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

Technical Specifications and Resource Manual for
Federal Fiscal Year 2022 Reporting

March 2022 (Updated July 2022)

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

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Updates to the FFY 2022 Adult Core Set Resource Manual since March 2022

Date	Location of change	Update
July 2022	Section III, COL-AD, Guidance for Reporting	Clarified that 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 75.

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

Background

Section 1139B of the Social Security Act (the Act) requires 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 Section 1139A of the Act 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 a standardized Adult Core Set is helping the Centers for Medicare & Medicaid Services (CMS) and states move toward a national system for quality measurement, reporting, and improvement. The data collected from these measures help CMS to better understand the quality of health care that adults enrolled in Medicaid receive. The Act requires the Secretary of HHS to make publicly available the information states voluntarily report to CMS on the quality of health care furnished to adults covered by Medicaid.[1]

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 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 the annual updates.

- **Initial Core Set.** Background on the Initial Core Set is available in a January 2012 CMCS Informational Bulletin (https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib-01-04-12.pdf).
- **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 is available in a December 2013 CMCS Informational Bulletin (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 is available in a December 2014 CMCS Informational Bulletin (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: (1) Use of Opioids at High Dosage in Persons Without Cancer, and (2) 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

[1] As part of Section 5001 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) of 2018, mandatory state reporting of the Behavioral Health measures on the Adult Core Set will take effect in 2024. Mandatory reporting of the Behavioral Health measures on the Adult Core Set will further advance CMS's efforts to ensure a standardized system for quality measurement with the goal of improving the quality of care for beneficiaries in Medicaid and CHIP.

2015 CMCS Informational Bulletin (http://medicaid.gov/federal-policy-guidance/downloads/CIB-12-11-15.pdf).

- **2017 Adult Core Set Update.** Three measures were added to the Adult Core Set: (1) Contraceptive Care – Postpartum Women Ages 21 to 44, (2) Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence, and (3) Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control [>9.0%]). In addition, the electronic specification format of PC-01: Elective Delivery, already a measure in the Adult Core Set, was added. One measure was retired from the Adult Core Set: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care). Additional information on the 2017 Adult Core Set is available in a December 2016 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf).
- **2018 Adult Core Set Update.** Three measures were added to the Adult Core Set: (1) Asthma Medication Ratio: Ages 19 to 64, (2) Concurrent Use of Opioids and Benzodiazepines, and (3) Contraceptive Care – All Women Ages 21 to 44. No measures were retired. Additional information on the 2018 Adult Core Set is available in a November 2017 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf).
- **2019 Adult Core Set Update.** One measure was retired from the Adult Core Set: PC03: Antenatal Steroids. No new measures were added. The electronic specification format of HIV Viral Load Suppression, already a measure in the Adult Core Set, was added. Additional information on the 2019 Adult Core Set is available in a November 2018 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf).
- **2020 Adult Core Set Update.** Two measures were added to the Adult Core Set: (1) National Core Indicators (NCI) Survey, and (2) Use of Pharmacotherapy for Opioid Use Disorder. Two measures were retired from the Adult Core Set: (1) Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing, and (2) Annual Monitoring for Patients on Persistent Medications. Additional information on the 2020 Adult Core Set is available in a November 2019 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib111919.pdf).
- **2021 Adult Core Set Update.** One measure was retired from the Adult Core Set, Adult Body Mass Index Assessment, because it was retired by the measure steward. No new measures were added. Additional information on the 2021 Adult Core Set is available in a November 2020 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib111920.pdf).
- **2022 Adult Core Set Update**. One measure was retired from the Adult Core Set, PC-01: Elective Delivery. Two measures were added to the Adult Core Set: (1) Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, and (2) Colorectal Cancer Screening. Additional information on the 2022 Adult Core Set is available in a December 2021 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib121021.pdf).

Table 1 lists each measure in the 2022 Adult Core Set, 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), survey, and electronic health record

(EHR, also referred to as the electronic specification method). The technical specifications in Chapter III of this manual provide additional details for each measure.

More information on the Adult Core Set is available on Medicaid.gov at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

Table 1. 2022 Adult Core Set

NQF#	Measure Steward[a]	Measure Name	Data Collection Method(s)
Preventive Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
0034	NCQA	Colorectal Cancer Screening (COL-AD)*	Administrative or EHR[b]
0039**	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418**/ 0418e**	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR[b]
Maternal and Perinatal Health			
1517**	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/ 2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0058	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)*	Administrative
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272**	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275**	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277**	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative

NQF#	Measure Steward[a]	Measure Name	Data Collection Method(s)
0283**	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768**	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
Behavioral Health Care			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)^	Administrative or EHR
0027**	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)^	Survey
0105	NCQA	Antidepressant Medication Management (AMM-AD)^	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)^	Administrative
1932	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)^	Administrative
2607	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)^	Administrative or hybrid
2940	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)^	Administrative
3389	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)^	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)^	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)^	Administrative
NA***	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)^	Administrative
Experience of Care			
0006****	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)[c]	Survey

NQF#	Measure Steward[a]	Measure Name	Data Collection Method(s)
Long-Term Services and Supports			
NA	NASDDDS/ HSRI	National Core Indicators Survey (NCIDDS-AD)	Survey

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NA = Measure is not NQF endorsed; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance.

* This measure was added to the 2022 Adult Core Set.

** This measure is no longer endorsed by NQF.

*** The Adult Core Set includes the NCQA version of this measure, which is adapted from the CMS measure (NQF #1879).

**** AHRQ is the measure steward for the survey instrument in the Adult Core Set (NQF #0006) and NCQA is the developer of the survey administration protocol.

^ This measure is part of the Behavioral Health Core Set. The complete list of 2022 Behavioral Health Core Set measures is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-bh-core-set.pdf .

[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] The Colorectal Cancer Screening and Breast Cancer Screening measures are also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Adult Core Set reporting.

[c] CAHPS® is a registered trademark of AHRQ.

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.

Refer to Table 1 in Chapter 1 for a list of 2022 Adult Core Set measures, measure acronyms, measure stewards, and data collection methods.

Data Collection and Preparation for Reporting

- **Version of specifications.** This manual includes the most applicable version of the measure specifications provided by the measure stewards to CMS as of December 2021. The 2022 Adult Core Set generally covers services provided during calendar year 2021. For Healthcare Effectiveness Data and Information Set (HEDIS)[1] measures, this manual follows HEDIS measurement year (MY) 2021 specifications. For non-HEDIS measures, the manual includes the most applicable version of the specifications available from the measure steward for reporting 2021 data.
- **Value sets.** Many of the Adult Core Set measure 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 HEDIS value sets are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-value-set-directory.zip. HEDIS value set references are underlined in the specifications (e.g., Major Depression Value Set). Refer to Appendix A for a HEDIS Value Set Directory User Manual.
  - Value sets for the CCP-AD, CCW-AD, OUD-AD, PQI01-AD, PQI05-AD, PQI08-AD, and PQI15-AD measures are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.
  - The value set for the COB-AD and OHD-AD measures, as well as the NDC codes for opioid medications, is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
  - Value sets for electronic specifications are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC), located at https://vsac.nlm.nih.gov. Access to the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a free UMLS license at https://uts.nlm.nih.gov/license.html. When searching for value sets for a measure, states should use the measure's associated electronic specification number or NQF number. To report on the 2022 Adult Core Set measures, use the version of the value sets associated with the March 2021 release. This applies to the following Adult Core Set measures that have electronic specifications: AMM-AD, BCS-AD, CBP-AD, CCS-AD, CDF-AD, CHL-AD, COL-AD, HPC-AD, and IET-AD.
- **Medication lists.** Several HEDIS measures in the Adult Core Set reference medication lists, which are a list of codes and medications used to identify dispensed medications. The Medication List Directory is available to order free of charge in the NCQA Store

[1] For FFY 2022, all Adult Core Set measures with NCQA as the measure steward are HEDIS measures, with the exception of HPCMI-AD, which is NCQA-owned and copyrighted but not currently contained in HEDIS.

(https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). This applies to the following Adult Core Set measures: AAB-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CHL-AD, COL-AD, HPC-AD, HPCMI-AD, IET-AD, SAA-AD, and SSD-AD.

- **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 2021 data should be reported for FFY 2022. For each measure, the measurement period used to calculate the denominator should be reported in the "Start Date" and "End Date" fields. For many measures, the denominator measurement period for FFY 2022 corresponds to calendar year 2021 (January 1, 2021–December 31, 2021).

  Some measures 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 about measurement periods for the 2022 Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2022-adult-core-set-measurement-periods.pdf.

- **Continuous enrollment.** Continuous enrollment specifies the minimum amount of time that a beneficiary must be enrolled before becoming eligible for a measure. It ensures that the state has enough time to render services during the measurement period. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, a beneficiary must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap (see next bullet). For the purpose of Core Set reporting, states should combine data across programs (e.g., Medicaid and CHIP), delivery systems (e.g., managed care and fee-for-service), and managed care plans when analyzing continuous enrollment for a beneficiary. For example, a beneficiary might switch between Medicaid programs or between managed care plans, and should be included in the numerator and denominator for the measure as long as the continuous enrollment criteria are met.

- **Allowable gap.** Some measures specify an allowable gap that can occur any time during continuous enrollment. For example, the CBP-AD measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in Medicaid and CHIP enrollment of up to 45 days. Thus, a beneficiary 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 beneficiary has one 38-day gap (January 1–February 7). A beneficiary who switches between Medicaid or CHIP programs, delivery systems, or managed care plans should be included in a measure as long as there is no gap in Medicaid or CHIP coverage that exceeds the allowable gap specified in the measure.

- **Retroactive eligibility.** This refers to the elapsed time between the actual date when Medicaid or CHIP became financially responsible for a beneficiary and the date when it received notification of the new beneficiary's eligibility. For measures with a continuous enrollment requirement, beneficiaries may be excluded if the retroactive eligibility exceeds

the allowable gap requirement. This guideline must be used consistently across all measures.

- **Anchor date.** Some measures include an anchor date, which is the date that an individual must be enrolled in Medicaid or CHIP 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 2022 measurement period (December 31, 2021). 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.
- **Date specificity.** A date must be specific enough to determine that an event occurred during the time frame specified in the measure. There are instances when documentation of the year alone is adequate; for example, most optional exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable. For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the BCS-AD measure, undated documentation on a problem list stating "bilateral mastectomy in 1999" is specific enough to determine that this exclusion occurred prior to December 31 of the measurement year.
- **Reporting unit.** CMS defines the reporting unit for each measure as each state's Medicaid program. This means that states should collect data across all of the health care delivery systems used in their state Medicaid and CHIP programs (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care [MC]). States are asked to include CHIP beneficiaries in their calculations; see bullet directly below. If data are collected separately for Medicaid and CHIP or across a state's delivery systems or across a state's managed care plans, states should aggregate data from all these sources into one state-level rate before reporting the data to CMS. As part of this process, the state should also assess the continuous eligibility of individuals that do not meet continuous eligibility for a single program, delivery system, or managed care plan, but meet continuous eligibility requirements for Medicaid and CHIP at the state-level. 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 must include all Medicaid and CHIP beneficiaries who satisfy all specified criteria (including age, continuous enrollment, benefit, event, and anchor date enrollment requirements). The eligible Medicaid and CHIP population should include Title XIX and Title XXI populations, but not populations funded only by states. States should include any special populations (e.g., waiver enrollees) covered by Medicaid or CHIP in the state.
- **Beneficiaries with partial benefits.** For each measure, states should include only the beneficiaries who are eligible to receive the services assessed in the numerator. If a beneficiary is not eligible to receive the services assessed in the measure, the beneficiary 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 beneficiaries 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 reporting units (such as multiple managed care plans or across managed care and FFS delivery systems), the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual plans) 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 "Calculating State-Level Rates Using Data from Multiple Reporting Units."[2]
- **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 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? and select an option on how the rates were weighted." The information entered in the numerator and denominator fields will vary depending on the method used to calculate a state-level rate:
    - If a state-level rate is calculated using only administrative method data, states should enter the numerator and denominator totals in the Numerator and Denominator fields.
    - If a state-level rate is calculated using only hybrid method data, states should enter the total size of the sample used to calculate the measure across reporting units in the Denominator field and sum the numerators for each reporting unit in the Numerator field. The state should also indicate that the denominator is a sum of samples in the "Additional Notes/Comments on Measure" section and provide numerators and denominators for each reporting unit.
    - If the state-level rate is calculated using a combination of administrative and hybrid method data, states should enter the total measure-eligible population in the Denominator field to denote that denominators are a mix of sample sizes and measure-eligible populations and enter 0 in the Numerator field. In the "Additional Notes/Comments on Measure" section, the state should identify the number of reporting units that used each method (administrative and hybrid) and provide numerators and denominators for each reporting unit.
- **Age criteria.** For the purpose of Adult Core Set reporting, states should calculate and report measures in two age groups (as applicable): beneficiaries under age 65 and those age 65 and older. States should note any deviations from the specifications in the "Deviations from Measure Specifications" field.
- **Exclusions.** Some measure specifications contain required or optional exclusions. A beneficiary 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.
- **Supplemental data.** Supplemental data are data other than claims and encounters and medical record data abstracted for hybrid reporting used by organizations to collect

[2] The TA Brief, "Calculating State-Level Rates Using Data from Multiple Reporting Units," is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf.

information about delivery of health services to their beneficiaries. Examples of supplemental data include immunization registries or case management program data.

- **Hospice exclusion.** Selected measures in the Adult Core Set include a required hospice exclusion: AAB-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CCS-AD, CHL-AD, COL-AD, FUA-AD, FUH-AD, FUM-AD, HPC-AD, HPCMI-AD, IET-AD, PCR-AD, PPC-AD, SAA-AD, and SSD-AD. For these measures, states should exclude beneficiaries who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These beneficiaries may be identified using various methods, which may include but are not limited to enrollment data, medical record, or claims/encounter data (Hospice Encounter Value Set; Hospice Intervention Value Set), or supplemental data.

  Supplemental data can be used for the hospice exclusion for all applicable measures, including measures that say "supplemental data may not be used for the measure" (e.g., PCR-AD).

  States should remove these beneficiaries as they determine the measure's eligible population. For hybrid measures, states should remove beneficiaries prior to drawing the sample. If a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed as a valid data error from the sample and replaced by a beneficiary from the oversample. Documentation that a beneficiary is near the end of life (e.g., comfort care, Do Not Resuscitate [DNR], Do Not Intubate [DNI]), or is in palliative care does not meet criteria for the hospice exclusion.

- **Deceased beneficiaries exclusion.** Selected measures in the Adult Core Set include a deceased beneficiary exclusion: AAB-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CCS-AD, CHL-AD, COL-AD, CPA-AD, FUA-AD, FUH-AD, FUM-AD, FVA-AD, HPC-AD, HPCMI-AD, IET-AD, MSC-AD, PPC-AD, SAA-AD, and SSD-AD. For these measures, if a state can identify beneficiaries who die during the measurement year, these beneficiaries should be excluded consistently from all measures and indicators. These beneficiaries may be identified using various methods that include, but are not limited to, enrollment data, medical record review, claims/encounter data or supplemental data.

  If a state excludes these beneficiaries, it should attempt to remove them as it determines the eligible population and prior to drawing the sample for hybrid measures. If during medical record review a beneficiary is found to be deceased, the beneficiary can be removed as a valid data error from the sample and replaced by a beneficiary from the oversample.

- **Telehealth.** HEDIS measures consider synchronous telehealth visits, telephone visits, and asynchronous telehealth (e-visits, virtual check-ins) as separate modalities.

  - Synchronous telehealth requires real-time interactive audio and video telecommunications. A HEDIS measure specification that is silent about telehealth includes synchronous telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A HEDIS measure specification will indicate when synchronous telehealth is not eligible for use and should be excluded.
  - A HEDIS measure specification will indicate when telephone visits are eligible for use by referencing the Telephone Visits Value Set.

- Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the beneficiary and the provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email. A HEDIS measure specification will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments Value Set.

Non-HEDIS measures will specify whether telehealth is allowed and what type of telehealth is included, if applicable.

- **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 (including individuals simultaneously enrolled in Medicare and Medicaid, also known as dually eligible beneficiaries, where applicable) and, for maternity measures, CHIP-enrolled women who satisfy the measure-specific eligibility criteria. This includes beneficiaries enrolled in all Medicaid and CHIP delivery systems as well as services received in all applicable health care settings (such as hospitals, outpatient settings, federally qualified health centers, rural health centers, and Indian Health Services or Tribal or Urban Indian Health Program facility). For a measure based on administrative data, all beneficiaries who meet the eligible population requirements for the measure should be included in the denominator. 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 electronic health record (EHR, also referred to as the electronic specification method). Each measure specifies the data collection method(s) that can be used. If a measure includes a choice of methods, any of the listed methods may be used.
  - The administrative method uses transaction data (such as claims and encounters) or other administrative data sources (such as vital records and registries) 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. Administrative data are reviewed to determine if beneficiaries in the systematic sample received the service, and medical record data are reviewed for beneficiaries who do not meet the numerator criteria through administrative data. The denominator consists of a systematic sample of beneficiaries drawn from the measure's eligible population. The hybrid method, when available, should be used when administrative data and 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., the CBP-AD measure).
  - The survey method uses data collected through a survey to calculate the measure. This data collection method applies to the following measures in the Adult Core Set: CPA-AD, FVA-AD, MSC-AD, and NCIDDS-AD.
  - The electronic specification method uses EHR data to calculate the measure. A link to the electronic specifications is included in the following measure specifications: AMM-AD, BCS-AD, CBP-AD, CCS-AD, CDF-AD, CHL-AD, COL-AD, HPC-AD, HVL-AD, and IET-AD.

