table CDC-A.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population whose diagnosis of hypertension is confirmed by chart review.

Use a sample size of 411, 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 this measure, NCQA recommends that states use an oversample of 10 to 15 percent to ensure enough confirmed cases of hypertension.

To confirm the diagnosis of hypertension, there must be a notation of one of the following in the medical record anytime during the enrollee's history on or before June 30 of the measurement year:

- Hypertension
- HTN
- High BP (HBP)
- Elevated BP (↑BP)
- Borderline HTN
- Intermittent HTN
- History of HTN
- Hypertensive vascular disease (HVD)
- Hyperpiesia
- Hyperpiesis

It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis that is not part of the office visit note; see Note at the end of this section)
- Office note
- Subjective, Objective, Assessment, Plan (SOAP) note
- Encounter form
- Diagnostic report
- Hospital discharge summary

Statements such as "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "consistent with HTN" are not sufficient to confirm the diagnosis if such statements are the only notations of hypertension in the medical record.

If the diagnosis of hypertension cannot be confirmed, the enrollee is excluded and replaced by the next enrollee from the oversample.

Identifying the Medical Record

States should use one medical record for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If a state cannot find the medical record, the enrollee remains in the measure denominator and is considered noncompliant for the numerator.

States should use the following steps to find the appropriate medical record to review.

Step 1

- Identify the enrollee's PCP.
- If the enrollee had more than one PCP for the time period, identify the PCP who most recently provided care to the enrollee.
- If the enrollee did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the enrollee.
- If a practitioner other than the enrollee's PCP manages the hypertension, the state may use the medical record of that practitioner.

Step 2

- Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the state may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples.
- If an enrollee sees one PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.
- If an enrollee has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the adult's hypertension after June 30, the state may use the PCP's chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the state may use this chart for the most recent BP reading. If the enrollee did not have any visit with the specialist prior to June 30 of the measurement year, the state must go to another medical record to confirm the diagnosis.

Numerator

The number of enrollees in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Enrollees ages 18 to 59 as of December 31 of the measurement year whose BP was <140/90 mm Hg
- Enrollees ages 60 to 85 as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Enrollees ages 60 to 85 as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg
- To determine if an enrollee's BP is adequately controlled, the representative BP must be identified.

E. MEDICAL RECORD SPECIFICATION

Follow the steps below to determine representative BP.

Step 1

Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed. Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)
- Obtained the same day as a major diagnostic or surgical procedure (e.g., EKG/ECG, stress test, administration of IV contrast for a radiology procedure, endoscopy)
- Reported by or taken by the enrollee

If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

Step 2

Determine numerator compliance based on the following criteria:

- Enrollees ages 18 to 59 as of December 31 of the measurement year whose BP was <140/90 mm Hg
- Enrollees ages 60 to 85 as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Enrollees ages 60 to 85 as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg

The enrollee is not compliant if the BP reading does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Step 3

A single rate is reported for all three groups. Sum the numerator events from Step 2 to obtain the rate.

Exclusions (optional)

- Exclude from the eligible population all Medicaid enrollees with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis.
- Exclude from the eligible population all Medicaid enrollees with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all Medicaid enrollees who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
 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 nonacute inpatient stay to determine whether it occurs during the measurement year.

F. ADDITIONAL NOTES

- Problem lists generally indicate established conditions; excluding undated entries might hinder confirmation of the denominator. If a problem list is found in an office visit note then it should be considered a dated problem list and the date of the visit must be used.
- Only administrative data should be used to assign the diabetes flag. The intent of the flag is to determine the appropriate BP threshold to use for the enrollee during numerator assessment. The only exception is if the enrollee is flagged as a diabetic but medical record evidence contains information that classifies the inclusion of the enrollee as a valid data error. To meet criteria as a valid data error, the medical record must contain no evidence of diabetes and include a notation that refutes the diagnosis. In this case, the diabetes flag may be changed to “not diabetic,” but the enrollee may not be removed from the sample.

MEASURE CCS-AD: CERVICAL CANCER SCREENING

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid-enrolled women ages 21 to 64 who were screened for cervical cancer using either of the following criteria:

- Women ages 21 to 64 who had cervical cytology (Pap test) performed every 3 years
- Women ages 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- 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.
- The eligible population (denominator) includes women who are ages 24 to 64 as of the end of the measurement year to account for the 3-year look-back period.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, LOINC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Women ages 24 to 64 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 each year of continuous enrollment. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee 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.

C. ADMINISTRATIVE SPECIFICATION**Denominator**

The eligible population.

Numerator

The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.

Step 1

Identify women ages 24 to 64 as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) during the measurement year or the two years prior to the measurement year.

Step 2

From the women who did not meet step 1 criteria, identify women ages 30 to 64 as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Value Set) and a human papillomavirus (HPV) test (HPV Tests Value Set) with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were age 30 or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the measurement year, then the HPV test must include a service date on or between November 27 and December 5 of the measurement year, representing the four days before or after the cervical cytology occurred.

Step 3

Sum the events from steps 1 and 2 to obtain the numerator.

Exclusions (optional)

Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (Absence of Cervix Value Set) any time during the enrollee's history through December 31 of the measurement year.

D. HYBRID SPECIFICATION**Denominator**

A systematic sample drawn from the eligible population.

Use a sample size of 411, 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 additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

The number of women who were appropriately screened for cervical cancer 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**Step 1**

Identify the number of women ages 24 to 64 as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed
- The result or finding

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present;” this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

Step 2

From the women who did not meet step 1 criteria, identify the number of women ages 30 to 64 as of December 31 of the measurement year who had cervical cytology and an HPV test on the same date of service during the measurement year or the four years prior to the measurement year and who were age 30 or older as of the date of testing. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
- The results or findings

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present;” this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

In administrative data, there is flexibility in the date of service to allow for a potential lag in claims. In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.

Note: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

Step 3

Sum the events from steps 1 and 2 to obtain the numerator.

E. ADDITIONAL NOTES**Exclusions (optional)**

Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the enrollee's history through December 31 of the measurement year. Documentation of "complete," "total," or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet the exclusion criteria:

- 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-AD: SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of Medicaid enrollees age 18 and older screened for clinical depression on 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 positive screen.

Data Collection Method: Hybrid

Guidance for Reporting:

- In the original specification, this measure includes Medicaid enrollees age 12 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- This measure uses administrative data and medical record review to calculate the denominator exclusions for the measure. States may also choose to use medical record review to identify numerator cases. States should indicate deviations from the measure specifications if they choose to use the hybrid method to identify numerator cases.
- This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from CMS. States should describe their sampling methodology in the “Additional Notes/Comments” field.
- The measure steward does not provide diagnosis codes for the depression and bipolar disorder exclusions; medical record review is required to determine the exclusions.
- The original specification for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of Adult Core Set reporting, there are two G codes included in the numerator to capture whether clinical depression screening was done and if the screen was positive, whether a follow-up plan was documented.
- The date of encounter and screening must occur on the same date of service; if a patient has more than one encounter during the measurement year, the patient should be counted in the numerator and denominator only once based on the most recent encounter.

The following coding systems are used in this measure: CPT and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	<p>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.</p> <p>Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner’s office that is filing the code.</p>
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Standardized tool	An 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. Some depression screening tools are: Patient Health Questionnaire (PHQ-9); Beck Depression Inventory (BDI or BDI-II); Center for Epidemiologic Studies Depression Scale (CES-D); Depression Scale (DEPS); Duke Anxiety-Depression Scale (DADS); Geriatric Depression Scale (GDS); Hopkins Symptom Checklist (HSCL); The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this screening tool is used in situations where the patient has cognitive impairment and is administered through the caregiver), and PRIME MD-PHQ2.
Follow-up plan	<p>Proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following:</p> <ul style="list-style-type: none"> • Additional evaluation • Suicide risk assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression <p>The documented follow-up plan must be related to positive depression screening, for example: “Patient referred for psychiatric evaluation due to positive depression screening.”</p>

C. ELIGIBLE POPULATION

Age	Age 18 or older on date of encounter.
Event/diagnosis	Medicaid enrollees age 18 and older who had an outpatient visit (Table CDF-A) during the measurement year.

D. HYBRID SPECIFICATION

Denominator

The eligible population with an outpatient visit during the measurement year (Table CDF-A).

Table CDF-A. Codes to Identify Outpatient Visits

CPT	HCPCS
90791, 90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	G0101, G0402, G0438, G0439, G0444

Numerator

Patients screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen using one of the codes in Table CDF-B.

Table CDF-B. Codes to Document Clinical Depression Screen

Code	Description
G8431	Positive screen for clinical depression using a standardized tool and a follow-up plan documented
G8510	Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented

Exclusions

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

- Patient has an active diagnosis of Depression or Bipolar Disorder
- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court-appointed cases or cases of delirium

In addition, use the codes in Table CDF-C to identify other exclusions.

Table CDF-C. Codes to Identify Exclusions

Code	Description
G8433	Screening for clinical depression not documented, patient not eligible/appropriate
G8940	Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate

MEASURE CHL-AD: CHLAMYDIA SCREENING IN WOMEN

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid-enrolled women ages 21 to 24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- In the original HEDIS specification, this measure has three reportable rates—ages 16 to 20 and 21 to 24 cohorts and a total (ages 16 to 24). For reporting of the Adult Core Set measure, include the rate for ages 21 to 24 only.
- Include all paid, suspended, pending, and denied claims.
- NDC codes to identify contraceptives are listed at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, LOINC, NDC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Women ages 21 to 24 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee 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	<p>Sexually active. Two methods identify sexually active women: pharmacy data and claims/encounter data. The state must use both methods to identify the eligible population; however, a woman only needs to be identified in one method to be eligible for the measure.</p> <p>Claim/encounter data. Women who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:</p> <ul style="list-style-type: none"> • <u>Pregnancy Value Set</u> • <u>Pregnancy Tests Value Set</u> • <u>Sexual Activity Value Set</u> <p>Pharmacy data. Women who were dispensed prescription contraceptives during the measurement year (Table CHL-A).</p>
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Table CHL-A. Prescriptions to Identify Contraceptives

Description	Prescription	
Contraceptives	Desogestrel-ethinyl estradiol Dienogest-estradiol multiphasic Drospirenone-ethinyl estradiol Drospirenone-ethinyl estradiol-levomefolate biphasic Ethinyl estradiol-ethynodiol Ethinyl estradiol-etonogestrel Ethinyl estradiol-levonorgestrel Ethinyl estradiol-norelgestromin	Ethinyl estradiol-norethindrone Ethinyl estradiol-norgestimate Ethinyl estradiol-norgestrel Etonogestrel Levonorgestrel Medroxyprogesterone Mestranol-norethindrone Norethindrone
Diaphragm	Diaphragm	
Spermicide	Nonxynol 9	

Source: Refer to Table CHL-A in HEDIS specifications (2016 version).

Note: A comprehensive list of medications and NDC codes can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

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

Exclusions (optional)

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

Table CHL-B. Medications to Identify Exclusions

Description	Prescription
Retinoid	Isotretinoin

Source: Refer to Table CHL-E in HEDIS specifications (2016 version).

**MEASURE CPA-AD: CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS
AND SYSTEMS (CAHPS) HEALTH PLAN SURVEY 5.0H, ADULT VERSION
(MEDICAID)**

National Committee for Quality Assurance

A. DESCRIPTION

This measure provides information on Medicaid enrollees' experiences with their health care and gives a general indication of how well the health care meets the enrollees' expectations. Results summarize Medicaid enrollees' experiences through ratings, composites, and 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

Five composite scores summarize responses in key areas:

- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Shared Decision Making

Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

- Health Promotion and Education
- Coordination of Care

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 years and older. For the purpose of Adult Core Set reporting, states should calculate survey results for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- The survey should be conducted by a third-party vendor certified by NCQA according to the HEDIS protocol. A current listing of NCQA-certified HEDIS 5.0H survey vendors is available at http://www.ncqa.org/Portals/0/HEDISQM/Programs/SVC/2016_HEDIS_CAHPS-Vendor_Web_List.pdf.
- See Appendix C for additional guidance on conducting the CAHPS Survey. See Appendix F for the CAHPS 5.0H Adult Questionnaire.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	For a Medicaid enrollee in a state where enrollment is verified monthly, the enrollee may not have more than a one-month gap in coverage (the enrollee must be enrolled for five of the last six months of the measurement year). For a Medicaid enrollee in a state where enrollment is verified daily, the enrollee may have no more than one gap in enrollment of up to 45 days during the last six months of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

C. ADDITIONAL NOTES

To conduct the CAHPS survey, states must contract with an NCQA Certified HEDIS Survey Vendor to administer HEDIS survey(s):

- Ascertain from the survey vendor the date when the sample frame is due. Dates are based on many factors, including the length of the survey protocol, the due date for enrollee-level data file submission and the time needed to draw the random sample and generate the final enrollee-level data file.
- Generate a complete, unbiased sample frame that represents the reporting entity for each survey sample. A state that outsources sample frame generation to a survey vendor must provide the vendor with the state’s enrollment file containing its entire population and, when necessary, claims and encounters data, from which the vendor generates the sample frame prior to sampling.

NCQA Certified HEDIS Survey Vendors must:

- Follow the sampling protocols contained in HEDIS 2016 Volume 3
- Administer HEDIS surveys according to the data collection protocols

Sample Size

The survey vendor will work with the state to determine the number of enrollees to be surveyed in order to yield 411 completed surveys, and at least 100 valid responses on each question. The sample size will depend on prior survey experience. See Appendix C for additional guidance on determining the sample size for the CAHPS survey.

**MEASURE CTR-AD: TIMELY TRANSMISSION OF TRANSITION RECORD
(DISCHARGES FROM AN INPATIENT FACILITY TO HOME/SELF CARE
OR ANY OTHER SITE OF CARE)**

American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI®)

A. DESCRIPTION

Percentage of discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for which a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge, among Medicaid enrollees age 18 and older.

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older. Age groups should be based on age as of December 31st of the measurement year.
- This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from AMA/PCPI. States should describe sampling methodology in the “Additional Notes/Comments” field.
- All applicable discharges for qualifying enrollees should be included, even if the same enrollee had multiple discharges during the reporting period.
- The measure includes transfers between hospitals, but excludes transfers within the same facility.
- The measure assesses whether a transition record including a standard set of data elements was sent to the facility, primary care physician, or other health care professional, but it is not necessary to capture the information recorded in these data elements.
- 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.

The following coding system is used in this measure: UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Transition record	A core, standardized set of data elements related to enrollee’s diagnosis, treatment, and care plan that is discussed with and provided to enrollee in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. The transition record may be provided in electronic format only if acceptable to the enrollee.
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Transmitted	Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR). The time and method of transmission should be documented to assess whether transmission was timely.
Primary physician or other health care professional designated for follow-up care	May be designated primary care physician (PCP), medical specialist, or other physician or health care professional who is responsible for follow-up care.
Current medication list	<p>All medications to be taken by enrollee after discharge, including all continued and new medications.</p> <p>The current medication list should include, at a minimum, medications in the following categories (including prescription, herbal products and over-the-counter medications):</p> <p>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.</p> <p>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.</p>
Advance directives	Written statement of enrollee wishes regarding future use of life-sustaining medical treatments.
Documented reason for not providing advance care plan	Documentation that advance care plan was discussed but enrollee did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the enrollee's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the enrollee's beliefs and thus harmful to the physician-enrollee relationship.
Contact information/plan for follow-up care	For enrollees discharged to an inpatient facility, the transition record may indicate that 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.
Plan for follow-up care	May include any post-discharge therapy needed (e.g., oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for enrollee support, etc.

C. ELIGIBLE POPULATION

Age	All enrollees age 18 and older as of December 31st of the measurement year.
Continuous enrollment	Enrolled in a Medicaid program on the date of discharge.
Allowable gap	None.
Event/diagnosis	Medicaid enrollees who were discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care as of December 31st of the measurement year.

D. HYBRID SPECIFICATION

Denominator

All discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care, among enrollees age 18 and older as of December 31st of the measurement year.

Identify discharges from an inpatient facility using one of the following options:

A code to Identify an Inpatient Facility (Table CTR-A) accompanied by a code to Identify Discharge Status (Table CTR-B), OR

A code to Identify Outpatient Facilities (Table CTR-C) accompanied by a code to Identify Locations (Table CTR-D) AND a code to Identify Discharge Status (Table CTR-B)

Table CTR-A. Codes to Identify Inpatient Facility Based on UB-04 (Form Locator 04—Type of Bill)

Code	Description
0111	Hospital, Inpatient, Admit through Discharge Claim
0121	Hospital, Inpatient—Medicare Part B only, Admit through Discharge Claim
0114	Hospital, Inpatient, Last Claim
0124	Hospital, Inpatient—Medicare Part B only, Interim-Last Claim
0211	Skilled Nursing-Inpatient, Admit through Discharge Claim
0214	Skilled Nursing-Inpatient, Interim, Last Claim
0221	Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim
0224	Skilled Nursing- Interim, Last Claim
0281	Skilled Nursing-Swing Beds, Admit through Discharge Claim
0284	Skilled Nursing-Swing Beds, Interim, Last Claim

Table CTR-B. Codes to Identify Discharge Status Based on UB-04 (Form Locator 17)

Code	Description
01	Discharged to home care or self care (routine discharge)
02	Discharged/transferred to a short term general hospital for inpatient care

Code	Description
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care
21	Discharged/transferred to court/law enforcement
43	Discharged/transferred to a federal health care facility
50	Hospice—home
51	Hospice—medical facility(certified) providing hospice level of care
61	Discharged/transferred to hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Table CTR-C. Codes to Identify Outpatient Facilities Based on UB-04 (Form Locator 04—Type of Bill)

Code	Description
0131	Hospital Outpatient, Admit through Discharge Claim
0134	Hospital Outpatient, Interim, Last Claim

Table CTR-D. Codes to Identify Locations Based on UB-04 (Form Locator 42—Revenue Code)

Code	Description
0762	Hospital Observation
0490	Ambulatory Surgery
0499	Other Ambulatory Surgery

Numerator

Discharges for which a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Medical record review is required to collect the numerator data elements. (Note: If a given element does not apply to the enrollee, the transition record should include documentation stating the element is not applicable, e.g., no pending studies at discharge.)

The transition record must include the data elements specified in the Retrospective Data Collection Flowsheet (Figure CTR-A).

Figure CTR-A. Retrospective Data Collection Flowsheet

Patient name:					
Medical record number or other patient identifier:					
Date of discharge:					
Numerator:					
		Yes	No	Instructions	
Transition record with all of the specified elements	Did patient receive a Transition Record at discharge?			If yes, answer questions below to determine that all appropriate elements were included in the Transition Record If a given element does not apply to the patient, the transition record should include documentation stating the element is not applicable (e.g., no pending studies at discharge)	
Are the following elements included in the transition record?		Yes	No		
Inpatient care	Reason for inpatient admission				
	Major procedures and tests, including summary of results				
	Principal diagnosis at discharge				
Post-discharge/patient self-management	Current medication list				
	Studies pending at discharge (or documentation that no studies are pending)				
	Patient instructions				
Advance care plan	Advance directives or surrogate decision maker documented OR documented reason for not providing advance care plan				
Contact information/ plan for follow-up care	24-hour/7-day contact information including physician for emergencies related to inpatient stay				
	Contact information for obtaining results of studies pending at discharge				
	Plan for follow-up care				
	Primary physician, or other health care professional, or site designated for follow-up care				
Discharge information	Date and time patient was discharged from facility				
	Date and time transition record was transmitted to receiving facility, or physician, or other health care professional				
	Was transition record transmitted within 24 hours of discharge?				
Review responses above to determine if all elements were included in transition record to be counted in the numerator for the measure.					

Exclusions (Table CTR-E):

- Enrollees who died
- Enrollees who left against medical advice (AMA) or discontinued care

Table CTR-E. Codes to Identify Exclusions Based on UB-04 (Form Locator 17—Discharge Status)

Code	Description
07	Left against medical advice or discontinued care
20	Expired
40	Expired at home
41	Expired in a medical facility
42	Expired-place unknown

MEASURE FUH-AD: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for Medicaid enrollees age 21 and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure includes age 6 and older. For reporting of the Adult Core Set measure, include age 21 and older. States should calculate and report this measure for two age groups (as applicable): ages 21 to 64 and age 65 and older.
- 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.
- 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.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for the definition of a mental health practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 21 and older as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).

Event/diagnosis	<p>An acute inpatient discharge with a principal diagnosis of mental illness (<u>Mental Illness Value Set</u>) on or between January 1 and December 1 of the measurement year.</p> <p>To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay to determine whether it falls on or between January 1 and December 1 of the measurement year. <p>Use only facility claims to identify discharges and diagnoses for denominator events (including readmissions or direct transfers). Do not use professional claims.</p> <p>The denominator for this measure is based on discharges, not enrollees. If enrollees had more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p>
Acute facility readmission or direct transfer	<p>If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>) 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.</p> <p>To identify readmissions to an acute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stays to determine whether they fall after December 1 of the measurement year. <p>States must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above.</p>
Exclusions	<p>Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.</p> <p>To identify readmissions to a nonacute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim. 3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period.

Exclusions (continued)	<p>Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the <u>Mental Health Diagnosis Value Set</u>).</p> <p>To identify readmissions to an acute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period. <p>States must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above.</p> <p>These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.</p>
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C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

30-Day Follow-Up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

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

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a mental health practitioner
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner
- A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set)
- A visit in a non-behavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner
- A visit in a non-behavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set)
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the eligible population event/diagnosis date of discharge

The following meets criteria for only the 30-Day Follow-Up indicator:

- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the eligible population event/diagnosis date of discharge

Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

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 period specified (e.g., within 30 days after discharge or within 7 days after discharge).

MEASURE FVA-AD: FLU VACCINATIONS FOR ADULTS AGES 18 TO 64

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees ages 18 to 64 who received an influenza vaccination between July 1 of the measurement year and the date when the CAHPS 5.0H Adult Survey was completed.

Data Collection Method: Survey

Guidance for Reporting:

- This measure no longer requires the use of a rolling average because it captures flu vaccinations for all adult Medicaid enrollees ages 18 to 64.

B. ELIGIBLE POPULATION

Age	Ages 18 to 64 as of July 1 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Current enrollment	Currently enrolled at the time the survey is completed.

C. PROTOCOL AND SURVEY INSTRUMENT

Collected annually as part of the CAHPS Health Plan Survey 5.0H, Adult Version.

