SUMMARY OF UPDATES TO THE ADULT CORE SET MEASURES TECHNICAL SPECIFICATIONS AND RESOURCE MANUAL FEBRUARY 2019

Overall Changes

- Updated reporting year to FFY 2019, and data collection timeframe to 2018.
- Updated specifications, value set codes, copyright, and table source information to HEDIS 2019 Vol. 2 for all HEDIS measures.
- Separated the FUA/FUM-AD measure into two separate measures: FUA-AD: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence and FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness.
- Retired one measure: PC03-AD: PC-03: Antenatal Steroids
- Replaced sampling guidance in the measure specification with reference to sampling guidance in Section II. Data Collection and Reporting of the Adult Core Set for the following measures: ABA-AD, CBP-AD, CCS-AD, HA1C-AD, HPC-AD, HPCMI-AD, and PPC-AD.

I. The Core Set of Adult Health Care Quality Measures

- Inserted information about updates to the 2019 Adult Core Set.

II. Data Collection and Reporting of the Adult Core Set

- Added bullet about how to obtain value sets for electronic specifications. This applies to the following Adult Core Set measures: AMM-AD, BCS-AD, CBP-AD, CCS-AD, CDF-AD, CHL-AD, HPC-AD, HVL-AD, IET-AD, and PC01-AD.
- Clarified that documentation that a beneficiary is near the end of life (e.g. comfort care, Do Not Resuscitate, Do Not Intubate) or is in palliative care does not meet criteria for hospice exclusion.
- Updated guidance on not reporting measures due to small numbers:
    - If a measure has a denominator that is less than 30 (for all measures except PCR-AD) or a Count of Index Hospital Stays less than 10 (for PCR-AD) and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.

III. Technical Specifications

Measure AMM-AD: Antidepressant Medication Management

- Restructured the codes and value sets for identifying the required exclusions (step 2). Refer to the Value Set Directory for a detailed summary of changes.

Measure AMR-AD: Asthma Medication Ratio: Ages 19–64

- Incorporated guidance into the measure specifications about when telehealth visits are allowed.
- Added instructions in step 4 of the numerator calculation to indicate that the ratio of controller medications to total asthma medications should be rounded to the nearest whole number using the .5 rule, before summing the number of beneficiaries in Step 5.

Measure BCS-AD: Breast Cancer Screening

- Added exclusions for beneficiaries with advanced illness and frailty.
- Added methods to identify bilateral mastectomy for the optional exclusion.

Measure CBP-AD: Controlling High Blood Pressure

- Removed requirement to identify and use different thresholds for beneficiaries 60-85 without a diagnosis of diabetes.
- Added administrative method for reporting.
- Revised the definition of representative blood pressure (BP) to indicate that the BP reading must occur on or after the second diagnosis of hypertension.
- Revised the event/diagnosis criteria to include beneficiaries who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.
- Removed the diabetes flag identification from the event/diagnosis criteria.
- Incorporated telehealth into the measure specifications.
- Added exclusions for beneficiaries with advanced illness and frailty.
- Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
- Updated the Hybrid specification to indicate that sample size reduction is not allowed.
- Removed the requirement to confirm the hypertension diagnosis in the medical record.
- Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

Measure CCP-AD: Contraceptive Care – Postpartum Women Ages 21–44

- Added Guidance for Reporting:
    - Include all paid, suspended, pending, and denied claims.
    - Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system; contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this

measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.

Measure CCW-AD: Contraceptive Care – All Women Ages 21–44

- Added Guidance for Reporting:
  - Include all paid, suspended, pending, and denied claims.
  - Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system; contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.

Measure CDF-AD: Screening for Depression and Follow-Up Plan: Age 18 and Older

- Updated data collection method from Hybrid or EHR to Administrative or EHR
- Added Guidance for Reporting:
  - This measure can be calculated using administrative data only. Medical record review may be used to validate the state's administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report the measure.
  - This measure contains both exclusions and exceptions:
    - Denominator exclusion criteria are evaluated before checking if a beneficiary meets the numerator criteria; a beneficiary who qualifies for the denominator exclusion should be removed from the denominator.
    - Denominator exception criteria are only evaluated if the beneficiary does not meet the numerator criteria; beneficiaries who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.
  - For a beneficiary to meet the depression or bipolar disorder exclusion criteria, there must be an active diagnosis for one of these conditions documented prior to any encounter during the measurement period. An active diagnosis for depression/bipolar disorder in this case indicates the absence of an end date/time of the diagnosis. Patients with active antidepressant medications listed in their medical record without an active bipolar/depression diagnosis documented in their record should not be excluded from the measure.
  - When multiple encounters that meet criteria for inclusion in the measure denominator take place in the measurement year, the most recent eligible encounter at which the screening took place should be used. The beneficiary should be counted in the

denominator and numerator only once based on the most recent screening documented at the eligible encounter.