- **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 minimum required sample size is 1,350 to achieve a goal of 411 completed surveys. The state may oversample if needed based on the state's prior experience with survey response rates. Additional information on sampling for CAHPS is available in Appendix C.
  - States should use the "Additional Notes/Comments on Measure" section to describe the sampling approach used for each measure.
- **Small numbers.** If a measure has a denominator that is less than 30 (for all measures except the FVA-AD, MSC-AD, and PCR-AD measures), or a denominator less than 100 (for FVA-AD and MSC-AD), or a Count of Index Hospital Stays less than 150 (for PCR-AD) and the state chooses not to report the measure due to the small numbers criterion, please note this in the question that asks "Why are you not reporting on this measure?" and specify the denominator size. The denominator for the Plan All-Cause Readmissions measure is the Count of Index Hospital Stays among non-outlier members. Outliers should not be considered.
- **Risk adjustment.** One measure in the Adult Core Set, PCR-AD, requires risk adjustment. Risk adjustment guidelines are included in the specification for the measure.
- **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 some measures, the Guidance for Reporting within each measure's technical specification indicates which claims (paid, suspending, pending, and/or denied) should be included. This applies to the following measures: AAB-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CCP-AD, CCS-AD, CCW-AD, CDF-AD, CHL-AD, COB-AD, COL-AD, FUA-AD, FUH-AD, FUM-AD, HPC-AD, HPCMI-AD, HVL-AD, IET-AD, OHD-AD, PCR-AD, PPC-AD, PQI01-AD, PQI05-AD, PQI08-AD, PQI15-AD, SAA-AD, and SSD-AD.
- **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. ICD-10 codes are available in the specification or in the corresponding Value Set Directory (see above). ICD-9-CM and ICD-9-PCS codes are still included in measures where the lookback period plus one year prior includes services before October 1, 2015. ICD-9 codes are still relevant to the following measures: AAB-AD, AMR-AD, BCS-AD, CBP-AD, CCS-AD, COL-AD, PCR-AD, and SAA-AD.

Reporting and Submission

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

- **Submission deadline.** The deadline for submitting and certifying final data on the Adult Core Set measures for FFY 2022 is December 31, 2022. States can update data submitted after the submission deadline; however, updates made after the deadline are not guaranteed to be used in the development of reports by CMS and performance rates on https://data.medicaid.gov, on the Medicaid & CHIP Scorecard, or in the Medicaid & CHIP State Profiles. States should submit data that are as complete as possible by the submission deadline.
- **Completing fields.** Specific fields are applicable to each measure. States should complete each applicable field for each measure submitted to ensure consistent and accurate reporting and comparability across states. States are encouraged to document the methods used to calculate the measures in order to improve CMS's understanding of variations across states.
- **Including attachments.** Supporting documents related to measures can be submitted with Adult Core Set data.
- **Reasons for not reporting a measure.** Although reporting the Adult Core Set is currently voluntary[3], 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.** CMS expects states to report measures adhering to the methods provided in the specifications. However, in cases where this is not possible, states should provide additional information and context about the rates reported. 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. States that have questions about the technical specifications (such as data sources, code sets, or methodologies for identifying numerators and denominators) should contact CMS through the TA mailbox at MACQualityTA@cms.hhs.gov.
- **Reporting by population.** For each Adult Core Set measure reported to CMS, states should specify the population included in the measure: Medicaid, CHIP, Dually eligible beneficiaries, and Other. Any populations excluded from the denominator should be noted in the applicable fields when defining the denominator in the web-based reporting system..
- **Data auditing.** For FFY 2022, 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 through another process, states should describe these processes in the applicable fields in the state-level 'Core Set Questions in the web-based reporting system.

[3] Reporting of the behavioral health measures in the Adult Core Set will be mandatory beginning with the FFY 2024 reporting cycle.

- **Reporting Promoting Interoperability (PI) measures.** For states voluntarily reporting on a core measure that is also a Promoting Interoperability (PI) measure (AMM-AD, BCS-AD, CBP-AD, CCS-AD, CDF-AD, CHL-AD, COL-AD, HPC-AD, and IET-AD), CMS asks that states indicate whether any information was extracted from EHRs in the Data Source fields.

Technical Assistance

To help states collect, report, and use the Adult Core Set measures, CMS offers technical assistance. Please submit technical assistance requests about the Adult Core Set measures to MACQualityTA@cms.hhs.gov.[4]

For access instructions or technical questions regarding use of the Quality Measures Reporting (QMR) application, please reach out to MDCT_Help@cms.hhs.gov.

For states needing further resources for integrating Medicare and Medicaid data for Medicare-Medicaid Dual-Eligible beneficiaries, please go to https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources.html. States can obtain forms to request data as well as gather information on webinars and other helpful resources for integrating Medicare and Medicaid data.

[4] States with technical questions about the Child Core Set or the Health Homes Core Set 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 2021.

MEASURE AAB-AD: AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of episodes for beneficiaries age 18 and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure applies to beneficiaries age 3 months 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.
- Include all paid, suspended, pending, and denied claims. Denied claims should be used to identify the eligible population, but cannot be used to identify numerator events.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- Supplemental data may not be used for this measure.
- The measure is reported as an inverted rate (see Section E. Calculation below).
- NCQA's Medication List Directory (MLD) for AAB Antibiotic Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-9-CM, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	The 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode date	The date of service for any outpatient, telephone, observation or ED visit, e-visit, or virtual check-in during the Intake Period with a diagnosis of acute bronchitis/bronchiolitis.

Negative medication history	To qualify for Negative Medication History, the following criteria must be met: • A period of 30 days prior to the Episode Date, when the beneficiary had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions that were filled more than 30 days prior to the Episode Date and are active on the Episode Date. A prescription is considered active if the "days supply" indicated on the date when the beneficiary filled the prescription is the number of days or more between the date and the relevant service date. The 30-day lookback period for pharmacy data includes the 30 days prior to the Intake Period.
Negative comorbid condition history	A period of 12 months prior to and including the Episode Date, when the beneficiary had no claims/encounters with any diagnosis for a comorbid condition.
Negative competing diagnosis	The Episode Date and 3 days following the Episode Date when the beneficiary had no claims/encounters with any competing diagnosis.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the Episode Date.
Continuous enrollment	30 days prior to the Episode Date through three days after the Episode Date (34 total days).
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population: Step 1: Identify beneficiaries with a visit with a diagnosis of acute bronchitis/bronchiolitis Identify all beneficiaries who had an outpatient visit (Outpatient Value Set), a telephone visit (Telephone Visits Value Set), an e-visit or virtual check-in (Online Assessments Value Set), an observation visit (Observation Value Set) or an ED visit (ED Value Set) during the Intake Period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set). Step 2: Determine all acute bronchitis/bronchiolitis Episode Dates For each beneficiary identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis. Do not include visits that result in an inpatient stay (Inpatient Stay Value Set).

Event/ diagnosis (continued)	Step 3: Test for negative comorbid condition history Exclude Episode Dates when the beneficiary had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition: • HIV Value Set • HIV Type 2 Value Set • Malignant Neoplasms Value Set • Other Malignant Neoplasm of Skin Value Set • Emphysema Value Set • COPD Value Set • Comorbid Conditions Value Set • Disorders of the Immune System Value Set Step 4: Test for negative medication history Exclude Episode Dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) was filled 30 days prior to the Episode Date or was active on the Episode Date. Step 5: Test for negative competing diagnosis Exclude Episode Dates where the beneficiary had a claim/encounter with a competing diagnosis on or 3 days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis: • Pharyngitis Value Set • Competing Diagnosis Value Set Step 6: Calculate continuous enrollment The beneficiary must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days). Step 7: Deduplicate eligible episodes If a beneficiary has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a beneficiary has an eligible episode on January 1, include the January 1 visits and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: The denominator for this measure is based on episodes, not on beneficiaries. All eligible episodes that were not excluded or deduplicated remain in the denominator.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) on or three days after the Episode Date.

E. CALCULATION

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (e.g., the proportion for episodes that did not result in an antibiotic dispensing event).

MEASURE AMM-AD: ANTIDEPRESSANT MEDICATION MANAGEMENT

National Committee for Quality Assurance

A. DESCRIPTION

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

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- This measure applies to beneficiaries 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.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Antidepressant Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms128v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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 (IPSD). The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.

Negative medication history	A period of 105 days prior to the IPSD when the beneficiary 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.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IPSD.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population, which is used for both rates. Step 1: Determine the IPSD Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2: Required exclusion Exclude beneficiaries who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Beneficiaries who meet any of the following criteria remain in the eligible population: • An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. • An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set with Major Depression Value Set • A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set with Major Depression Value Set

Event/ diagnosis (continued)	• An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Outpatient POS Value Set with Major Depression Value Set • An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set with Major Depression Value Set • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set with Major Depression Value Set • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set with Major Depression Value Set • A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with Major Depression Value Set • Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set with Major Depression Value Set • Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set with Major Depression Value Set • A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Telehealth POS Value Set with Major Depression Value Set • An observation visit (Observation Value Set) with any diagnosis of major depression (Major Depression Value Set) • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set) • An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with ED POS Value Set with Major Depression Value Set • A telephone visit (Telephone Visits Value Set) with any diagnosis of major depression (Major Depression Value Set) • An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of major depression (Major Depression Value Set) Step 3: Test for Negative Medication History Exclude beneficiaries who filled a prescription for an antidepressant medication 105 days prior to the IPSD. Step 4: Calculate continuous enrollment Beneficiaries must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Effective Acute Phase Treatment

At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above) beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Effective Continuation Phase Treatment

At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above), beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

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 AMR-AD: ASTHMA MEDICATION RATIO: AGES 19 TO 64

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of beneficiaries ages 19 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- The Asthma Medication Ratio measure is stratified into two age groups: ages 5 to 18 and ages 19 to 64. The Child Core Set measure applies to beneficiaries ages 5 to 18 and the Adult Core Set measure applies to beneficiaries ages 19 to 64.
- For the purpose of Adult Core Set reporting, states should calculate and report the three rates for this measure: ages 19 to 50, ages 51 to 64, and a total rate (ages 19 to 64).
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Asthma Controller Medications and Asthma Reliever Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, Modifier, POS, SNOMED, and UB. The Medication List Directory includes the following coding for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

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 (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled. 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, sum the days supply and divide by 30. Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. • Two prescriptions for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each). • Two prescriptions for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each). • Two prescriptions for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days). • Two prescriptions for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).
Inhaler dispensing event	When identifying the eligible population, use the definition below to count inhaler dispensing events. All inhalers (e.g., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a beneficiary received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled. Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.

Injection dispensing event	Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a beneficiary received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events. Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
Units of medication	When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event. Use the package size and units columns in the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicates the dispensed amount is 30 g, three inhaler canisters were dispensed.

C. ELIGIBLE POPULATION

Age	Ages 19 to 64 as of December 31 of the measurement year. Report the following age stratifications and a total rate: • Ages 19 to 50 • Ages 51 to 64 • Total ages 19 to 64
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 continuous enrollment. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not consider continuously enrolled) during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical during the measurement year and the year prior to the measurement year. Pharmacy during the measurement year.

Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. • At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set) • At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) • At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay • At least four outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set) or e-visits or virtual check-ins (Online Assessments Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) and at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits. Use all of the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for reporting above) to identify asthma controller and reliever medications. • At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for reporting above) to identify asthma controller and reliever medications. Step 2 A beneficiary identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (e.g., the measurement year or the year prior to the measurement year).

Event/diagnosis (continued)	Step 3: Required exclusions Exclude beneficiaries who met any of the following criteria: • Beneficiaries who had any diagnosis from any of the following value sets, any time during the beneficiary's history through December 31 of the measurement year: - Emphysema Value Set - Other Emphysema Value Set - COPD Value Set - Obstructive Chronic Bronchitis Value Set - Chronic Respiratory Conditions Due to Fumes or Vapors Value Set - Cystic Fibrosis Value Set - Acute Respiratory Failure Value Set • Beneficiaries who had no asthma controller medications or reliever medications dispensed during the measurement year. Use all the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for reporting above) to identify asthma controller and reliever medications.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries who have a medication ratio of 0.50 or greater during the measurement year. Follow the steps below to calculate the ratio.

Use all the medication lists in Table AMR-A. Asthma Controller Medications table below to identify asthma controller medications. Use all the medication lists in Table AMR-B. Asthma Reliever Medications table below to identify asthma reliever medications.

Step 1

For each beneficiary, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of Units of medications.

Step 2

For each beneficiary, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of Units of medications.

Step 3

For each beneficiary, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4

For each beneficiary, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

Units of Controller Medications (step 1) / Units of Total Asthma Medications (step 3)

Step 5

Sum the total number of beneficiaries who have a ratio of 0.50 or greater in step 4.

Table AMR-A. Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antiasthmatic combinations	Dyphylline-guaifenesin	Dyphylline Guaifenesin Medications List	Oral
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Table AMR-B. Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Note

- Do not use RxNorm codes when assessing the numerator.
- When mapping NDC codes, medications described as “injection,” “prefilled syringe,” “subcutaneous,” “intramuscular” or “auto-injector” are considered “injections” (route).
- When mapping NDC codes, medications described as “metered dose inhaler,” “dry powder inhaler,” or “inhalation powder” are considered “inhalation” (route) medications.
- Do not map medications described as “nasal spray” to “inhalation” medications.

MEASURE BCS-AD: BREAST CANCER SCREENING

National Committee for Quality Assurance

A. DESCRIPTION

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

Data Collection Method: Administrative or EHR[1]

Guidance for Reporting:

- This measure applies to women ages 52 to 74 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 ages 52 to 74 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.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Dementia Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms125v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, Modifier, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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.

[1] The Breast Cancer Screening measure is also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Adult Core Set reporting.

Allowable gap	No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (the measurement year and the year prior to the measurement year). To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment. 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.
Required exclusion	Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Optional exclusion	Exclude beneficiaries who meet any of the following criteria: Note: Supplemental and medical record data may not be used for this exclusion. Beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay

Optional exclusion (continued)	- At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay. - A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above)

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

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.

Exclusion (optional)

Bilateral mastectomy any time during the beneficiary'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)
- Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral modifier (Clinical Bilateral Modifier Value Set)

Note: The "clinical" mastectomy value sets identify mastectomy; the word "clinical" refers to the data source, not to the type of mastectomy.

- History of bilateral mastectomy (History of Bilateral Mastectomy Value Set)
- Any combination of codes from the table below that indicate a mastectomy on both the left and right side on the same or different dates of service:

Left Mastectomy (any of the following):	**Right Mastectomy (any of the following):**
• Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (Left Modifier Value Set) (same procedure)	• Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right-side modifier (Right Modifier Value Set) (same procedure)

Left Mastectomy (any of the following):	**Right Mastectomy (any of the following):**
• Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a left-side modifier (Clinical Left Modifier Value Set) (same procedure)	• Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a right-side modifier (Clinical Right Modifier Value Set) (same procedure)
• Absence of the left breast (Absence of Left Breast Value Set)	• Absence of the right breast (Absence of Right Breast Value Set)
• Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)	• Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)

D. ADDITIONAL NOTES

This measure assesses the use of imaging to detect early breast cancer in women. Because the measure denominator does not remove women at higher risk of breast cancer, all types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance. Do not count MRIs, ultrasounds, or biopsies toward the numerator: although these procedures may be indicated for evaluating women at higher risk of breast cancer or for diagnostic purposes, they are performed as an adjunct to mammography and do not alone count toward the numerator.

MEASURE CBP-AD: CONTROLLING HIGH BLOOD PRESSURE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- This measure applies to beneficiaries 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.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Dementia Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms165v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, SNOMED, and UB. The Medication List Directory include the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Adequate control	Both a representative systolic BP < 140 mm Hg and a representative diastolic BP of < 90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second 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 beneficiary is "not controlled."

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary 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	Beneficiaries who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set)
Required exclusion	Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Optional exclusions	Exclude beneficiaries who meet any of the following criteria: Note: Supplemental and medical record data may not be used for these exclusions. • Beneficiaries ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years):

Optional exclusions (continued)	○ At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay ○ At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) ○ At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay ○ A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above) • Beneficiaries age 81 and older as of December 31 of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during an outpatient visit (Outpatient Without UBREV Value Set), telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), a nonacute inpatient encounter (Nonacute Inpatient Value Set), or remote monitoring event (Remote Blood Pressure Monitoring Value Set) during the measurement year.