Flu Vaccinations for Adults Ages 18 to 64 Eligibility Flag

A Flu Vaccinations for Adults Ages 18 to 64 Eligibility Flag is assigned for each Medicaid enrollee in the CAHPS 5.0H adult survey sample frame data file.

Flu Vaccinations for Adults Ages 18 to 64 Eligibility Flag
1 = Eligible (was born on or between July 2, 1950, and July 1, 1997)
2 = Ineligible (was born before July 2, 1950, or after July 1, 1997)

The Flu Vaccinations for Adults Ages 18 to 64 Eligibility Flag identifies the population eligible for the Flu Vaccinations for Adults Ages 18 to 64 measure. The results are calculated using responses from respondents with a flag of "1 = Eligible." The use of an eligibility flag protects enrollee confidentiality (using the date of birth could result in a breach of confidentiality).

D. QUESTIONS INCLUDED IN THE MEASURE

Table FVA-A. Flu Vaccinations for Adults Ages 18 to 64

Question		Response Choices
Q38	Have you had either a flu shot or flu spray in the nose since July 1, YYYY? ^a	Yes No Don't know

^aYYYY = the measurement year (2015 for the survey fielded in 2016).

E. CALCULATION OF MEASURE**Denominator**

The number of Medicaid enrollees with a Flu Vaccinations for Adults Ages 18 to 64 Eligibility Flag of “Eligible” who responded “Yes” or “No” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

Numerator

The number of Medicaid enrollees in the denominator who responded “Yes” to the question “Have you had either a flu shot or flu spray in the nose since July 1, YYYY?”

F. ADDITIONAL NOTE

Small denominator threshold. States must achieve a denominator of at least 100 responses to obtain a reportable result. If the denominator is less than 100, then the measure is not reportable.

**MEASURE HA1C-AD: COMPREHENSIVE DIABETES CARE:
HEMOGLOBIN A1C TESTING**

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure applies to Medicaid enrollees ages 18 to 75. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, and denied claims.
- NCQA's list of NDC codes for insulin or oral hypoglycemic/antihyperglycemic medications can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, LOINC, NDC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

<p>Event/diagnosis</p>	<p>There are two ways to identify Medicaid enrollees with diabetes: by pharmacy data and by claim/encounter data. The state must use both methods to identify the eligible population, but an enrollee only needs to be identified by one method to be included in the measure. Medicaid enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p>Pharmacy data. Medicaid enrollees who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table HA1C-A).</p> <p>Claim/encounter data. Medicaid enrollees who met any of the following criteria during the measurement year or year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> • At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED Visits (<u>ED Value Set</u>), or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>)
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Table HA1C-A. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canaglifozin-metformin Empaglifozin-linagliptin Empaglifozin/metformin Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Sitagliptin-simvastatin

Description	Prescription
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin human inhaled Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human
Meglitinides	Nateglinide Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Dulaglutide Exenatide Liraglutide Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitagliptin

Notes: Table HA1C-A corresponds to NDC Code Table CDC-A.

Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; enrollees with diabetes on these medications are identified through diagnosis codes only. A complete list of medications and NDC codes is posted to <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

Exclusions (optional)

Medicaid enrollees who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If the enrollee was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the enrollee had a diagnosis of diabetes.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, 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 additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

Administrative Data

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

Medical Record Review

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. States may count notation of the following in the medical record:

- A1c
- HbA1c
- Hemoglobin A1c
- Glycohemoglobin A1c
- HgbA1c

Exclusions (optional)

Refer to the “Administrative Specification” for exclusion criteria. Identify enrollees who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and 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-AD: COMPREHENSIVE DIABETES CARE:
HEMOGLOBIN A1C POOR CONTROL (>9.0%)**

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c in poor control (>9.0%).

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure applies to Medicaid enrollees ages 18 to 75. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, and denied claims.
- NCQA's list of NDC codes for insulin or oral hypoglycemic/antihyperglycemic medications can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, LOINC, NDC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee 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	<p>There are two ways to identify Medicaid enrollees with diabetes: by pharmacy data and by claim/encounter data. The state must use both methods to identify the eligible population, but an enrollee only needs to be identified by one method to be included in the measure. Medicaid enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p>Pharmacy data. Medicaid enrollees who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table HPC-A).</p> <p>Claim/encounter data. Medicaid enrollees who met any of the following criteria during the measurement year or year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none"> • At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED Visits (<u>ED Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>)
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Table HPC-A. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canaglifozin-metformin Empaglifozin/linagliptin Empaglifozin/metformin Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Sitagliptin-simvastatin

Description	Prescription
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin human inhaled Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human
Meglitinides	Nateglinide Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Dulaglutide Exenatide Liraglutide Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitagliptin

Notes: Table HPC-A corresponds to NDC Code Table CDC-A.

Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; enrollees with diabetes on these medications are identified through diagnosis codes only. A complete list of medications and NDC codes is posted to <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

An HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

The Medicaid enrollee is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The Medicaid enrollee is not numerator compliant if the result for the most recent HbA1c test during the measurement year is <9.0%.

If a state uses CPT Category II codes to identify numerator compliance for this measure, it must be done by searching for all codes in the following value sets and using the most recent code during the measurement year to evaluate whether the Medicaid enrollee is numerator compliant.

Value Set	Numerator Compliance
<u>HbA1c Level Less Than 7.0 Value Set</u>	Not compliant
<u>HbA1c Level 7.0-9.0 Value Set</u>	Not compliant
<u>HbA1c Level Greater Than 9.0 Value Set</u>	Compliant

Note: A lower rate indicates better performance for this measure (i.e., low rates of poor control indicate better care).

Exclusions (optional)

Medicaid enrollees who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If the enrollee was included in the measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the enrollee had a diagnosis of diabetes.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, 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 additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

The most recent HbA1c level (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.

Note: A lower rate indicates better performance for this measure (i.e., low rates of poor control indicate better care).

Administrative Data

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

Medical Record Review

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The Medicaid enrollee is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The Medicaid enrollee is not numerator compliant if the most recent HbA1c level during the measurement year is ≤9.0%.

Ranges and thresholds do not meet criteria for this measure. A distinct numeric result is required for numerator compliance.

Exclusions (optional)

Refer to the “Administrative Specification” for exclusion criteria. Identify Medicaid enrollees who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and 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-AD: HIV VIRAL LOAD SUPPRESSION

Health Resources and Services Administration

A. DESCRIPTION

Percentage of Medicaid enrollees age 18 and older with a diagnosis of Human Immunodeficiency Virus (HIV) who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- There are no patient exclusions for this measure.
- The denominator should be limited to people for whom the HIV diagnosis code occurs during the measurement year, and there are no restrictions regarding the date of the visit relative to the date of HIV diagnosis. The measure does not include a look-back period for an HIV diagnosis before the measurement year.
- Medical visits should be conducted by a provider with prescribing privileges (i.e., physician, nurse practitioner, and/or physician's assistant) within a primary care or infectious disease specialty care setting.
- 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.

The following coding systems are used in this measure: CPT, ICD-9, ICD-10, LOINC, and SNOMED. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

HIV viral load	The HIV viral load is the number of copies of the human immunodeficiency virus in the blood or bodily fluid.
HIV viral load Test	The HIV viral load test measures the number of HIV copies in a milliliter of blood.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Event/diagnosis	Medicaid enrollees who had a diagnosis of HIV (Tables HVL-A, HVL-B, or HVL-C) and at least one medical visit (Tables HVL-D or HVL-E) during the measurement year.

D. ADMINISTRATIVE SPECIFICATION**Denominator**

The number of Medicaid enrollees age 18 and older with both a diagnosis of HIV (Table HVL-A, Table HVL-B, or Table HVL-C) in the measurement year and at least one medical visit (Table HVL-D or Table HVL-E) in the measurement year. 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.

Table HVL-A. ICD-9-CM Diagnosis Codes to Identify HIV

ICD-9-CM Code	Description
042	Human immunodeficiency virus [HIV] disease
V08	Asymptomatic human immunodeficiency virus [HIV] infection status

Note: For services provided on or after October 1, 2015, use the ICD-10 Codes found in Table HVL-B.

Table HVL-B. ICD-10-CM Diagnosis Codes to Identify HIV

ICD-10-CM Code	Description
B20	Human immunodeficiency virus [HIV] disease
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status

Table HVL-C. SNOMED-CT Codes to Identify HIV

5810003, 186706006, 230201009, 40780007, 186707002, 230598008, 48794007, 186708007, 235009000, 52079000, 186709004, 235726002, 62246005, 186717007, 240103002, 62479008, 186718002, 276666007, 77070006, 186719005, 315019000, 79019005, 186721000, 359791000, 86406008, 186723002, 397763006, 87117006, 186725009, 398329009, 91947003, 186726005, 402915006, 111880001, 230180003, 402916007

Table HVL-D. CPT Codes to Identify Medical Visits

99201, 99381, 99202, 99382, 99203, 99383, 99204, 99384, 99205, 99385, 99212, 99386, 99213, 99387, 99214, 99391, 99215, 99392, 99241, 99393, 99242, 99394, 99243, 99395, 99244, 99396, 99245, 99397

Table HVL-E. SNOMED-CT Codes to Identify Outpatient and Ambulatory Medical Visits

18170008, 87790002, 90526000, 185349003, 185463005, 185465003, 207195004, 270427003, 270430005, 308335008, 390906007, 406547006, 439708006

Numerator

The number of Medicaid enrollees in the denominator with a HIV viral load less than 200 copies/mL (Table HVL-F) at last HIV viral load test during the measurement year.

Table HVL-F. LOINC Codes to Identify HIV Viral Load <200 copies/ml

20447-9, 21333-0, 23876-6, 41515-8, 48511-0, 59419-2, 70241-5

MEASURE IET-AD: INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees age 18 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

- Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis
- Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

Data Collection Method: Administrative

Guidance for Reporting:

- Two rates are reported: initiation of AOD treatment and engagement of AOD treatment.
- In the original HEDIS specification, this measure has two reportable age groups (ages 13 to 17 and age 18 and older). For the purpose of Adult Core Set reporting, the measure should be calculated for Medicaid enrollees age 18 and older. States should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	January 1 to November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
Index episode	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or emergency department (ED) visit during the Intake Period with a diagnosis of AOD. For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.

IESD	<p>Index Episode Start Date (IESD). The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification, or ED visit during the Intake Period with a diagnosis of AOD.</p> <p>For an outpatient, intensive outpatient, partial hospitalization, detoxification, or ED visit (not resulting in an inpatient stay), the IESD is the date of service.</p> <p>For an inpatient (acute or nonacute) event, the IESD is the date of discharge.</p> <p>For an ED visit that results in an inpatient event, the IESD is the date of the inpatient discharge.</p> <p>For direct transfers, the IESD is the discharge date from the last admission.</p>
Negative diagnosis history	<p>A period of 60 days (2 months) before the IESD when the enrollee had no claims/encounters with a diagnosis of AOD dependence.</p> <p>For an inpatient event, use the admission date to determine the Negative Diagnosis History.</p> <p>For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.</p> <p>For direct transfers, use the first admission to determine the Negative Diagnosis History.</p>

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	60 days (2 months) prior to the IESD through 44 days after the IESD (105 total days).
Allowable gap	None.
Anchor date	None.
Benefits	<p>Medical and chemical dependency (inpatient and outpatient).</p> <p>Note: Medicaid enrollees with detoxification-only chemical dependency benefits do not meet these criteria.</p>

<p>Event/ diagnosis</p>	<p>New episode of AOD during the Intake Period.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p> <p>Step 1</p> <p>Identify the Index Episode. Identify all Medicaid enrollees in the specified age range who during the Intake Period had one of the following:</p> <ul style="list-style-type: none"> • An outpatient visit, intensive outpatient visit, or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> • <u>IET Stand Alone Visits Value Set</u> with <u>AOD Dependence Value Set</u> • <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and <u>AOD Dependence Value Set</u> • <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and <u>AOD Dependence Value Set</u> • A detoxification visit (<u>Detoxification Value Set</u>) • An ED visit (<u>ED Value Set</u>) with an AOD diagnosis (<u>AOD Dependence Value Set</u>) • An acute or nonacute inpatient discharge with either an AOD diagnosis (<u>AOD Dependence Value Set</u>) or an AOD procedure code (<u>AOD Procedures Value Set</u>). To identify acute and nonacute inpatient discharges: <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Determine whether the discharge date for the stay falls within the Intake Period (on or between January 1 and November 15 of the measurement year). <p>For Medicaid enrollees with more than one episode of AOD, use the first episode.</p> <p>For Medicaid enrollees whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.</p> <p>Select the IESD.</p> <p>Step 2</p> <p>Test for Negative Diagnosis History. Exclude Medicaid enrollees who had a claim/encounter with a diagnosis of AOD (<u>AOD Dependence Value Set</u>) during the 60 days (2 months) before the IESD.</p> <p>For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.</p> <p>For an ED visit that results in an inpatient stay, use the ED date of service to determine the 60-day Negative Diagnosis History period.</p> <p>Step 3</p> <p>Calculate continuous enrollment. Medicaid enrollees must be continuously enrolled for 60 days (2 months) before the IESD through 44 days after the IESD (105 total days), with no gaps.</p>
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D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

Rate 1: Initiation of AOD Treatment

Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the IESD.

If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the enrollee is compliant.

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification, or ED visit, the enrollee must have an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization, with a diagnosis of AOD, on the IESD or in the 13 days after the IESD (14 total days). If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria:

- An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Determine whether the admission date for the stay falls within 14 days of the IESD.
- IET Stand Alone Visits Value Set with AOD Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and AOD Dependence Value Set
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and AOD Dependence Value Set

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying initiation of treatment.

Exclude enrollees from the denominator for both numerators (Rate 1 and Rate 2) if the initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

Rate 2: Engagement of AOD Treatment

Identify all Medicaid enrollees who meet the following criteria:

- Numerator compliant for the Initiation of AOD Treatment numerator and
- Two or more inpatient admissions, outpatient visits, intensive outpatient visits, or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). Multiple engagement visits may occur on the same day, but they must be with different providers in order to count. Any of the following code combinations meet criteria:
 - An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:
 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
 2. Determine whether the admission date for the stay occurs the day after the initiation encounter through 29 days after the initiation event.

- IET Stand Alone Visits Value Set with AOD Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and AOD Dependence Value Set
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and AOD Dependence Value Set

For Medicaid enrollees who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying the engagement of AOD treatment.

The time frame for engagement, which includes the initiation event, is 30 total days.

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 required time frame for the rate.

MEASURE MPM-AD: ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the three rates separately and as a total rate.

- Annual monitoring for enrollees on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for enrollees on digoxin
- Annual monitoring for enrollees on diuretics
- Total rate (the sum of the three numerators divided by the sum of the three denominators)

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report the three separate rates and total rate listed above for each of the two age groups (as applicable): ages 18 to 64 and 65 and older.
- Include all paid, suspended, pending, and denied claims.
- NCQA's list of NDC codes for ACE Inhibitors/ARBs can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

The following coding systems are used in this measure: CPT, LOINC, NDC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 and older 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.

Event/ diagnosis	<p>Medicaid enrollees on persistent medications (i.e., Medicaid enrollees who received at least 180 treatment days of ambulatory medication in the measurement year). Refer to Additional Eligible Population Criteria for each rate.</p> <p>Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days' supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days' supply for all medications and subtract any days' supply that extends beyond December 31 of the measurement year.</p> <p>Note: Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.</p>
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C. ADMINISTRATIVE SPECIFICATION

Report each of the three rates separately and as a total rate. The total rate is the sum of the three numerators divided by the sum of the three denominators.

Rate 1: Annual Monitoring for Medicaid Enrollees on ACE Inhibitors or ARBs

Additional Eligible Population Criteria

Medicaid enrollees who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year. Refer to Table MPM-A (which corresponds to NDC code Table CDC-L) to identify ACE inhibitors and ARBs.

Medicaid enrollees may switch therapy with any medication listed in Table MPM-A during the measurement year and have the day's supply for those medications count toward the total 180 treatment days (i.e., an enrollee who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).

Table MPM-A. ACE Inhibitors/ARBs

Description	Prescription		
Angiotensin converting enzyme inhibitors	Benazepril Captopril Enalapril Fosinopril	Lisinopril Moexipril Perindopril Quinapril	Ramipril Trandolapril
Angiotensin II inhibitors	Azilsartan Candesartan Eprosartan Irbesartan	Losartan Olmesartan Telmisartan Valsartan	

Description	Prescription		
Antihypertensive combinations	Aliskiren-valsartan Amlodipine-benazepril Amlodipine-hydrochlorothiazide-valsartan Amlodipine-hydrochlorothiazide-olmesartan Amlodipine-olmesartan Amlodipine-telmisartan Amlodipine-valsartan Azilsartan-chlorthalidone	Benazepril-hydrochlorothiazide Candesartan-hydrochlorothiazide Captopril-hydrochlorothiazide Enalapril-hydrochlorothiazide Eprosartan-hydrochlorothiazide Fosinopril-hydrochlorothiazide Hydrochlorothiazide-irbesartan Hydrochlorothiazide-lisinopril	Hydrochlorothiazide-losartan Hydrochlorothiazide-moexipril Hydrochlorothiazide-olmesartan Hydrochlorothiazide-quinapril Hydrochlorothiazide-telmisartan Hydrochlorothiazide-valsartan Trandolapril-verapamil

Numerator

At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set)
- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set)

The tests do not need to occur on the same service date, only within the measurement year.

Rate 2: Annual Monitoring for Medicaid Enrollees on Digoxin

Additional Eligible Population Criteria

Medicaid enrollees who received at least 180 treatment days of digoxin (Table MPM-B) during the measurement year.

Table MPM-B. Drugs to Identify Medicaid Enrollees on Digoxin

Description	Prescription
Inotropic agents	Digoxin

Numerator

At least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set) and a serum digoxin test (Digoxin Level Value Set)
- A serum potassium test (Serum Potassium Value Set), and a serum creatinine test (Serum Creatinine Value Set) and a serum digoxin test (Digoxin Level Value Set)

The tests do not need to occur on the same service date, only within the measurement year.

Rate 3: Annual Monitoring for Medicaid Enrollees on Diuretics

Additional Eligible Population Criteria

Medicaid enrollees who received at least 180 treatment days of a diuretic (Table MPM-C), during the measurement year.

Medicaid enrollees may switch therapy with any medication listed in Table MPM-C during the measurement year and have the day's supply for those medications count toward the total 180 treatment days.

Table MPM-C. Drugs to Identify Medicaid Enrollees on Diuretics

Description	Prescription	
Antihypertensive combinations	Aliskiren-hydrochlorothiazide Aliskiren-hydrochlorothiazide-amlodipine Amiloride-hydrochlorothiazide Amlodipine-hydrochlorothiazide-olmesartan Amlodipine-hydrochlorothiazide-valsartan Atenolol-chlorthalidone Azilsartan-chlorthalidone Benazepril-hydrochlorothiazide Bendroflumethiazide-nadolol Bisoprolol-hydrochlorothiazide Candesartan-hydrochlorothiazide Captopril-hydrochlorothiazide Chlorthalidone-clonidine Enalapril-hydrochlorothiazide	Eprosartan-hydrochlorothiazide Fosinopril-hydrochlorothiazide Hydrochlorothiazide-irbesartan Hydrochlorothiazide-lisinopril Hydrochlorothiazide-losartan Hydrochlorothiazide-methyldopa Hydrochlorothiazide-metoprolol Hydrochlorothiazide-moexipril Hydrochlorothiazide-olmesartan Hydrochlorothiazide-propranolol Hydrochlorothiazide-quinapril Hydrochlorothiazide-spirolactone Hydrochlorothiazide-telmisartan Hydrochlorothiazide-triamterene Hydrochlorothiazide-valsartan
Loop diuretics	Bumetanide Ethacrynic acid	Furosemide Torsemide
Potassium-sparing diuretics	Amiloride Eplerenone	Spirolactone Triamterene
Thiazide diuretics	Chlorothiazide Chlorthalidone Hydrochlorothiazide	Indapamide Methyclothiazide Metolazone

Numerator

At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set)
- A serum potassium test (Serum Potassium Value Set) and a serum creatinine test (Serum Creatinine Value Set)

The tests do not need to occur on the same service date, only within the measurement year.

Exclusions (optional)

Exclude enrollees from each eligible population rate who had an acute inpatient encounter (Acute Inpatient Value Set) or nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

MEASURE MSC-AD: MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION

National Committee for Quality Assurance

A. DESCRIPTION

A rolling average represents the percentage of Medicaid enrollees age 18 and older who are current smokers or tobacco users and who received medical assistance with smoking and tobacco use cessation during the measurement year. The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation and are reported as three separate rolling averages:

- **Advising Smokers and Tobacco Users to Quit**—A rolling average represents the percentage of Medicaid enrollees age 18 and older who are current smokers or tobacco users and who received advice to quit during the measurement year.
- **Discussing Cessation Medications**—A rolling average represents the percentage of Medicaid enrollees age 18 and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- **Discussing Cessation Strategies**—A rolling average represents the percentage of Medicaid enrollees age 18 and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report the three separate rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- 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.

B. ELIGIBLE POPULATION

Age	Age 18 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Current enrollment	Currently enrolled at the time the survey is completed.

C. PROTOCOL AND SURVEY INSTRUMENT

Collected annually as part of the Adult CAHPS Health Plan Survey 5.0H using a rolling average methodology.

D. QUESTIONS INCLUDED IN THE MEASURE

	Questions	Response Choices
Q39	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all → If Not at all, Go to Question 43 Don't know → If Don't know, Go to Question 43
Q40	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q41	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q42	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

E. CALCULATION OF MEASURE

Rolling averages are calculated using the formula below.

$$\text{Rate} = \frac{\text{Year 1 Numerator} + \text{Year 2 Numerator}}{\text{Year 1 Denominator} + \text{Year 2 Denominator}}$$

- If the denominator is less than 100, the measure is not reported.
- If the denominator is 100 or more, a rate is calculated.
- If the state did not report results for the current year (Year 2), the measure is not reported.
- If the state did not report results in the prior year (Year 1) but reports results for the current year and achieves a denominator of 100 or more, a rate is calculated; if the denominator is less than 100, the measure is not reported.

COMPONENT 1: ADVISING SMOKERS AND TOBACCO USERS TO QUIT**Denominator**

The number of Medicaid enrollees who responded to the survey and indicated that they were current smokers or tobacco users. Enrollee response choices must be as follows to be included in the denominator:

Q39 = “Every day” or “Some days.” AND

Q40 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of Medicaid enrollees in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to Q40.

