

FFY 2019 Adult Core Set Reporting: Data Quality Checklist for States

This data quality checklist was developed to help states improve the completeness, accuracy, consistency, and documentation of data reported for the 2019 Adult Core Set measures. This will enable more accurate understanding of variations across states due to deviations from the technical specifications or unique aspects of a state’s Medicaid program. The checklist includes common issues noted in the data reported for FFY 2018. States can use the checklist below to assess their data as it is entered. The list of 2019 Adult Core Set measures, including the acronyms used in this technical assistance resource, is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf>. To obtain technical assistance with reporting the Adult Core Set measures, please contact the TA mailbox at MACQualityTA@cms.hhs.gov.

| Data Completeness | |
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| <input type="checkbox"/> | Numerators, denominators, and rates should be reported for all measures that the state chooses to report for FFY 2019. For measures that the state chooses not to report, please provide specific information on the reasons for not reporting the measure for FFY 2019. |
| <input type="checkbox"/> | For all measures that include rates stratified by age or have multiple rate categories (ABA-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CCP-AD, CCW-AD, CDF-AD, COB-AD, FUA-AD, FUH-AD, FUM-AD, HA1C-AD, HPC-AD, HPCMI-AD, HVL-AD, IET-AD, MPM-AD, MSC-AD, OHD-AD, PQI01-AD, PQI05-AD, PQI08-AD), numerators, denominators, and rates should be reported for all age groups and rate categories. If one or more rates within a measure cannot be reported, states should use the text box provided to explain why the rate is not being reported. |
| <input type="checkbox"/> | If a measure was calculated using the hybrid method, states should report as much information as possible about how the state calculated the state-level rate. <ul style="list-style-type: none"> States should enter the numerator and denominator that were used to calculate the state-level rate in the Numerator and Denominator fields. If this information is not available, states should enter 0 in these fields and explain why the information is unavailable in the “Additional Notes/Comments on Measure” section. States should also complete the additional fields for measures calculated using the hybrid method, including the Sample Size and Measure-Eligible Population fields. In most cases, the Denominator should equal the Sample Size reported. If the Sample Size differs from the Denominator (for example, due to weighting or oversampling), the state should explain the difference in the “Additional Notes/Comments on Measure” section. If the state-level rate is based on data from multiple reporting units, states should provide as many of the following items as possible for each reporting unit in the “Additional Notes/Comments on Measure” section: numerator, denominator, measure-eligible population, and rate. The state should also check “Yes” under “Did you Combine Rates from Multiple Reporting Units (e.g., health plans, delivery systems, programs) to Create a State-Level Rate.” |

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| <input type="checkbox"/> | <p>The reported data for each measure should include the total measure-eligible population as defined by the Adult Core Set Technical Specifications. All beneficiaries who are eligible for the services or outcomes assessed in the measure should be included.</p> <ul style="list-style-type: none"> • If eligible groups were excluded from the measure (such as programs, delivery systems, or populations), the excluded group(s) should be described; the percentage of the eligible population excluded should be noted; and the reason for the exclusion should be explained in the “Definition of Population Included in the Measure” section. States should report this information for all applicable measures. • In the field “Which delivery systems are represented in the Denominator?” states should provide information about each delivery system in the state (fee-for-service, primary care case management, managed care, integrated care models, and other). In this field, states should estimate the percentage of measure-eligible beneficiaries from that delivery system included in the data for the measure. For example, if the population included in the reported data represents all of the state’s managed care beneficiaries and half of the state’s fee-for-service beneficiaries, states should enter 100 percent for managed care and 50 percent for fee-for-service. States should also enter the number of health plans included in the data. If some of the health plans are missing from a measure, the state should identify the number of missing managed care organizations (MCOs) and explain why they are missing in the “Additional Notes/Comments on Measure” section. States should report this information for each measure. • In addition to reporting the populations included in each measure, states can also provide information about the delivery systems that are used for the state’s total adult Medicaid population in the “Delivery System” section on the Administration Screen. This information provides important context about the population included in and excluded from reported measures. On the Administration Screen, the percentage of beneficiaries in each delivery system should add up to 100 percent for each age group. For example, a state might indicate that 60 percent of its Medicaid population ages 21 to 64 is enrolled in managed care and 40 percent of that age group is covered under fee-for-service. The state might also report that 100 percent of beneficiaries age 65 and older are covered under fee-for-service. If beneficiaries are enrolled in an “other” delivery system, please describe this delivery system in the text field. |
| <input type="checkbox"/> | <p>Data sources and methods (such as administrative, medical records, and hybrid) should be reported for each measure in the “Data Source” section and should adhere to the measure’s specifications. Any deviations to data sources and methods should be described in the “Deviations from Measurement Specifications” section and states should explain how their data source or method differed from Core Set technical specifications.</p> |
| <input type="checkbox"/> | <p>If any of the Core Set measures were audited or validated, please indicate this in the “Audit or Validation of Measures” question on the Administration Screen. Indicate which measures were audited or validated and who conducted the audit or validation.</p> |
| <p>Data Accuracy</p> | |
| <input type="checkbox"/> | <p>Reported rates should be calculated according to the Adult Core Set Technical Specifications for each measure.</p> <ul style="list-style-type: none"> • All deviations from Core Set Specifications should be described in the “Deviations from Measurement Specifications” section. • If the state used “Other” specifications to report a measure, the “Other” specifications should be described in the “Measurement Specification” section and the explanation should describe how the state’s methodology differs from the Core Set specifications. |
| <input type="checkbox"/> | <p>For most measures, numerators should be less than or equal to denominators.</p> |
| <input type="checkbox"/> | <p>Rates should be rounded and reported to one decimal point for all measures except PCR-AD. For example: If a state calculates a rate of 74.13, then 74.1 is the correct format for reporting, and 74 and 74.0 are incorrect.</p> <ul style="list-style-type: none"> • For PCR-AD, the Count of Expected 30-Day Readmissions should be reported to four decimal points. |