The BP reading must occur on or after the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The beneficiary is numerator compliant if the BP is < 140/90 mm Hg. The beneficiary is not compliant if the BP is ≥ 140/90 mm Hg, 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). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

States that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80-89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

Exclusions (optional)

- Exclude from the eligible population all beneficiaries with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) on or prior to December 31 of the measurement year.
- Exclude from the eligible population female beneficiaries with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all beneficiaries 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 stay.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

For FFY 2022 Core Set reporting (measurement year 2021), the state may reduce sample size using the current year's administrative rate or the prior year's rate (FFY 2021 Core Set reporting).

Identifying the Medical Record

All eligible BP measurements recorded in the record must be considered. If a beneficiary's medical record cannot be found, the beneficiary remains in this measure denominator and is considered noncompliant for the numerator.

Use the following guidance to find the appropriate medical record to review.

- Identify the beneficiary's PCP.
- If the beneficiary had more than one PCP for the time-period, identify the PCP who most recently provided care to the beneficiary.
- If the beneficiary 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 beneficiary.
- If a practitioner other than the beneficiary's PCP manages the hypertension, the medical record of that practitioner may be used.

Numerator

The number of beneficiaries in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a beneficiary's BP to be controlled the systolic and diastolic BP must be < 140/90 mm Hg (adequate control). To determine if a beneficiary's BP is adequately controlled, the representative BP must be identified.

Administrative Data

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

Medical Record Review

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or ED visit
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests
- Taken by the beneficiary using a non-digital device such as with a manual blood pressure cuff and a stethoscope

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. 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.

The beneficiary is not numerator compliant if the BP reading is ≥ 140/90 mm Hg or is missing, 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).

Exclusions (optional)

Refer to the Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating diagnosis of pregnancy or evidence of a nonacute inpatient admission during the measurement year, or evidence of ESRD, dialysis, nephrectomy, or kidney transplant any time during the beneficiary's history through December 31 of the measurement year.

F. ADDITIONAL NOTES

- When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).
- An electronic medical record (EMR) can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.
- When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet, or a change in medication. Examples of such procedures include colonoscopies; dialysis, infusions, and chemotherapy; nebulizer treatments with albuterol; and lidocaine injections. A beneficiary forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.
- BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. These include procedures such as vaccinations; injections; tuberculosis tests; intrauterine device (IUD) insertions; eye exams; or wart or mole removal.

MEASURE CCP-AD: CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 21 to 44 who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 60 days of delivery is used to monitor the provision of contraception throughout the postpartum period. (A 60-day period is used because the 2016 American College of Obstetricians and Gynecologists [ACOG] Committee Opinion No. 666 recommended a postpartum visit at 6 weeks, and two additional weeks are allowed for women whose postpartum care visit is delayed.) [1]

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – Postpartum Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- In total, four rates will be reported for the Adult Core Set measure:
  - Ages 21 to 44: Most or moderately effective contraception – 3 days
  - Ages 21 to 44: Most or moderately effective contraception – 60 days
  - Ages 21 to 44: LARC – 3 days
  - Ages 21 to 44: LARC – 60 days
- The measurement year is calendar year 2021. There is no lookback period for this measure.
- Include all paid, suspended, pending, and denied claims.
- Some women may have more than one delivery in the measurement year; this measure is designed to identify unique live births (defined as those that occur ≥ 180 days apart) rather than women who had a live birth.

[1] Committee Opinion No. 666: Optimizing Postpartum Care. (2016). *Obstetrics and gynecology*, *127*(6), e187–e192. https://doi.org/10.1097/AOG.0000000000001487

- Women with a live birth occurring after October 31 are excluded from the denominator because there may not have been an opportunity to provide the woman with contraception in the postpartum period (defined as within 60 days of delivery).
- When calculating the number of days postpartum for the numerator, consider the date of delivery to be day 0. For instance, if a live birth occurred on October 28, 2021, review all claims through October 31, 2021 for the 3-day postpartum rates and review all claims through December 27, 2021 for the 60-day postpartum rates.
- The codes used to calculate this measure are available in Tables CCP-A through CCP-D at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.
- The code sets and SAS programs needed to calculate this measure are available at https://opa.hhs.gov/claims-data-sas-program-instructions.
- 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.
- For more information on interpreting performance results on this measure, see Section E, "Additional Notes."

This measure includes the following coding systems: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, or ring.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2021.

C. ELIGIBLE POPULATION

Age	Women ages 21 to 44 as of December 31 of the measurement year who had a live birth.
Continuous enrollment	Within the measurement year, women enrolled from the date of delivery to 60 days postpartum.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	Date of delivery.

Benefit	Medical or Family Planning Only Services.
Event/diagnosis	Delivery of a live birth.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population includes women ages 21 to 44 who had a live birth in the measurement year.

Women with a live birth occurring after October 31 will be excluded from the denominator because they may not have an opportunity to receive contraception in the postpartum period (defined as within 60 days of delivery). Follow the steps below to identify the eligible population:

Step 1

Identify live births and deliveries by using codes in Table CCP-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Step 2

Exclude deliveries that did not end in a live birth (e.g., miscarriage, ectopic, stillbirth, or pregnancy termination) by using the codes in Table CCP-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Step 3

Exclude live births that occurred during the last 2 months of the measurement year. These deliveries should be excluded from the denominator because there may not have been an opportunity to provide the woman with contraception during the postpartum period. ACOG recommends having a postpartum visit by 6 weeks.

Numerator for Rate 1

The eligible population that was provided a most or moderately effective method of contraception.

Step 4

Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD/IUS, implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCP-C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Step 5

Determine the date that the contraceptive method was provided to identify: (a) women that were provided contraception in the immediate postpartum period of 3 days after delivery; and (b) women that were provided contraception within 60 days of delivery. The second category will also include women who were provided contraception in the first 3 days postpartum.

Numerator for Rate 2

The eligible population that was provided a LARC method.

Step 4

Define the numerator by identifying women in the denominator who were provided a LARC in the measurement year. To do this, use the codes in Table CCP-D, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Step 5

Determine the date that the LARC method was provided to identify: (a) women that were provided LARC in the immediate postpartum period of 3 days after delivery; and (b) women that were provided LARC within 60 days of delivery. The second category will also include women who were provided LARC in the first 3 days postpartum.

E. ADDITIONAL NOTES

Healthy People 2030[2] and the World Health Organization recommend an inter-pregnancy interval of at least 18 months; therefore, all postpartum women can be considered at risk of unintended pregnancy for that period of time.

More information on how to interpret performance results on this measure is available at https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf.

The Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception that can be used in the postpartum period. If the infant is being fed only its mother's breast milk, and the woman has not experienced her first postpartum menses, then LAM provides 98% protection from pregnancy in the first 6 months postpartum.[3]

Despite the protection from LAM, many health care providers will want to provide contraceptive services to women at the postpartum visit because the effectiveness of breastfeeding for pregnancy prevention drops quickly when women stop exclusive breastfeeding. It may be difficult for many clients to receive contraceptive services at that time.

[2] Office of Disease Prevention and Health Promotion. "Family Planning." N.d. Available at https://health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning.

[3] Trussell J., A.R.A. Aiken, E. Micks, K.A. Guthrie. "Efficacy, safety, and personal considerations." In: R.A. Hatcher, A.L. Nelson, J. Trussell, C. Cwiak, P. Cason, M.S. Policar, A. Edelman, A.R.A. Aiken, J. Marrazzo, D. Kowal, eds. Contraceptive technology. 21st ed. New York, NY: Ayer Company Publishers, Inc., 2018.

MEASURE CCS-AD: CERVICAL CANCER SCREENING

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of 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 performed within the last 3 years
- Women ages 30 to 64 who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years
- Women ages 30 to 64 who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- This measure should include (1) all women ages 24 to 64 who have had cervical cytology during the measurement year or the two years prior to the measurement year, and (2) women ages 30 to 64 who have had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year. Both criteria must be evaluated for numerator compliance; however, beneficiaries only need to meet one criterion to be included in the numerator for this measure. Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.
- 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 for assessing numerator criterion (e.g., the measure is looking back three years from age 24 for evidence of cervical cytology).
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms124v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, SNOMED, 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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary 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.
Required exclusion	Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of women who were screened for cervical cancer. Either of the following meets criteria:

- Women ages 24 to 64 as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year
- Women ages 30 to 64 as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set; High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of the test

Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.

Exclusion (optional)

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

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

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

Medical Record Review

Appropriate screenings are defined by any of the following:

- 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.

- Women ages 30 to 64 as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year and who were 30 years 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 hrHPV test was performed. Generic documentation of “HPV test” can be counted as evidence of hrHPV test
    - The results or findings
  - Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.

Exclusion (optional)

Refer to the Administrative Specification for exclusion criteria. Evidence of a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix any time during the beneficiary's history through December 31 of the measurement year. The following examples meet criteria for documentation of hysterectomy with no residual cervix.

- Documentation of "complete," "total," or "radical" hysterectomy (abdominal, vaginal, or unspecified)
- Documentation of "vaginal hysterectomy"
- 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 CCW-AD: CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 21 to 44 at risk of unintended pregnancy, the percentage that:

1. Were provided a most effective or moderately effective method of contraception.
2. Were provided a long-acting reversible method of contraception (LARC).

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods. A state should exercise caution in using this measure for payment purposes, because performance on this measure is a function of a woman's preferences. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state, and see where there is room for improvement. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – All Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- The Contraceptive Care – All Women Ages 21 to 44 measure in the Adult Core Set includes the most and moderately effective methods rate (NQF #2903) and the access to LARC rate (NQF #2904). Two rates will be reported for the Adult Core Set measure – one for the provision of most or moderately effective methods and one for provision of LARC.
- The measurement year is calendar year 2021. There is no lookback period for this measure to determine if there was a previous sterilization, LARC insertion, or other contraceptive method provided prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- A secondary data source, such as the National Survey of Family Growth (NSFG) can be used to interpret the results of this measure. For more information, see Section E, "Additional Notes."
- The codes used to calculate this measure are available in Tables CCW-A through CCW-F at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.
- The code sets and SAS programs needed to calculate this measure are available at https://opa.hhs.gov/claims-data-sas-program-instructions.

- 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.

This measure includes the following coding systems: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, or ring.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2021.

C. ELIGIBLE POPULATION

Age	Women ages 21 to 44 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 continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Follow the steps below to define the denominator:

Step 1

Identify all women ages 21 to 44.

Step 2

Define the denominator by excluding women not at risk of unintended pregnancy because they:

- Were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table CCW-A.
- Had a live birth in the last 2 months of the measurement year because there may not have been an opportunity to provide them with contraception. A two-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 6 weeks, and an additional 2 weeks was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table CCW-D.
- Were still pregnant at the end of the measurement year, as indicated by a pregnancy code (Table CCW-B) and an absence of a pregnancy outcome code indicating a non-live birth (Table CCW-C) or a live birth (Table CCW-D).

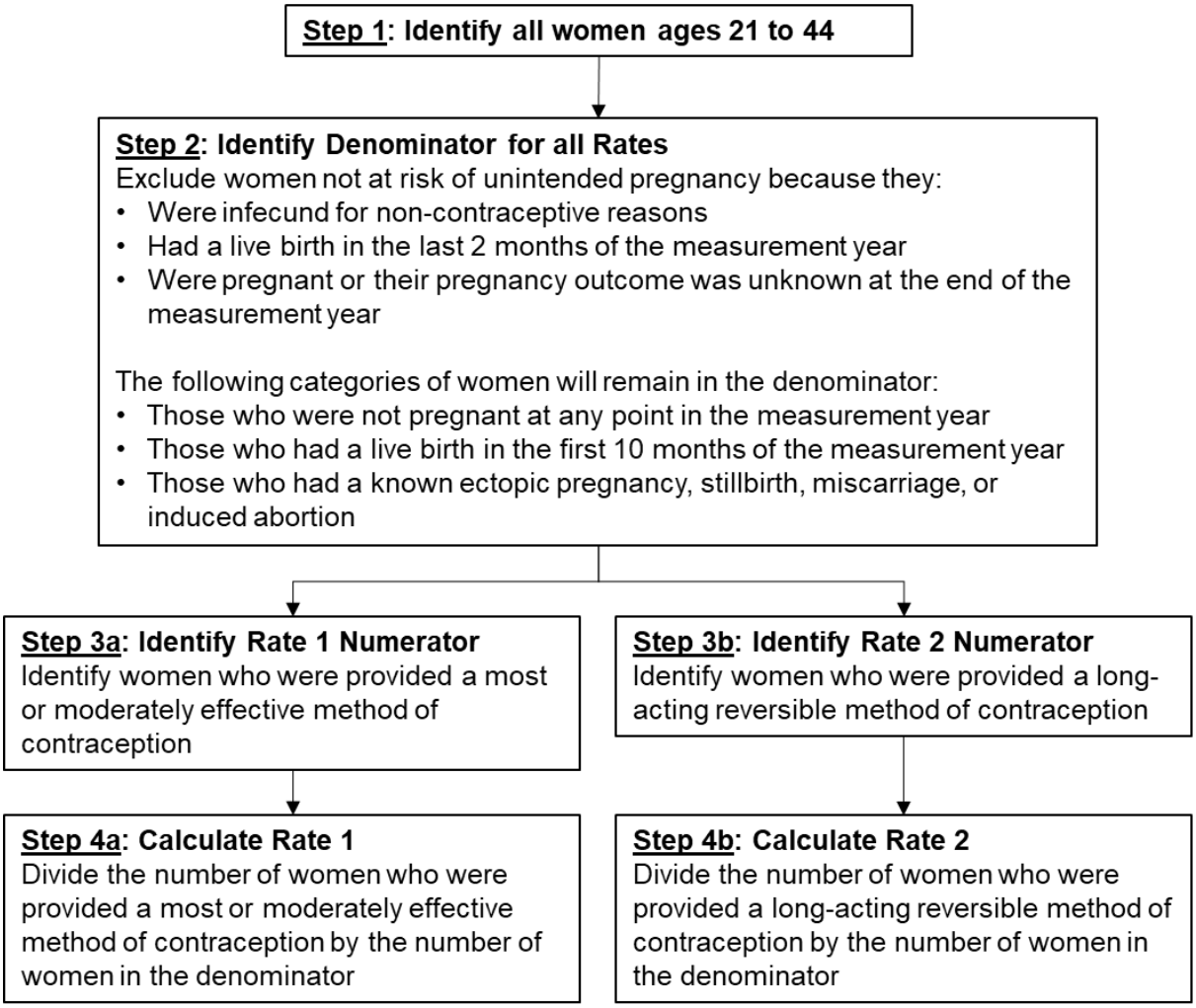
Once the exclusions are applied, the denominator includes women who were:

- Not pregnant at any point in the measurement year.
- Pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.
- Pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

All code tables used in the calculation of the denominator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Figure CCW-A provides a flowchart for implementing these exclusion and inclusion categories.

Figure CCW-A. Measure Flowchart



Step 3a: Identify Rate 1 Numerator

The eligible population provided a most or moderately effective method of contraception.

Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD/IUS, or implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCW-E.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Step 3b: Identify Rate 2 Numerator

The eligible population that was provided a LARC method.

Define the numerator by identifying women in the denominator who were provided a LARC in the measurement year. To do this, use the codes in Table CCW-F.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Step 4a: Calculate Rate 1

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

Step 4b: Calculate Rate 2

Calculate the rates by dividing the number of women who were provided a LARC by the number of women in the denominator.

E. ADDITIONAL NOTES

Stratification of the results by category of Medicaid eligibility (e.g., family planning waiver vs. other Medicaid eligibility) is recommended for interpretation. A secondary data source, such as the National Survey of Family Growth[1] (NSFG) or the Behavioral Risk Factor Surveillance System[2] (BRFSS) should be used to interpret provision of most and moderately effective contraceptive methods. Secondary data sources may be used to interpret the results for the general Medicaid population. However, the results for the family planning waiver recipients do not need to be adjusted with secondary data as the vast majority of clients who receive services from these programs are seeking contraceptive services and should therefore be considered at risk of unintended pregnancy.

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy (e.g., who are fecund, are not pregnant or seeking pregnancy, and have ever had sex). However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention or history of sexual activity. Further, both sterilization and LARC are long-lasting but there is no systematic record of receipt of sterilization or LARC in the year(s) preceding the measurement year. These limitations can be offset by using estimates from secondary survey data to help interpret this measure's results and to set better understand the limitations of claims data.

NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men ages 15 to 49. Approximately 5,000 individuals are interviewed each year, and updated data files are released every two years. This survey can be used to identify the portion of beneficiaries that are not at risk of unintended pregnancy because they never had sex, are infecund, or are trying to get pregnant. This information can then help determine the population at risk for unintended pregnancy to provide context for measure performance.

BRFSS is a national telephone survey that collects data about health-related risk factors, chronic health conditions, and use of preventive health services.

More information on how to interpret performance results on this measure is available at https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf.

[1] Centers for Disease Control and Prevention. "National Survey of Family Growth." November 2020. Available at https://www.cdc.gov/nchs/nsfg/index.htm.

[2] Centers for Disease Control and Prevention. "Behavioral Risk Factor Surveillance System." August 2020. Available at https://www.cdc.gov/brfss/.