COMPONENT 2: DISCUSSING CESSATION MEDICATIONS**Denominator**

The number of Medicaid enrollees who responded to the survey and indicated that they were current smokers or tobacco users. Enrollee response choices must be as follows to be included in the denominator:

Q39 = “Every day” or “Some days.” AND

Q41 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of Medicaid enrollees in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering “Sometimes” or “Usually” or “Always” to Q41.

COMPONENT 3: DISCUSSING CESSATION STRATEGIES**Denominator**

The number of Medicaid enrollees who responded to the survey and indicated that they were current smokers or tobacco users. Enrollee response choices must be as follows to be included in the denominator:

Q39 = “Every day” or “Some days.” AND

Q42 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of Medicaid enrollees in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering “Sometimes” or “Usually” or “Always” to Q42.

PERCENTAGE OF CURRENT SMOKERS AND TOBACCO USERS—SUPPLEMENTAL CALCULATION

This calculation is provided to support analysis of Medical Assistance with Smoking and Tobacco Use Cessation rates and provides additional context for unreportable results. A state with a small number of smokers or tobacco users may not be able to obtain a large enough denominator to achieve reportable rates.

The percentage of current smokers and tobacco users is calculated using data collected during the current reporting year only (not calculated as a rolling average).

Denominator

The number of Medicaid enrollees who responded “Every day,” “Some days,” “Not at all,” or “Don’t know” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Numerator

The number of Medicaid enrollees in the denominator who responded “Every day” or “Some days” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

MEASURE OHD-AD: USE OF OPIOIDS AT HIGH DOSAGE

Pharmacy Quality Alliance

A. DESCRIPTION

Rate per 1,000 Medicaid enrollees age 19 and older without cancer who received prescriptions for opioids with a daily dosage greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure is one of three opioid use measures endorsed by the Pharmacy Quality Alliance. The other measures include: Use of Opioids from Multiple Providers, and Use of Opioids at High Dosage and from Multiple Providers. The other measures are not included in the Adult Core Set.
- This measure applies to Medicaid enrollees age 19 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 19 to 64 and age 65 and older. Age groups should be based on age as of December 31st of the measurement year.
- States should report this measure as a rate per 1,000 enrollees.
- The Pharmacy Quality Alliance provides NDC codes for opioid medications, which are available upon request by contacting MACQualityTA@cms.hhs.gov.
- Enrollees with cancer are excluded from this measure and may be identified using the ICD-9 codes in Table OHD-B. This measure was originally specified for Medicare enrollees using prescription drug hierarchical condition categories (RxHCCs) to identify enrollees with cancer, and the ICD-9 codes in this measure map to those categories. States may use RxHCCs 8, 9, 10, and 11 to identify enrollees with cancer if they have access to that information.
- 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. The ICD-10 codes for this measure are available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.

The following coding systems are used in this measure: ICD-9, ICD-10, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	Twelve-month measurement year.
Treatment period	The period of time beginning on the date of the member's first fill of the target medication (index date) through the last day of the measurement year, or until death or disenrollment. Disenrollment from the pharmacy benefit counts as disenrollment.
Opioid	See medications listed in Table OHD-A.

Morphine equivalent dose (MED)	The dose of oral morphine that is the analgesic equivalent of a given dose of another opioid analgesic. (See Table OHD-C for conversions.)
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C. ELIGIBLE POPULATION

Age	Age 19 and older as of December 31 of the measurement period.
Continuous enrollment	No gaps in enrollment during the treatment period, except for "allowable gap," as defined, below.
Allowable gap	In cases where Medicaid enrollment is verified monthly, the enrollee is considered continuously enrolled if there is no more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Benefit	Pharmacy.
Treatment period	The enrollee's treatment period begins on the date of the first fill of the target medication (i.e., index date) and extends through the last day of the measurement year or until death or disenrollment.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Any enrollee with two or more prescription claims for opioids (Table OHD-A) filled on at least two separate days, for which the sum of the days' supply is ≥ 15 .

Table OHD-A. Opioid Medications

Opioid Medications			
Buprenorphine	Hydrocodone	Morphine	Oxymorphone
Butorphanol	Hydromorphone	Nalbuphine	Pentazocine
Codeine	Levorphanol	Opium	Tapentadol
Dihydrocodeine	Meperidine	Oxycodone	Tramadol
Fentanyl	Methadone		

Note: Opioid cough and cold products and combination products containing buprenorphine and naloxone (e.g., Bunavail™, Suboxone®, Zubsolv®) are excluded from the Morphine Equivalent Dose calculations.

Exclusions

Denominator exclusion: Any enrollee with ICD-9-CM diagnosis code for cancer (Table OHD-B).

Table OHD-B. ICD-9-CM Diagnosis Codes for Cancer

ICD-9-CM Code	Description
20510	Ch myl leuk wo achv rmsn
20511	Chr myl leuk w rmsion

ICD-9-CM Code	Description
20512	Chr myel leuk in relapse
20520	Sbac myl leu wo ach rmsn
20521	Sbac myl leuk w rmsion
20522	Sbac myl leuk in relapse
20530	Myl sarcoma wo achv rmsn
20531	Myl srcoma w rmsion
20532	Myel sarcoma in relapse
20580	Oth my leuk wo achv rmsn
20581	Oth myl leuk w rmsion
20582	Oth myel leuk in relapse
20590	Uns my leu wo ach rmsn
20591	Uns myl leuk w rmsion
20592	Myel leuk NOS in relapse
20610	Ch mono leu wo achv rmsn
20611	Chr mono leuk w rmsion
20612	Chr mono leuk in relapse
20620	Sbac mno leu wo ach rmsn
20621	Sbac mono leuk w rmsion
20622	Sbac mono leu in relapse
20680	Ot mono leu wo achv rmsn
20681	Oth mono leuk w rmsion
20682	Oth mono leuk in relapse
20690	Uns mno leu wo ach rmsn
20691	Uns mono leuk w rmsion
20692	Mono leuk NOS relapse
20710	Chr erythrm w/o ach rmsn
20711	Chr erythrm w remision
20712	Chr erythrmia in relapse
20720	Mgkrcyt leuk wo ach rmsn
20721	Mgkrcyt leuk w rmsion
20722	Mgkrcyt leuk in relapse
20780	Oth leuk w/o achv rmsn
20781	Oth spf leuk w remision
20782	Oth spf leuk in relapse

ICD-9-CM Code	Description
1715	Mal neo soft tis abdomen
2386	Mal neo soft tis abdomen
20300	Mult mye w/o achv rmson
20301	Mult myelm w remission
20302	Mult myeloma in relapse
20310	Pls cl leu w/o achv rmsn
20311	Plsm cell leuk w rmson
20312	Plsm cel leuk in relapse
20380	Oth imno npl wo ach rmsn
20381	Oth imnprfl npl w rmsn
20382	Oth imnprlf neo-relapse
23873	Hi grde myelodys syn les
23874	Myelodyspls syn w 5q del
23876	Myelofi w myelo metaplas
28983	Myelofibrosis
1510	Mal neo stomach cardia
1511	Malignant neo pylorus
1512	Mal neo pyloric antrum
1513	Mal neo stomach fundus
1514	Mal neo stomach body
1515	Mal neo stom lesser curv
1516	Mal neo stom great curv
1518	Malig neopl stomach NEC
1519	Malig neopl stomach NOS
1550	Mal neo liver, primary
1551	Mal neo intrahepat ducts
1552	Malignant neo liver NOS
1570	Mal neo pancreas head
1571	Mal neo pancreas body
1572	Mal neo pancreas tail
1573	Mal neo pancreatic duct
1574	Mal neo islet langerhans
1578	Malig neo pancreas NEC
1579	Malig neo pancreas NOS

ICD-9-CM Code	Description
1620	Malignant neo trachea
1622	Malig neo main bronchus
1623	Mal neo upper lobe lung
1624	Mal neo middle lobe lung
1625	Mal neo lower lobe lung
1628	Mal neo bronch/lung NEC
1629	Mal neo bronch/lung NOS
1630	Mal neo parietal pleura
1631	Mal neo visceral pleura
1638	Malig neopl pleura NEC
1639	Malig neopl pleura NOS
1710	Mal neo soft tissue head
1712	Mal neo soft tissue arm
1713	Mal neo soft tissue leg
1714	Mal neo soft tis thorax
1716	Mal neo soft tis pelvis
1717	Mal neopl trunk NOS
1718	Mal neo soft tissue NEC
1719	Mal neo soft tissue NOS
1740	Malig neo nipple
1741	Mal neo breast-central
1742	Mal neo breast up-inner
1743	Mal neo breast low-inner
1744	Mal neo breast up-outer
1745	Mal neo breast low-outer
1746	Mal neo breast-axillary
1748	Malign neopl breast NEC
1749	Malign neopl breast NOS
1750	Mal neo male nipple
1759	Mal neo male breast NEC
1760	Skin - kaposi's sarcoma
1761	Sft tissue - kpsi's srcma
1762	Palate - kpsi's sarcoma
1763	GI sites - kpsi's srcoma

ICD-9-CM Code	Description
1764	Lung - kaposi's sarcoma
1765	Lym nds - kpsi's sarcoma
1768	Spf sts - kpsi's sarcoma
1769	Kaposi's sarcoma NOS
1890	Malig neopl kidney
1891	Malig neo renal pelvis
1970	Secondary malig neo lung
1971	Sec mal neo mediastinum
1972	Second malig neo pleura
1973	Sec malig neo resp NEC
1974	Sec malig neo sm bowel
1975	Sec malig neo lg bowel
1976	Sec mal neo peritoneum
1977	Second malig neo liver
1978	Sec mal neo GI NEC
1985	Secondary malig neo bone
7595	Tuberous sclerosis
7596	Hamartoses NEC
20972	Sec neuroend tumor-liver
20973	Sec neuroendo tumor-bone
20974	Sec neuroendo tu-periton
185	Malign neopl prostate
193	Malign neopl thyroid
1520	Malignant neopl duodenum
1521	Malignant neopl jejunum
1522	Malignant neoplasm ileum
1523	Mal neo meckel's divert
1528	Mal neo small bowel NEC
1529	Mal neo small bowel NOS
1560	Malig neo gallbladder
1561	Mal neo extrahepat ducts
1562	Mal neo ampulla of vater
1568	Malig neo biliary NEC
1569	Malig neo biliary NOS

ICD-9-CM Code	Description
1580	Mal neo retroperitoneum
1588	Mal neo peritoneum NEC
1589	Mal neo peritoneum NOS
1700	Mal neo skull/face bone
1701	Malignant neo mandible
1702	Malig neo vertebrae
1703	Mal neo ribs/stern/clav
1704	Mal neo long bones arm
1705	Mal neo bones wrist/hand
1706	Mal neo pelvic girdle
1707	Mal neo long bones leg
1708	Mal neo bones ankle/foot
1709	Malig neopl bone NOS
1910	Malign neopl cerebrum
1911	Malig neo frontal lobe
1912	Mal neo temporal lobe
1913	Mal neo parietal lobe
1914	Mal neo occipital lobe
1915	Mal neo cereb ventricle
1916	Mal neo cerebellum NOS
1917	Mal neo brain stem
1918	Malig neo brain NEC
1919	Malig neo brain NOS
1920	Mal neo cranial nerves
1921	Mal neo cerebral mening
1922	Mal neo spinal cord
1923	Mal neo spinal meninges
1928	Mal neo nervous syst NEC
1929	Mal neo nervous syst NOS
1940	Malign neopl adrenal
1941	Malig neo parathyroid
1943	Malig neo pituitary
1944	Malign neo pineal gland
1945	Mal neo carotid body

ICD-9-CM Code	Description
1946	Mal neo paraganglia NEC
1948	Mal neo endocrine NEC
1949	Mal neo endocrine NOS
1963	Mal neo lymph-axilla/arm
1969	Mal neo lymph node NOS
1980	Second malig neo kidney
1981	Sec malig neo urin NEC
1986	Second malig neo ovary
1987	Second malig neo adrenal
1990	Malig neo disseminated
2250	Benign neoplasm brain
2251	Benign neo cranial nerve
2252	Ben neo cerebr meninges
2253	Benign neo spinal cord
2254	Ben neo spinal meninges
2258	Benign neo nerv sys NEC
2259	Benign neo nerv sys NOS
2273	Benign neo pituitary
2274	Ben neopl pineal gland
2592	Carcinoid syndrome
19889	Secondary malig neo NEC
20400	Ac lym leuk wo achv rmsn
20401	Act lym leuk w rmsion
20402	Act lym leuk in relapse
20600	Ac mono leu wo achv rmsn
20601	Act mono leuk w rmsion
20602	Act mono leuk in relapse
20700	Ac erth/erlk wo ach rmsn
20701	Act erth/erylk w rmson
20702	Ac erth/erylk in relapse
20800	Ac leu un cl wo ach rmsn
20801	Act leuk uns cl w rmson
20802	Ac leuk uns cl relapse
20900	Mal crcnoid sm intst NOS

ICD-9-CM Code	Description
20901	Malig carcinoid duodenum
20902	Malig carcinoid jejunum
20903	Malig carcinoid ileum
20910	Mal crcnoid lg intst NOS
20911	Malig carcinoid appendix
20912	Malig carcinoid cecum
20913	Mal crcnoid ascend colon
20914	Mal crcnoid transv colon
20915	Mal carcinoid desc colon
20916	Mal carcinoid sig colon
20917	Malig carcinoid rectum
20920	Mal crcnd prim site unkn
20921	Mal carcinoid bronc/lung
20922	Malig carcinoid thymus
20923	Malig carcinoid stomach
20924	Malig carcinoid kidney
20925	Mal carcnoide foregut NOS
20926	Mal carcinoid midgut NOS
20927	Mal carcnoide hindgut NOS
20929	Malig carcinoid oth site
20930	Malig neuroendo ca NOS
20931	Merkel cell ca-face
20932	Merkel cell ca-sclp/neck
20933	Merkel cell ca-up limb
20934	Merkel cell ca-low limb
20935	Merkel cell ca-trunk
20936	Merkel cell ca-oth sites
20970	Sec neuroendo tumor NOS
20975	Secondary Merkel cell ca
20979	Sec neuroend tu oth site
22802	Hemangioma intracranial

Numerator

Any enrollee in the denominator who exceeds the 120mg Morphine Equivalent Dose Threshold for ≥ 90 consecutive days.

Follow the steps below to identify enrollees with prescription opioids that exceeded the Morphine Equivalent Dose Threshold:

- For each opioid prescription claim during the measurement period, calculate the Daily Morphine Equivalent Dose per Claim using the following equations:
 - Opioid Dosage Units per Day = (Opioid claim quantity) / (Opioid claim days supply)
 - Daily Morphine Equivalent Dose per Claim = (Opioid Dosage Units per Day) X (mg opioid per dosage unit) X (Morphine Equivalent Dose conversion factor from Table OHD-C)
- Sum the Daily Morphine Equivalent Dose per Claim from all opioid claims for each day to arrive at a Total Daily Morphine Equivalent Dose for each enrollee.
- Identify the days where the Total Daily Morphine Equivalent Dose Threshold of 120mg is exceeded.
- Any enrollee who exceeded the Total Daily Morphine Equivalent Dose Threshold for 90 consecutive days or longer meets the numerator criteria.

Table OHD-C. Opioid Morphine Milligram Equivalent Conversion Factors^a

Type of Opioid	Morphine Equivalent Conversion Factor
Buprenorphine patch ^b	12.6
Buprenorphine tab or film	10
Butorphanol	7
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl buccal or SL tablets, or lozenge/ troche ^c	0.13
Fentanyl film or oral spray ^d	0.18
Fentanyl nasal spray ^e	0.16
Fentanyl patch ^f	7.2
Hydrocodone	1
Hydromorphone	4
Levorphanol tartrate	11
Meperidine hydrochloride	0.1
Methadone	3
Morphine	1
Nalbuphine	1
Opium	1
Oxycodone	1.5

Type of Opioid	Morphine Equivalent Conversion Factor
Oxymorphone	3
Pentazocine	0.37
Tapentadol	0.4
Tramadol	0.1

^a Centers for Disease Control and Prevention Morphine Milligram Equivalent (MME) conversion factors for opioids, 2012 RED BOOK® Version, CDC, Atlanta, GA, 2014.

^b MME conversion factor for buprenorphine patches is 12.6 based on the assumption that one milligram of parenteral buprenorphine is equivalent to 75 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day and remains in place for 7 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 5 µg/hr. buprenorphine patch * (4 patches/ 28 days) * 12.6 = 9 MME/day.

^c MME conversion factor for fentanyl buccal tablets, sublingual tablets, and lozenges/troche is 0.13. This conversion factor should be multiplied by the number of micrograms in a given lozenge/troche.

^d MME conversion factor for fentanyl films and oral sprays is 0.18. This reflects a 40% greater bioavailability for films compared to lozenges/tablets and a 38% greater bioavailability for oral sprays compared to lozenges/tablets.

^e MME conversion factor for fentanyl nasal spray is 0.16, which reflects a 20% greater bioavailability for sprays compared to lozenges/tablets.

^f MME conversion factor for fentanyl patches is 7.2 based on the assumption that one milligram of parental fentanyl is equivalent to 100 milligrams of oral morphine and that one patch delivers the dispensed micrograms per hour over a 24 hour day and remains in place for 3 days. Using the formula, Strength per Unit * (Number of Units/ Days Supply) * MME conversion factor = MME/Day: 25 µg/hr. fentanyl patch * (10 patches/30 days) * 7.2 = 60 MME/day.

MEASURE PC01-AD: PC 01: ELECTIVE DELIVERY

The Joint Commission

A. DESCRIPTION

Percentage of Medicaid and CHIP enrolled women with elective vaginal deliveries or elective cesarean sections at ≥ 37 and < 39 weeks of gestation completed.

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled women that meet the measure eligibility criteria.
- Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.
- This measure requires administrative data and medical record review to determine the required data elements for the numerator and denominator. Appendix E provides additional information on data elements for this measure.
- 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.
- To determine gestational age, it is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix E.
- 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 <https://www.medicare.gov/medicare/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.

The following coding systems are used in this measure: ICD-9 and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population of Medicaid and CHIP enrollees delivering newborns with ≥ 37 and < 39 weeks of gestation completed. See specifications related to Medicaid Record Review below.

The following table provides guidance for the minimum recommended sample size for Medical Record Review.

Eligible Population	Minimum Recommended Sample Size
≥ 1,551	311
391 – 1,550	20% of the Eligible Population (78 – 310)
78 – 390	78
30 – 77	No sampling; 100% of Eligible Population required
<30	Denominator too small to report

Source: Adapted from The Joint Commission, “Quarterly Sampling Examples,” available at <https://manual.jointcommission.org/releases/TJC2015A1/SamplingChapterTJC.html>.

Regardless of the selected sample size, The Joint Commission 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 additional information on sampling, refer to The Joint Commission’s “Population and Sampling Specifications” guidelines located at: <https://manual.jointcommission.org/releases/TJC2015A1/SamplingChapterTJC.html>.

Include populations with ICD-9-CM Principal or Other Diagnosis Codes for planned cesarean section in labor as defined in Table PC01-A.

Include populations with ICD-9-CM diagnosis codes for pregnancy resulting in a delivery during the hospitalization as defined in Tables PC01-B, PC01-C, PC01-D, and PC01-E.

Medical Record Review

Medical record review is required to collect the following denominator data element: gestational age. See Appendix E for additional guidance on collecting this data element.

To determine gestational age, it is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix E.