  - For example, if a beneficiary had a qualifying encounter in January of the measurement year and no depression screening was performed and then had a qualifying encounter in December of the same measurement year and had a depression screening, the encounter during December would be used for the measure denominator. If a beneficiary had an eligible encounter during January with a depression screening performed and an encounter during December with no screening performed, the January encounter would be used for the measure denominator.

- Include all paid, suspended, pending, and denied claims.

- Added examples of standardized Adult and Perinatal Screening Tools.
- Added guidance about pharmacologic treatment for depression during pregnancy and/or lactation.
- Added clarification that there is no continuous enrollment requirement to the eligible population table.
- Updated codes in Tables CDF-A and CDF-C.
- Added Table CDF-D. Codes to Identify Active Diagnosis of Depression (Exclusions), Table CDF-E. Codes to Identify Diagnosed Bipolar Disorder (Exclusions), and Table CDF-F. Code to Identify Exceptions.

Measure COB-AD: Concurrent Use of Opioids and Benzodiazepines

- Deleted "Identifying days' supply for opioids (or benzodiazepines)" from Definitions table; added this information to "Event/diagnosis" field in the Eligible Population table.
- Added Anchor Date to Eligible Population table.
- Updated benefit in Eligible Population table to include medical and pharmacy.

Measure CPA-AD: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid)

- Clarified under Allowable Gap that a beneficiary whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

Measure FUA-AD: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

- Separated FUA-AD from FUM-AD (rather than a combined measure).
- Renamed "Exclusions" to "ED visits followed by inpatient admission" in the Eligible Population.
- Added the Observation Value Set to the measure to account for the removal of observation codes from the IET Stand Alone Visits Value Set. Codes remain unchanged.

Measure FUH-AD: Follow-Up After Hospitalization for Mental Illness: Age 18 and Older

- Updated measure age range from beneficiaries ages 21 and older to beneficiaries ages 18 and older.
- Revised the measure description and denominator to include beneficiaries with a principal diagnosis of intentional self-harm.
- Clarified and reordered the instructions for acute and nonacute readmissions and direct transfers.
- Renamed "Exclusions" to "Nonacute readmission or direct transfer" in the Eligible Population.
- Restructured the codes and value sets for identifying the numerators. Refer to the Value Set Directory for a detailed summary of changes.
- Removed the use of a mental health diagnosis as a proxy for a visit with a mental health practitioner (all numerator events require a visit with a mental health practitioner).

Measure FUM-AD: Follow-Up After Emergency Department Visit for Mental Illness

- Separated FUM-AD from FUA-AD (rather than a combined measure).
- Revised the denominator to include beneficiaries with a principal diagnosis of intentional self-harm.
- Renamed "Exclusions" to "ED visits followed by inpatient admission" in the Eligible Population.
- Clarified and reordered the instructions for acute and nonacute readmissions and direct transfers.
- Restructured the codes and value sets for identifying the numerators. Refer to the Value Set Directory for a detailed summary of changes.
- Revised the numerator to include beneficiaries with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder.
- Revised the numerator to always require a diagnosis code (previously some codes were not required to be in conjunction with a diagnosis code).

Measure FVA-AD: Flu Vaccinations for Adults Ages 18 to 64

- Clarified under Allowable Gap that a beneficiary whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

Measure HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing

- Incorporated telehealth into the measure specifications.
- Added exclusions for beneficiaries with advanced illness and frailty.

Measure HPC-AD: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

- Added Note to measure description: "A lower rate indicates better performance."
- Incorporated telehealth into the measure specifications.
- Added exclusions for beneficiaries with advanced illness and frailty.

Measure HPCMI-AD: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

- Added Note to measure description: "A lower rate indicates better performance."
- Restructured the codes and value sets for identifying beneficiaries with diabetes and serious mental illness. Refer to the Value Set Directory for a detailed summary of changes.

Measure HVL-AD: HIV Viral Load Suppression

- Added EHR as a data collection method and added link to electronic specifications in Guidance for Reporting.
- Added Guidance for Reporting:
  - Include all paid, suspended, pending, and denied claims.
  - 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. The Codes to Identify Medical Visits tables (Table HVL-C. CPT Codes to Identify Medical Visits and Table HVL-D. SNOMED-CT Codes to Identify Outpatient and Ambulatory Medical Visits) contain codes used only by providers with prescribing privileges (physicians, nurse practitioners, and physician assistants). Therefore, use of the codes assumes the visit was conducted by a provider with prescribing privileges.