MEASURE CDF-AD: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure includes beneficiaries ages 12 and older. The Child Core Set measure applies to beneficiaries ages 12 to 17 and the Adult Core Set measure applies to beneficiaries 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.
- The intent of the measure is to screen for depression in beneficiaries who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Beneficiaries who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.
- The denominator for this measure includes beneficiaries age 18 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  1. Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
  2. Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool.
- The QPP claims/CQM specifications for this measure include 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 depression screening using an age-appropriate standardized tool was done on the date of the eligible encounter or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.
- The screening should occur during a qualifying encounter or up to 14 days prior to the date of the qualifying encounter.
- The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a beneficiary screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which does not include use of a standardized depression screening tool.

- Should a beneficiary screen positive for depression, a clinician could opt to complete a suicide risk assessment when appropriate and based on individual beneficiary characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any 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.
- 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.
- 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 this measure.
- Include all paid, suspended, pending, and denied claims.
- The electronic specification for FFY 2021 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10.

This measure includes the following coding systems: CPT and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	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. The depression screening must be reviewed and addressed in the office of the provider on the date of the eligible encounter.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed 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. Examples of depression screening tools include but are not limited to:

Standardized Depression Screening Tool (continued)	• Adult Screening Tools (age 18 and older) 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), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD). • Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.
Follow-up plan	Documented follow-up for a positive depression screening must include one or more of the following: • 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 Examples of a follow-up plan include but are not limited to: • Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression • Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options The documented follow-up plan must be related to positive depression screening, for example: “Patient referred for psychiatric evaluation due to positive depression screening.”

C. ELIGIBLE POPULATION

Age	Age 18 or older on date of encounter.
Event/diagnosis	Outpatient visit (Table CDF-A) during the measurement year.
Continuous enrollment	None.

D. ADMINISTRATIVE 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
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99401, 99402, 99403, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

Numerator

Beneficiaries screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter using one of the codes in Table CDF-B.

Table CDF-B. Codes to Document Depression Screen

Code	Description
G8431	Screening for depression is documented as being positive and a follow-up plan is documented
G8510	Screening for depression is documented as negative, a follow-up plan is not required

Exclusions

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

- Beneficiaries who have been diagnosed with depression or bipolar disorder

Use the codes in Table CDF-C, CDF-D, and CDF-E to identify exclusions.

Table CDF-C. HCPCS Code to Identify Exclusions

Code	Description
G9717	Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder

Table CDF-D. ICD-10 Codes to Identify Diagnosis of Depression (Exclusions)

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate

ICD-10 Code	Description
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

Table CDF-E. ICD-10 Codes to Identify Diagnosed Bipolar Disorder (Exclusions)

ICD-10 Code	Description
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified

ICD-10 Code	Description
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified

Exceptions

A beneficiary that does not meet the numerator criteria and meets the following exception criteria should be removed from the measure denominator. However, if the beneficiary

meets the numerator criteria, the beneficiary would be included in the measure denominator.

- Beneficiary refuses to participate
- Beneficiary is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the beneficiary's health status
- Situations where the beneficiary's cognitive, functional, or motivational limitations may impact the accuracy of results

Table CDF-F. HCPCS Code to Identify Exceptions

Code	Description
G8433	Screening for depression not completed, documented reason

MEASURE CHL-AD: CHLAMYDIA SCREENING IN WOMEN AGES 21 TO 24

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of 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 or EHR

Guidance for Reporting:

- For HEDIS, this measure has three reportable rates—ages 16 to 20, ages 21 to 24, and a total (ages 16 to 24). The Adult Core Set measure applies to beneficiaries ages 21 to 24 and the Child Core Set measure applies to beneficiaries ages 16 to 20.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Contraceptive Medications and Retinoid Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms153v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary 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	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 beneficiary only needs to be identified in one method to be eligible for this measure. Claim/encounter data. Beneficiaries who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria: • Pregnancy Value Set • Sexual Activity Value Set • Pregnancy Tests Value Set Pharmacy data. Beneficiaries who were dispensed prescription contraceptives during the measurement year (Contraceptive Medications List, see link to the Medication List Directory in Guidance for Reporting above).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

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

Exclusion (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 (Retinoid Medications List, see link to the Medication List Directory in Guidance for Reporting above) on the date of the pregnancy test or within the six 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 six days after the pregnancy test

MEASURE COB-AD: CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES

Pharmacy Quality Alliance

A. DESCRIPTION

Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries 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 January 1 of the measurement year.
- The opioid medications used to calculate this measure are in the "Value Sets – Medications" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice or palliative care at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10 codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice may be identified using the codes in the Hospice Encounter Value Set and Hospice Intervention Value Set or Palliative Care Value Set available in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- When determining the eligible population, under Step 1 of the Event/Diagnosis, the process for counting the total days' supply when there are multiple prescriptions with overlapping days of supply depends on whether the prescriptions are filled on the same day or on different days.
  - If prescriptions are filled on the **same day**, states should count only the days' supply for the prescription filled with the longest supply toward the total. For example, if an individual had two prescriptions filled on October 15 during the measurement year, one with a 7-day supply and the other with a 30-day supply, of the two claims filled, the state should count only the 30 days' supply claim toward the cumulative days' supply.

- If prescriptions are dispensed on **different days** with overlapping days' supply, states should not account for overlapping days' supply. Each day of overlap should be counted separately towards the total days' supply. For example, if a beneficiary has two claims that were dispensed during the measurement year, the first on January 15, 2019 for a 30-day supply, and the second, on January 20, 2019 for a 7-day supply, then the beneficiary's cumulative days' supply is 37 days.

- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
Opioid	See medications listed in Table COB-A.
Benzodiazepine	See medications listed in Table COB-B.
Concurrent Use	Overlapping supply for an opioid and a benzodiazepine for 30 or more cumulative days. Concurrent use is identified using the dates of service and days' supply of a beneficiary's prescription claims. The days of concurrent use is the count of days with overlapping days' supply for an opioid and a benzodiazepine.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 30 days before the end of the measurement year. (e.g., January 1–December 2).
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
Cancer Diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Cancer Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.

Sickle Cell Disease Diagnosis	Any beneficiary with an ICD-10 diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
Palliative Care	Any beneficiary with an ICD-10 diagnosis code for palliative care, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Palliative Care Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/Diagnosis	Use the steps below to determine the eligible population. Step 1 Identify beneficiaries with 2 or more prescription claims for opioid medications (Table COB-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply. Step 2 • Identify beneficiaries with an IPSD on January 1 through December 2 of the measurement year.

Event/Diagnosis (continued)	Step 3 Exclude beneficiaries who met at least one of the following during the measurement year: • Hospice • Cancer Diagnosis • Sickle Cell Disease Diagnosis • Palliative Care

Table COB-A. Opioid Medications[a,b]

Benzohydrocodone	Hydrocodone	Morphine	Oxymorphone
Buprenorphine[c]	Hydromorphone	Opium	Pentazocine
Butorphanol	Levorphanol	Oxycodone	Tapentadol
Codeine	Meperidine		Tramadol
Dihydrocodeine	Methadone		
Fentanyl			

[a] Includes combination products and prescription opioid cough medications.

[b] Excludes the following: injectable formulations; sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (e.g., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries from the denominator with:

- Two or more prescription claims for any benzodiazepine (Table COB-B) with different dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days

Follow the steps below to identify beneficiaries for the numerator.

Step 1

From the denominator population, identify beneficiaries with two or more prescription claims with different dates of service for any benzodiazepine (Table COB-B) during the measurement year.

Step 2

Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioids and benzodiazepine prescriptions during the measurement year. Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of supply and overlap that occur after the end of the measurement year.

NOTE:

- If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days' supply.
- If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days' supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

Step 3

Count the number of beneficiaries with concurrent use for 30 or more cumulative days. This is the numerator.

Table COB-B. Benzodiazepine Medications[a,b]

Alprazolam Chlordiazepoxide Clobazam Clonazepam	Clorazepate Diazepam Estazolam Flurazepam	Lorazepam Midazolam Oxazepam Quazepam	Temazepam Triazolam

[a] Excludes injectable formulations.

[b] Includes combination products.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Center for Disease Control and Prevention CDC Guideline for Prescribing Opioids for Chronic Pain and Guideline Resources.

MEASURE COL-AD: COLORECTAL CANCER SCREENING

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 50 to 75 who had appropriate screening for colorectal cancer.

Data Collection Method: Administrative or EHR[1]

Guidance for Reporting:

- This measure applies to beneficiaries ages 51 to 75 to account for the lookback 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 75.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Dementia Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms130v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, ICD-9-CM, ICD-9-PCS, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Beneficiaries ages 51 to 75 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 continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical.
Event/ diagnosis	None.

[1] The Colorectal Cancer Screening measure is also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Adult Core Set reporting.

Required exclusion	Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Optional exclusion	Exclude beneficiaries who meet any of the following criteria: Note: Supplemental and medical record data may not be used for these exclusions. • Beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay. o At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) o At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay. o A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above)

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; History of Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- FIT-DNA test (FIT DNA Lab Test Value Set; FIT DNA Test Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.

Exclusion (optional)

Either of the following any time during the beneficiary's history through December 31 of the measurement year:

- Colorectal cancer (Colorectal Cancer Value Set)
- Total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set)

MEASURE CPA-AD: CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) HEALTH PLAN SURVEY 5.1H, ADULT VERSION (MEDICAID)

Agency for Healthcare Research and Quality (survey instrument)

National Committee for Quality Assurance (survey administration protocol)

A. DESCRIPTION

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

Four global rating questions reflect overall satisfaction:

- Rating of All Health Care
- Rating of Health Plan
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

Four composite scores summarize responses in key areas:

- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate

A single question reflects experience of care in the following key area:

- Coordination of Care

In addition, item-specific results ("question summary rates") are reported for the rating questions and each composite question.

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to beneficiaries age 18 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 ages 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 CAHPS 5.1H survey vendors is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-1h-survey-certification/vendor-directory/.

- When reporting this measure, states should document (1) how this measure was reported (e.g., whether raw data was submitted to AHRQ's CAHPS Database), (2) which measurement specification (e.g., HEDIS) and data source (e.g., survey version, supplemental item sets, and administrative protocol) were used, and (3) the population included in the denominator (e.g., dually eligible beneficiaries). Finally, states should upload a summary of their CAHPS results as an attachment.
- Any deviations in the questionnaire, data collection or survey administration, sampling, or data analysis should be reported in the "Additional Notes/Comments on Measure" section.
- See Appendix C for additional guidance on conducting the CAHPS Survey. See Appendix D for the CAHPS 5.1H Adult Questionnaire.
- CMS encourages states (or their managed care plans) to submit raw CAHPS data to the AHRQ CAPHS Health Plan Survey Database to increase the completeness of Adult Medicaid CAHPS data included in the database. More information about the CAHPS Health Plan Survey Database is available at https://cahpsdatabase.ahrq.gov/HPSurveyGuidance.aspx.

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	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 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 beneficiary-level data file submission and the time needed to draw the systematic sample and generate the final beneficiary-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 MY 2021 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 beneficiaries to be surveyed in order to achieve a goal of 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 FUA-AD: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR ALCOHOL AND OTHER DRUG ABUSE OR DEPENDENCE: AGE 18 AND OLDER

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported:

- Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has four reportable rates – ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). The Child Core Set measure applies to beneficiaries ages 13 to 17 and the Adult Core Set measure applies to beneficiaries 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.
- The denominator should be the same for the 30-day rate and the 7-day rate within each age group.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, POS, SNOMED, 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 the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency. Note: Beneficiaries with detoxification-only chemical dependency benefits do not meet these criteria.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Weekly Non Drug Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Monthly Office Based Treatment Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Weekly Drug Treatment Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)

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 required period for the rate (e.g., within 30 days after the ED visit or within 7 days after the ED visit).

MEASURE FUH-AD: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGE 18 AND OLDER

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has four reportable rates – ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The Child Core Set measure applies to beneficiaries ages 6 to 17 and the Adult Core Set measure applies to beneficiaries 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.
- Follow the detailed specifications to (1) include the appropriate discharge when the beneficiary 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 beneficiary 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 within each age group.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or from the same visit.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.

- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- Refer to Appendix E for the definition of a mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, 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 date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim 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. Identify the discharge date for the stay to determine whether it falls on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 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 stays to determine whether they occur after December 1 of the measurement year.

Acute readmission or direct transfer (continued)	Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge. If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.
Nonacute readmission or direct transfer	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. To identify readmissions and direct transfers to a nonacute inpatient care setting: 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 stay to determine whether it occurs within the 30-day follow-up period These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

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

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (BH Outpatient Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)

- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health provider
- An observation visit (Observation Value Set) with a mental health provider
- Transitional care management services (Transitional Care Management Services Value Set) with a mental health provider
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)
- A telephone visit (Telephone Visits Value Set) with a mental health provider

States must develop their own methods to identify mental health providers, using the definition of a mental health provider in Appendix E.

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 required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

MEASURE FUM-AD: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS: AGE 18 AND OLDER

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:

- Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has four reportable rates – ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The Child Core Set measure applies to beneficiaries ages 6 to 17 and the Adult Core Set measure applies to beneficiaries 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.
- The denominator 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 within each age group.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, 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 the date of the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

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 required period specified for the rate (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 beneficiaries ages 18 to 64 who received a flu vaccination between July 1 of the measurement year and the date when the CAHPS 5.1H Adult Survey was completed.

Data Collection Method: Survey

Guidance for Reporting:

- If the denominator is less than 100, this measure is not reported. States should note the reason for not reporting as "denominator too small."
- CMS encourages states (or their managed care plans) to submit raw CAHPS data to the AHRQ CAHPS Health Plan Survey Database to increase the completeness of Adult Medicaid CAHPS data included in the database. More information about the CAHPS Health Plan Survey Database is available at https://cahpsdatabase.ahrq.gov/HPSurveyGuidance.aspx.

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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
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 5.1H, 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 beneficiary in the CAHPS 5.1H adult survey sample frame data file.

Flu Vaccinations for Adults Ages 18 to 64 Eligibility Flag
1 = Eligible (the beneficiary was born on or between July 2, 1956, and July 1, 2003)
2 = Ineligible (the beneficiary was born before July 2, 1956, or after July 1, 2003)

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 beneficiary confidentiality (using the date of birth could result in a breach of confidentiality).

D. QUESTION INCLUDED IN THIS MEASURE

Question		Response Choices
Q31	Have you had either a flu shot or flu spray in the nose since July 1, YYYY?[a]	Yes No Don't know

[a] YYYY = the measurement year (2021 for the survey fielded in 2022).

E. CALCULATION OF MEASURE

Denominator

The number of beneficiaries 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 beneficiaries 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 NOTES

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 this measure is not reportable.

MEASURE HPC-AD: COMPREHENSIVE DIABETES CARE: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9.0%)

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%).

Note: A lower rate indicates better performance.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- This measure applies to beneficiaries 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.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Dementia Medications and Diabetes Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms122v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, LOINC, Modifier, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary 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	There are two ways to identify beneficiaries with diabetes: by claim/encounter data and by pharmacy data. The state must use both methods to identify the eligible population, but a beneficiary only needs to be identified by one method to be included in this measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Beneficiaries 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): • At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) • At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay. • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge: 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 discharge date for the stay. Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Event/diagnosis (continued)	Pharmacy data. Beneficiaries who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or year prior to the measurement year (Diabetes Medications List, see link to the Medication List Guidance for Reporting above).
Required exclusion	Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Optional exclusion	Exclude beneficiaries who meet any of the following criteria: Note: Supplemental and medical record data may not be used for this exclusion. Beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay. - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. - To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

Optional exclusion (continued)	2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. - A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above)

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Use codes (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The beneficiary 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 beneficiary is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤ 9.0%.

States that use CPT Category II codes to identify numerator compliance for this measure must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the beneficiary is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

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

Exclusion (optional)

Beneficiaries 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 polycystic ovarian syndrome, 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 beneficiary 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 beneficiary had a diagnosis of diabetes.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

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 laboratory data or medical record review.

Note: A lower rate indicates better performance (e.g., 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 beneficiary 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 beneficiary 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.

Exclusion (optional)

Refer to Administrative Specification for exclusion criteria. Identify beneficiaries 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 polycystic ovarian syndrome, gestational diabetes, or steroid-induced diabetes in any setting during the measurement year or the year prior to the measurement year.

E. ADDITIONAL NOTES

If a combination of administrative, supplemental, or hybrid data are used, the most recent result must be used, regardless of data source.

MEASURE HPCMI-AD: DIABETES CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS: HEMOGLOBIN A1C (HBA1C) POOR CONTROL (>9.0%)

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%).