Table PC01-A. ICD-9-CM Diagnosis Codes for Planned Cesarean Section in Labor

ICD-9-CM Code	Description
649.81	SPON LABR W PLAN C/S-DEL
649.82	LBR W PLAN C/S-DEL W P/P

Table PC01-B. ICD-9-CM Diagnosis Codes to Identify Complications Mainly Related to Pregnancy

ICD-9-CM Code	Description
640.81	HEM EARLY PREG NEC-DELIV
640.91	HEM EARLY PREG-DELIVERED
641.01	PLACENTA PREVIA-DELIVER
641.11	PLACENTA PREV HEM-DELIV
641.21	PREM SEPAR PLACEN-DELIV
641.31	COAG DEF HEMORR-DELIVER
641.81	ANTEPARTUM HEM NEC-DELIV
641.91	ANTEPARTUM HEM NOS-DELIV
642.01	ESSEN HYPERTEN-DELIVERED
642.02	ESSEN HYPERTEN-DEL W P/P
642.11	RENAL HYPERTEN PG-DELIV
642.12	RENAL HYPERTEN-DEL P/P
642.21	OLD HYPERTEN NEC-DELIVER
642.22	OLD HYPERTEN-DELIV W P/P
642.31	TRANS HYPERTEN-DELIVERED
642.32	TRANS HYPERTEN-DEL W P/P
642.41	MILD/NOS PREECLAMP-DELIV
642.42	MILD PREECLAMP-DEL W P/P
642.51	SEVERE PREECLAMP-DELIVER
642.52	SEV PREECLAMP-DEL W P/P
642.61	ECLAMPSIA-DELIVERED
642.62	ECLAMPSIA-DELIV W P/P
642.71	TOX W OLD HYPERTEN-DELIV
642.72	TOX W OLD HYP-DEL W P/P
642.91	HYPERTENS NOS-DELIVERED
642.92	HYPERTENS NOS-DEL W P/P
643.01	MILD HYPEREM GRAV-DELIV
643.11	HYPEREM W METAB DIS-DEL
643.21	LATE VOMIT OF PREG-DELIV
643.81	VOMIT COMPL PREG-DELIVER
643.91	VOMIT OF PREG NOS-DELIV
644.21	EARLY ONSET DELIVERY-DEL

ICD-9-CM Code	Description
645.11	POST TERM PREG-DEL
645.21	PROLONGED PREG-DEL
646.01	PAPYRACEOUS FETUS-DELIV
646.11	EDEMA IN PREG-DELIVERED
646.12	EDEMA IN PREG-DEL W P/P
646.21	RENAL DIS NOS-DELIVERED
646.22	RENAL DIS NOS-DEL W P/P
646.31	RECURNT PREG LOSS-DELIV
646.41	NEURITIS-DELIVERED
646.42	NEURITIS-DELIVERED W P/P
646.51	ASYM BACTERIURIA-DELIVER
646.52	ASY BACTERURIA-DEL W P/P
646.61	GU INFECTION-DELIVERED
646.62	GU INFECTION-DELIV W P/P
646.71	LIVER/BIL TRCT DISR-DEL
646.81	PREG COMPL NEC-DELIVERED
646.82	PREG COMPL NEC-DEL W P/P
646.91	PREG COMPL NOS-DELIVERED
647.01	SYPHILIS-DELIVERED
647.02	SYPHILIS-DELIVERED W P/P
647.11	GONORRHEA-DELIVERED
647.12	GONORRHEA-DELIVER W P/P
647.21	OTHER VD-DELIVERED
647.22	OTHER VD-DELIVERED W P/P
647.31	TUBERCULOSIS-DELIVERED
647.32	TUBERCULOSIS-DELIV W P/P
647.41	MALARIA-DELIVERED
647.42	MALARIA-DELIVERED W P/P
647.51	RUBELLA-DELIVERED
647.52	RUBELLA-DELIVERED W P/P
647.61	OTH VIRAL DIS-DELIVERED
647.62	OTH VIRAL DIS-DEL W P/P
647.81	INFECT DIS NEC-DELIVERED
647.82	INFECT DIS NEC-DEL W P/P

ICD-9-CM Code	Description
647.91	INFECT NOS-DELIVERED
647.92	INFECT NOS-DELIVER W P/P
648.01	DIABETES-DELIVERED
648.02	DIABETES-DELIVERED W P/P
648.11	THYROID DYSFUNC-DELIVER
648.12	THYROID DYSFUN-DEL W P/P
648.21	ANEMIA-DELIVERED
648.22	ANEMIA-DELIVERED W P/P
648.31	DRUG DEPENDENCE-DELIVER
648.32	DRUG DEPENDEN-DEL W P/P
648.41	MENTAL DISORDER-DELIVER
648.42	MENTAL DIS-DELIV W P/P
648.51	CONGEN CV DIS-DELIVERED
648.52	CONGEN CV DIS-DEL W P/P
648.61	CV DIS NEC PREG-DELIVER
648.62	CV DIS NEC-DELIVER W P/P
648.71	BONE DISORDER-DELIVERED
648.72	BONE DISORDER-DEL W P/P
648.81	ABN GLUCOSE TOLER-DELIV
648.82	ABN GLUCOSE-DELIV W P/P
648.91	OTH CURR COND-DELIVERED
648.92	OTH CURR COND-DEL W P/P
649.01	TOBACCO USE DISOR-DELLIV
649.02	TOBACCO USE DIS-DEL-P/P
649.11	OBESITY-DELIVERED
649.12	OBESITY-DELIVERED W P/P
649.21	BARIATRIC SURG STAT-DEL
649.22	BARIATRIC SURG-DEL W P/P
649.31	COAGULATION DEF-DELIV
649.32	COAGULATN DEF-DEL W P/P
649.41	EPILEPSY-DELIVERED
649.42	EPILEPSY-DELIVERED W P/P
649.51	SPOTTING-DELIVERED
649.61	UTERINE SIZE DESCREP-DEL

ICD-9-CM Code	Description
649.62	UTERINE SIZE-DEL W P/P
649.81	SPON LABR W PLAN C/S-DEL
649.82	LBR W PLAN C/S-DEL W P/P

Table PC01-C. ICD-9-CM Diagnosis Codes to Identify Normal Delivery and Other Indications for Care

ICD-9-CM Code	Description
650	NORMAL DELIVERY
651.01	TWIN PREGNANCY-DELIVERED
651.11	TRIPLET PREGNANCY-DELIV
651.21	QUADRUPLET PREG-DELIVER
651.31	TWINS W FETAL LOSS-DEL
651.41	TRIPLETS W FET LOSS-DEL
651.51	QUADS W FETAL LOSS-DEL
651.61	MULT GES W FET LOSS-DEL
651.71	MULT GEST-FET REDUCT DEL
651.81	MULTI GESTAT NEC-DELIVER
651.91	MULT GESTATION NOS-DELIV
652.01	UNSTABLE LIE-DELIVERED
652.11	CEPHALIC VERS NOS-DELIV
652.21	BREECH PRESENTAT-DELIVER
652.31	TRANSVER/OBLIQ LIE-DELIV
652.41	FACE/BROW PRESENT-DELIV
652.51	HIGH HEAD AT TERM-DELIV
652.61	MULT GEST MALPRES-DELIV
652.71	PROLAPSED ARM-DELIVERED
652.81	MALPOSITION NEC-DELIVER
652.91	MALPOSITION NOS-DELIVER
653.01	PELVIC DEFORM NOS-DELIV
653.11	CONTRACT PELV NOS-DELIV
653.21	INLET CONTRACTION-DELIV
653.31	OUTLET CONTRACTION-DELIV
653.41	FETOPELV DISPROPOR-DELIV
653.51	FETAL DISPROP NOS-DELIV

ICD-9-CM Code	Description
653.61	HYDROCEPH FETUS-DELIVER
653.71	OTH ABN FET DISPRO-DELIV
653.81	DISPROPORTION NEC-DELIV
653.91	DISPROPORTION NOS-DELIV
654.01	CONGEN ABN UTERUS-DELIV
654.02	CONG ABN UTER-DEL W P/P
654.11	UTERINE TUMOR-DELIVERED
654.12	UTERINE TUMOR-DEL W P/P
654.21	PREV C-DELIVERY-DELIVRD
654.31	RETROVERT UTERUS-DELIVER
654.32	RETROVERT UTER-DEL W P/P
654.41	ABN UTERUS NEC-DELIVERED
654.42	ABN UTERUS NEC-DEL W P/P
654.51	CERVICAL INCOMPET-DELIV
654.52	CERV INCOMPET-DEL W P/P
654.61	ABN CERVIX NEC-DELIVERED
654.62	ABN CERVIX NEC-DEL W P/P
654.71	ABNORM VAGINA-DELIVERED
654.72	ABNORM VAGINA-DEL W P/P
654.81	ABNORMAL VULVA-DELIVERED
654.82	ABNORMAL VULVA-DEL W P/P
654.91	ABN PELV ORG NEC-DELIVER
654.92	ABN PELV NEC-DELIV W P/P
655.01	FETAL CNS MALFORM-DELIV
655.11	FETAL CHROMOSO ABN-DELIV
655.21	FAMIL HEREDIT DIS-DELIV
655.31	FET DAMG D/T VIRUS-DELIV
655.41	FET DAMG D/T DIS-DELIVER
655.51	FET DAMAG D/T DRUG-DELIV
655.61	RADIAT FETAL DAMAG-DELIV
655.71	DECREASE FETAL MOVMT DEL
655.81	FETAL ABNORM NEC-DELIVER
655.91	FETAL ABNORM NOS-DELIVER
656.01	FETAL-MATERNAL HEM-DELIV

ICD-9-CM Code	Description
656.11	RH ISOIMMUNIZAT-DELIVER
656.21	ABO ISOIMMUNIZAT-DELIVER
656.31	FETAL DISTRESS-DELIVERED
656.41	INTRAUTER DEATH-DELIVER
656.51	POOR FETAL GROWTH-DELIV
656.61	EXCESS FETAL GRTH-DELIV
656.71	OTH PLACENT COND-DELIVER
656.81	FET/PLAC PROB NEC-DELIV
656.91	FET/PLAC PROB NOS-DELIV
657.01	POLYHYDRAMNIOS-DELIVERED
658.01	OLIGOHYDRAMNIOS-DELIVER
658.11	PREM RUPT MEMBRAN-DELIV
658.21	PROLONG RUPT MEMB-DELIV
658.31	ARTIFIC RUPT MEMBR-DELIV
658.41	AMNIOTIC INFECTION-DELIV
658.81	AMNIOTIC PROB NEC-DELIV
658.91	AMNIOTIC PROB NOS-DELIV
659.01	FAIL MECH INDUCT-DELIVER
659.11	FAIL INDUCTION NOS-DELIV
659.21	PYREXIA IN LABOR-DELIVER
659.31	SEPTICEM IN LABOR-DELIV
659.41	GRAND MULTIPARITY-DELIV
659.51	ELDERLY PRIMIGRAVIDA-DEL
659.61	ELDERLY MULTIGRAVIDA-DEL
659.71	ABN FTL HRT RATE/RHY-DEL
659.81	COMPLIC LABOR NEC-DELIV
659.91	COMPLIC LABOR NOS-DELIV

Table PC01-D. ICD-9-CM Diagnosis Codes to Identify Complications Mainly in the Course of Labor or Delivery

ICD-9-CM Code	Description
660.01	OBSTRUC/FET MALPOS-DELIV
660.11	BONY PELV OBSTRUCT-DELIV
660.21	ABN PELV TIS OBSTR-DELIV
660.31	PERSIST OCCIPTPOST-DELIV
660.41	SHOULDER DYSTOCIA-DELIV
660.51	LOCKED TWINS-DELIVERED
660.61	FAIL TRIAL LAB NOS-DELIV
660.71	FAILED FORCEPS NOS-DELIV
660.81	OBSTRUCT LABOR NEC-DELIV
660.91	OBSTRUCT LABOR NOS-DELIV
661.01	PRIM UTERINE INERT-DELIV
661.11	SEC UTERINE INERT-DELIV
661.21	UTERINE INERT NEC-DELIV
661.31	PRECIPITATE LABOR-DELIV
661.41	UTER DYSTOCIA NOS-DELIV
661.91	ABNORMAL LABOR NOS-DELIV
662.01	PROLONG 1ST STAGE-DELIV
662.11	PROLONG LABOR NOS-DELIV
662.21	PROLONG 2ND STAGE-DELIV
662.31	DELAY DEL 2ND TWIN-DELIV
663.01	CORD PROLAPSE-DELIVERED
663.11	CORD AROUND NECK-DELIVER
663.21	CORD COMPRESS NEC-DELIV
663.31	CORD ENTANGLE NEC-DELIV
663.41	SHORT CORD-DELIVERED
663.51	VASA PREVIA-DELIVERED
663.61	VASC LESION CORD-DELIVER
663.81	CORD COMPLICAT NEC-DELIV
663.91	CORD COMPLICAT NOS-DELIV
664.01	DEL W 1 DEG LACERAT-DEL
664.11	DEL W 2 DEG LACERAT-DEL
664.21	DEL W 3 DEG LACERAT-DEL

ICD-9-CM Code	Description
664.31	DEL W 4 DEG LACERAT-DEL
664.41	OB PERINEAL LAC NOS-DEL
664.51	OB PERINEAL HEMATOMA-DEL
664.81	OB PERINEAL TRAU NEC-DEL
664.91	OB PERINEAL TRAU NOS-DEL
665.01	PRELABOR RUPT UTERUS-DEL
665.11	RUPTURE UTERUS NOS-DELIV
665.22	INVERS UTERUS-DEL W P/P
665.31	LACERAT OF CERVIX-DELIV
665.41	HIGH VAGINAL LACER-DELIV
665.51	OB INJ PELV ORG NEC-DEL
665.61	DAMAGE TO PELVIC JT-DEL
665.71	OB PELVIC HEMATOMA-DELIV
665.72	PELVIC HEMATOM-DEL W PP
665.81	OB TRAUMA NEC-DELIVERED
665.82	OB TRAUMA NEC-DEL W P/P
665.91	OB TRAUMA NOS-DELIVERED
665.92	OB TRAUMA NOS-DEL W P/P
666.02	THRD-STAGE HEM-DEL W P/P
666.12	POSTPA HEM NEC-DEL W P/P
666.22	DELAY P/P HEM-DEL W P/P
666.32	P/P COAG DEF-DEL W P/P
667.02	RETND PLAC NOS-DEL W P/P
667.12	RET PROD CONC-DEL W P/P
668.01	PULM COMPL IN DEL-DELIV
668.02	PULM COMPLIC-DEL W P/P
668.11	HEART COMPL IN DEL-DELIV
668.12	HEART COMPL-DEL W P/P
668.21	CNS COMPL LAB/DEL-DELIV
668.22	CNS COMPLIC-DEL W P/P
668.81	ANESTH COMPL NEC-DELIVER
668.82	ANESTH COMPL NEC-DEL P/P
668.91	ANESTH COMPL NOS-DELIVER
668.92	ANESTH COMPL NOS-DEL P/P

ICD-9-CM Code	Description
669.01	MATERNAL DISTRESS-DELIV
669.02	MATERN DISTRES-DEL W P/P
669.11	OBSTETRIC SHOCK-DELIVER
669.12	OBSTET SHOCK-DELIV W P/P
669.21	MATERN HYPOTEN SYN-DELIV
669.22	MATERN HYPOTEN-DEL W P/P
669.32	AC REN FAIL-DELIV W P/P
669.41	OTH OB COMPL-DELIVERED
669.42	OTH OB COMPL-DELIV W P/P
669.51	FORCEP DELIV NOS-DELIVER
669.61	BREECH EXTR NOS-DELIVER
669.71	CESAREAN DELIVERY NOS
669.81	COMP LAB/DELIV NEC-DELIV
669.82	COMPL DEL NEC-DEL W P/P
669.91	COMP LAB/DELIV NOS-DELIV
669.92	COMPL DEL NOS-DEL W P/P

Table PC01-E. ICD-9-CM Diagnosis Codes to Identify Complications of the Puerperium

ICD-9-CM Code	Description
670.02	MAJOR PUERP INF-DEL P/P
670.12	PUERP ENDOMET DEL W P/P
670.22	PUERPRL Septicemias or Bacteremias-DEL W P/P
670.32	PRP SPTC THRMB-DEL W P/P
670.82	MAJ PRP INF NEC-DL W P/P
671.01	VARICOSE VEIN LEG-DELIV
671.02	VARIC VEIN LEG-DEL W P/P
671.11	VARICOSE VULVA-DELIVERED
671.12	VARICOSE VULVA-DEL W P/P
671.21	THROMBOPHLEBITIS-DELIVER
671.22	THROMBOPHLEB-DELIV W P/P
671.31	DEEP THROM ANTEPAR-DELIV
671.42	THROMB POSTPAR-DEL W P/P
671.51	THROMBOSIS NEC-DELIVERED
671.52	THROMB NEC-DELIV W P/P
671.81	VENOUS COMPL NEC-DELIVER
671.82	VEN COMP NEC-DELIV W P/P
671.91	VENOUS COMPL NOS-DELIVER
671.92	VEN COMP NOS-DELIV W P/P
672.02	PUERP PYREXIA-DEL W P/P
673.01	OB AIR EMBOLISM-DELIVER
673.02	OB AIR EMBOL-DELIV W P/P
673.11	AMNIOTIC EMBOLISM-DELIV
673.12	AMNIOT EMBOL-DELIV W P/P
673.21	PULM EMBOL NOS-DELIVERED
673.22	PULM EMBOL NOS-DEL W P/P
673.31	OB PYEMIC EMBOL-DELIVER
673.32	OB PYEM EMBOL-DEL W P/P
673.81	PULMON EMBOL NEC-DELIVER
673.82	PULM EMBOL NEC-DEL W P/P
674.01	PUERP CEREBVAS DIS-DELIV
674.02	CEREBVAS DIS-DELIV W P/P
674.12	DISRUPT C-SECT-DEL W P/P

ICD-9-CM Code	Description
674.22	DISRUPT PERIN-DEL W P/P
674.32	OB SURG COMPL-DEL W P/P
674.42	PLACENT POLYP-DEL W P/P
674.82	PUERP COMP NEC-DEL W P/P
674.92	PUERP COMP NOS-DEL W P/P
675.01	INFECT NIPPLE-DELIVERED
675.02	INFECT NIPPLE-DEL W P/P
675.11	BREAST ABSCESS-DELIVERED
675.12	BREAST ABSCESS-DEL W P/P
675.21	MASTITIS-DELIVERED
675.22	MASTITIS-DELIV W P/P
675.81	BREAST INFECT NEC-DELIV
675.82	BREAST INF NEC-DEL W P/P
675.91	BREAST INFECT NOS-DELIV
675.92	BREAST INF NOS-DEL W P/P
676.01	RETRACTED NIPPLE-DELIVER
676.02	RETRACT NIPPLE-DEL W P/P
676.11	CRACKED NIPPLE-DELIVERED
676.12	CRACKED NIPPLE-DEL W P/P
676.21	BREAST ENGORGE-DELIVERED
676.22	BREAST ENGORGE-DEL W P/P
676.31	BREAST DIS NEC-DELIVERED
676.32	BREAST DIS NEC-DEL W P/P
676.41	LACTATION FAIL-DELIVERED
676.42	LACTATION FAIL-DEL W P/P
676.51	SUPPR LACTATION-DELIVER
676.52	SUPPR LACTAT-DEL W P/P
676.61	GALACTORRHEA-DELIVERED
676.62	GALACTORRHEA-DEL W P/P
676.81	LACTATION DIS NEC-DELIV
676.82	LACTAT DIS NEC-DEL W P/P
676.91	LACTATION DIS NOS-DELIV
676.92	LACTAT DIS NOS-DEL W P/P

Numerator

Medicaid and CHIP enrollees with elective deliveries. Include patients with ICD-9-CM Principal or Other Procedure Codes for one or more of the following:

- Medical induction of labor as defined in Table PC01-F
- Cesarean section as defined in Table PC01-G, and both of the following:
 - Not in Labor, and
 - No history of a prior uterine surgery (see specifications for Labor and Prior Uterine Surgery related to Medical Record Review below)

Medical Record Review

Medical record review is required to collect the following numerator data elements: labor and prior uterine surgery. See Appendix E for additional guidance on collecting these data elements.

Table PC01-F. ICD-9-CM Procedure Codes to Identify Medical Induction of Labor

ICD-9-CM Code	Description
73.01	INDUCT LABOR-RUPT MEMB
73.1	SURG INDUCT LABOR NEC
73.4	MEDICAL INDUCTION LABOR

Table PC01-G. ICD-9-CM Procedure Codes to Identify Cesarean Section

ICD-9-CM Code	Description
74.0	CLASSICAL C-SECTION
74.1	LOW CERVICAL C-SECTION
74.2	EXTRAPERITONEAL C-SECTION
74.4	CESAREAN SECTION NEC
74.99	CESAREAN SECTION NOS

Exclusions:

- Principal or Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Table PC01-H
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials (See Appendix E for guidance)
- Prior uterine surgery (See Appendix E for guidance)
- Gestational age < 37 or ≥ 39 weeks or Unable to Determine

Medical Record Review

Medical record review is required to collect the following exclusion data elements: admission date, birthdate, clinical trial, discharge date, and prior uterine surgery. See Appendix E for additional guidance on collecting these data elements.

Table PC01-H. ICD-9-CM Diagnosis Codes to Identify Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation

ICD-9-CM Code	Description
042	HUMAN IMMUNO VIRUS DIS
641.01	PLACENTA PREVIA-DELIVER
641.11	PLACENTA PREV HEM-DELIV
641.21	PREM SEPAR PLACEN-DELIV
641.31	COAG DEF HEMORR-DELIVER
641.81	ANTEPARTUM HEM NEC-DELIV
641.91	ANTEPARTUM HEM NOS-DELIV
642.01	ESSEN HYPERTEN-DELIVERED
642.02	ESSEN HYPERTEN-DEL W P/P
642.11	RENAL HYPERTEN PG-DELIV
642.12	RENAL HYPERTEN-DEL P/P
642.21	OLD HYPERTEN NEC-DELIVER
642.22	OLD HYPERTEN-DELIV W P/P
642.31	TRANS HYPERTEN-DELIVERED
642.32	TRANS HYPERTEN-DEL W P/P
642.41	MILD/NOS PREECLAMP-DELIV
642.42	MILD PREECLAMP-DEL W P/P
642.51	SEVERE PREECLAMP-DELIVER
642.52	SEV PREECLAMP-DEL W P/P
642.61	ECLAMPSIA-DELIVERED
642.62	ECLAMPSIA-DELIV W P/P
642.71	TOX W OLD HYPERTEN-DELIV
642.72	TOX W OLD HYP-DEL W P/P
642.91	HYPERTENS NOS-DELIVERED
642.92	HYPERTENS NOS-DEL W P/P
645.11	POST TERM PREG-DEL
646.21	RENAL DIS NOS-DELIVERED
646.22	RENAL DIS NOS-DEL W P/P
646.71	LIVER/BIL TRCT DISR-DEL
648.01	DIABETES-DELIVERED
648.51	CONGEN CV DIS-DELIVERED
648.52	CONGEN CV DIS-DEL W P/P

ICD-9-CM Code	Description
648.61	CV DIS NEC PREG-DELIVER
648.62	CV DIS NEC-DELIVER W P/P
648.81	ABN GLUCOSE TOLER-DELIV
648.82	ABN GLUCOSE-DELIV W P/P
649.31	COAGULATION DEF-DELIV
649.32	COAGULATN DEF-DEL W P/P
651.01	TWIN PREGNANCY-DELIVERED
651.11	TRIPLET PREGNANCY-DELIV
651.21	QUADRUPLET PREG-DELIVER
651.31	TWINS W FETAL LOSS-DEL
651.41	TRIPLETS W FET LOSS-DEL
651.51	QUADS W FETAL LOSS-DEL
651.61	MULT GES W FET LOSS-DEL
651.71	MULT GEST-FET REDUCT DEL
651.81	MULTI GESTAT NEC-DELIVER
651.91	MULT GESTATION NOS-DELIV
652.01	UNSTABLE LIE-DELIVERED
652.61	MULT GEST MALPRES-DELIV
655.01	FETAL CNS MALFORM-DELIV
655.11	FETAL CHROMOSO ABN-DELIV
655.31	FET DAMG D/T VIRUS-DELIV
655.41	FET DAMG D/T DIS-DELIVER
655.51	FET DAMAG D/T DRUG-DELIV
655.61	RADIAT FETAL DAMAG-DELIV
655.81	FETAL ABNORM NEC-UNSPEC
656.01	FETAL-MATERNAL HEM-DELIV
656.11	RH ISOIMMUNIZAT-DELIVER
656.21	ABO ISOIMMUNIZAT-DELIVER
656.31	FETAL DISTRESS-DELIVERED
656.41	INTRAUTER DEATH-DELIVER
656.51	POOR FETAL GROWTH-DELIV
657.01	POLYHYDRAMNIOS-DELIVERED
658.01	OLIGOHYDRAMNIOS-DELIVER
658.11	PREM RUPT MEMBRAN-DELIV

ICD-9-CM Code	Description
658.21	PROLONG RUPT MEMB-DELIV
658.41	AMNIOTIC INFECTION-DELIV
659.71	ABN FTL HRT RATE/RHY-DEL
663.51	VASA PREVIA-DELIVERED
V08	ASYMP HIV INFECTN STATUS
V23.5	PREG W POOR REPRODUCT HX
V27.1	DELIVER-SINGLE STILLBORN

MEASURE PC03-AD: PC-03: ANTENATAL STEROIDS

The Joint Commission

A. DESCRIPTION

Percentage of Medicaid and CHIP enrolled women at risk of preterm delivery at ≥ 24 and < 32 weeks gestation that received antenatal steroids prior to delivering preterm newborns.