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| <input type="checkbox"/> | <p>For all measures using administrative data only except for PCR-AD, a rate will be automatically calculated to one decimal point based on the reported numerator and denominator. States should review this rate during data entry. For PCR-AD, rates will automatically be calculated to four decimal points based on the reported Count of Index hospital stays, observed 30-day readmissions, and expected 30-day readmissions.</p> <p>States should calculate and manually enter rates for measures reported using the hybrid method or a combination of administrative and hybrid methods; these rates will not be calculated automatically.</p> <ul style="list-style-type: none"> • For most measures, rates should be reported as percentages in the range of 0.0 to 100.0 and calculated using the following formula: $(\text{numerator}/\text{denominator}) * 100$. • For the PQI measures (PQI01-AD, PQI05-AD, PQI08-AD, PQI15-AD), rates should be reported per 100,000 beneficiary months and calculated using the following formula: $(\text{Number of hospital admissions}/\text{number of beneficiary months}) * 100,000$. |
| Data Consistency | |
| <input type="checkbox"/> | <p>Reporting for related measures should be consistent:</p> <ul style="list-style-type: none"> • HA1C-AD /HPC-AD: The measures should have the same measure-eligible population. • PQI01-AD /PQI08-AD: The denominators for these measures should be the same. |
| <input type="checkbox"/> | <p>For measures with multiple rates, reporting should be consistent for all rates:</p> <ul style="list-style-type: none"> • AMM-AD: The Acute Phase rate should be greater than or equal to the Continuation Phase rate and the denominator for both rates should be the same. • CCP-AD: The 3-day rate should be less than or equal to the 60-day rate for both “Most or Moderately Effective Contraception” and “Long-Acting Reversible Contraception (LARC).” The “Most or Moderately Effective Contraception” rate should be greater than or equal to the LARC rate for both 3 days postpartum and 60 days postpartum, since LARC is a subset of most or moderately effective contraception methods. The denominators for all 4 rates in the measure should be the same. • CCW-AD: The “Most or Moderately Effective Contraception” rate should be greater than or equal to the Long-Acting Reversible Contraception (LARC) rate, since LARC is a subset of most or moderately effective contraception methods. Denominators for both rates within the measure should be the same. • FUA-AD / FUM-AD / FUH-AD: The 7-day rates should be less than or equal to the 30-day rates and the denominator for both rates should be the same. • IET-AD: The Initiation rates should be greater than or equal to the Engagement rates and the denominator for both rates should be the same (for each of the three AOD diagnosis cohorts and the Total rates for each age group). Note that the numerators and denominators for each diagnosis cohort do not need to sum to the Total numerator and denominator. • MPM-AD: Numerators and denominators for each medication should sum to the Total numerator and denominator. |
| <input type="checkbox"/> | <p>For measures that are included in both the Child and Adult Core Sets (AMR-AD, CCP-AD, CCW-AD, CDF-AD, CHL-AD, FUH-AD, PPC-AD), the reporting method should be consistent for both Core Sets:</p> <ul style="list-style-type: none"> • If the measure is reported for one Core Set (that is, Adult or Child), it should also be reported for the other Core Set. If not, the reason for not reporting should be explained in the “Please explain why you are not reporting on the measure” section. • The same method (administrative, hybrid) should be used to calculate the measures in both Core Sets. • The denominators should be calculated consistently in both Core Sets. |
| Data Documentation | |
| <input type="checkbox"/> | <p>For measures not reported for FFY 2019, reasons for not reporting should be explained in detail in the “Please explain why you are not reporting on the measure” section.</p> |