Note: A lower rate indicates better performance.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This is a NCQA owned and copyrighted measure that is not currently contained in HEDIS®.
- This measure applies to beneficiaries 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.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Dementia Medications and Diabetes Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, Modifier, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary 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	Follow the steps below to identify beneficiaries with diabetes and serious mental illness. Step 1 Identify beneficiaries ages 18 to 75 as of the end of the measurement year. Step 2 Identify beneficiaries from step 1 with a diagnosis of serious mental illness. Beneficiaries are identified as having serious mental illness if they met at least one of the following criteria during the measurement year: • At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder. Any of the following code combinations meet criteria: - BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set • At least two of the following, on different dates of service where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) or both encounters have any diagnosis of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) - An outpatient visit (Visit Setting Unspecified Value Set) with Outpatient POS Value Set - An outpatient visit (BH Outpatient Value Set) - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) - An observation visit (Observation Value Set) - An ED visit (ED Value Set)

Event/ diagnosis (continued)	- An ED visit (Visit Setting Unspecified Value Set with ED POS Value Set) - A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) - A nonacute inpatient encounter (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set) - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) - A telephone visit (Telephone Visits Value Set) - An e-visit or virtual check-in (Online Assessments Value Set) Step 3 Identify beneficiaries from step 2 with diabetes. There are two ways to identify beneficiaries with diabetes: by claim/encounter data and by pharmacy data. The state must use both methods to identify the eligible population, but a beneficiary only needs to be identified by one method to be included in this measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Beneficiaries 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): • At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) • At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay. • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telehealth visits (Telephone Visits Value Set), e-visit or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge: 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 discharge date for the stay.

Event/ diagnosis (continued)	Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) Pharmacy data. Beneficiaries who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. For prescriptions that can be used to identify beneficiaries with diabetes, refer to the Diabetes Medications List (see link to the Medication List Directory in Guidance for Reporting above).
Required exclusion	Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.
Optional exclusion	Exclude beneficiaries who meet any of the following criteria: Note: Supplemental and medical record data may not be used for this exclusion. Beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay. - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:

Optional exclusion (continued)	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 discharge date for the stay. - A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above)

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Use codes (see HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The beneficiary 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 beneficiary is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤ 9.0%.

States that use CPT Category II codes to identify numerator compliance for this measure must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the beneficiary is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

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

Exclusions (optional)

Beneficiaries 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 polycystic ovarian syndrome, 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 beneficiary 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 beneficiary had a diagnosis of diabetes.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

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 laboratory data or medical record review.

Note: A lower rate indicates better performance (e.g., 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 beneficiary 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 beneficiary 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 indicator. A distinct numeric result is required for numerator compliance.

Exclusions (optional)

Refer to the Administrative Specification for exclusion criteria. Identify beneficiaries 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.

E. ADDITIONAL NOTES

If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.

MEASURE HVL-AD: HIV VIRAL LOAD SUPPRESSION

Health Resources and Services Administration

A. DESCRIPTION

Percentage of beneficiaries 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 or EHR

Guidance for Reporting:

- This measure applies to beneficiaries 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.
- The denominator includes beneficiaries who have received a medical visit, but not necessarily an HIV viral load test, during the measurement year.
- States may match Medicaid claims data with HIV surveillance data to identify the eligible population and to calculate the numerator and denominator. States that are interested in using HIV surveillance data to calculate this measure may request additional information by emailing MACQualityTA@cms.hhs.gov.
- Include all paid, suspended, pending, and denied claims.
- Medical visits should be conducted by a provider with prescribing privileges (e.g., 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.
- The electronic specifications for FFY 2022 are located at https://targethiv.org/library/eqm.

This measure includes the following coding systems: CPT, ICD-10-CM, 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.
HIV viral load test	The HIV viral load test measures the number of HIV copies in a milliliter of blood.

Measurement year	Calendar year 2021.

C. ELIGIBLE POPULATION

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

The number of beneficiaries age 18 and older with both a diagnosis of HIV (Table HVL-A or Table HVL-B) in the measurement year and at least one medical visit (Table HVL-C or Table HVL-D) in the measurement year. Medical visits that occurred any time during the measurement year should be included in the denominator for this measure; there are no restrictions regarding the date of the visit relative to the date of HIV diagnosis.

Table HVL-A. 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-B. 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-C. 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, 99424, 99426

Table HVL-D. 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 beneficiaries in the denominator with a HIV viral load less than 200 copies/mL (Table HVL-E) at last HIV viral load test during the measurement year.

Table HVL-E. 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 ABUSE OR DEPENDENCE TREATMENT

National Committee for Quality Assurance

A. DESCRIPTION

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

- **Initiation of AOD Treatment**. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis
- **Engagement of AOD Treatment**. Percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- This measure has two reportable age groups (ages 13 to 17 and age 18 and older). For the purpose of Adult Core Set reporting, this measure should be calculated for beneficiaries age 18 and older. States should calculate and report each of the rates for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Two rates are reported: initiation of AOD treatment and engagement of AOD treatment. For each rate, report the following AOD diagnosis cohorts for each age group:
- Alcohol abuse or dependence
- Opioid abuse or dependence
- Other drug abuse or dependence
- Total AOD abuse or dependence

- The total AOD abuse or dependence rate is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. Report beneficiaries with multiple diagnoses on the Index Episode claim only once for the total rate for the denominator.
- Exclude beneficiaries from the denominator for both rates (initiation of AOD treatment and engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

- This measure requires that medication assisted treatment (MAT) services match the diagnosis category of the index episode identified in the denominator in order to count towards the numerator of the engagement rate. Depending on the diagnosis used in the denominator (e.g., opioid abuse or dependence and alcohol abuse and dependence), a corresponding MAT medication should be used to satisfy the numerator.
- NCQA's Medication List Directory (MLD) for Alcohol Use Disorder Treatment Medications and Opioid Use Disorder Treatment Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms137v9.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	January 1 to November 14 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.
Index episode	The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. For ED or observation visits that result in an inpatient stay, the inpatient discharge is the Index Episode.
Dates of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events).
IESD	Index Episode Start Date (IESD). The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification, or ED visit (not resulting in an inpatient stay), the IESD is the date of service. For an inpatient stay or for detoxification that occurred during an inpatient stay, the IESD is the date of discharge. For detoxification (other than detoxification that occurred during an inpatient stay), the IESD is the date of service.

IESD (continued)	For ED and observation visits that result in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort). For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
Negative diagnosis history	A period of 60 days (2 months) before the IESD when the beneficiary had no claims/encounters with a diagnosis of AOD abuse or dependence. For an inpatient stay, use the admission date to determine the Negative Diagnosis History. For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. For direct transfers, use the first admission to determine the Negative Diagnosis History.
Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
AOD diagnosis cohorts	Report the following diagnosis cohorts for each age stratification: • Alcohol abuse or dependence • Opioid abuse or dependence • Other drug abuse or dependence • Total AOD abuse or dependence
Continuous enrollment	60 days (2 months) prior to the IESD through 47 days after the IESD (108 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.

Benefits	Medical, pharmacy, and chemical dependency (inpatient and outpatient). Note: Beneficiaries with detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	New episode of AOD abuse or dependence during the Intake Period. Follow the steps below to identify the eligible population, which is the denominator for both rates. Step 1 Identify the Index Episode. Identify all beneficiaries in the specified age range who during the Intake Period had one of the following: • An outpatient visit, telehealth, intensive outpatient visit, or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: - IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependency Value Set - OUD Weekly Non Drug Service Value Set with Opioid Abuse and Dependence Value Set - OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set - OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set • A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

Event/ diagnosis (continued)	• An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. • A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set) For beneficiaries with more than one episode of AOD abuse or dependence, use the first episode. For beneficiaries whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD. Step 2 Select the Index Episode and stratify based on age and AOD diagnosis cohort. • If the beneficiary has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the beneficiary in the alcohol cohort. • If the beneficiary has a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), place the beneficiary in the opioid cohort. • If the beneficiary has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the beneficiary in the other drug cohort. If the beneficiary has multiple substance use diagnoses for the visit, report the beneficiary in all AOD diagnosis stratifications for which they meet criteria.

Event/ diagnosis (continued)	The total is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. Report beneficiaries with multiple diagnoses on the Index Episode only once for the total rate for the denominator. Step 3 Test for Negative Diagnosis History. Exclude beneficiaries who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set), or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period. For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. Step 4 Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator 1: Initiation of AOD Treatment

Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the beneficiary is compliant.

If the Index Episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the beneficiary is compliant.

If the Index Episode was not an inpatient discharge, the beneficiary must initiate the treatment on the start date of the Index Episode or in the 13 days after the Index Episode (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Identify the admission date for the stay.

- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non Drug Service Value Set)
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set)
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set)
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above), initiation on the same day as the IESD must be with different providers in order to count.

If a beneficiary is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug), or for multiple cohorts, count the beneficiary only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.

Exclude the beneficiary from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Numerator 2: Engagement of AOD Treatment

Step 1

Identify all beneficiaries compliant for the Initiation of AOD Treatment numerator.

For beneficiaries who initiated treatment via an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 2

Identify beneficiaries who had an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (OUD Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

For these beneficiaries, if the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), the beneficiary is numerator compliant for Engagement of AOD Treatment.

Step 3

Identify beneficiaries whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set, see link to the Medication List Directory in Guidance for Reporting above).

These beneficiaries are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

Step 4

Identify the remaining beneficiaries whose initiation of AOD treatment was not a medication treatment event (beneficiaries not identified in step 3).

These beneficiaries are numerator compliant if they meet either of the following:

- At least one engagement medication treatment event
- At least two engagement visits

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement Visits

Any of the following beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and

Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Identify the admission date for the stay.

- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), an opioid treatment service (OUD Weekly Non Drug Service Value Set)

Engagement Medication Treatment Events

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the beneficiary is compliant for multiple cohorts, only count the beneficiary once for the Total Engagement numerator. The Total rate is not the sum of the diagnosis columns.

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.
- 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.
- Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder; therefore, pharmacy claims for methadone are not included in the medication lists for this measure. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.

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

National Committee for Quality Assurance

A. DESCRIPTION

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

- **Advising Smokers and Tobacco Users to Quit**. A rolling average represents the percentage of beneficiaries age 18 and older who were 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 beneficiaries age 18 and older who were 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 beneficiaries age 18 and older who were 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 beneficiaries 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, this measure is not reported. States should note the reason for not reporting as "denominator too small."
- CMS encourages states (or their managed care plans) to submit CAHPS data to the AHRQ CAHPS Database to increase the completeness of Adult Medicaid CAHPS data included in the database. More information about the CAHPS Health Plan Survey Database is available at https://cahpsdatabase.ahrq.gov/HPSurveyGuidance.aspx.

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	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
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 5.1H, Adult Version using a rolling average methodology.

D. QUESTIONS INCLUDED IN THIS MEASURE

Questions		Response Choices
Q32	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 36 Don't know → If Don't know, Go to Question 36
Q33	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
Q34	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
Q35	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.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

- If the denominator is less than 100, this 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), this 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, this measure is not reported.

Advising Smokers and Tobacco Users to Quit

Denominator

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

Q32 = “Every day” or “Some days.”

Q33 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries 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 Q33.

Discussing Cessation Medications

Denominator

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

Q32 = “Every day” or “Some days.”

Q34 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering “Sometimes” or “Usually” or “Always” to Q34.

Discussing Cessation Strategies

Denominator

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

Q32 = “Every day” or “Some days.”

Q35 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries 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 Q35.

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 (that is, where the denominator is less than 100). 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 beneficiaries 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 beneficiaries 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 NCIDDS-AD: NATIONAL CORE INDICATORS SURVEY

National Association of State Directors of Developmental Disabilities Services (NASDDDS) and Human Services Research Institute (HSRI)

A. DESCRIPTION

The National Core Indicators® (NCI®)[1] provide information on beneficiaries' experience and self-reported outcomes of long-term services and supports for individuals with intellectual and/or developmental disabilities (I/DD) and their families. NCI includes an in-person survey, family surveys for parents and guardians of adults and children who receive I/DD supports, and a staff stability survey. For the purpose of the Adult Core Set, only data from the NCI In-Person Survey will be reported. Therefore, the technical specifications for the NCI measure in the Adult Core Set include only the In-Person Survey.

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to Medicaid beneficiaries age 18 and older with intellectual and/or developmental disabilities, receiving at least one service from the state-administered Developmental Disabilities system in addition to case management.
- To begin collecting NCI In-Person Survey data each year, states must complete an annual planning call and work plan with NASDDDS and HSRI (NCI National Team). The work plan identifies the methods for conducting the survey, including any populations being oversampled or excluded from the sample.
- The In-Person Survey can be conducted by either state staff or a contracted survey vendor. States are responsible for assuring all surveyors have received training consistent with NCI requirements and protocols for demonstration of adequate knowledge and skill in carrying out the interview procedures. Portions of the survey may be completed via specific videoconference protocols as specified in Appendix F.
- When reporting this measure for the Adult Core Set, states should document the methods used to conduct the In-Person Survey, including the survey version year (e.g., 2020–2021), who conducted the survey (e.g., state staff or contracted survey vendor), population included in and excluded from the sample (e.g., waiver programs, Intermediate Care Facilities for Individuals with Intellectual Disability [ICF-ID]), and the number of surveys completed in compliance with NCI protocols and certified valid by the surveyor.
- To reduce the burden on states, CMS plans to use data submitted to NASDDDS/HSRI to report state-level performance results for this measure. When reporting this measure, states should document: (1) whether the state submitted raw data to the NCI National Team using the Online Data Entry System (ODESA), and (2) whether the state gave permission for data to be released to CMS for the purpose of Adult Core Set reporting.
- See Appendix F for additional guidance on conducting the NCI In-Person Survey, including sampling and administration protocols. See https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-national-core-indicators-questionnaire.pdf for the NCI In-Person Survey Questionnaire.

[1] National Core Indicators is a registered trademark of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI).

B. ELIGIBLE POPULATION

Age	Age 18 and older as of June 30 of the measurement year.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	June 30 of the measurement year.
Current enrollment	Currently enrolled in Medicaid at the time the survey is completed.
Event/diagnosis	Beneficiaries with intellectual and/or developmental disabilities receiving at least one service through the state-administered Developmental Disabilities system in addition to case management.

C. IMPLEMENTING THE NCI IN-PERSON SURVEY

Administration	Survey must be conducted by the state or a state-contracted third-party vendor according to NCI requirements and protocols.
Collection mode	The Background Information Section of the survey requires states to collect demographic, service, and health care data from administrative records and submit them along with responses from the in-person questionnaire. Sub-section I of the direct-contact section of the NCI In-Person Survey requires in-person or videoconference-based data collection. Sub-section II of the direct-contact section of the NCI In-Person Survey also requires in-person or videoconference-based data collection and permits proxy respondents. Surveys must follow protocols established in NCI trainings and training materials. The NCI In-Person Survey Questionnaire is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-national-core-indicators-questionnaire.pdf.
Sample size	The NCI National Team will work with the state to determine the number of beneficiaries to be surveyed in order to yield at least a 95 percent confidence level and a 5 percent margin of error. The recommended minimum sample size is typically 400 completed surveys but will depend on the size of the eligible population in each state and any additional stratification. See Appendix F for additional guidance on determining the sample size for the NCI In-Person Survey.

D. ADDITIONAL NOTES

The NCI National Team works with new and continuing states on implementation and provides general oversight of NCI activities; states are responsible for the operational administration of the NCI surveys in accordance with NCI requirements and protocols. See https://www.nationalcoreindicators.org/states/ for a list of states currently participating in NCI.

For more information on how to get started with NCI, please contact MACQualityTA@cms.hhs.gov.

MEASURE OHD-AD: USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER

Pharmacy Quality Alliance

A. DESCRIPTION

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, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries 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 January 1 of the measurement year.
- The opioid medications used to calculate this measure are available in the "Value Sets – Medications" tab of the value set directory available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab. This file also contains additional guidance on MME conversion factors.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice or palliative care at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10 codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice may be identified using the codes in the Hospice Encounter Value Set and Hospice Intervention Value Set or Palliative Care Value Set in the "Value Sets – Other"" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
Opioid	See medications listed in Table OHD-A.
Morphine milligram equivalent (MME)	Oral morphine milligram equivalent. The MME conversion factor used to retrospectively calculate daily MME to inform analyses of risks associated with opioid prescribing. MME conversion factors are available in the "Value Sets – Medications" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 90 days before the end of the measurement year (e.g., January 1–October 3).
Opioid Episode	The period of time beginning on the date of the first fill (e.g., IPSD) of an opioid medication during the measurement year and ending on the date of the last fill of any opioid medication plus the days' supply of the last fill during the measurement year, minus 1. If the days' supply extends past the measurement year, the opioid episode length is truncated to the last day of the measurement year (e.g., December 31). The opioid episode must be 90 or more days during the measurement year.
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
Cancer Diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Cancer Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.
Sickle Cell Disease Diagnosis	Any beneficiary with an ICD-10 diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.

Palliative Care	Any beneficiary with an ICD-10 diagnosis code for palliative care, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Palliative Care Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-COB-OHD-value-set-NDC-directory.zip.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/Diagnosis	Use the steps below to determine the eligible population. Step 1 Identify beneficiaries with 2 or more prescription claims for opioids medications (Table OHD-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply. Step 2 Identify beneficiaries with an IPSD on January 1 through October 3 of the measurement year. Step 3 Identify beneficiaries with an opioid episode of 90 or more days during the measurement year. NOTE: Exclude days of supply that occur after the end of the measurement year.