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled women that meet the measure eligibility criteria.
- The Joint Commission does not identify NDC codes for Antenatal Steroid medication.
- Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.
- This measure requires administrative data and medical record review to determine required data elements for the numerator and denominator. Appendix E provides additional information on data elements for this measure.
- 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.
- To determine gestational age it is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix E.
- 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 <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.

The following coding systems are used in this measure: ICD-9 and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population of Medicaid and CHIP enrolled women delivering live preterm newborns with ≥ 24 and < 32 weeks gestation completed. See specifications for Medical Record Review below.

The following table provides guidance for the minimum recommended sample size for Medical Record Review.

Eligible Population	Minimum Recommended Sample Size
≥ 1,551	311
391 – 1,550	20% of the Eligible Population (78 – 310)
78 – 390	78
30 – 77	No sampling; 100% of Eligible Population required
<30	Denominator too small to report

Source: Adapted from The Joint Commission, “Quarterly Sampling Examples,” available at <https://manual.jointcommission.org/releases/TJC2015A1/SamplingChapterTJC.html>.

Regardless of the selected sample size, The Joint Commission 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 additional information on sampling, refer to the The Joint Commission’s “Population and Sampling Specifications” guidelines located at: <https://manual.jointcommission.org/releases/TJC2015A1/SamplingChapterTJC.html>.

The ICD-9-CM Principal or Other Diagnosis Codes for pregnancy resulting in a delivery during the hospitalization can be found in Tables PC03-A, PC03-B, PC03-C, and PC03-D.

Medical Record Review

Medical record review is required to collect the following denominator data element: gestational age. See Appendix E for additional guidance on collecting this data element.

To determine gestational age, it is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix E.

Table PC03-A. ICD-9-CM Diagnosis Codes to Identify Complications Mainly Related to Pregnancy

ICD-9-CM Code	Description
640.81	HEM EARLY PREG NEC-DELIV
640.91	HEM EARLY PREG-DELIVERED
641.01	PLACENTA PREVIA-DELIVER
641.11	PLACENTA PREV HEM-DELIV
641.21	PREM SEPAR PLACEN-DELIV
641.31	COAG DEF HEMORR-DELIVER
641.81	ANTEPARTUM HEM NEC-DELIV
641.91	ANTEPARTUM HEM NOS-DELIV
642.01	ESSEN HYPERTEN-DELIVERED
642.02	ESSEN HYPERTEN-DEL W P/P
642.11	RENAL HYPERTEN PG-DELIV
642.12	RENAL HYPERTEN-DEL P/P
642.21	OLD HYPERTEN NEC-DELIVER

ICD-9-CM Code	Description
642.22	OLD HYPERTEN-DELIV W P/P
642.31	TRANS HYPERTEN-DELIVERED
642.32	TRANS HYPERTEN-DEL W P/P
642.41	MILD/NOS PREECLAMP-DELIV
642.42	MILD PREECLAMP-DEL W P/P
642.51	SEVERE PREECLAMP-DELIVER
642.52	SEV PREECLAMP-DEL W P/P
642.61	ECLAMPSIA-DELIVERED
642.62	ECLAMPSIA-DELIV W P/P
642.71	TOX W OLD HYPERTEN-DELIV
642.72	TOX W OLD HYP-DEL W P/P
642.91	HYPERTENS NOS-DELIVERED
642.92	HYPERTENS NOS-DEL W P/P
643.01	MILD HYPEREM GRAV-DELIV
643.11	HYPEREM W METAB DIS-DEL
643.21	LATE VOMIT OF PREG-DELIV
643.81	VOMIT COMPL PREG-DELIVER
643.91	VOMIT OF PREG NOS-DELIV
644.21	EARLY ONSET DELIVERY-DEL
645.11	POST TERM PREG-DEL
645.21	PROLONGED PREG-DEL
646.01	PAPYRACEOUS FETUS-DELIV
646.11	EDEMA IN PREG-DELIVERED
646.12	EDEMA IN PREG-DEL W P/P
646.21	RENAL DIS NOS-DELIVERED
646.22	RENAL DIS NOS-DEL W P/P
646.31	RECURNT PREG LOSS-DELIV
646.41	NEURITIS-DELIVERED
646.42	NEURITIS-DELIVERED W P/P
646.51	ASYM BACTERIURIA-DELIVER
646.52	ASY BACTERURIA-DEL W P/P
646.61	GU INFECTION-DELIVERED
646.62	GU INFECTION-DELIV W P/P
646.71	LIVER/BIL TRCT DISR-DEL

ICD-9-CM Code	Description
646.81	PREG COMPL NEC-DELIVERED
646.82	PREG COMPL NEC-DEL W P/P
646.91	PREG COMPL NOS-DELIVERED
647.01	SYPHILIS-DELIVERED
647.02	SYPHILIS-DELIVERED W P/P
647.11	GONORRHEA-DELIVERED
647.12	GONORRHEA-DELIVER W P/P
647.21	OTHER VD-DELIVERED
647.22	OTHER VD-DELIVERED W P/P
647.31	TUBERCULOSIS-DELIVERED
647.32	TUBERCULOSIS-DELIV W P/P
647.41	MALARIA-DELIVERED
647.42	MALARIA-DELIVERED W P/P
647.51	RUBELLA-DELIVERED
647.52	RUBELLA-DELIVERED W P/P
647.61	OTH VIRAL DIS-DELIVERED
647.62	OTH VIRAL DIS-DEL W P/P
647.81	INFECT DIS NEC-DELIVERED
647.82	INFECT DIS NEC-DEL W P/P
647.91	INFECT NOS-DELIVERED
647.92	INFECT NOS-DELIVER W P/P
648.01	DIABETES-DELIVERED
648.02	DIABETES-DELIVERED W P/P
648.11	THYROID DYSFUNC-DELIVER
648.12	THYROID DYSFUN-DEL W P/P
648.21	ANEMIA-DELIVERED
648.22	ANEMIA-DELIVERED W P/P
648.31	DRUG DEPENDENCE-DELIVER
648.32	DRUG DEPENDEN-DEL W P/P
648.41	MENTAL DISORDER-DELIVER
648.42	MENTAL DIS-DELIV W P/P
648.51	CONGEN CV DIS-DELIVERED
648.52	CONGEN CV DIS-DEL W P/P
648.61	CV DIS NEC PREG-DELIVER

ICD-9-CM Code	Description
648.62	CV DIS NEC-DELIVER W P/P
648.71	BONE DISORDER-DELIVERED
648.72	BONE DISORDER-DEL W P/P
648.81	ABN GLUCOSE TOLER-DELIV
648.82	ABN GLUCOSE-DELIV W P/P
648.91	OTH CURR COND-DELIVERED
648.92	OTH CURR COND-DEL W P/P
649.01	TOBACCO USE DISOR-DELLIV
649.02	TOBACCO USE DIS-DEL-P/P
649.11	OBESITY-DELIVERED
649.12	OBESITY-DELIVERED W P/P
649.21	BARIATRIC SURG STAT-DEL
649.22	BARIATRIC SURG-DEL W P/P
649.31	COAGULATION DEF-DELIV
649.32	COAGULATN DEF-DEL W P/P
649.41	EPILEPSY-DELIVERED
649.42	EPILEPSY-DELIVERED W P/P
649.51	SPOTTING-DELIVERED
649.61	UTERINE SIZE DESCREP-DEL
649.62	UTERINE SIZE-DEL W P/P
649.81	SPON LABR W PLAN C/S-DEL
649.82	LBR W PLAN C/S-DEL W P/P

Table PC03-B. ICD-9-CM Diagnosis Codes to Identify Normal Delivery and Other Indications for Care

ICD-9-CM Code	Description
650	NORMAL DELIVERY
651.01	TWIN PREGNANCY-DELIVERED
651.11	TRIPLET PREGNANCY-DELIV
651.21	QUADRUPLET PREG-DELIVER
651.31	TWINS W FETAL LOSS-DEL
651.41	TRIPLETS W FET LOSS-DEL
651.51	QUADS W FETAL LOSS-DEL
651.61	MULT GES W FET LOSS-DEL
651.71	MULT GEST-FET REDUCT DEL
651.81	MULTI GESTAT NEC-DELIVER
651.91	MULT GESTATION NOS-DELIV
652.01	UNSTABLE LIE-DELIVERED
652.11	CEPHALIC VERS NOS-DELIV
652.21	BREECH PRESENTAT-DELIVER
652.31	TRANSVER/OBLIQ LIE-DELIV
652.41	FACE/BROW PRESENT-DELIV
652.51	HIGH HEAD AT TERM-DELIV
652.61	MULT GEST MALPRES-DELIV
652.71	PROLAPSED ARM-DELIVERED
652.81	MALPOSITION NEC-DELIVER
652.91	MALPOSITION NOS-DELIVER
653.01	PELVIC DEFORM NOS-DELIV
653.11	CONTRACT PELV NOS-DELIV
653.21	INLET CONTRACTION-DELIV
653.31	OUTLET CONTRACTION-DELIV
653.41	FETOPELV DISPROPOR-DELIV
653.51	FETAL DISPROP NOS-DELIV
653.61	HYDROCEPH FETUS-DELIVER
653.71	OTH ABN FET DISPRO-DELIV
653.81	DISPROPORTION NEC-DELIV
653.91	DISPROPORTION NOS-DELIV
654.01	CONGEN ABN UTERUS-DELIV

ICD-9-CM Code	Description
654.02	CONG ABN UTER-DEL W P/P
654.11	UTERINE TUMOR-DELIVERED
654.12	UTERINE TUMOR-DEL W P/P
654.21	PREV C-DELIVERY-DELIVRD
654.31	RETROVERT UTERUS-DELIVER
654.32	RETROVERT UTER-DEL W P/P
654.41	ABN UTERUS NEC-DELIVERED
654.42	ABN UTERUS NEC-DEL W P/P
654.51	CERVICAL INCOMPET-DELIV
654.52	CERV INCOMPET-DEL W P/P
654.61	ABN CERVIX NEC-DELIVERED
654.62	ABN CERVIX NEC-DEL W P/P
654.71	ABNORM VAGINA-DELIVERED
654.72	ABNORM VAGINA-DEL W P/P
654.81	ABNORMAL VULVA-DELIVERED
654.82	ABNORMAL VULVA-DEL W P/P
654.91	ABN PELV ORG NEC-DELIVER
654.92	ABN PELV NEC-DELIV W P/P
655.01	FETAL CNS MALFORM-DELIV
655.11	FETAL CHROMOSO ABN-DELIV
655.21	FAMIL HEREDIT DIS-DELIV
655.31	FET DAMG D/T VIRUS-DELIV
655.41	FET DAMG D/T DIS-DELIVER
655.51	FET DAMAG D/T DRUG-DELIV
655.61	RADIAT FETAL DAMAG-DELIV
655.71	DECREASE FETAL MOVMT DEL
655.81	FETAL ABNORM NEC-DELIVER
655.91	FETAL ABNORM NOS-DELIVER
656.01	FETAL-MATERNAL HEM-DELIV
656.11	RH ISOIMMUNIZAT-DELIVER
656.21	ABO ISOIMMUNIZAT-DELIVER
656.31	FETAL DISTRESS-DELIVERED
656.41	INTRAUTER DEATH-DELIVER
656.51	POOR FETAL GROWTH-DELIV

ICD-9-CM Code	Description
656.61	EXCESS FETAL GRTH-DELIV
656.71	OTH PLACENT COND-DELIVER
656.81	FET/PLAC PROB NEC-DELIV
656.91	FET/PLAC PROB NOS-DELIV
657.01	POLYHYDRAMNIOS-DELIVERED
658.01	OLIGOHYDRAMNIOS-DELIVER
658.11	PREM RUPT MEMBRAN-DELIV
658.21	PROLONG RUPT MEMB-DELIV
658.31	ARTIFIC RUPT MEMBR-DELIV
658.41	AMNIOTIC INFECTION-DELIV
658.81	AMNIOTIC PROB NEC-DELIV
658.91	AMNIOTIC PROB NOS-DELIV
659.01	FAIL MECH INDUCT-DELIVER
659.11	FAIL INDUCTION NOS-DELIV
659.21	PYREXIA IN LABOR-DELIVER
659.31	SEPTICEM IN LABOR-DELIV
659.41	GRAND MULTIPARITY-DELIV
659.51	ELDERLY PRIMIGRAVIDA-DEL
659.61	ELDERLY MULTIGRAVIDA-DEL
659.71	ABN FTL HRT RATE/RHY-DEL
659.81	COMPLIC LABOR NEC-DELIV
659.91	COMPLIC LABOR NOS-DELIV

Table PC03-C. ICD-9-CM Diagnosis Codes to Identify Complications Mainly in the Course of Labor or Delivery

ICD-9-CM Code	Description
660.01	OBSTRUC/FET MALPOS-DELIV
660.11	BONY PELV OBSTRUCT-DELIV
660.21	ABN PELV TIS OBSTR-DELIV
660.31	PERSIST OCCIPTPOST-DELIV
660.41	SHOULDER DYSTOCIA-DELIV
660.51	LOCKED TWINS-DELIVERED
660.61	FAIL TRIAL LAB NOS-DELIV
660.71	FAILED FORCEPS NOS-DELIV
660.81	OBSTRUCT LABOR NEC-DELIV
660.91	OBSTRUCT LABOR NOS-DELIV
661.01	PRIM UTERINE INERT-DELIV
661.11	SEC UTERINE INERT-DELIV
661.21	UTERINE INERT NEC-DELIV
661.31	PRECIPITATE LABOR-DELIV
661.41	UTER DYSTOCIA NOS-DELIV
661.91	ABNORMAL LABOR NOS-DELIV
662.01	PROLONG 1ST STAGE-DELIV
662.11	PROLONG LABOR NOS-DELIV
662.21	PROLONG 2ND STAGE-DELIV
662.31	DELAY DEL 2ND TWIN-DELIV
663.01	CORD PROLAPSE-DELIVERED
663.11	CORD AROUND NECK-DELIVER
663.21	CORD COMPRESS NEC-DELIV
663.31	CORD ENTANGLE NEC-DELIV
663.41	SHORT CORD-DELIVERED
663.51	VASA PREVIA-DELIVERED
663.61	VASC LESION CORD-DELIVER
663.81	CORD COMPLICAT NEC-DELIV
663.91	CORD COMPLICAT NOS-DELIV
664.01	DEL W 1 DEG LACERAT-DEL
664.11	DEL W 2 DEG LACERAT-DEL
664.21	DEL W 3 DEG LACERAT-DEL

ICD-9-CM Code	Description
664.31	DEL W 4 DEG LACERAT-DEL
664.41	OB PERINEAL LAC NOS-DEL
664.51	OB PERINEAL HEMATOMA-DEL
664.81	OB PERINEAL TRAU NEC-DEL
664.91	OB PERINEAL TRAU NOS-DEL
665.01	PRELABOR RUPT UTERUS-DEL
665.11	RUPTURE UTERUS NOS-DELIV
665.22	INVERS UTERUS-DEL W P/P
665.31	LACERAT OF CERVIX-DELIV
665.41	HIGH VAGINAL LACER-DELIV
665.51	OB INJ PELV ORG NEC-DEL
665.61	DAMAGE TO PELVIC JT-DEL
665.71	OB PELVIC HEMATOMA-DELIV
665.72	PELVIC HEMATOM-DEL W PP
665.81	OB TRAUMA NEC-DELIVERED
665.82	OB TRAUMA NEC-DEL W P/P
665.91	OB TRAUMA NOS-DELIVERED
665.92	OB TRAUMA NOS-DEL W P/P
666.02	THRD-STAGE HEM-DEL W P/P
666.12	POSTPA HEM NEC-DEL W P/P
666.22	DELAY P/P HEM-DEL W P/P
666.32	P/P COAG DEF-DEL W P/P
667.02	RETND PLAC NOS-DEL W P/P
667.12	RET PROD CONC-DEL W P/P
668.01	PULM COMPL IN DEL-DELIV
668.02	PULM COMPLIC-DEL W P/P
668.11	HEART COMPL IN DEL-DELIV
668.12	HEART COMPL-DEL W P/P
668.21	CNS COMPL LAB/DEL-DELIV
668.22	CNS COMPLIC-DEL W P/P
668.81	ANESTH COMPL NEC-DELIVER
668.82	ANESTH COMPL NEC-DEL P/P
668.91	ANESTH COMPL NOS-DELIVER

ICD-9-CM Code	Description
668.92	ANESTH COMPL NOS-DEL P/P
669.01	MATERNAL DISTRESS-DELIV
669.02	MATERN DISTRES-DEL W P/P
669.11	OBSTETRIC SHOCK-DELIVER
669.12	OBSTET SHOCK-DELIV W P/P
669.21	MATERN HYPOTEN SYN-DELIV
669.22	MATERN HYPOTEN-DEL W P/P
669.32	AC REN FAIL-DELIV W P/P
669.41	OTH OB COMPL-DELIVERED
669.42	OTH OB COMPL-DELIV W P/P
669.51	FORCEP DELIV NOS-DELIVER
669.61	BREECH EXTR NOS-DELIVER
669.71	CESAREAN DELIVERY NOS
669.81	COMP LAB/DELIV NEC-DELIV
669.82	COMPL DEL NEC-DEL W P/P
669.91	COMP LAB/DELIV NOS-DELIV
669.92	COMPL DEL NOS-DEL W P/P

Table PC03-D. ICD-9-CM Diagnosis Codes to Identify Complications of the Puerperium

ICD-9-CM Code	Description
670.02	MAJOR PUERP INF-DEL P/P
670.12	PUERP ENDOMET DEL W P/P
670.22	PUERPRL Septicemias or Bacteremias-DEL W P/P
670.32	PRP SPTC THRMB-DEL W P/P
670.82	MAJ PRP INF NEC-DL W P/P
671.01	VARICOSE VEIN LEG-DELIV
671.02	VARIC VEIN LEG-DEL W P/P
671.11	VARICOSE VULVA-DELIVERED
671.12	VARICOSE VULVA-DEL W P/P
671.21	THROMBOPHLEBITIS-DELIVER
671.22	THROMBOPHLEB-DELIV W P/P
671.31	DEEP THROM ANTEPAR-DELIV
671.42	THROMB POSTPAR-DEL W P/P

ICD-9-CM Code	Description
671.51	THROMBOSIS NEC-DELIVERED
671.52	THROMB NEC-DELIV W P/P
671.81	VENOUS COMPL NEC-DELIVER
671.82	VEN COMP NEC-DELIV W P/P
671.91	VENOUS COMPL NOS-DELIVER
671.92	VEN COMP NOS-DELIV W P/P
672.02	PUERP PYREXIA-DEL W P/P
673.01	OB AIR EMBOLISM-DELIVER
673.02	OB AIR EMBOL-DELIV W P/P
673.11	AMNIOTIC EMBOLISM-DELIV
673.12	AMNIOT EMBOL-DELIV W P/P
673.21	PULM EMBOL NOS-DELIVERED
673.22	PULM EMBOL NOS-DEL W P/P
673.31	OB PYEMIC EMBOL-DELIVER
673.32	OB PYEM EMBOL-DEL W P/P
673.81	PULMON EMBOL NEC-DELIVER
673.82	PULM EMBOL NEC-DEL W P/P
674.01	PUERP CEREBVAS DIS-DELIV
674.02	CEREBVAS DIS-DELIV W P/P
674.12	DISRUPT C-SECT-DEL W P/P
674.22	DISRUPT PERIN-DEL W P/P
674.32	OB SURG COMPL-DEL W P/P
674.42	PLACENT POLYP-DEL W P/P
674.82	PUERP COMP NEC-DEL W P/P
674.92	PUERP COMP NOS-DEL W P/P
675.01	INFECT NIPPLE-DELIVERED
675.02	INFECT NIPPLE-DEL W P/P
675.11	BREAST ABSCESS-DELIVERED
675.12	BREAST ABSCESS-DEL W P/P
675.21	MASTITIS-DELIVERED
675.22	MASTITIS-DELIV W P/P
675.81	BREAST INFECT NEC-DELIV
675.82	BREAST INF NEC-DEL W P/P

ICD-9-CM Code	Description
675.91	BREAST INFECT NOS-DELIV
675.92	BREAST INF NOS-DEL W P/P
676.01	RETRACTED NIPPLE-DELIVER
676.02	RETRACT NIPPLE-DEL W P/P
676.11	CRACKED NIPPLE-DELIVERED
676.12	CRACKED NIPPLE-DEL W P/P
676.21	BREAST ENGORGE-DELIVERED
676.22	BREAST ENGORGE-DEL W P/P
676.31	BREAST DIS NEC-DELIVERED
676.32	BREAST DIS NEC-DEL W P/P
676.41	LACTATION FAIL-DELIVERED
676.42	LACTATION FAIL-DEL W P/P
676.51	SUPPR LACTATION-DELIVER
676.52	SUPPR LACTAT-DEL W P/P
676.61	GALACTORRHEA-DELIVERED
676.62	GALACTORRHEA-DEL W P/P
676.81	LACTATION DIS NEC-DELIV
676.82	LACTAT DIS NEC-DEL W P/P
676.91	LACTATION DIS NOS-DELIV
676.92	LACTAT DIS NOS-DEL W P/P

Numerator

Medicaid and CHIP enrollees with antenatal steroid therapy initiated prior to delivering preterm newborns (see Table PC03-E for the list of antenatal steroid medications).

Medical Record Review

Medical record review is required to collect the following numerator data element: antenatal steroid therapy initiated. See Appendix E for additional guidance on collecting this data element.