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| <input type="checkbox"/> | <p>For each measure, states should report the measurement period that was used to calculate the denominator for that measure in the “Start Date” and “End Date” fields. For many measures, the denominator measurement period for FFY 2019 corresponds to calendar year 2018 (January 1, 2018 – December 31, 2018). 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 additional review periods (sometimes referred to as “look-back” periods) in the Start and End date range. The FFY 2019 measurement periods for denominators and numerators for each measure are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-adult-core-set-measurement-periods.pdf for the Adult Core Set measures.</p> <p>For example: For FFY 2019, the AMM-AD measurement specifications instruct states to identify beneficiaries with antidepressant prescriptions that started May 1, 2017 through April 30, 2018. To review the medication history for these beneficiaries, states should also review each beneficiary’s medication history for 105 days prior to the start of the index prescription. Although states will need to review data prior to May 1, 2017, the denominator is based on prescriptions that start between May 1, 2017 and April 30, 2018 and states that followed the Core Set specifications for FFY 2019 should enter “May 2017” in the Start Date field and “April 2018” in the End Date field.</p> <p>Any deviations from the specified measurement period for the denominator or the numerator of a measure should be explained in the “Additional Notes/Comments on Measure” section.</p> |
| <input type="checkbox"/> | <p>If state-level rates include multiple reporting units (such as multiple managed care organizations or a combination of managed care and fee-for-service delivery systems), the method for combining and weighting rates should be explained in the “Combined Rate from Multiple Reporting Units” section. For measures reported based on data from multiple reporting units:</p> <ul style="list-style-type: none"> • State-level values should be entered in the Rate, Numerator, and Denominator fields. • The reporting units included in the data should be defined in the “Additional Notes/Comments on Measure” section. For example, if data from multiple MCOs were combined, the number of MCOs included should be noted in the “Additional Notes/Comments on Measure” section. • If the state reports that rates were weighted using “Other” methods, the weighting method should be described in the “Additional Notes/Comments on Measure” section. |
| <input type="checkbox"/> | <p>For measures that have optional exclusions in the specifications, states should explain in the “Additional Notes/Comments on Measure” section whether optional exclusions were applied.</p> |
| <input type="checkbox"/> | <p>States should compare their FFY 2019 data to data reported for previous years. If denominators or rates have changed substantially for a measure, please document these changes, as well as any possible explanations for these changes, in the “Additional Notes/Comments on Measure” section. This information should provide context about changes in the state’s data over time (such as changes in populations or calculation methodologies).</p> <p>When assessing performance, states should be aware that lower rates are better on the following measures: COB-AD, HPC-AD, HPCMI-AD, OHD-AD, PC01-AD, PQI01-AD, PQI05-AD, PQI08-AD, and PQI15-AD.</p> <ul style="list-style-type: none"> • For PCR-AD, the O/E ratio is interpreted as “lower-is-better.” |

For Further Information

Additional information about the 2019 Adult Core Set measures, including the 2019 Resource Manual and Technical Specifications, is available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>.

Additional resources for reporting Adult Core Set data are available at <https://www.medicaid.gov/state-resource-center/medicaid-and-chip-program-portal/medicaid-and-chip-program-portal.html>.

To obtain technical assistance with reporting the Medicaid/CHIP Health Care Quality Measures, please contact the TA mailbox at MACQualityTA@cms.hhs.gov.