Event/Diagnosis (continued)	Step 4 Exclude beneficiaries who met at least one of the following during the measurement year: • Hospice • Cancer Diagnosis • Sickle Cell Disease Diagnosis • Palliative Care

Table OHD-A. Opioid Medications[a,b]

Benzhydrocodone	Hydrocodone	Morphine	Oxymorphone
Butorphanol	Hydromorphone	Opium	Pentazocine
Codeine	Levorphanol	Oxycodone	Tapentadol
Dihydrocodeine	Meperidine		Tramadol
Fentanyl	Methadone		

[a] Includes combination products

[b] Excludes the following: injectable formulations; opioid cough and cold products; and sufentanil (used in a supervised setting); and all buprenorphine products (as a partial opioid agonist is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Any beneficiary in the denominator with an average daily dosage ≥ 90 Morphine Milligram Equivalent during the opioid episode.

Follow the steps below to identify beneficiaries for the numerator:

Step 1

For each beneficiary in the denominator population, identify all opioid prescription claims during the opioid episode.

Step 2

Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation:

[Strength * (Quantity Dispensed / Days Supply)] * MME conversion factor = MME / day

The “Quantity Dispensed” and “Days Supply” comes from the prescription claim. Strength and MME conversion factor is determined by the NDC code and provided in the “Value Sets – Medications” tab of the value set directory.

Example: 10 mg oxycodone tablets * (120 tablets / 30 days) * 1.5 = 60 MME/day

Step 3

Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days’ supply - 1).

NOTE:

- If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim.
- Apply the MME through to the last day of the opioid episode, e.g., do not include days that extend beyond the end of the opioid episode.

Step 4

For each beneficiary, sum the daily MMEs across all days during the opioid episode.

Step 5

Calculate the average MME across all days during the opioid episode. The average daily MME = total MME / days in opioid episode. Calculate the average daily MME rounded to the nearest hundredth (e.g., 89.97597 is rounded to 89.98).

Step 6

Count the beneficiaries with an average daily dosage ≥ 90.00 MME during the opioid episode.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Center for Disease Control and Prevention CDC Guideline for Prescribing Opioids for Chronic Pain and Guideline Resources.

The MME conversion factor is intended solely for research, analytical purposes, surveillance of population-level medication utilization, and other population-level monitoring purposes. This measure and oral MME conversion factors are NOT intended for any clinical decision-making by clinicians while prescribing opioids. Furthermore, the oral MME conversion factors of opioid analgesics DO NOT constitute any clinical guidance or recommendations for converting patients from one form of opioid analgesic to another. Please consult the manufacturer's full prescribing information for such guidance. For additional clinical guidance on oral MME conversion factors for some opioids commonly prescribed for treatment of chronic pain and additional information on calculations of daily oral MME, please see CDC's provider resources (https://www.cdc.gov/drugoverdose/prescribing/guideline.html#tabs-2-3).

MEASURE OUD-AD: USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of Medicaid beneficiaries ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

- A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1)
- Four separate rates representing the following types of FDA-approved drug products:
  - Buprenorphine (Rate 2)
  - Oral naltrexone (Rate 3)
  - Long-acting, injectable naltrexone (Rate 4)
  - Methadone (Rate 5)

Data Collection Method: Administrative

Guidance for Reporting:

- The measure includes a total rate (Rate 1) and four separate rates for the following four types of FDA-approved drug products:
  - Buprenorphine (Rate 2)
  - Oral naltrexone (Rate 3)
  - Long-acting, injectable naltrexone (Rate 4)
  - Methadone (Rate 5).
- Tables OUD-A and OUD-B are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip. Table OUD-B designates which medications are assigned to the separate rates. Filter on the 'Numerator' column to identify which NDC codes are assigned to each rate.
- The measure uses inpatient, outpatient, residential, long-term care, and pharmacy claims and encounters.
- The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.
- Only formulations with an OUD indication (not pain management) are included in value sets for measure calculation.

This measure includes the following coding systems: HCPCS, NDC, ICD-10-CM, and ICD-10-PCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 years. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/ Diagnosis	Beneficiaries who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in Table OUD-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.
Care settings	Inpatient/hospital, outpatient, emergency department.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

For each beneficiary in the denominator population, follow the steps below to identify beneficiaries for the total numerator and the numerator for each rate.

Numerator 1: Total

Identify beneficiaries with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip.

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.

Numerator 2: Buprenorphine

Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 2 in the Numerator column in Table OUD-B.

Numerator 3: Oral Naltrexone

Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 3 in the Numerator column in Table OUD-B.

Numerator 4: Long-Acting, Injectable Naltrexone

Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 4 in the Numerator column in Table OUD-B.

Numerator 5: Methadone

Identify beneficiaries with evidence of at least one dose of methadone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip. This rate includes HCPCS codes only. There are no NDC codes assigned to this rate.

Rates

The total rate is calculated by dividing the number of beneficiaries with evidence of at least one prescription (Numerator 1) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

To calculate the separate rates for each of the four FDA-approved medications for OUD, divide the Numerator for the medication by the Denominator. For example, to calculate the buprenorphine rate, divide the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Numerator 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

E. ADDITIONAL NOTES

None.

MEASURE PCR-AD: PLAN ALL-CAUSE READMISSIONS

National Committee for Quality Assurance

A. DESCRIPTION

For beneficiaries ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS)
- Count of Observed 30-Day Readmissions
- Count of Expected 30-Day Readmissions

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries ages 18 to 64. Although the HEDIS measure includes stratified reporting by age, for the Adult Core Set, states should calculate and report only the Total rate.
- This measure requires risk adjustment. Risk adjustment guidelines are provided in the administrative specification. Please note that in the risk adjustment tables, clinical conditions (CCs) and hierarchical clinical conditions (HCCs) not listed receive a weight of ZERO (e.g., 0.0000).
- Report the Count of Expected 30-Day Readmissions for this measure to four decimal places.
- As shown in Table PCR-A, the data elements in columns 1, 2, 4, 7, and 8 are reported by the state. The data elements in columns 3, 5, 6, and 9 will be derived from the reported data.
- Supplemental data may not be used for this measure.
- When applying risk adjustment, include all services, whether or not the state paid for them or expects to pay for them (e.g., include denied claims). When identifying all other events, do not include denied services (e.g., only include paid services and services expected to be paid).
- If this measure has a Count of Index Hospital Stays less than 150 and the state chooses not to report this measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, SNOMED, 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 or observation stay with a discharge on or between January 1 and December 1 of the measurement year as identified in the denominator.
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 or observation 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 under step 3, Count of Observed 30-Day Readmissions.
Direct transfer	A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example: • A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer. • A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer. • A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct inpatient stays. • A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer. Direct transfers may occur from and between different facilities and/or different services levels.
Medicaid population	Beneficiaries in the eligible population prior to exclusion of outliers (denominator steps 1-5). The Medicaid population is only used as a denominator for the Outlier rate. Beneficiaries must be ages 18 to 64 as of the earliest Index Discharge Date. The Medicaid population is based on beneficiaries, not discharges. Count beneficiaries only once in the Medicaid population.
Outliers	Beneficiaries in the eligible population with four or more index hospital stays between January 1 and December 1 of the measurement year.
Nonoutliers	Beneficiaries in the eligible population who are not considered outliers.
Classification period	365 days prior to and including an Index Discharge Date.

Risk Adjustment Tables

Table	Table Description
Table CC-Mapping	Discharge Clinical Condition category codes for Risk Adjustment Determination. Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2.
Table HCC–Rank	HCC rankings for Risk Adjustment Determination step 3.
Table HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5.
PCR Risk Adjustment Table, Medicaid	Medicaid primary discharge weights for Risk Adjustment Weighting step 3. Medicaid comorbidity weights for Risk Adjustment Weighting step 4. Medicaid observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5.

Please refer to the HEDIS® MY2021 Volume 2 Risk Adjustment Utilization Tables User Manual for technical detail on table format and content.

Note: The risk adjustment tables and Risk Adjustment Utilization Tables User Manual are available to order free of charge in the NCQA store at https://store.ncqa.org/index.php/catalog/product/view/id/3762/s/hedis-my-2021-risk-adjustment-tables/. Once ordered, the risk adjustment tables can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). The tables needed to calculate this measure are found in both the PCR Risk Adjustment Tables and the RAU Table - PCR Medicaid MY2021 (which includes the CC-Mapping, HCC-Rank, and HCC-Comb tables).

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 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 or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not beneficiaries. Include all acute inpatient or observation stay discharges for nonoutlier beneficiaries who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.

D. ADMINISTRATIVE SPECIFICATION

Count of Index Hospital Stays (IHS)

The eligible population as defined above.

Step 1

Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year.

To identify acute inpatient and observation stay discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

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

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of "direct transfer" above.

Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.

Step 3

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

Step 4

Exclude hospital stays for the following reasons:

- The beneficiary died during the stay.
- Female beneficiaries with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 5

Calculate continuous enrollment.

Step 6

Remove hospital stays for outlier beneficiaries and report these beneficiaries as outliers.

Note: Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier beneficiaries.

Risk Adjustment Determination

For each IHS among nonoutlier beneficiaries, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender.

Observation Stay	Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.
Surgeries	Determine if the beneficiary underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.
Discharge Condition	Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its primary discharge diagnosis, using Table CC-Mapping. For direct transfers, use the primary discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table CC-Mapping.
Comorbidities	Assign Risk Adjustment Comorbidity Category Determination based on all the encounters during the classification period, as described in the Steps for Risk Adjustment Comorbidity Category Determination.

Steps for Risk Adjustment Comorbidity Category Determination

Follow the steps below for Risk Adjustment Comorbidity Category Determination.

Step 1

Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters:

- Outpatient visits (Outpatient Value Set)
- Telephone Visits (Telephone Visits Value Set)
- Observation visits (Observation Value Set)
- ED visits (ED Value Set)
- Inpatient events:
  - Nonacute inpatient encounters (Nonacute Inpatient Value Set)
  - Acute inpatient encounters (Acute Inpatient Value Set)
  - Acute and nonacute inpatient discharges (Inpatient Stay Value Set)

Use the date of service for outpatient, observation, and ED visits. Use the discharge date for inpatient events.

Exclude the primary discharge diagnosis on the index hospital stay (IHS).

Step 2

Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Mapping, available at https://store.ncqa.org/index.php/catalog/product/view/id/3762/s/hedis-

my-2021-risk-adjustment-tables/. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For beneficiaries with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3

Determine Hierarchical Condition Categories (HCCs) for each comorbid CC identified. Refer to Table HCC—Rank, available at https://store.ncqa.org/index.php/catalog/product/view/id/3762/s/hedis-my-2021-risk-adjustment-tables/.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group
- The rank
- The HCC

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4

Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example

Assume a denominator unit with the following comorbid CCs: CC-85, CC-17, and CC-19 (assume no other CCs).

- CC-85 does not have a map to the ranking table and becomes HCC-85.
- HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
- The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Example: Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
Not Applicable (NA)	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18

Ranking Group	CC	Description	Rank	HCC
Diabetes 1 (continued)	CC-19	Diabetes without Complication	3	HCC-19

Step 5

Identify combination HCCs listed in Table HCC—Comb, available at https://store.ncqa.org/index.php/catalog/product/view/id/3762/s/hedis-my-2021-risk-adjustment-tables/.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and congestive heart failure are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the Comorbid HCC columns in Table HCC—Comb and assign any additional HCC conditions.

If there are fully nested combinations, use only the more comprehensive pattern. For example, if the diabetes/CHF combination is nested in the diabetes/CHF/renal combination, count only the diabetes/CHF/renal combination.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a denominator unit can have none, one, or more than one of these added HCCs.

Example:

For a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.

Example: Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	Combination HCC 4	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk Adjustment Weighting

For each IHS among nonoutlier beneficiaries, use the following steps to identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

Step 1	For each IHS discharge that is an observation stay, link the observation stay IHS weight.
Step 2	For each IHS with a surgery, link the surgery weight.

Step 3	For each IHS with a discharge CC Category, link the primary discharge weights.
Step 4	For each IHS with a comorbidity HCC Category, link the comorbidity weights.
Step 5	Link the age and gender weights for each IHS.
Step 6	Sum all weights associated with the IHS (e.g., observation stay status at discharge, presence of surgery, primary discharge diagnosis, comorbidities, age, and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS. $\text{Estimated Readmission Risk} = \frac{e^{(\Sigma Weights for IHS)}}{1 + e^{(\Sigma Weights for IHS)}}$ OR Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)] Note: "Exp" refers to the exponential or antilog function.
Step 7	Calculate the Count of Expected Readmissions. The Count of Expected Readmissions is the sum of the Estimated Readmissions Risk calculated in step 6 for each IHS. *Count of Expected Readmissions* = $\sum$ *(Estimated Readmission Risk)*

Count of Observed 30-Day Readmissions

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

Step 1

Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Identify the admission date for the stay.

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of "direct transfer" above.

Step 3

Exclude acute hospitalizations meeting any of the following criteria on the discharge claim:

- Female beneficiaries with a principal diagnosis of pregnancy (Pregnancy Value Set)
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set)

- Planned admissions using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter 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, Introduction of Autologous Pancreatic Cells Value Set)
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Conditions Value Set)

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 4

For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: Count each acute hospitalization only once toward the numerator for the last denominator event.

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- Acute Inpatient Stay 1: May 1-10
- Acute Inpatient Stay 2: May 15-25 (principal diagnosis of maintenance chemotherapy)
- Acute Inpatient Stay 3: May 30–June 5.

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only toward the last denominator event (Stay 2, May 15-25).

Reporting: Count of Index Hospital Stays (IHS)

Count the number of IHS among nonoutlier beneficiaries and enter this value into the reporting table under Count of Index Stays (Table PCR-A, column 1).

Reporting: Count of 30-Day Readmissions

Count the number of observed IHS among nonoutlier beneficiaries with a readmission within 30 days of discharge and enter this value into the reporting table under Count of Observed 30-Day Readmissions (Table PCR-A, column 2).

Reporting: Count of Expected 30-Day Readmissions

Sum the Expected Readmission Risk for each IHS among nonoutlier beneficiaries to calculate the Count of Expected Readmissions. Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting table (Table PCR-A, column 4).

Reporting: Count of Beneficiaries in Medicaid Population

Determine the beneficiary's age as of the earliest Index Discharge Date.

Report the count of beneficiaries in the Medicaid population and enter this value into the reporting table under Count of Beneficiaries in Medicaid Population (Table PCR-A, column 7).

Reporting: Number of Outliers

Determine the beneficiary's age as of the earliest Index Discharge Date.

Report the count of outlier beneficiaries and enter this value into the reporting table under Number of Outliers (Table PCR-A, column 8).

E. ADDITIONAL NOTES

The following data elements will be calculated based on the five reported data elements:

- Observed Readmission Rate: Count of Observed 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 3).
- Expected Readmission Rate: Count of Expected 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 5).
- Observed-to-Expected Ratio (O/E): Count of Observed 30-Day Readmissions divided by Count of Expected 30-Day Readmissions (Table PCR-A, column 6).
- Outlier Rate: Number of Outliers divided by Count of Beneficiaries in Medicaid Population (Table PCR-A, column 9).
- 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

Table PCR-A. Plan All-Cause Readmissions Rates

	Count of Index Hospital Stays (1)	Count of Observed 30-Day Readmissions (2)	Observed Readmission Rate (3)	Count of Expected 30-Day Readmissions (4)	Expected Readmission Rate (5)	O/E Ratio (Count of Observed 30-Day Readmissions/ Count of Expected 30-Day Readmissions) (6)	Count of Beneficiaries in Medicaid Population (7)	Number of Outliers (8)	Outlier Rate (9)
Total			Calculated		Calculated	Calculated			Calculated

MEASURE PPC-AD: PRENATAL AND POSTPARTUM CARE: POSTPARTUM CARE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that had a postpartum visit on or between 7 and 84 days after delivery.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- For HEDIS, this measure includes a Timeliness of Prenatal Care rate and a Postpartum Care rate. The Child Core Set includes the Timeliness of Prenatal Care rate and the Adult Core Set includes the Postpartum Care rate.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- Refer to Appendix E for definitions of a PCP, OB/GYN, and other prenatal care practitioners.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, 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 60 days after delivery.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/ diagnosis	Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include women who delivered in any setting.

Event/ diagnosis (continued)	Multiple births. Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once. Follow the steps below to identify the eligible population, which is the denominator for the rate. Step 1 Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge. Step 2 Exclude non-live births (Non-live Births Value Set). Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery and 60 days after delivery, with no gaps.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Visits Value Set)
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding 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)

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

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. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

For FFY 2022 Core Set reporting (measurement year 2021), the state may reduce the sample size using the current year's administrative rate or the prior year's rate (FFY 2021 Core Set reporting).

Numerator

A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Administrative Data

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

Medical Record Review

Postpartum visit to an OB/GYN practitioner or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following.

- Pelvic exam
- 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
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
- Glucose screening for women with gestational diabetes
- Documentation of any of the following topics:
  - Infant care or breastfeeding
  - Resumption of intercourse, birth spacing, or family planning
  - Sleep/fatigue
  - Resumption of physical activity
  - Attainment of healthy weight

E. ADDITIONAL NOTES

- Services that occur over multiple visits count toward the measure if all services are within the time frame established in this measure.
- A Pap test is acceptable for the Postpartum Care numerator as evidence of a pelvic exam. A colposcopy alone is not numerator compliant.
- Services provided during a telephone visit, e-visit or virtual check-in are eligible for use in reporting.