Table PC03-E. Antenatal Steroid Medications

Medication	Generic
Betamethasone	Betamethasone
Betamethasone Sodium Phosphate	Betamethasone Sodium Phosphate
Betamethasone Sodium Phosphate and Betamethasone Acetate	Betamethasone Sodium Phosphate and Betamethasone Acetate
Celestone	Betamethasone
Celestone Phosphate	Betamethasone Sodium Phosphate
Celestone Soluspan	Betamethasone Sodium Phosphate and Betamethasone Acetate
Cortastat	Dexamethasone Sodium Phosphate
Dalalone	Dexamethasone Sodium Phosphate
Dalalone DP	Dexamethasone Acetate
Dalalone LA	Dexamethasone Acetate
Decadron	Dexamethasone
Decadron LA	Dexamethasone Acetate
Decadron Phosphate	Dexamethasone Sodium Phosphate
Decadron w/Xylocaine	Dexamethasone Sodium Phosphate with Lidocaine HCL
Decaject	Dexamethasone Sodium Phosphate
Decaject LA	Dexamethasone Sodium Phosphate
Dexamethasone	Dexamethasone
Dexamethasone Acetate	Dexamethasone Acetate
Dexamethasone Intensol	Dexamethasone
Dexamethasone Sodium Phosphate	Dexamethasone Sodium Phosphate
Dexamethasone Sodium Phosphate with Lidocaine	Dexamethasone Sodium Phosphate with Lidocaine
Dexamethasone Sodium Phosphate with Lidocaine HCL	Dexamethasone Sodium Phosphate with Lidocaine HCL
Dexasone	Dexamethasone Sodium Phosphate

Medication	Generic
Dexasone LA	Dexamethasone Acetate
Dexone	Dexamethasone
Dexone LA	Dexamethasone Acetate
Hexadrol	Dexamethasone
Hexadrol Phosphate	Dexamethasone Sodium Phosphate
Solurex	Dexamethasone Sodium Phosphate
Solurex LA	Dexamethasone Acetate

Exclusions

- Documented reason for not initiating antenatal steroid therapy (See Appendix E for guidance)
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials (See Appendix E for guidance)
- Principal or Other Diagnosis Codes for fetal demise as defined in Table PC03-F
- Gestational age <24 or ≥32 weeks or Unable to Determine

Medical Record Review

Medical record review is required to collect the following exclusion data elements: admission date, birthdate, clinical trial, discharge date, and reason for not initiating antenatal steroid therapy. See Appendix E for additional guidance on collecting these data elements.

Table PC03-F. ICD-9-CM Diagnosis Codes to Identify Fetal Demise

ICD-9-CM Code	Description
656.40	INTRAUTERINE DEATH-UNSP
656.41	INTRAUTER DEATH-DELIVER

MEASURE PCR-AD: PLAN ALL-CAUSE READMISSIONS RATE

National Committee for Quality Assurance

A. DESCRIPTION

For Medicaid enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories:

- Count of Index Hospital Stays (IHS) (denominator)
- Count of 30-Day Readmissions (numerator)
- Readmission Rate

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, CMS suggests that states report unadjusted rates for this measure (Columns 1, 2, and 3 in Tables PCR-A and PCR-B) until a standardized risk adjustor is made available.
- Include paid claims only.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Index hospital stay (IHS)	An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index admission date	The IHS admission date.
Index discharge date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index readmission stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index readmission date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the Eligible Population.
Classification period	365 days prior to and including an Index Discharge Date.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/ diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not enrollees. Include all acute inpatient discharges for Medicaid enrollees who had one or more discharges on or between January 1 and December 1 of the measurement year. The state should follow the steps below to identify acute inpatient stays.

D. ADMINISTRATIVE SPECIFICATION**Denominator**

The eligible population.

Step 1

Identify all acute inpatient discharges 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. Determine whether the discharge date for the stay falls on or between January 1 and December 1 of the measurement year.

The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2

Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. States must identify "transfers" using their own methods and then confirm the acute inpatient care setting using the process in step 1.

Step 3

Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Required exclusions

Exclude hospital stays for the following reasons:

- The enrollee died during the stay.
- A principal diagnosis of pregnancy (Pregnancy Value Set)
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set)

Note: For hospital stays where there was an acute-to-acute transfer (identified in step 2), use both the original stay and the transfer stay to identify exclusions in this step.

Step 5: Required exclusions for planned readmissions

For all acute inpatient discharges identified using steps 1–4, determine if there was a planned hospital stay within 30 days. To identify planned hospital stays, identify all acute inpatient discharges on or between January 1 and December 31 of the measurement year:

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.
4. Exclude any hospital stay as an Index Hospital Stay if the admission date of the first stay within 30 days meets any of the following criteria:
 - A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set)
 - A principal diagnosis of rehabilitation (Rehabilitation Value Set)
 - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set)
 - A potentially planned procedure (Potentially Planned Procedure Value Set) without a principal acute diagnosis (Acute Condition Value Set)

Note: For hospital stays where there was an acute-to-acute transfer (identified in step 2), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the transfer stay).

Example 1

For an enrollee with the following acute inpatient stays, exclude stay 1 as an Index Hospital Stay.

- Stay 1 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD
- Stay 2 (February 5–7 of the measurement year): Acute inpatient discharge with a principal diagnosis of maintenance chemotherapy

Example 2

For an enrollee with the following acute inpatient stays, exclude stays 2 and 3 as Index Hospital Stays in the following scenario.

- Stay 1 (January 15–17 of the measurement year): Acute inpatient discharge with a principal diagnosis of diabetes
- Stay 2 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD
- Stay 3 (February 5–7 of the measurement year): Acute inpatient discharge with an organ transplant

- Stay 4 (February 10–15 of the measurement year): Acute inpatient discharge with a principal diagnosis of rehabilitation

Step 6

Calculate continuous enrollment.

Step 7

Assign each acute inpatient stay to an age category. Refer to Table PCR-A and Table PCR-B.

Numerator

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1

Identify all acute inpatient stays with an admission date on or between January 2 and December 31 of the measurement year. To identify acute inpatient admissions:

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 to determine whether it falls on or between January 2 and December 31 of the measurement year.

Step 2

Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. States must identify "transfers" using their own methods and then confirm the acute inpatient care setting using the steps above.

Step 3

Exclude acute inpatient hospital discharges with a principal diagnosis of pregnancy (Pregnancy Value Set) or a principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).

Step 4

For each IHS, determine if any of the acute inpatient stays had an admission date within 30 days after the Index Discharge Date.

Reporting: Denominator

Count the number of IHS and enter these values into the table.

Reporting: Numerator

Count the number of IHS with a readmission within 30 days and enter these values into the table.

Reporting: Readmission Rate

This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. CMS suggests that states report unadjusted rates (columns 1, 2, and 3 in Tables PCR-A and PCR-B) for this measure until a standardized risk adjustor is made available.

Note: Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6 in Tables PCR-A and PCR-B.

Table PCR-A. Plan All-Cause Readmissions Rates by Age and Risk Adjustment: Ages 18 to 64

Age	Count of Index Stays (Denominator) (1)	Count of 30-Day Readmissions (Numerator) (2)	Observed Readmissions (Num/Den) (3)	Average Adjusted Probability (4)	Total Variance (5)	O/E Ratio (Observed Readmissions/ Average Adjusted Probability) (6)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
18–44	_____	_____	_____	_____	_____	_____	_____	_____
45–54	_____	_____	_____	_____	_____	_____	_____	_____
55–64	_____	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____	_____

Note: This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, CMS suggests that states report the unadjusted total rates for this measure (columns 1, 2, and 3) because Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6.

Table PCR-B. Plan All-Cause Readmissions Rates by Age and Risk Adjustment: Age 65 and Older

Age	Count of Index Stays (Denominator) (1)	Count of 30-Day Readmissions (Numerator) (2)	Observed Readmissions (Num/Den) (3)	Average Adjusted Probability (4)	Total Variance (5)	O/E Ratio (Observed Readmissions/ Average Adjusted Probability) (6)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
65–74	_____	_____	_____	_____	_____	_____	_____	_____
75–84	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____	_____

Note: This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, CMS suggests that states report the unadjusted total rates for this measure (columns 1, 2, and 3) because Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6.

MEASURE PPC-AD: POSTPARTUM CARE RATE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled women that meet the measure eligibility criteria.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for definitions of a PCP and OB/GYN practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, LOINC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	<p>Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting.</p> <p>Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for the rate:</p> <p>Step 1</p> <p>Identify deliveries. Identify all women with a delivery (<u>Deliveries Value Set</u>) between November 6 of the year prior to the measurement year and November 5 of the measurement year.</p> <p>Step 2</p> <p>Exclude non-live births (<u>Non-live Births Value Set</u>).</p>

Event/diagnosis (continued)	<p>Step 3</p> <p>Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.</p>
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C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

Postpartum Care

A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:

- A postpartum visit ([Postpartum Visits Value Set](#))
- Cervical cytology ([Cervical Cytology 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)

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

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, 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 additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

Postpartum Care

A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 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 practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following.

- Pelvic exam
 - A Pap test alone is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for the rate.
- 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

MEASURE PQI01-AD: PQI 01: DIABETES SHORT-TERM COMPLICATIONS
ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 enrollee months for Medicaid enrollees age 18 and older.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 Medicaid enrollees.
- A two-step process should be used to determine whether enrollees should be counted in the measure:
 - For each enrollee month considered for the denominator, assess the enrollee's age at either the 15th or 30th of the month (or the 28th of the month in February). If the enrollee was age 18 or older by that date, the enrollee month should be counted in the denominator. A consistent date should be used to assess age across all months.
 - For each hospital admission representing a qualifying numerator event, assess the enrollee's age on the date of admission. Only admissions for enrollees age 18 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI01-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure: <http://www.qualityindicators.ahrq.gov/Software/Default.aspx>. These specifications are based on version 5.0 of the software. 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 <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.
- Include paid claims only.

The following coding systems are used in this measure: ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Enrollee months	All enrollee months for Medicaid enrollees age 18 and older as of the 15th or the 30th day of the month. Date for counting enrollee months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION**Denominator**

Total number of months of Medicaid enrollment for enrollees age 18 and older during the measurement period.

Numerator

All inpatient hospital admissions with ICD-9-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) (Table PQI01-A).

Table PQI01-A. ICD-9-CM Diagnosis Codes for Short-term Complications of Diabetes

ICD-9-CM Code	Description
25010	DMII KETO NT ST UNCNTRLD
25011	DMI KETO NT ST UNCNTRLD
25012	DMI KETOACD UNCONTROLD
25013	DMI KETOACD UNCONTROLD
25020	DMII HPRSM NT ST UNCNTRL
25021	DMI HPRSM NT ST UNCNTRLD
25022	DMII HPROSMLR UNCONTROLD
25023	DMI HPROSMLR UNCONTROLD
25030	DMII O CM NT ST UNCNTRLD
25031	DMI O CM NT UNCNTRLD
25032	DMII OTH COMA UNCONTROLD
25033	DMI OTH COMA UNCONTROLD

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI01-B for admission codes for transfers.)
- Admissions with missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), principal diagnosis (DX1 = missing)

- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of diabetes with short-term complications are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)

Table PQI01-B. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility
	6 – Transfer from another health care facility

MEASURE PQI05-AD: PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE
(COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 enrollee months for Medicaid enrollees age 40 and older.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 40 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 40 to 64 and age 65 and older.
- States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 Medicaid enrollees.
- A two-step process should be used to determine whether enrollees should be counted in the measure:
 - For each enrollee month considered for the denominator, assess the enrollee's age at either the 15th or 30th of the month (or the 28th of the month in February). If the enrollee was age 40 or older by that date, the enrollee month should be counted in the denominator. A consistent date should be used to assess age across all months.
 - For each hospital admission representing a qualifying numerator event, assess the enrollee's age on the date of admission. Only admissions for enrollees age 40 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI05-D, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure: <http://www.qualityindicators.ahrq.gov/Software/Default.aspx>. These specifications are based on version 5.0 of the software. 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 <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.
- Include paid claims only.

The following coding systems are used in this measure: ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Enrollee months	All enrollee months for Medicaid enrollees age 40 and older as of the 15th or the 30th day of the month. Date for counting enrollee months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of Medicaid enrollment for enrollees age 40 and older during the measurement period.

Numerator

All non-maternal inpatient hospital admissions with an ICD-9-CM principal diagnosis code for:

- COPD (Table PQI05-A) or
- Asthma (Table PQI05-B) or
- Acute bronchitis and any secondary ICD-9-CM diagnosis codes for COPD (Table PQI05-C)

Table PQI05-A. ICD-9-CM Diagnosis Codes for COPD

ICD-9-CM Code	Description
4910	SIMPLE CHR BRONCHITIS
4911	MUCOPURUL CHR BRONCHITIS
49120	OBST CHR BRONC W/O EXAC
49121	OBS CHR BRONC W(AC) EXAC
49122	OBS CHR BRONC W AC BRONC
4918	CHRONIC BRONCHITIS NEC
4919	CHRONIC BRONCHITIS NOS
4920	EMPHYSEMATOUS BLEB
4928	EMPHYSEMA NEC
494	BRONCHIECTASIS
4940	BRONCHIECTAS W/O AC EXAC
4941	BRONCHIECTASIS W AC EXAC
496	CHR AIRWAY OBSTRUCT NEC

Table PQI05-B. ICD-9-CM Diagnosis Codes for Asthma

ICD-9-CM Code	Description
49300	EXTRINSIC ASTHMA NOS
49301	EXT ASTHMA W STATUS ASTH
49302	EXT ASTHMA W(ACUTE) EXAC
49310	INTRINSIC ASTHMA NOS
49311	INT ASTHMA W STATUS ASTH
49312	INT ASTHMA W (AC) EXAC
49320	CHRONIC OBST ASTHMA NOS
49321	CH OB ASTHMA W STAT ASTH
49322	CH OBST ASTH W (AC) EXAC
49381	EXERCISE IND BRONCHOSPASM
49382	COUGH VARIANT ASTHMA
49390	ASTHMA NOS
49391	ASTHMA W STATUS ASTHMAT
49392	ASTHMA NOS W (AC) EXAC

Table PQI05-C. ICD-9-CM Diagnosis Codes for Acute Bronchitis*

ICD-9-CM Code	Description
4660	ACUTE BRONCHITIS
490	BRONCHITIS NOS

*Must be accompanied by a secondary diagnosis code of COPD.

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI05-D for admission codes for transfers)
- Admissions with missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of COPD, asthma, or acute bronchitis are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)
- ICD-9-CM or ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Table PQI05-E)

Table PQI05-D. Admission Codes for Transfers

SID ASOURCE Codes	2- Another hospital
	3- Another facility, including long-term care
Point of Origin UB-04 Codes	4- Transfer from a hospital
	5- Transfer from a Skilled Nursing Facility
	6- Transfer from another health care facility

Table PQI05-E. ICD-9-CM Diagnosis Codes for Cystic Fibrosis and Anomalies of the Respiratory System

ICD-9-CM Code	Description
27700	CYSTIC FIBROSIS W/O ILEUS
27701	CYSTIC FIBROSIS W ILEUS
27702	CYSTIC FIBROSIS W PUL MAN
27703	CYSTIC FIBROSIS W GI MAN
27709	CYSTIC FIBROSIS NEC
51661	NEUROEND CELL HYPRPL INF
51662	PULM INTERSTITL GYLCOGEN
51663	SURFACTANT MUTATION LUNG
51664	ALV CAP DYSP W VN MISALN
51669	OTH INTRST LUNG DIS CHLD
74721	ANOMALIES OF AORTIC ARCH
7483	LARYNGOTRACH ANOMALY NEC
7484	CONGENITAL CYSTIC LUNG
7485	AGENESIS OF LUNG
74860	LUNG ANOMALY NOS
74861	CONGEN BRONCHIECTASIS
74869	LUNG ANOMALY NEC
7488	RESPIRATORY ANOMALY NEC
7489	RESPIRATORY ANOMALY NOS
7503	CONG ESOPH FISTULA/ATRES
7593	SITUS INVERSUS
7707	PERINATAL CHR RESP DIS

MEASURE PQI08-AD: PQI 08: HEART FAILURE ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for heart failure per 100,000 enrollee months for Medicaid enrollees age 18 and older.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 Medicaid enrollees.
- A two-step process should be used to determine whether enrollees should be counted in the measure:
 - For each enrollee month considered for the denominator, assess the enrollee's age at either the 15th or 30th of the month (or the 28th of the month in February). If the enrollee was age 18 or older by that date, the enrollee month should be counted in the denominator. A consistent date should be used to assess age across all months.
 - For each hospital admission representing a qualifying numerator event, assess the enrollee's age on the date of admission. Only admissions for enrollees age 18 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI08-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure: <http://www.qualityindicators.ahrq.gov/Software/Default.aspx>. These specifications are based on version 5.0 of the software. 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 <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.
- Include paid claims only.

The following coding systems are used in this measure: ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Enrollee months	All enrollee months for Medicaid enrollees age 18 and older as of the 15th or the 30th day of the month. Date for counting enrollee months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION**Denominator**

Total number of months of Medicaid enrollment for enrollees age 18 and older during the measurement period.

Numerator

All inpatient hospital admissions with ICD-9-CM principal diagnosis code for heart failure (Table PQI08-A).

Table PQI08-A. ICD-9-CM Diagnosis Codes for Heart Failure

ICD-9-CM Code	Description
39891	RHEUMATIC HEART FAILURE
40201	MAL HYPERT HRT DIS W CHF
40211	BENIGN HYP HRT DIS W CHF
40291	HYPERTEN HEART DIS W CHF
40401	MAL HYPER HRT/REN W CHF
40403	MAL HYP HRT/REN W CHF/RF
40411	BEN HYPER HRT/REN W CHF
40413	BEN HYP HRT/REN W CHF/RF
40491	HYPERT HRT/REN NOS W CHF
40493	HYP HT/REN NOS W CHF/RF
4280	CONGESTIVE HEART FAILURE
4281	LEFT HEART FAILURE
42820	SYSTOLIC HRT FAILURE NOS OCT02-
42821	AC SYSTOLIC HRT FAILURE OCT02-
42822	CHR SYSTOLIC HRT FAILURE OCT02-
42823	AC ON CHR SYST HRT FAIL OCT02-
42830	DIASTOLC HRT FAILURE NOS OCT02-
42831	AC DIASTOLIC HRT FAILURE OCT02-

ICD-9-CM Code	Description
42832	CHR DIASTOLIC HRT FAIL OCT02-
42833	AC ON CHR DIAST HRT FAIL OCT02-
42840	SYST/DIAST HRT FAIL NOS OCT02-
42841	AC SYST/DIASTOL HRT FAIL OCT02-
42842	CHR SYST/DIASTL HRT FAIL OCT02-
42843	AC/CHR SYST/DIA HRT FAIL OCT02-
4289	HEART FAILURE NOS

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI08-B for admission codes for transfers)
- Admissions with missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of heart failure are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)
- With any listed ICD-9-CM or ICD-10-CM procedure codes for cardiac procedure (Table PQI08-C)

Table PQI08-B. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility
	6 – Transfer from another health care facility

Table PQI08-C. ICD-9-CM Procedure Codes for Cardiac Procedures

ICD-9-CM Code	Description
0050	IMPL CRT PACEMAKER SYS OCT02-
0051	IMPL CRT DEFIBRILLAT OCT02-
0052	IMP/REP LEAD LF VEN SYS OCT02-
0053	IMP/REP CRT PACEMKR GEN OCT02-
0054	IMP/REP CRT DEFIB GENAT OCT02-
0056	INS/REP IMPL SENSOR LEAD OCT06-
0057	IMP/REP SUBCUE CARD DEV OCT06-
0066	PTCA OCT06-
1751	IMPLANTATION OF RECHARGEABLE CARDIAC CONTRACTILITY MODULATION [CCM], TOTAL SYSTEM OCT09-
1752	IMPLANTATION OR REPLACEMENT OF CARDIAC CONTRACTILITY MODULATION [CCM] RECHARGEABLE PULSE, GENERATOR ONLY OCT09-
1755	TRANSLUM COR ATHERECTOMY
3500	CLOSED VALVOTOMY NOS
3501	CLOSED AORTIC VALVOTOMY
3502	CLOSED MITRAL VALVOTOMY
3503	CLOSED PULMON VALVOTOMY
3504	CLOSED TRICUSP VALVOTOMY
3505	ENDOVAL REPL AORTIC VALVE
3506	TRANSAPCL REP AORTIC VALVE
3507	ENDOVAL REPL PULM VALVE
3508	TRANSAPCL REPL PULM VALVE
3509	ENDOVAL REPL UNS HRT VLV
3510	OPEN VALVULOPLASTY NOS
3511	OPN AORTIC VALVULOPLASTY
3512	OPN MITRAL VALVULOPLASTY
3513	OPN PULMON VALVULOPLASTY
3514	OPN TRICUS VALVULOPLASTY
3520	REPLACE HEART VALVE NOS
3521	REPLACE AORT VALV-TISSUE
3522	REPLACE AORTIC VALVE NEC
3523	REPLACE MITR VALV-TISSUE
3524	REPLACE MITRAL VALVE NEC

ICD-9-CM Code	Description
3525	REPLACE PULM VALV-TISSUE
3526	REPLACE PULMON VALVE NEC
3527	REPLACE TRIC VALV-TISSUE
3528	REPLACE TRICUSP VALV NEC
3531	PAPILLARY MUSCLE OPS
3532	CHORDAE TENDINEAE OPS
3533	ANNULOPLASTY
3534	INFUNDIBULECTOMY
3535	TRABECUL CARNEAE CORD OP
3539	TISS ADJ TO VALV OPS NEC
3541	ENLARGE EXISTING SEP DEF
3542	CREATE SEPTAL DEFECT
3550	PROSTH REP HRT SEPTA NOS
3551	PROS REP ATRIAL DEF-OPN
3552	PROS REPAIR ATRIA DEF-CL
3553	PROST REPAIR VENTRIC DEF
3554	PROS REP ENDOCAR CUSHION
3555	PROS REP VENTRC DEF-CLOS OCT06-
3560	GRFT REPAIR HRT SEPT NOS
3561	GRAFT REPAIR ATRIAL DEF
3562	GRAFT REPAIR VENTRIC DEF
3563	GRFT REP ENDOCAR CUSHION
3570	HEART SEPTA REPAIR NOS
3571	ATRIA SEPTA DEF REP NEC
3572	VENTR SEPTA DEF REP NEC
3573	ENDOCAR CUSHION REP NEC
3581	TOT REPAIR TETRAL FALLOT
3582	TOTAL REPAIR OF TAPVC
3583	TOT REP TRUNCUS ARTERIOS
3584	TOT COR TRANSPOS GRT VES
3591	INTERAT VEN RETRN TRANSP
3592	CONDUIT RT VENT-PUL ART
3593	CONDUIT LEFT VENTR-AORTA
3594	CONDUIT ARTIUM-PULM ART