Measure IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

- Replaced MAT references with reference to "medication treatment."
- Added the Observation Value Set to the measure to account for the removal of observation codes from the IET Stand Alone Visits Value Set. Codes remain unchanged.
- Clarified the Engagement of AOD Treatment numerator.
- Clarified in the Notes that for beneficiaries in the "other drug abuse or dependence" cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment and that methadone is not included in the medication lists for the measure.

Measure OHD-AD: Use of Opioids at High Dosage in Persons Without Cancer

- Changed the measure description to: The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90

morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis or in hospice are excluded.

- Changed numerator criteria to include beneficiaries in the eligible population with an average daily dosage greater than or equal to 90 MME over a period of 90 days or more.
- Added Guidance for Reporting:
  - For FFY 2019, the rate is expressed as a percentage. In previous years, it was reported as a rate per 1,000 beneficiaries.
- Replaced "Treatment Period" with "Opioid Episode" in Definitions table and throughout the specification.
- Deleted "Identifying days' supply for opioids" from Definitions table; added "Event/diagnosis" field in the Eligible Population table with this information.
- Changed continuous enrollment requirement for the measure from "the treatment period with one allowable gap" to "the measurement year with one allowable gap."
- Added Anchor Date to Eligible Population table.
- Updated benefit in Eligible Population table to include medical and pharmacy.

Measure PCR-AD: Plan All-Cause Readmissions

- Replaced the "Expected Readmission Rate" reporting category with "Count of Expected 30-Day Readmissions"
- Added Guidance for Reporting:
  - Report the Count of Expected 30-Day Readmissions for this measure to four decimal places.
  - When applying risk adjustment, include all services, whether or not the state paid for them or expects to pay for them (i.e., include denied claims). When identifying all other events, do not include denied services (i.e., only include paid services and services expected to be paid).
  - If this measure has a Count of Index Hospital Stays less than 10 and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- Revised the Planned Hospital Stay definition:
  - Removed exclusion for planned hospital stays from the Count of Index Hospital Stays and added exclusion about planned admissions to step 3 in the Count of Observed 30-Day Readmissions.
- For Risk Adjustment Weighting:
  - Revised step 6 and renamed "Expected Readmission Rate" to "Estimated Readmission Risk."
  - Added step 7 and guidance on how to calculate the "Count of Expected Readmissions."
- Updated Additional Notes:

- Note: The O/E ratio is interpreted as "lower-is-better":
    - O/E ratio < 1.0 means the state had fewer readmissions than expected given the case mix
    - O/E ratio = 1.0 means that the number of readmissions was the same as expected given the case mix
    - O/E ratio > 1.0 means that the state had more readmissions than expected given the case mix
- Updated column headers in Table PCR-A.

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

- Added Note to measure description: "A lower rate indicates better performance."
- Removed exclusions for admissions with missing gender (SEX=missing), quarter (DQTR=missing), and county (PSTCO=missing).

Measure PQI05-AD: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate

- Added Note to measure description: "A lower rate indicates better performance."
- Removed exclusions for admissions with missing gender (SEX=missing), quarter (DQTR=missing), and county (PSTCO=missing).

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

- Added Note to measure description: "A lower rate indicates better performance."
- Removed exclusions for admissions with missing gender (SEX=missing), quarter (DQTR=missing), and county (PSTCO=missing).

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

- Added Note to measure description: "A lower rate indicates better performance."
- Removed exclusions for admissions with missing gender (SEX=missing), quarter (DQTR=missing), and county (PSTCO=missing).

Measure SAA-AD: Adherence to Antipsychotic Medications for Individuals With Schizophrenia

- Clarified that schizoaffective disorder is included in the measure in the description and step 1 of the event/diagnosis.
- Incorporated telehealth into the measure specification.
- Restructured the codes and value sets for identifying beneficiaries with schizophrenia (step 1). Refer to the Value Set Directory for a detailed summary of changes.
- Revised step 4 of the numerator calculation to indicate that the ratio should be rounded to the nearest whole number using the .5 rule.

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

- Clarified that schizoaffective disorder is included in the measure in the description and step 1 of the event/diagnosis.
- Incorporated telehealth into the measure specification.
- Restructured the codes and value sets for identifying beneficiaries with schizophrenia or bipolar disorder (step 1). Refer the Value Set Directory for a detailed summary of changes.
- Added "Psychotherapeutic combinations" medications to SSD Antipsychotic Medications List and removed the Antipsychotic Combination Medications List.
- Renamed Antipsychotic Medications List to SSD Antipsychotic Medications List.

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

- Clarified under Allowable Gap that a beneficiary whose coverage lapses for 2 months (60 days) is not considered continuously enrolled.

Appendix F: Definition of Medicaid/CHIP Core Set Practitioner Types

- Updated definition of Primary Care Practitioner (PCP) to include guidance on federally qualified health centers (FQHCs).