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 beneficiary months for beneficiaries age 18 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries 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 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 18 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries 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 at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. 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" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 18 and older as of the 15th or the 30th day of the month. Date for counting beneficiary 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 beneficiaries age 18 and older during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries age 18 and older with ICD-10-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, or coma) (Table PQI01-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip).

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 below for admission codes for transfers)
- Admissions with an ungroupable DRG (DRG = 999)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of diabetes with short-term complications are precluded from assignment of MDC 14 by grouper software. Thus, obstetric discharges 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 (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility (NF)
	6 – Transfer from another health care facility
	F – Transfer from a hospice 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 beneficiary months for beneficiaries age 40 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries 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 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 40 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 40 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries 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-C, 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 at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. 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" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 40 and older as of the 15th or the 30th day of the month. Date for counting beneficiary 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 beneficiaries age 40 and older during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries age 40 and older with an ICD-10-CM principal diagnosis code for:

- COPD (Table PQI05-A), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip or
- Asthma (Table PQI05-B), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip

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-C below for admission codes for transfers)
- Admissions with an ungroupable DRG (DRG = 999)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of COPD, asthma, or acute bronchitis are precluded from assignment of MDC 14 by grouper software. Thus, obstetric discharges should not be considered in the PQI rate.)
- Cases with any listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Table PQI05-D, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip)

Table PQI05-C. 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 (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility (NF)
	6 – Transfer from another health care facility
	F – Transfer from a hospice facility

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 beneficiary months for beneficiaries age 18 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries 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 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 18 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries 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 at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. 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" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM, ICD-10-PCS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 18 and older as of the 15th or the 30th day of the month. Date for counting beneficiary 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 beneficiaries age 18 and older during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries age 18 and older with ICD-10-CM principal diagnosis code for heart failure (Table PQI08-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip).

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 below for admission codes for transfers)
- Admissions with an ungroupable DRG (DRG = 999)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of heart failure are precluded from assignment of MDC 14 by grouper software. Thus, obstetric discharges should not be considered in the PQI rate.)
- Cases with any listed ICD-10-PCS procedure codes for cardiac procedure (Table PQI08-C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip)

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 (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility (NF)
	6 – Transfer from another health care facility
	F – Transfer from a hospice facility

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 beneficiary months for beneficiaries ages 18 to 39.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was ages 18 to 39 on that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries 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 at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. 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" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries ages 18 to 39 as of the 15th or the 30th day of the month. Date for counting beneficiary 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 beneficiaries ages 18 to 39 during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries ages 18 to 39 with an ICD-10-CM principal diagnosis code of asthma (Table PQI15-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip).

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 below for admission codes for transfers)
- Admissions with an ungroupable DRG (DRG = 999)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of asthma are precluded from assignment of MDC 14 by grouper software. Thus, obstetric discharges should not be considered in the PQI rate.)
- Cases with any listed ICD-10-CM diagnosis code for cystic fibrosis and anomalies of the respiratory system (Table PQI15-C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-non-hedis-value-set-directory.zip)

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 (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility
	6 – Transfer from another health care facility
	F – Transfer from a hospice facility

MEASURE SAA-AD: ADHERENCE TO ANTIPSYCHOTIC MEDICATIONS FOR INDIVIDUALS WITH SCHIZOPHRENIA[1]

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder 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:

- If an oral medication and a long-acting injection 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.
- If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward the numerator.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for Dementia Medications, Oral Antipsychotic Medications, and Long-Acting Injections is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

IPSD	Index Prescription Start Date (IPSD). 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 a beneficiary is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.

[1] Adapted by NCQA with permission of the measure developer, CMS.

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 medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to determine if the drugs are the same or different. Drugs in different lists are considered different drugs.
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	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. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator. 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). Use the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to determine if the drugs are the same or different. Drugs in different lists are considered different drugs.
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 the medication list or in the value set name. 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.

Note: If an oral medication and a long-acting injection 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.

If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward the numerator.

C. ELIGIBLE POPULATION

Age	Ages 18 and older as of January 1 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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary 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	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries with schizophrenia or schizoaffective disorder as those who met at least one of the following criteria during the measurement year: • At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder. Either of the following code combinations meets criteria: - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set • 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 or schizoaffective disorder. Two of any of the following meets criteria: - An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Outpatient POS Value Set with Schizophrenia Value Set) - An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (BH Outpatient Value Set with Schizophrenia Value Set) - An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set with Schizophrenia Value Set) - An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Partial Hospitalization or Intensive Outpatient Value Set with Schizophrenia Value Set)

Event/ diagnosis (continued)	- A community mental health center visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set with Schizophrenia Value Set) - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) - An observation visit (Observation Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) - An ED visit (ED Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) - An ED visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with ED POS Value Set with Schizophrenia Value Set) - A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) - A nonacute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set with Schizophrenia Value Set) - A telehealth visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Telehealth POS Value Set with Schizophrenia Value Set) - A telephone visit (Telephone Visits Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) - An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) Step 2: Required Exclusions Exclude beneficiaries who met at least one of the following during the measurement year: • A diagnosis of dementia (Dementia Value Set) • 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 (Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set; Long Acting Injections 30 Days Supply Value Set) - Pharmacy data. Dispensed an antipsychotic medication on an ambulatory basis. Use all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections (see Medication List table below and link to the Medication List

	Directory in Guidance for Reporting above) to identify antipsychotic medication dispensing events
Optional exclusions	Exclude beneficiaries who meet any of the following criteria: Note: Supplemental and medical record data may not be used for the following exclusions. • Beneficiaries ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay. o At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) o At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay. o A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above) • Beneficiaries age 81 and older as of December 31 of the measurement year with frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.

Oral Antipsychotic Medications

Description	Prescription	Medication Lists
Miscellaneous antipsychotic agents (oral)	Aripiprazole	Aripiprazole Oral Medications List
	Asenapine	Asenapine Oral Medications List
	Brexpiprazole	Brexpiprazole Oral Medications List
	Cariprazine	Cariprazine Oral Medications List
	Clozapine	Clozapine Oral Medications List
	Haloperidol	Haloperidol Oral Medications List
	Iloperidone	Iloperidone Oral Medications List
	Loxapine	Loxapine Oral Medications List
	Lurasidone	Lurasidone Oral Medications List
	Molindone	Molindone Oral Medications List
	Olanzapine	Olanzapine Oral Medications List
	Paliperidone	Paliperidone Oral Medications List
	Quetiapine	Quetiapine Oral Medications List
	Risperidone	Risperidone Oral Medications List
	Ziprasidone	Ziprasidone Oral Medications List
Phenothiazine antipsychotics (oral)	Chlorpromazine	Chlorpromazine Oral Medications List
	Fluphenazine	Fluphenazine Oral Medications List
	Perphenazine	Perphenazine Oral Medications List
	Prochlorperazine	Prochlorperazine Oral Medications List
	Thioridazine	Thioridazine Oral Medications List
	Trifluoperazine	Trifluoperazine Oral Medications List
Psychotherapeutic combinations (oral)	Amitriptyline-perphenazine	Amitriptyline Perphenazine Oral Medications List
Thioxanthenes (oral)	Thiothixene	Thiothixene Oral Medications List

Long-Acting Injections

Description	Prescription	Medication Lists
Long-acting injections 14 days supply	Risperidone (excluding Perseris®)	Long Acting Injections 14 Days Supply Medications List
Long-acting injections 28 days supply	Aripiprazole Fluphenazine decanoate	Long Acting Injections 28 Days Supply Medications List

Description	Prescription	Medication Lists
Long-acting injections 28 days supply (continued)	Haloperidol decanoate Olanzapine Paliperidone palmitate	
Long-acting injections 30 days supply	Risperidone (Perseris®)	Long Acting Injections 30 Days Supply Medications List

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries who achieved a PDC of at least 80 percent for their antipsychotic medications during the measurement year.

Follow the steps below to identify numerator compliance. Use the Long Acting Injections 14 Days Supply Value Set; Long Acting Injections 28 Days Supply Value Set; Long Acting Injections 30 Days Supply Value Set and all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections (see Medication List table above and link to the Medication List Directory in Guidance for Reporting above) to identify antipsychotic medication dispensing events.

Step 1

Identify the IPSD. The IPSD is the earliest dispensing event 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 during the treatment period. To ensure that days supply that extend beyond the measurement year are not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4

Calculate the beneficiary's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a beneficiary has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{Total\ days\ \text{cov}ered\ by\ antipscyhotic\ medication\ in\ the\ treatment\ \ period\ (Step\ 3)}{Total\ days\ in\ treatment\ \ period\ (Step\ 2)}$$

Step 5

Sum the number of beneficiaries 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 beneficiaries ages 18 to 64 with schizophrenia, schizoaffective disorder, 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:

- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.
- NCQA's Medication List Directory (MLD) for SSD Antipsychotic Medications and Diabetes Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory) . Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, Modifier, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 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 beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary 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 beneficiaries with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year: • At least one acute inpatient encounter with any diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. Any of the following code combinations meet criteria: - BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set • At least two of the following, on different dates of service, where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) or both encounters have any diagnosis of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) - An outpatient visit (Visit Setting Unspecified Value Set) with Outpatient POS Value Set - An outpatient visit (BH Outpatient Value Set) - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) - An observation visit (Observation Value Set) - An ED visit (ED Value Set) - An ED visit (Visit Setting Unspecified Value Set with ED POS Value Set) - A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) - A nonacute inpatient encounter (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set) - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) - A telephone visit (Telephone Visits Value Set) - An e-visit or virtual check-in (Online Assessments Value Set) Step 2: Required exclusions Exclude beneficiaries who met any of the following criteria:

Event/ diagnosis (continued)	• Beneficiaries with diabetes. There are two ways to identify beneficiaries with diabetes: by claims/encounter data and by pharmacy data. The state must use both methods to identify beneficiaries with diabetes, but a beneficiary need only be identified by one method to be excluded from the measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. - Claim/encounter data. Beneficiaries 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): o At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) without (Telehealth Modifier Value Set; Telehealth POS Value Set) o At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge: 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 discharge date for the stay. o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge: 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 discharge date for the stay. Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) - Pharmacy data. Beneficiaries who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year on an ambulatory basis (Diabetes Medications List, see link to the Medication List Directory in Guidance for Reporting above)

Event/ diagnosis (continued)	• Beneficiaries who had no antipsychotic medications dispensed during the measurement year. 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. - Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set) - Pharmacy data. Dispensed an antipsychotic medication (SSD Antipsychotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) on an ambulatory basis

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

A glucose test (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or an HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year.

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

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A. What is the HEDIS Adult Core Set 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 HEDIS Adult Core Set Value Set Directory (VSD) includes all value sets and codes needed to report HEDIS measurement year 2021 measures included in the 2022 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:

- Copyright & Licensing
- Adult Measures to Value Sets*
- Adult Value Sets to Codes*
- Summary of Changes – Codes
- Summary of Changes – Value Sets

* Elements are based on those included in the National Library of Medicine Value Set Authority Center (VSAC) standardized value set file. Not all elements are needed for Adult Core Set reporting.

C. What's New in the Value Set Directory?

There are no significant changes to the 2022 VSD. Refer to the Summary of Changes spreadsheets for changes to codes or value sets.

D. Adult Measures to Value Sets

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

Table A.1. Adult Measures to Value Sets

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

Use the Adult 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 "CHL-AD" demonstrates that the Chlamydia Screening in Women Ages 21 to 24 measure uses the following value sets:

Measure ID	Measure Name	Value Set Name	Value Set OID
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Chlamydia Tests	2.16.840.1.113883.3.464.1004.1060
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Diagnostic Radiology	2.16.840.1.113883.3.464.1004.1081
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Pregnancy	2.16.840.1.113883.3.464.1004.1219
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Pregnancy Test Exclusion	2.16.840.1.113883.3.464.1004.1344
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Pregnancy Tests	2.16.840.1.113883.3.464.1004.1221
CHL-AD	Chlamydia Screening in Women Ages 21 to 24	Sexual Activity	2.16.840.1.113883.3.464.1004.1238

Setting the Value Set Name filter to “Cervical Cytology Lab Test” 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 Lab Test	2.16.840.1.113883.3.464.1004.1525
PPC-AD	Postpartum Care Rate	Cervical Cytology Lab Test	2.16.840.1.113883.3.464.1004.1525

E. Adult Value Sets to Codes

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

Table A.2. Adult 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	Version date for the value set (11/15/2021 for federal fiscal year 2022 reporting).
Code	The code.

Element Name	Element Description
Definition	The code definition. Note: The definition is not included for Uniform Bill, CPT-CAT-II, or CPT codes due to licensing restrictions.
Code System	The code system for the code. Code systems are labeled as: • CPT: Current Procedural Terminology • CPT-CAT-II: Current Procedural Terminology Category II Codes • 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: Logical Observation Identifiers Names and Codes • Modifier: Current Procedural Terminology and HCPCS Modifier Codes • POS: CMS Place of Service • SNOMED CT US Edition: Systematized Nomenclature of Medicine—Clinical Terms US Edition • UBREV: Uniform Bill (Revenue codes) • UBTOB: Uniform Bill (Type of Bill codes)
Code System OID	Unique identifier for the code system, if available
Code System Version	Code system version tracking number, if available

Use the Adult 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 “Absence of Left Breast” 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
Absence of Left Breast	2.16.840.1.113883.3.464.1004.1329	11/15/2021	Z90.12	[Z90.12] Acquired absence of left breast and nipple	ICD10CM	2.16.840.1.113883.6.90	2021.2.20AB
Absence of Left Breast	2.16.840.1.113883.3.464.1004.1329	11/15/2021	429009003	History of left mastectomy (situation)	SNOMED CT US Edition	2.16.840.1.113883.6.96	2020.09.20AA
Absence of Left Breast	2.16.840.1.113883.3.464.1004.1329	11/15/2021	137671000119105	History of prophylactic mastectomy of left breast (situation)	SNOMED CT US Edition	2.16.840.1.113883.6.96	2020.09.20AA

Setting the Code filter to “Z90.11” 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
Absence of Right Breast	2.16.840.1.113883.3.464.1004.1330	11/15/2021	Z90.11	[Z90.11] Acquired absence of right breast and nipple	ICD10CM	2.16.840.1.113883.6.90	2021.2.20AB
Acute Condition	2.16.840.1.113883.3.464.1004.1324	11/15/2021	Z90.11	[Z90.11] Acquired absence of right breast and nipple	ICD10CM	2.16.840.1.113883.6.90	2021.2.20AB

F. Summary of Changes – Codes

The Summary of Changes – Codes spreadsheet lists code changes in FFY 2022 by value set and includes the elements in Table A.3.

Table A.3. Summary of Changes – Codes

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.

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 "Bipolar Disorder" demonstrates deleted codes.

Value Set	Change	Code System	Code
Bipolar Disorder	Deleted	SNOMED CT US Edition	191632009

Codes for new value sets are not listed individually (as Added) in the Summary of Changes – Codes spreadsheet.

Codes for deleted value sets are not listed individually (as Deleted) in the Summary of Changes – Codes spreadsheet.

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

G. Summary of Changes – Value Sets

The Summary of Changes – Value Sets spreadsheet lists the FFY 2022 changes to value sets and includes the elements in Table A.4.

Use the Summary of Changes – Value Sets spreadsheet to identify revised, added or deleted value sets.

Table A.4. Summary of Changes – Value Sets

Element Name	Element Description
Value Set Name	The name of the affected value set.
Change	The change (Added; Deleted; Revised).
Description	Describes the affected measures or, for renamed value sets, the new value set name.
Revised	Changes are identified by a revised date.

For FFY 2022 there were no revised, added, or deleted value sets.

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. States may use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the sample size. 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.

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

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
≤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

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
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

Notes: Table B.1 reflects the minimum sample size. When reducing, a state's sample size may be between the allowed minimum sample size in Table B.1 and 411.

States that report using socioeconomic status (SES) categories must use the total rate for sample size reduction, not the cohort rates based on SES stratification.

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 5.1H (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 2022 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 2022 Adult Core Set is the CAHPS Health Plan Survey 5.1H (Medicaid).[2] Appendix D contains the survey instrument.

B. Contracting with a Survey Vendor

To adhere to CAHPS 5.1H measure specifications, states must follow the HEDIS protocol, which includes creating a sample frame and contracting with a NCQA-certified HEDIS measurement year (MY) 2021 survey vendor to administer the survey. The survey vendor draws the actual samples and fields the survey.

NCQA maintains a list of survey vendors that have been trained and certified to administer the CAHPS 5.1H 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 MY 2021 survey vendors is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-1h-survey-certification/vendor-directory/.

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.

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

[2] AHRQ is the measure steward for the survey instrument and NCQA is the developer of the survey administration protocol.