ICD-9-CM Code	Description
3595	HEART REPAIR REVISION
3596	PERC HEART VALVULOPLASTY
3597	PERC MTRL VLV REPR W IMP
3598	OTHER HEART SEPTA OPS
3599	OTHER HEART VALVE OPS
3601	PTCA-1 VESSEL W/O AGENT
3602	PTCA-1 VESSEL WITH AGNT
3603	OPEN CORONRY ANGIOPLASTY
3604	INTRACORONRY THROMB INFUS
3605	PTCA-MULTIPLE VESSEL
3606	INSERT OF COR ART STENT OCT95-
3607	INS DRUG-ELUT CORONRY ST OCT02-
3609	REM OF COR ART OBSTR NEC
3610	AORTOCORONARY BYPASS NOS
3611	AORTOCOR BYPAS-1 COR ART
3612	AORTOCOR BYPAS-2 COR ART
3613	AORTOCOR BYPAS-3 COR ART
3614	AORTCOR BYPAS-4+ COR ART
3615	1 INT MAM-COR ART BYPASS
3616	2 INT MAM-COR ART BYPASS
3617	ABD-CORON ART BYPASS OCT96-
3619	HRT REVAS BYPS ANAS NEC
362	ARTERIAL IMPLANT REVASC
363	OTH HEART REVASCULAR
3631	OPEN CHEST TRANS REVASC
3632	OTH TRANSMYO REVASCULAR
3633	ENDO TRANSMYO REVASCULAR OCT06-
3634	PERC TRANSMYO REVASCULAR OCT06-
3639	OTH HEART REVASULAR
3691	CORON VESS ANEURYSM REP
3699	HEART VESSLE OP NEC
3731	PERICARDIECTOMY
3732	HEART ANEURYSM EXCISION
3733	EXC/DEST HRT LESION OPEN

ICD-9-CM Code	Description
3734	EXC/DEST HRT LES OTHER
3735	PARTIAL VENTRICULECTOMY
3736	EXCISION OR DESTRUCTION OF LEFT ATRIAL APPENDAGE (LAA) OCT08-
3737	EXC/DEST HRT LES, THRSPC
3741	IMPLANT PROSTH CARD SUPPORT DEV OCT06
3751	HEART TRANPLANTATION OCT03-
3752	IMPLANT TOT REP HRT SYS OCT03-
3753	REPL/REP THORAC UNIT HRT OCT03-
3754	REPL/REP OTH TOT HRT SYS OCT03-
3755	REMOVAL OF INTERNAL BIVENTRICULAR HEART REPLACEMENT SYSTEM OCT08
3760	IMPLANTATION OR INSERTION OF BIVENTRICULAR EXTERNAL HEART ASSIST SYSTEM OCT08
3761	IMPLANT OF PULSATION BALLOON
3762	INSERTION OF NON-IMPLANTABLE HEART ASSIST SYSTEM
3763	REPAIR OF HEART ASSIST SYSTEM
3764	REMOVAL OF HEART ASSIST SYSTEM
3765	IMPLANT OF EXTERNAL HEART ASSIST SYSTEM
3766	INSERTION OF IMPLANTABLE HEART ASSIST SYSTEM
3770	INT INSERT PACEMAK LEAD
3771	INT INSERT LEAD IN VENT
3772	INT INSERT LEAD ATRI-VENT
3773	INT INSEAR LEAD IN ATRIUM
3774	INT OR REPL LEAD EPICAR
3775	REVISION OF LEAD
3776	REPL TV ATRI-VENT LEAD
3777	REMOVAL OF LEAD W/O REPL
3778	INSER TEAM PACEMAKER SYS
3779	REVIS OR RELOCATE POCKET
3780	INT OR REPL PERM PACEMKR
3781	INT INSERT 1-CHAM, NON
3782	INT INSERT 1-CHAM, RATE
3783	INT INSERT DUAL-CHAM DEV
3785	REPL PACEM W 1-CHAM, NON

ICD-9-CM Code	Description
3786	REPL PACEM 1-CHAM, RATE
3787	REPL PACEM W DUAL-CHAM
3789	REVISE OR REMOVE PACEMAK
3794	IMPLT/REPL CARDDEFIB TOT
3795	IMPLT CARDIODEFIB LEADS
3796	IMPLT CARDIODEFIB GENATR
3797	REPL CARDIODEFIB LEADS
3798	REPL CARDIODEFIB GENRATR
3826	INSRT PRSR SNSR W/O LEAD

MEASURE PQI15-AD: PQI 15: ASTHMA IN YOUNGER ADULTS
ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for asthma per 100,000 enrollee months for Medicaid enrollees ages 18 to 39.

Data Collection Method: Administrative

Guidance for Reporting:

- States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 Medicaid enrollees.
- A two-step process should be used to determine whether enrollees should be counted in the measure:
 - For each enrollee month considered for the denominator, assess the enrollee's age at either the 15th or 30th of the month (or the 28th of the month in February). If the enrollee was ages 18 to 39 on that date, the enrollee month should be counted in the denominator. A consistent date should be used to assess age across all months.
 - For each hospital admission representing a qualifying numerator event, assess the enrollee's age on the date of admission. Only admissions for enrollees ages 18 to 39 should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI15-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure: <http://www.qualityindicators.ahrq.gov/Software/Default.aspx>. These specifications are based on version 5.0 of the software. 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 <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-Adult-ICD10-Codes.zip>.
- Include paid claims only.

The following coding systems are used in this measure: ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Enrollee months	All enrollee months for Medicaid enrollees age 18-39 as of the 15th or the 30th day of the month. Date for counting enrollee months must be consistent across the reporting period.
Continuous enrollment	None.

Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of Medicaid enrollment for enrollees ages 18 to 39 during the measurement period.

Numerator

All non-maternal inpatient hospital admissions for enrollees ages 18 to 39 with an ICD-9-CM principal diagnosis code of asthma (Table PQI15-A).

Table PQI15-A. ICD-9-CM Diagnosis Codes for Asthma

ICD-9-CM Code	Description
49300	EXT ASTHMA W/O STAT ASTH
49301	EXT ASTHMA W STATUS ASTH
49302	EXT ASTHMA W ACUTE EXAC OCT00-
49310	INT ASTHMA W/O STAT ASTH
49311	INT ASTHMA W STAT ASTH
49312	INT ASTHMA W ACUTE EXAC OCT00-
49320	CH OB ASTH W/O STAT ASTH
49321	CH OB ASTHMA W STAT ASTH
49322	CH OBS ASTH W ACUTE EXAC OCT00-
49381	EXERCSE IND BRONCHOSPASM OCT03-
49382	COUGH VARIANT ASTHMA OCT03-
49390	ASTHMA W/O STATUS ASTHM
49391	ASTHMA W STATUS ASTHMAT
49392	ASTHMA W ACUTE EXACERBTN OCT00-

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI15-B for admission codes for transfers).
- Admissions with missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing).
- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of asthma are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)
- With any listed ICD-9-CM diagnosis code for cystic fibrosis and anomalies of the respiratory system (Table PQI15-C).

Table PQI15-B. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility
	6 – Transfer from another health care facility

Table PQI15-C. ICD-9-CM Diagnosis Codes for Cystic Fibrosis and Anomalies of the Respiratory System

ICD-9-CM Code	Description
27700	CYSTIC FIBROS W/O ILEUS
27701	CYSTIC FIBROSIS W ILEUS
27702	CYSTIC FIBROS W PUL MAN
27703	CYSTIC FIBROSIS W GI MAN
27709	CYSTIC FIBROSIS NEC
51661	NEUROEND CELL HYPRPL INF
51662	PULM INTERSTITL GLYCOGEN
51663	SURFACTANT MUTATION LUNG
51664	ALV CAP DYSP W VN MISALIGN
51669	OTH INTRST LUNG DIS CHLD
747.21	ANOMALIES OF AORTIC ARCH
7483	LARYNGOTRACH ANOMALY NEC
7484	CONGENITAL CYSTIC LUNG
7485	AGENESIS OF LUNG
74860	LUNG ANOMALY NOS
74861	CONGEN BRONCHIECTASIS
74869	LUNG ANOMALY NEC
7488	RESPIRATORY ANOMALY NEC
7489	RESPIRATORY ANOMALY NOS
7503	CONG ESOPH FISTULA/ATRES
7593	SITUS INVERSUS
7707	PERINATAL CHR RESP DIS

MEASURE SAA-AD: ADHERENCE TO ANTIPSYCHOTICS FOR INDIVIDUALS WITH SCHIZOPHRENIA

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid enrollees ages 19 to 64 during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Data Collection Method: Administrative

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- NCQA's list of NDC codes for antipsychotic medications can be found at:
<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

IPSD	Index Prescription Start Date. The earliest prescription dispensing date for any antipsychotic medication during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of Days Covered. The number of days an enrollee is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
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. 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, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.
Long-acting injections dispensing event	Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.

Calculating number of days covered for oral medications	<p>If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days' supply.</p> <p>If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the same oral medication are dispensed on different days, sum the days' supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days' supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap).</p> <p>Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.</p>
Calculating number of days covered for long-acting injections	Calculate number of days covered (for the numerator) for long-acting injections using the days-supply specified for the medication in Table SAA-A. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days' supply. For multiple J Codes or NDCs for the same or different medications on different days with overlapping days' supply, count each day within the treatment period only once toward the numerator.

C. ELIGIBLE POPULATION

Age	Ages 19 to 64 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.

Event/ diagnosis	<p>Follow the steps below to identify the eligible population.</p> <p>Step 1</p> <p>Identify Medicaid enrollees with schizophrenia as those who met at least one of the following criteria during the measurement year:</p> <ul style="list-style-type: none"> • At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria: <ul style="list-style-type: none"> • <u>BH Stand Alone Acute Inpatient Value Set</u> with <u>Schizophrenia Value Set</u> • <u>BH Acute Inpatient Value Set</u> with <u>BH Acute Inpatient POS Value Set</u> and <u>Schizophrenia Value Set</u> • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED, or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: <ul style="list-style-type: none"> • <u>BH Stand Alone Outpatient/PH/IOP Value Set</u> with <u>Schizophrenia Value Set</u> • <u>BH Outpatient/PH/IOP Value Set</u> with <u>BH Outpatient/PH/IOP POS Value Set</u> and <u>Schizophrenia Value Set</u> • <u>ED Value Set</u> with <u>Schizophrenia Value Set</u> • <u>BH ED Value Set</u> with <u>BH ED POS Value Set</u> and <u>Schizophrenia Value Set</u> • <u>BH Stand Alone Nonacute Inpatient Value Set</u> with <u>Schizophrenia Value Set</u> • <u>BH Nonacute Inpatient Value Set</u> with <u>BH Nonacute Inpatient POS Value Set</u> and <u>Schizophrenia Value Set</u> <p>Step 2: Required Exclusions</p> <p>Exclude enrollees who met at least one of the following during the measurement year:</p> <ul style="list-style-type: none"> • A diagnosis of dementia (<u>Dementia Value Set</u>) • Did not have at least two antipsychotic medication dispensing events. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The state must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. • Claims/encounter data. An antipsychotic medication (<u>Long-Acting Injections 14 Days Supply Value Set</u> or <u>Long-Acting Injections 28 Days Supply Value Set</u>) • Pharmacy data. Dispensed an antipsychotic medication (Table SAA-A) on an ambulatory basis
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Table SAA-A. Antipsychotic Medications

Description	Prescription		Covered Days
Miscellaneous antipsychotic agents (oral)	Aripiprazole Asenapine Brexipiprazole Clozapine Haloperidol Iloperidone Loxapine Lurasidone Molindone	Olanzapine Paliperidone Pimozide Quetiapine Quetiapine-fumarate Risperidone Ziprasidone	
Phenothiazine antipsychotics (oral)	Chlorpromazine Fluphenazine Perphenazine Perphenazine-amitriptyline	Prochlorperazine Thioridazine Trifluoperazine	
Psychotherapeutic combinations (oral)	Fluoxetine-olanzapine		
Thioxanthenes (oral)	Thiothixene		
Long-acting injections	Aripiprazole Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate	28 days' supply
	Risperidone		14 days' supply

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

The number of Medicaid enrollees who achieved a PDC of at least 80 percent for their antipsychotic medications (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.

Follow the steps below to identify numerator compliance:

Step 1

Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.

Step 2

To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3

Count the days covered by at least one antipsychotic medication (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the treatment period. To ensure that the day's supply does not exceed the treatment period, subtract any day's supply that extends beyond December 31 of the measurement year.

Step 4

Calculate the enrollee's PDC using the following equation:

$$\frac{\text{Total days covered by an antipsychotic medication in the treatment period (Step 3)}}{\text{Total days in treatment period (Step 2)}}$$

Round to two decimal places, using the .5 rule (if the decimal is 0.5 or above round up to the nearest whole number. If the decimal is 0.499999 or below round down to the nearest whole number).

Step 5

Sum the number of enrollees whose PDC is ≥ 80 percent for their treatment period.

MEASURE SSD-AD: DIABETES SCREENING FOR PEOPLE WITH
SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING
ANTIPSYCHOTIC MEDICATIONS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of enrollees ages 18 to 64 with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- NCQA's list of NDC codes for antipsychotic medications can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 18 to 64 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 Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify Medicaid enrollees with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year: <ul style="list-style-type: none"> • At least one acute inpatient encounter with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria: <ul style="list-style-type: none"> • <u>BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set</u> • <u>BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set</u> • <u>BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set</u>

<p>Event/ diagnosis (cont'd)</p>	<ul style="list-style-type: none"> • <u>BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Schizophrenia Value Set</u> <u>BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Bipolar Disorder Value Set</u> • <u>BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and Other Bipolar Disorder Value Set</u> • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED, or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria: <ul style="list-style-type: none"> • <u>BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set</u> • <u>BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and Schizophrenia Value Set</u> • <u>ED Value Set with Schizophrenia Value Set</u> • <u>BH ED Value Set with BH ED POS Value Set and Schizophrenia Value Set</u> • <u>BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set</u> • <u>BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Schizophrenia Value Set</u> • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED, or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria: <ul style="list-style-type: none"> • <u>BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set</u> • <u>BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set</u> • <u>BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and Bipolar Disorder Value Set</u> • <u>BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and Other Bipolar Disorder Value Set</u> • <u>ED Value Set with Bipolar Disorder Value Set</u> • <u>ED Value Set with Other Bipolar Disorder Value Set</u> • <u>BH ED Value Set with BH ED POS Value Set and Bipolar Disorder Value Set</u> • <u>BH ED Value Set with BH ED POS Value Set and Other Bipolar Disorder Value Set</u> • <u>BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set</u> • <u>BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set</u> • <u>BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Bipolar Disorder Value Set</u> • <u>BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and Other Bipolar Disorder Value Set</u> <p>Step 2: Required Exclusions</p> <p>Exclude enrollees who met any of the following criteria: Enrollees with diabetes. There are two ways to identify enrollees with diabetes: (1) by claims/encounter data and (2) by pharmacy data. The state must use both methods to identify enrollees with diabetes, but an enrollee need only be identified by one method to be excluded from the measure. Enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p>
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Event/ diagnosis (cont'd)	<ul style="list-style-type: none"> • Claims/encounter data. Enrollees who met any of the following criteria during the measurement year or year prior to the measurement year (count services that occur over both years): <ul style="list-style-type: none"> • At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED Visits (<u>ED Value Set</u>), or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>). • Pharmacy data. Enrollees who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Table SSD-A). <p>Enrollees who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: (1) by claims/encounter data and (2) by pharmacy data. Both methods must be used to identify dispensing events, but an event need only be identified by one method to be counted.</p> <ul style="list-style-type: none"> • Claim/encounter data. An antipsychotic medication (<u>Long-Acting Injections Value Set</u>). • Pharmacy data. Dispensed an antipsychotic medication (Table SSD-B) on an ambulatory basis.
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Table SSD-A. Prescriptions to Identify Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canaglifozin-metformin Empaglifozin-linagliptin Empaglifozin/metformin Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Sitagliptin-simvastatin

Description	Prescription
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin human inhaled Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human
Meglitinides	Nateglinide Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Dulaglutide Exenatide Liraglutide Albiglutide
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitagliptin

Notes: Table SSD-A corresponds to NDC Code Table CDC-A.

Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; enrollees with diabetes on these medications are identified through diagnosis codes only. A comprehensive list of medications and NDC codes can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

Table SSD-B. Antipsychotic Medications

Description	Prescription		
Miscellaneous antipsychotic agents (oral)	Aripiprazole Asenapine Brexipiprazole Clozapine Haloperidol Iloperidone	Loxapine Lurasidone Molindone Olanzapine Paliperidone Pimozide	Quetiapine Quetiapine-fumarate Risperidone Ziprasidone
Phenothiazine antipsychotics (oral)	Chlorpromazine Fluphenazine Perphenazine	Perphenazine-amitriptyline Prochlorperazine	Thioridazine Trifluoperazine
Psychotherapeutic combinations (oral)	Fluoxetine-olanzapine		
Thioxanthenes (oral)	Thiothixene		
Long-acting injections	Aripiprazole Fluphenazine decanoate	Haloperidol decanoate Olanzapine	Paliperidone palmitate Risperidone

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claims/encounter or automated laboratory data.

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Appendix A
Adult Core Set
HEDIS® Value Set Directory
User Manual

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A. WHAT IS THE VALUE SET DIRECTORY?

Measure specifications for HEDIS® measures included in the Adult 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 Value Set Directory (VSD) includes all value sets and codes needed to report HEDIS measures included in the Adult Core Set. This appendix describes how to use value sets in calculating measures in the Adult Core Set.

B. STRUCTURE OF THE VALUE SET DIRECTORY

The VSD (Excel workbook) contains the following spreadsheets:

- Measures to Value Sets
- Value Sets to Codes
- Summary of Changes – Codes
- Summary of Changes – Value Sets

The columns in the value sets are based on those included in the National Library of Medicine Value Set Authority Center (VSAC) standardized value set file. Not all columns will be needed for Adult Core Set reporting, depending on how the state’s information systems are organized. All columns have been included in the value set to preserve consistency with the national standard.

C. WHAT’S NEW IN THE VALUE SET DIRECTORY?

ICD-10-CM and ICD-10-PCS codes are included in the value sets and are not listed individually in the “Summary of Changes – Codes” spreadsheet.

Other specific code and value set changes are included in the Summary of Changes spreadsheets, as described in this manual.

D. MEASURES TO VALUE SETS

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

Table A.1. Measures to Value Sets

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

Use the 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 “ABA-AD” demonstrates that the Adult BMI Assessment measure uses the following value sets:

Measure ID	Measure Name	Value Set Name	Value Set OID
ABA-AD	Adult BMI Assessment	BMI	2.16.840.1.113883.3.464.1004.1037
ABA-AD	Adult BMI Assessment	BMI Percentile	2.16.840.1.113883.3.464.1004.1038
ABA-AD	Adult BMI Assessment	Outpatient	2.16.840.1.113883.3.464.1004.1202
ABA-AD	Adult BMI Assessment	Pregnancy	2.16.840.1.113883.3.464.1004.1219

Setting the Value Set Name filter to “Cervical Cytology” identifies the two measures that use the value set.

Measure ID	Measure Name	Value Set Name	Value Set OID
CCS-AD	Cervical Cancer Screening	Cervical Cytology	2.16.840.1.113883.3.464.1004.1208
PPC-AD	Postpartum Care Rate	Cervical Cytology	2.16.840.1.113883.3.464.1004.1208

E. VALUE SETS TO CODES

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

Table A.2. 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	The version date for the value set directory (2015-11-13 for federal fiscal year 2016 reporting)
Code	The code
Definition	The code definition Note: The definition is not included for Uniform Bill ^a or CPT ^b codes due to licensing restrictions.
Code System	The code system for the code. Code systems are labeled as: CPT Current Procedural Terminology 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, Procedure Coding System (Procedure codes) LOINC ^c Logical Observation Identifiers Names and Codes POS CMS Place of Service UBREV Uniform Bill (Revenue codes) UBTOB Uniform Bill (Type of Bill codes)
Code System OID	Unique identifier for the code system

Element Name	Element Description
Code System Version	Code system version tracking number

^a Uniform Bill Codes (“UB Codes”) are protected under federal copyright laws and are owned by the American Hospital Association (AHA). The UB Revenue and Type of Service Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Software vendors and all others desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other use, must obtain a commercial use license directly from the AHA. To inquire about licensing, please contact ub04@healthforum.com.

^b CPT codes copyright 2015 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

^c LOINC[®] is a registered trademark of the Regenstrief Institute.

Use the 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 “Essential Hypertension” 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
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2015-11-13	I10	[I10] Essential (primary) hypertension	ICD10CM	2.16.840.1.113883.6.90	2014.0.0.13AA
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2015-11-13	401.0	Malignant essential hypertension	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2015-11-13	401.1	Benign essential hypertension	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2015-11-13	401.9	Unspecified essential hypertension	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA

Setting the Code filter to “296.20” 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
Major Depression	2.16.840.1.113883.3.464.1004.1166	2015-11-13	296.20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Mental Health Diagnosis	2.16.840.1.113883.3.464.1004.1178	2015-11-13	296.20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Mental Illness	2.16.840.1.113883.3.464.1004.1179	2015-11-13	296.20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA

F. SUMMARY OF CHANGES – CODES

The Summary of Changes – Codes spreadsheet lists code changes in FFY 2016 by value set and includes the elements in Table A.3.

Table A.3. Summary of Changes

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
Revised	The date the revision occurred

Use the Summary of Changes – Codes spreadsheet to identify codes added to or deleted from a concept. For example, setting the Value Set Name filter to “Absence of Cervix” demonstrates one deleted code.

Value Set	Change	Code System	Code
Absence of Cervix	Deleted	CPT	58551

Codes for value sets that are new to the Adult Core Set and value sets that are new to a specific Adult Core Set measures are not listed individually in the “Summary of Changes – Codes” spreadsheet.

Codes for value sets that have been deleted from the Adult Core Set or from a specific Adult Core Set measures are not listed individually in the “Summary of Changes – Codes” spreadsheet.

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

As part of the code transition from tables to value sets, codes in concepts that spanned multiple measures were standardized into a single value set. Standardization resulted in the deletion of codes from some measures and the addition of codes to some measures.

G. SUMMARY OF CHANGES – VALUE SETS

The Summary of Changes – Value Sets spreadsheet lists changes in FFY 2016 by value sets and includes the elements in Table A.3.