Table C.1. Eligible Population for Adult CAHPS 5.1H (Medicaid)

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	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Source: HEDIS MY 2021 Volume 3: Specifications for Survey Measures (https://store.ncqa.org/hedis-my-2021-volume-3-epub.html)

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 beneficiaries 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. The survey vendor must use the deduplication method included in HEDIS MY 2021 Volume 3 before pulling the systematic 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 eligible 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 eligible 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 goal of 411 completed surveys, the survey vendor should oversample. 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. The survey vendor will work with the state to determine an appropriate sampling strategy. For a detailed discussion of oversampling, see "HEDIS MY 2021 Volume 3: Specifications for Survey Measures," Appendix 7, "General Recommendations for Oversampling Survey Measures."

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 5.1H survey specifications, the state's survey vendor must follow one of the standard CAHPS 5.1H survey protocols. The state will have to work with its survey vendor to select one of two standard options for administering HEDIS CAHPS surveys:

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

The basic tasks and time frames for the two protocol options are detailed in Tables C.2 and C.3. 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 selected data collection protocol is exhausted. Achieving the targeted number of completed surveys does not justify ceasing the survey protocol.

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

Table C.2 Mail-Only Methodology

Survey Vendor Tasks	Time Frame
Send first questionnaire and cover letter to the surveyed adult	0 days
Send a postcard reminder to non-respondents 4–10 days after mailing the first questionnaire	4–10 days
Send a second questionnaire and second cover letter to non-respondents approximately 35 days after mailing the first questionnaire	35 days
Send a second postcard reminder to non-respondents 4–10 days after mailing the second questionnaire	39–45 days
Send a third questionnaire and third cover letter to non-respondents approximately 25 days after mailing the second questionnaire	60 days
Allow at least 21 days for the third questionnaire to be returned by the respondent	81 days

Source: HEDIS MY 2021 Volume 3: Specifications for Survey Measures.

Table C.3 Mixed Methodology

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

Source: HEDIS MY 2021 Volume 3: Specifications for Survey Measures.

F. Completion Criteria

The survey vendors assigns a disposition code of Complete and Eligible when the following conditions are met:

- Responses indicate that the beneficiary meets the eligible population criteria
- Three of the five questions listed in the table below are answered appropriately

Survey Type	Questions for Complete and Eligible Survey				
Adult Medicaid	Q3	Q10	Q19	Q23	Q28

G. For Further Information

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

Information about the NCQA's HEDIS Survey Vendor Certification program can be found at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-1h-survey-certification/vendor-directory/.

Information on "HEDIS MY 2021 Volume 3: Specifications for Survey Measures" is available at https://store.ncqa.org/hedis-my-2021-volume-3-epub.html.

Appendix D:
CAHPS® Health Plan Survey 5.1H
Adult Questionnaire (Medicaid)

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CAHPS® 5.1H 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?

1☐ Yes → **If Yes, Go to Question 3**

2☐ 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 from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video. 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?

1☐ Yes

2☐ 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?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

5. In the last 6 months, did you make any in person, phone, or video appointments for a check-up or routine care?

1☐ Yes

2☐ 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 as soon as you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you get health care for yourself in person, by phone, or by video?

0☐ None → **If None, Go to Question 10**

1☐ 1 time

2☐ 2

3☐ 3

4☐ 4

5☐ 5 to 9

6☐ 10 or more times

8. 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?

00☐ 0 Worst health care possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best health care possible

9. 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

10. A personal doctor is the one you would talk to 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 19**

11. In the last 6 months, how many times did you have an in person, phone, or video visit with your personal doctor about your health?

0☐ None → **If None, Go to Question 18**

1☐ 1 time

2☐ 2

3☐ 3

4☐ 4

5☐ 5 to 9

6☐ 10 or more times

12. 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

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

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

14. 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

15. In the last 6 months, how often did your personal doctor spend enough time with you?

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

16. 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 18**

17. 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

18. 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, include the care you got in person, by phone, or by video. Do not include dental visits or care you got when you stayed overnight in a hospital.

19. 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 with a specialist?

1☐ Yes

2☐ No → **If No, Go to Question 23**

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

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

21. How many specialists have you talked to in the last 6 months?

0☐ None → **If None, Go to Question 23**

1☐ 1 specialist

2☐ 2

3☐ 3

4☐ 4

5☐ 5 or more specialists

22. We want to know your rating of the specialist you talked to 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.

23. In the last 6 months, did you get information or help from your health plan's customer service?

1☐ Yes

2☐ No → **If No, Go to Question 26**

24. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

25. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

26. In the last 6 months, did your health plan give you any forms to fill out?

1☐ Yes

2☐ No → **If No, Go to Question 28**

27. In the last 6 months, how often were the forms from your health plan easy to fill out?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

28. 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?

00☐ 0 Worst health plan possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best health plan possible

ABOUT YOU

29. In general, how would you rate your overall health?

1☐ Excellent
2☐ Very Good
3☐ Good
4☐ Fair
5☐ Poor

30. In general, how would you rate your overall mental or emotional health?

1☐ Excellent
2☐ Very Good
3☐ Good
4☐ Fair
5☐ Poor

31. Have you had either a flu shot or flu spray in the nose since July 1, 2021?

1☐ Yes
2☐ No
3☐ Don't know

32. 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 36**
4☐ Don't know → **If Don't know, Go to Question 36**

33. 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

34. 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

35. 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

36. What is your age?

1☐ 18 to 24
2☐ 25 to 34
3☐ 35 to 44
4☐ 45 to 54
5☐ 55 to 64
6☐ 65 to 74
7☐ 75 or older

37. Are you male or female?

1☐ Male
2☐ Female

38. What is the highest grade or level of school that you have completed?

1☐ 8th grade or less
2☐ Some high school, but did not graduate
3☐ High school graduate or GED
4☐ Some college or 2-year degree
5☐ 4-year college graduate
6☐ More than 4-year college degree

39. Are you of Hispanic or Latino origin or descent?

1☐ Yes, Hispanic or Latino
2☐ No, Not Hispanic or Latino

40. What is your race? Mark one or more.

a☐ White
b☐ Black or African-American
c☐ Asian
d☐ Native Hawaiian or other Pacific Islander
e☐ American Indian or Alaska Native
f☐ Other

THANK YOU

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

Appendix E: Definitions of Medicaid/CHIP Core Set Practitioner Types

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Practitioner Type	Definition
Mental Health Provider	A provider who delivers mental health services and meets any of the following criteria: • 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) • A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry. • A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).

Practitioner Type	Definition
Mental Health Provider (continued)	- Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria: o The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act) o The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or country in which it is located - Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria: o Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a)(42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC o Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grants or funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC
Obstetrician/Gynecologist (OB/GYN) and Other Prenatal Care Practitioner	Includes: • 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 • Certified nurse midwives, nurse practitioners, and physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)
Primary Care Practitioner (PCP)	A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHCs) are considered PCPs.

Practitioner Type	Definition
Primary Care Practitioner (PCP) (continued)	• To be certified as an FQHC, an entity must meet any one of the following criteria: - Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements - Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration - Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990 - Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991 • For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): - Provide comprehensive services and have an ongoing quality assurance program - Meet other health and safety requirements - Not be concurrently approved as a Rural Health Clinic (RHC) o Only certified RHCs are considered PCPs o To be certified as a RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
Prescribing Practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications

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Appendix F: Guidance for Conducting the National Core Indicators® (NCI®) In-Person Survey (IPS)

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The National Core Indicators® (NCI®)[1] provide information on beneficiaries' experience and self-reported outcomes of long-term services and supports for individuals with intellectual and/or developmental disabilities (I/DD) and their families. This appendix provides additional guidance to states about NCI, including information on the NCI Survey used for Adult Core Set reporting, state responsibilities and coordination with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) (NCI National Team), determining a sample frame, generating a sample, and conducting the survey using standard protocols.

A. NCI Survey for Adult Core Set Reporting

NCI is a family of surveys designed to assess the experiences and outcomes of individuals with I/DD (and their families) who receive services from their state Developmental Disabilities (DD) system. The NCI Survey specified in the Adult Core Set is the NCI In-Person Survey (IPS). The survey instrument includes a Background Information Section and two direct-contact sections, conducted directly with the person receiving DD system supports and a proxy, if applicable. The Background Information Section gathers fact-based data about the individual from existing records or documents (such as case management records, state databases, etc.).

The direct-contact section includes two sub-sections, both of which may be completed via specific video conference protocols. Sub-section I includes perception-based questions that can only be answered by the person receiving DD service system supports from the state. Sub-section II includes objective, fact-based questions that can be answered by the person receiving supports from the state or, if needed, a proxy respondent who knows the person well. The full survey instrument is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-national-core-indicators-questionnaire.pdf.

States have the option to tailor the survey by customizing some language used in the survey (using terms most common in the state such as 'service coordinator' or 'support coordinator') and/or adding up to 10 state-specific questions, complementary. States cannot remove questions from the In-Person Survey. Any requested changes to the survey should be detailed in the state work plan (described below) and approved by the NCI National Team. NCI reserves the right to deny changes if they alter the intent of the question and/or compromise the comparability of a state's data.

B. State Responsibilities and Coordination with the NCI National Team

The NCI National Team works with new and continuing states on implementation of the NCI and provides general oversight of NCI activities. The NCI National Team consults and collaborates with state agency partners with respect to operations, content focus, data and product development, research, and other related activities. Participation dues are determined by the NASDDDS Board of Directors each year.

States are responsible for the operational administration of the NCI surveys. This includes:

- Managing the project at the state level, with technical assistance from NASDDDS and HSRI. A yearly work plan and yearly planning call must be completed with the NCI National Team. This is usually completed in the fall of each data cycle.

[1] National Core Indicators is a registered trademark of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI).

  - The annual NCI Work Plan identifies which surveys will be completed in the year and the sampling method for each, including any populations being oversampled or excluded from the sample.

- Completing the In-Person Survey Background Crosswalk, where state agency partners identify the potential data source for each question in the Background Information section of the survey.
- Assuring awareness of and complying with NCI policies and procedures including, but not limited to: (1) survey administration, (2) survey methodology (e.g., sampling, surveyor competency requirements), (3) maintaining the confidentiality of the survey respondents, and (4) protocols for conducting remote surveys using videoconference technology.
- Preparing an In-Person Survey sample that will reach the 95% confidence level and 5% margin of error, with consultation from the NCI National Team.
- Collecting specified background information on each individual surveyed.
- Ensuring all surveyors have received training consistent with NCI requirements for demonstration of adequate knowledge and skill in carrying out the survey procedures.
- Conducting face-to-face or videoconference surveys using the In-Person Survey tool.
- Entering raw data and submitting complete data files to HSRI in accordance with established timelines.
  - Raw data must be retained until the final data reports are released. States may need to refer to the raw data if the NCI National Team request verification.
  - Each year, all In-Person Survey data must be completed and submitted by June 30 using the Online Data Entry System (ODESA).
- Keeping the NCI National Team informed of changes in state contact information (e.g., state agency partners currently working on NCI and updated email addresses) as well as any revisions that have been made to the state's work plans, timelines, or the data being gathered.
- Reviewing draft reports for accuracy and providing comments and feedback to the NCI National Team within specified timelines.

C. Generating a Sample Frame

States are responsible for generating a complete, accurate, and valid sample frame data file that is representative of the eligible population (Table H.1). States are required to work closely with the NCI National Team as they design their sample.

Table H.1. Eligible Population for In-Person Survey

Age	Age 18 and older as of June 30 of the measurement year.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	June 30 of the measurement year.
Current enrollment	Currently enrolled in Medicaid at the time the survey is completed.

Event/diagnosis	Beneficiaries with intellectual and/or developmental disabilities receiving at least one service through the state-administered Developmental Disabilities system in addition to case management.

States must generate a sample frame data file for fielding the In-Person Survey. States are strongly encouraged to generate the sample frame after eliminating disenrolled and deceased beneficiaries and updating eligibility files with address and telephone number corrections. When sampling, keep the following in mind:

- Any adult age 18 or older who receives at least one service in addition to case management from the state-administered Developmental Disabilities system is eligible to be surveyed. No exclusions should be made before sampling based on, for example, geography or level of disability.
- States may include adults who received only state-funded I/DD services in their sampling frame. However, states must identify surveys completed by adults who are not enrolled in Medicaid at the time of the survey and must ensure that their final sample meets the requirements described below after excluding respondents without Medicaid coverage.
- The sample frame should represent all adults that meet the eligibility criteria specified in Table H.1.

Additional guidance about generating the sample frame is available at: https://www.nationalcoreindicators.org/upload/core-indicators/Quality_Sample_Guide_March_061.pdf

D. Drawing the Sample

The state (or a survey vendor contracted by the state) is responsible for drawing the survey sample pool from the sampling frame. Each state's final sample of surveys completed in compliance with NCI protocols and certified valid by the surveyor must reach the 95 percent confidence level and 5 percent margin of error based on the total eligible, Medicaid-enrolled population served by the state. Typically, this is 400 surveys, but may be in lower in states with a small eligible population. Because it is expected that there will be some refusals and/or inaccurate or outdated contact information, the sample pool should be larger than 400 to allow for replacement.

Oversampling

If the state wants to examine sub-populations (for example in a particular waiver program or by region), there may be a need to oversample a population or stratify the sample to assure the sample is statistically valid for comparative purposes.

E. Survey Administration

Data collection strategies are standardized across all states, regardless of the personnel used to carry out the direct-contact sections (independent contractors contracted by the state or state staff). All surveyors are taught the data collection protocols through formal trainings using materials developed by the NCI National Team. The survey data are recorded online using a data entry system called ODESA. These requirements promote both the standardized administration of the survey instrument by different states and survey vendors and the comparability of resulting data. As described above, the survey instrument includes a

Background Information Section and two direct-contact sections conducted directly with the person receiving DD system supports (and a proxy, if applicable).

Background Information Section

The completion of this section is critical for the validity of NCI. These data should come from administrative records and are collected separately from the direct-contact sections. States may choose to give case managers or agency staff limited access to ODESA to enter background information directly into the system.

Direct-Contact Sections

Data for sub-section I and sub-section II of the In-Person Survey are collected through direct surveys of service participants. On average, it takes between 45 and 60 minutes to conduct the direct-contact sections of the In-Person Survey. States are responsible for identifying surveyors. Surveyors must not have a personal connection with the individual to be surveyed, which precludes service providers, relatives, and case managers from conducting the surveys with individuals they know.

States are responsible for assuring all surveyors and training staff have received training consistent with NCI requirements for demonstration of adequate knowledge and skill in carrying out the survey procedures. NCI National Team members have created self-paced, online training modules for surveyors, and will consult with new states, states with all-new surveyors, states with new NCI state coordinators, and any states needing training assistance to be sure that surveyors receive training that will ensure consistent surveying approaches.

In addition, a live, webinar-based training conducted by the state's lead trainer (with NCI National Team assistance, if necessary) is required to go over state-specific training needs.

Data Entry

ODESA is the web-based platform that all states use to enter survey data for the In-Person Survey. Every year ODESA is updated to reflect the current year’s survey tools. Survey data must be entered into ODESA by June 30 of each year. The ODESA application resides on a secure server and requires unique log-in information for each user.

Steps to Prepare for Survey Administration

The NCI National Team is available to provide guidance at all stages of data collection. The following steps should help guide states in preparing for survey administration:

1. Decide whether the state will add questions/customizations to the In-Person Survey. Communicate with the NCI National Team about these customizations to understand timelines for approval and ODESA customization.
2. Understand state requirements for gathering consent from individuals receiving services and guardians, if necessary.
3. Determine whether the state will conduct surveys using a face-to-face and/or remote (videoconference) protocol.
4. Distribute training materials and schedule a live, webinar training.
5. Decide on a strategy for coordinating survey schedules, including assigning surveys to surveyors (the ODESA platform supports these administrative functions). Set a timeline for scheduling surveys and figure out whether scheduling will be conducted at the same time consent is obtained.
6. Determine a strategy for engaging interpreters and/or using the translations of the NCI surveys if necessary.
7. Set a date when surveys will begin and will be completed.

8. Determine who will enter data from completed surveys into ODESA and when. This includes setting up ODESA accounts, training data enterers, etc.
9. Ensure that refusals, incompletes, inaccurate contacts, etc. will be tracked (this should be tracked in ODESA).
10. Understand how surveyors will contact and gain access to individuals living in settings where they do not have direct access to a phone.
11. Determine how to ensure participation when there is a lack of technology or support and face-to-face surveys are not possible.
12. Understand how the state will address systemic disparities in the populations that have access to, and respond to the survey.
13. Determine whether surveyors will present a badge or show any other kind of official document.
14. Identify or develop state-specific leave-behind documents for surveyors to leave with people or email, such as useful numbers to call to address unmet need, etc.
15. Identify how quality oversight and monitoring of survey administration will be accomplished.
16. Determine the protocol for reporting abuse and/or neglect, if indicated or suspected during the survey.

F. For More Information

More information about the National Core Indicators and the In-Person Survey is available at https://www.nationalcoreindicators.org/. The website contains state pages with relevant information about the NCI contact in the state, the state history with NCI, and recent state reports. The resources section of the website is where all reports are published online, including data briefs and technical guides. The full survey instrument is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-national-core-indicators-questionnaire.pdf.