Table A.4. Summary of Changes – Value Sets

Element Name	Element Description
Adult Core Set 2015	The name of the value set in the FFY 2015 manual (value sets that did not exist are labeled NA)
Change	The change (Added; Deleted; Revised)
Adult Core Set 2016	The name of the value set in the FFY 2016 manual or the affected measures (for deleted value sets)

Use the Summary of Changes – Value Sets spreadsheet to identify revised, added or deleted value sets. For example, this spreadsheet demonstrates:

- The Polycystic Ovaries Value Set was deleted from the value set directory (affecting the CBP-AD, HA1C-AD, and HPC-AD measures).
- The Outpatient CPT Value Set was renamed the Outpatient Without UBREV Value Set.

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. The sample size is based on the current year's administrative rate or the prior year's reported rate. 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. More information on the use of the hybrid method for Adult Core Set Reporting is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf>.

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

Current Year's Administrative Rate or the Prior Year's Reported Rate	Minimum Sample Size
≤50%	411
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
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

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

Appendix C
Guidance for Conducting the Adult
Consumer Assessment of Healthcare
Providers and Systems (CAHPS®) Health
Plan Survey 5.0H (Medicaid)

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Assessing patient experiences with health care is an important dimension of the quality of care. The Adult 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 Adult Core Set reporting, contracting with a survey vendor, generating a sample frame, and conducting the survey using standard protocols.

A. VERSION OF CAHPS FOR ADULT 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 Adult Core Set is the CAHPS Health Plan Survey 5.0H (Medicaid). Appendix F contains the survey instrument.

B. CONTRACTING WITH A SURVEY VENDOR

To adhere to CAHPS 5.0H measure specifications, states must create a sample frame and contract with a National Committee for Quality Assurance (NCQA) certified HEDIS 2016 survey vendor that will administer the survey according to HEDIS protocols. The survey vendor draws the actual samples and fields the survey.

NCQA maintains a list of survey vendors that have been trained and certified by NCQA to administer the CAHPS 5.0H 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 2016 survey vendors is available at

http://www.ncqa.org/Portals/0/HEDISQM/Programs/SVC/2016_HEDIS_CAHPS-Vendor_Web_List.pdf.

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 C.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.

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

Table C.1. Eligible Population for Adult CAHPS 5.0H (Medicaid)

Ages	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	For a Medicaid enrollee in a state where enrollment is verified monthly, the enrollee may not have more than a one-month gap in coverage (the enrollee must be enrolled for five of the last six months of the measurement year). For a Medicaid enrollee in a state where enrollment is verified daily, the enrollee may have no more than one gap in enrollment of up to 45 days during the last six months of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Source: HEDIS 2016 Volume 3: Specifications for Survey Measures (<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx>).

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 enrollees and updating eligibility files with address and telephone number corrections. When sampling, keep the following in mind:

- 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 adults 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 adults covered by the entire program. A state may generate one statewide sample frame that includes adults in all delivery systems or separate sample frames for each delivery system. The sample frame(s) should represent all adults that meet the eligibility criteria specified in Table C.1.

D. 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 1,350 adults.

Deduplication

To reduce respondent burden, the survey vendor should deduplicate samples so that only one adult per household is included in the 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 adults from eligibility files, or if it does not expect to achieve a denominator of 100 for most survey calculations. The required sample size is based on the average number of complete and valid 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 valid 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 411 completed surveys required, the survey vendor should oversample to achieve the goal of 411 completed surveys. For example, if the vendor increases the sample by 5 percent, the final sample size would be 1,418. If the vendor increases the sample by 20 percent, the final sample size would be 1,620. Table C.2 displays final sample sizes at various oversampling rates. The survey vendor will work with the state to determine an appropriate sampling strategy. For a detailed discussion of oversampling, see “HEDIS 2016 Volume 3: Specifications for Survey Measures,” Appendix 7, “General Recommendations for Oversampling Survey Measures.”

Table C.2. Oversampling Rates and Final Sample Sizes for the CAHPS 5.0H Adult Survey

Sample	Required Sample Size	Oversampling Rate and Final Sample Size					
		5%	10%	15%	20%	25%	30%
CAHPS 5.0H Adult Sample	1,350	1,418	1,485	1,553	1,620	1,688	1,755

Source: Tables S-3 in HEDIS 2015 2016 Volume 3: Specifications for Survey Measures (<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2015.aspx>).

E. 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 5.0H survey specifications, the state’s survey vendor must follow one of the standard CAHPS 5.0H survey protocols. The state will have to work with its survey vendor to select one of two standard options for administering CAHPS 5.0H surveys:

1. The mail-only methodology, a five-wave mail protocol with three questionnaire mailings and two reminder postcards (81 days)
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 (70 days)

The basic tasks and time frames for the two protocol options are detailed in Tables C.3 and C.4. 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 completing the selected data collection protocol. Achieving the targeted number of completed surveys does not justify ceasing the survey protocol.

Neither the state nor the survey vendor may offer incentives of any kind for completion of the survey. The vendor is expected to maintain the confidentiality of systematically sampled adults.

Table C.3. Survey Vendor Tasks and Time Frames for the Mail-Only Methodology

Vendor Tasks	Time Frame (Days)
Send first questionnaire and cover letter to the surveyed adult	0
Send a postcard reminder to nonrespondents 4–10 days after mailing the first questionnaire	4–10
Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire	35

Vendor Tasks	Time Frame (Days)
Send a second postcard reminder to nonrespondents 4–10 days after mailing the second questionnaire	39–45
Send a third questionnaire and third cover letter to nonrespondents approximately 25 days after mailing the second questionnaire	60
Allow at least 21 days for the respondent to return the third questionnaire	81

Source: HEDIS 2016 Volume 3: Specifications for Survey Measures.

Table C.4. Survey Vendor Tasks and Time Frames for the Mixed Methodology

Vendor Tasks	Time Frame (Days)
Send first questionnaire and cover letter to the surveyed adult	0
Send a postcard reminder to nonrespondents 4–10 days after mailing the first questionnaire	4–10
Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire	35
Send a second postcard reminder to nonrespondents 4–10 days after mailing the second questionnaire	39–45
Initiate computer-assisted telephone interviews (CATI) for nonrespondents approximately 21 days after mailing the second questionnaire	56
Initiate systematic contact for all nonrespondents 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
Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all nonrespondents) approximately 14 days after initiation	70

Source: HEDIS 2016 Volume 3: Specifications for Survey Measures.

F. FOR FURTHER INFORMATION

Information about the CAHPS family of surveys and the CAHPS Database is available at <http://www.cahps.ahrq.gov/>.

Information about the NCQA’s HEDIS Survey Vendor Certification program can be found at <http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISSurveyVendorCertification/CAHPS50HSurvey.aspx>.

Information on “HEDIS 2016 Volume 3: Specifications for Survey Measures” is available at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx>.

Appendix D
Definition of Medicaid/CHIP
Core Set Practitioner Types

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Practitioner Type	Definition
Mental Health Practitioner	<p>A practitioner who provides mental health services and meets any of the following criteria:</p> <ul style="list-style-type: none"> • 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)

Practitioner Type	Definition
Obstetrical/Gynecological (OB/GYN) and Other Prenatal Care Practitioner	<p data-bbox="573 254 695 285">Includes:</p> <ul data-bbox="573 296 1414 600" style="list-style-type: none"><li data-bbox="573 296 1414 495">• 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<li data-bbox="573 506 1414 600">• Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)
Primary Care Practitioner (PCP)	<ul data-bbox="573 621 1414 758" style="list-style-type: none"><li data-bbox="573 621 1414 684">• A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services<li data-bbox="573 695 1414 758">• Licensed practical nurses and registered nurses are not considered PCPs
Prescribing Practitioner	<p data-bbox="573 779 1414 873">A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications</p>

Appendix E
Additional Information on Data Elements for
Measure PC-01: Elective Delivery and
Measure PC-03: Antenatal Steroids

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This appendix provides additional information on the data elements required to calculate the rates for PC-01: Elective Delivery and PC-03: Antenatal Steroids using medical record review. Section A lists the data elements required for the denominator and Section B lists those required for the numerator. For each of the data elements, the tables below specify which measure uses the data element for calculation of the rate (PC-01 and/or PC-03).

A. DENOMINATOR DATA ELEMENTS REQUIRING MEDICAL RECORD REVIEW

Data element	Admission Date (PC-01, PC-03)
Definition	The month, day, and year of admission for inpatient care.
Suggested data collection question	What is the date the patient was admitted to inpatient care?
Allowable values	MM = Month (01-12) DD = Day (01-31) YYYY = Year (20XX)
Notes for abstraction	<p>The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value. If using claim information, the ‘Statement Covers Period’ is not synonymous with the ‘Admission Date’ and should not be used to abstract this data element. These are two distinctly different identifiers:</p> <ul style="list-style-type: none"> • The Admission Date is purely the date the patient was admitted as an inpatient to the facility. • The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim. <p>For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.</p> <p>Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-2015. On 04-06-2015 the physician writes an order to admit to acute inpatient effective 04-05-2015. The Admission Date would be abstracted as 04-06-2015; the date the determination was made to admit to acute inpatient care and the order was written.</p> <p>The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, the date should not be used.</p>

Data element	Admission Date (PC-01, PC-03)
Notes for abstraction (continued)	<p>Example: Preoperative Orders are dated as 04-05-2015 with an order to admit to Inpatient. Postoperative Orders, dated 05-01-2015, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-2015. The admission date would be abstracted as 05-01-2015.</p> <p>If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.</p> <p>For newborns that are born within this hospital, the admission date is the date the baby was born.</p>
Only allowable data sources	<p>Physician orders Face sheet UB-04</p> <p>Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other “only allowable sources” to determine the <i>Admission Date</i>.</p>
Excluded data sources	UB-04, “From” and “Through” dates

Data element	Birth Date (PC-01, PC-03)
Definition	<p>The month, day, and year the patient was born.</p> <p>Note: Patient’s age (in years) is calculated by Admission Date minus Birth date. The algorithm to calculate age must use the month and day portion of admission date and birth date to yield the most accurate age.</p>
Suggested data collection question	What is the patient’s date of birth?
Allowable values	<p>MM = Month (01-12) DD = Day (01-31) YYYY = Year (1880-Current Year)</p>
Notes for abstraction	<p>Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birth date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birth date through chart review, she/he should default to the date of birth on the claim information.</p>
Suggested data sources	<p>Emergency department record Face sheet Registration form UB-04</p>

Data element	Clinical Trial (PC-01, PC-03)
Definition	Documentation that during this hospital stay, the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied.
Suggested data collection question	During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure being studied?
Allowable values	<p>Y (Yes): There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied.</p> <p>N (No): There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied, or unable to determine from medical record documentation.</p>
Notes for abstraction	<p>To select “Yes” to this data element, BOTH of the following must be true:</p> <ol style="list-style-type: none"> 1. There must be a signed consent form for clinical trial. For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized. 2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied. Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continue active participation in that clinical trial during this hospital stay. <p>Only capture patients enrolled in clinical trials studying pregnant patients or newborns. For Perinatal Care measures ONLY, it is appropriate to default the data element to “No” unless a diagnosis code for clinical trial is present. If a code is present, or the state knows via some other electronic method that the patient is participating in a clinical trial, default the data element to “Yes.” Abstractors may change defaulted value of “No” based on hospital participation in clinical trial.</p> <p>In the following situations, select “No”:</p> <ol style="list-style-type: none"> 1. There is a signed patient consent form for an observational study only. Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data are collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups. 2. It is not clear whether the study described in the signed patient consent form is experimental or observational. 3. It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.
Only allowable data sources	Signed consent form for clinical trial

Data element	Discharge Date (PC-01, PC-03)
Definition	The month, day and year the patient was discharged from acute care, left against medical advice, or died during this stay.
Suggested data collection question	What is the date the patient was discharged from acute care, left against medical advice (AMA), or died?
Allowable values	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2001-Current Year)
Notes for abstraction	Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.
Suggested data sources	Face sheet Progress notes Physician orders Discharge summary Nursing discharge notes Transfer note UB-04

Data element	Gestational Age (PC-01 and PC-03)
Definition	The weeks of gestation completed at the time of delivery. Gestational age is defined as the number of weeks that have elapsed between the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery, irrespective of whether the gestation results in a live birth or a fetal death.
Suggested data collection question	How many weeks of gestation were completed at the time of delivery?
Allowable values	1-50 UTD=Unable to Determine

Data element	Gestational Age (PC-01 and PC-03)
Notes for abstraction	<p>Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.</p> <p>The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note, and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase “estimated gestational age” is an acceptable descriptor for gestational age.</p> <p>If the patient has not received prenatal care and the gestational age is unknown, select allowable value UTD.</p> <p>When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.</p> <p>Gestational age should be documented by the clinician as a numeric value between 1 and 50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery. If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.</p> <p>Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA), or registered nurse (RN).</p>
Only allowable data sources in order of preference	<p>Delivery room record Operating room record History and physical Prenatal forms Admission clinician progress notes Discharge summary Vital Statistics</p> <p>Note: It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs, or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed above.</p>

Data element	Prior Uterine Surgery (PC-01)
Definition	Documentation that the patient experienced prior uterine surgery.
Suggested data collection question	Is there documentation that the patient experienced prior uterine surgery?
Allowable values	Y (Yes): The medical record contains documentation that the patient had undergone prior uterine surgery. N (No): The medical record does not contain documentation that the patient had undergone prior uterine surgery OR unable to determine from medical record documentation.
Notes for abstraction	The only prior uterine surgeries considered for the purposes of the measure are: <ul style="list-style-type: none"> • Prior classical cesarean section resulting in a vertical incision into the upper uterine segment • Prior myomectomy • Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury • History of a uterine window noted during prior uterine surgery or during ultrasound • History of uterine rupture requiring surgical repair. • History of a cornual ectopic pregnancy. Exclusions: <ul style="list-style-type: none"> • Prior low transverse cesarean section • Prior cesarean section without specifying prior classical cesarean section
Suggested data sources	History and physical Nursing admission assessment Progress notes Physician's notes Prenatal forms

Data element	Reason for Not Initiating Antenatal Steroid Therapy (PC-03)
Definition	Reasons for not initiating antenatal steroid therapy before delivery are clearly documented in the medical record. Reasons for not initiating antenatal steroid therapy may include fetal distress, imminent delivery or other reasons documented by physician/ advanced practice nurse (APN)/physician assistant (PA)/certified nurse midwife (CNM). Initial antenatal steroid therapy is 12mg betamethasone IM or 6mg dexamethasone IM.
Suggested data collection question	Is there documentation in the medical record of reasons for not initiating antenatal steroid therapy before delivery?
Allowable values	Y (Yes): There is documentation by physician/APN/PA/CNM that the patient has one or more reasons for not initiating antenatal steroid therapy before delivery. N (No): There is no documentation by physician/APN/PA/CNM of a reason for not initiating antenatal steroid therapy before delivery or unable to determine from medical record documentation.
Notes for abstraction	When determining whether there is a reason documented by a physician/APN/PA or CNM for not initiating antenatal steroid therapy, reasons must be explicitly documented (e.g., “patient had an adverse reaction to the medication in the past—unable to initiate antenatal steroid therapy”) or clearly implied (for example, there is documentation the delivery occurred before antenatal steroid therapy could be initiated, there is documentation the fetus has anomalies that are not compatible with life, there is documentation that the patient has chorioamnionitis).
Suggested data sources	PHYSICIAN/APN/PA/CNM DOCUMENTATION ONLY History and physical Physician progress notes Prenatal forms

B. NUMERATOR DATA ELEMENTS

Data element	Labor (PC-01)
Definition	Documentation that the patient was in labor.
Suggested data collection question	Is there documentation that the patient was in labor?
Allowable values	Y (Yes): There is documentation that the patient was in labor. N (No): There is no documentation that the patient was in labor OR unable to determine from medical record documentation.
Notes for abstraction	A clinician is defined as a physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). Documentation of labor by the clinician should be abstracted at face value. There is no requirement for acceptable descriptors to be present in order to answer "yes" to labor. Documentation of regular contractions or cervical change without mention of labor cannot be used to answer "yes" to labor.
Suggested data sources	History and physical Nursing notes Physician progress notes
Guidelines for abstraction	Inclusion: <ul style="list-style-type: none"> • Active labor • Early labor • Spontaneous labor Exclusion: <ul style="list-style-type: none"> • Latent labor • Prodromal labor

Data element	Antenatal Steroid Therapy Initiated (PC-03)
Definition	Documentation that antenatal steroid therapy was initiated before delivery. Initial antenatal steroid therapy is 12mg betamethasone IM or 6mg dexamethasone IM.
Suggested data collection question	Is there documentation that antenatal steroid therapy was initiated before delivery?
Allowable values	Y (Yes): There is documentation that antenatal steroid therapy was initiated before delivery. N (No): There is no documentation that antenatal steroid therapy was initiated before delivery OR unable to determine from medical record documentation.
Notes for abstraction	If there is documentation that antenatal steroid therapy was initiated prior to current hospitalization in another setting of care, i.e., doctor's office, clinic, birthing center, hospital before delivery, select allowable value "yes." If antenatal steroid therapy was initiated in the hospital, the name of the medication must be documented in the medical record in order to select allowable value "yes."
Suggested data sources	History and physical Progress notes Medication administration record (MAR) Prenatal forms

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Appendix F
CAHPS® Health Plan Survey 5.0H
Adult Questionnaire (Medicaid)

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CAHPS® 5.0H Adult Questionnaire (Medicaid)

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 you get.

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}.

1. Our records show that you are now in {INSERT HEALTH PLAN NAME/
STATE MEDICAID PROGRAM
NAME}. Is that right?
 - Yes →If Yes, Go to Question 3
 - No
2. What is the name of your health plan?
(Please print)

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?
 - Yes
 - No →If No, Go to Question 5
4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
 - Never
 - Sometimes
 - Usually
 - Always
5. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?
 - Yes
 - 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 at a doctor's office or clinic as soon as you needed?
 - Never
 - Sometimes
 - Usually
 - Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?
- None → If None, Go to Question 15
- 1 time
- 2
- 3
- 4
- 5 to 9
- 10 or more times
8. In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?
- Yes
- No
9. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?
- Yes
- No → If No, Go to Question 13
10. Did you and a doctor or other health provider talk about the reasons you might want to take a medicine?
- Yes
- No
11. Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine?
- Yes
- No
12. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?
- Yes
- No
13. 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 health care in the last 6 months?
- 0 Worst health care possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best health care possible

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

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

YOUR PERSONAL DOCTOR

15. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- 1 Yes
- 2 No → If No, go to question 24

16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- 0 None → If None, Go to Question 23
- 1 1 time
- 2 2
- 3 3
- 4 4
- 5 5 to 9
- 6 10 or more times

17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

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

18. In the last 6 months, how often did your personal doctor listen carefully to you?

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

19. In the last 6 months, how often did your personal doctor show respect for what you had to say?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
20. In the last 6 months, how often did your personal doctor spend enough time with you?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
21. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?
- 1 Yes
 - 2 No → If No, Go to Question 23
22. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
23. 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 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

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do not include dental visits or care you got when you stayed overnight in a hospital.

24. 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 to see a specialist?

- 1 Yes
 2 No → If No, Go to Question 28

25. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

- 1 Never
 2 Sometimes
 3 Usually
 4 Always

26. How many specialists have you seen in the last 6 months?

- 0 None → If None, Go to Question 28
 1 1 specialist
 2 2
 3 3
 4 4
 5 5 or more specialists

27. We want to know your rating of the specialist you saw 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 HEALTH PLAN

The next questions ask about your experience with your health plan.

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?
- Yes
- No→If No, Go to Question 30
29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?
- Never
- Sometimes
- Usually
- Always
30. In the last 6 months, did you get information or help from your health plan's customer service?
- Yes
- No→If No, Go to Question 33
31. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
- Never
- Sometimes
- Usually
- Always
32. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?
- Never
- Sometimes
- Usually
- Always
33. In the last 6 months, did your health plan give you any forms to fill out?
- Yes
- No→If No, Go to Question 35
34. In the last 6 months, how often were the forms from your health plan easy to fill out?
- Never
- Sometimes
- Usually
- Always

35. 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 health plan?

- 0 Worst health plan possible
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 Best health plan possible

ABOUT YOU

36. In general, how would you rate your overall health?
- 1 Excellent
 2 Very Good
 3 Good
 4 Fair
 5 Poor
37. In general, how would you rate your overall mental or emotional health?
- 1 Excellent
 2 Very Good
 3 Good
 4 Fair
 5 Poor
38. Have you had either a flu shot or flu spray in the nose since July 1, 2015?
- 1 Yes
 2 No
 3 Don't know
39. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?
- 1 Every day
 2 Some days
 3 Not at all → If Not at all, Go to Question 43
 4 Don't know → If Don't know, Go to Question 43

40. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?
- 1 Never
 2 Sometimes
 3 Usually
 4 Always
41. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.
- 1 Never
 2 Sometimes
 3 Usually
 4 Always
42. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
- 1 Never
 2 Sometimes
 3 Usually
 4 Always
43. Do you take aspirin daily or every other day?
- 1 Yes
 2 No
 3 Don't know
44. Do you have a health problem or take medication that makes taking aspirin unsafe for you?
- 1 Yes
 2 No
 3 Don't know
45. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?
- 1 Yes
 2 No
46. Are you aware that you have any of the following conditions? Mark one or more.
- a High cholesterol
 b High blood pressure
 c Parent or sibling with heart attack before the age of 60
47. Has a doctor ever told you that you have any of the following conditions? Mark one or more.
- a A heart attack
 b Angina or coronary heart disease
 c A stroke
 d Any kind of diabetes or high blood sugar
48. In the last 6 months, did you get health care 3 or more times for the same condition or problem?
- 1 Yes
 2 No If No, Go to Question 50
49. Is this a condition or problem that has lasted for at least 3 months? Do not include pregnancy or menopause.
- 1 Yes
 2 No

50. Do you now need or take medicine prescribed by a doctor? Do not include birth control.
- Yes
- No → If No, Go to Question 52
51. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.
- Yes
- No
52. What is your age?
- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older
- No
53. Are you male or female?
- Male
- Female
54. What is the highest grade or level of school that you have completed?
- 8th grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Some college or 2-year degree
- 4-year college graduate
- More than 4-year college degree
55. Are you of Hispanic or Latino origin or descent?
- Yes, Hispanic or Latino
- No, Not Hispanic or Latino
56. What is your race? Mark one or more.
- White
- Black or African-American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- Other
57. Did someone help you complete this survey?
- Yes → If Yes, Go to Question 58
- No → Thank you. Please return the completed survey in the postage-paid envelope.
58. How did that person help you? Mark one or more.
- Read the questions to me
- Wrote down the answers I gave
- Answered the questions for me
- Translated the questions into my language
- Helped in some other way

THANK YOU

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