Summary of Updates to the Initial Core Set Measures Technical Specifications and Resource Manual – November 2012

Section/Measure	Page(s)	Type	Change
All	n/a	Change	Updated reporting dates to December 31, 2012, reporting year to FFY 2012, and data collection timeframe to 2011.
All	n/a	Change	Updated HEDIS copyright and table sources information to HEDIS 2012 for all measures.
All	n/a	Change	Modified measure names to align with CARTS.
I. The Initial Core Set of Children's Health Care Quality Measures			
Identifying the Initial Core Set	1-2	Change	Modified text: • Additional information about the initial core set measures can be found in a February 2011 State Health Official letter (http://www.cms.gov/smdl/downloads/SHO11001.pdf). • CHIPRA, which added Section 1139A (b)(5) of the Social Security Act, requires the Secretary to publish recommended changes to the core set measures beginning in January 2013. These changes to the core set measures may include adding and/or retiring measures. CMS will release changes to the 2013 core set through a state health official letter. • Other related quality measurement activities can be found on Medicaid.gov (http://www.medicaid.gov/Medicaid-CHIP-Program-Information/Medicaid-and-CHIP-Program-Information.html) and at the AHRQ web site (http://www.ahrq.gov/chipra/).
Initial Core Set Measures	2-7	Change	Defined abbreviation for primary care practitioner (PCP) and obstetrical/gynecological (OB/GYN) practitioner in description for Measure 7. Included acronym for PCP and/or OB/GYN in description for Measures 10, 11, 12, and 14.
	4 and 53	Change	Updated Measure 8 measure steward: • Oregon Health and Science University, Child and Adolescent Health Measurement Initiative (CAHMI)
	6 and 72	Change	Updated Measure 13 description: • Percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received preventive dental services.
	6 and 83	Change	Updated Measure 17 description: • Percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received dental treatment services.
	7	Addition	Added footnote for Measure 24: • CAHPS 5.0H, Child Version, with the Children with Chronic Conditions supplemental items should be used to collect data beginning in 2013.

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II. Data Collection and Reporting of the Initial Core Set			
Data Collection and Preparation for Reporting	9-11	Addition	Added three new bullets: Reporting a Weighted Rate in CARTS; Sampling; and Inclusion of Paid, Suspended, Pending, Reversed, and Denied Claims.
	9	Change	Modified text for the following bullets: Version of Specifications; Data collection time frames for measures; Aggregating Information for State-Level Reporting.
Reporting and Submission	11	Change	Modified introductory paragraph to reflect elimination of the "Explanation of Progress" section.
	11	Change	Modified text for Including Attachments bullet to include the following guidance: • Document titles uploaded as an attachment in CARTS must be 100 characters or less.
	12	Change	Modified text for Further Assistance with CARTS bullet: • For more information about using CARTS, including obtaining a CARTS user name and password, please contact Shambrekia Wise (Shambrekia.Wise@cms.hhs.gov).
Technical Assistance	12	Change	Modified text: • The overarching goals for providing technical assistance and analytic support are to increase the number of states consistently reporting the core measures; increase the number of measures reported by each state; and improve the completeness of the data reported (that is, reporting for both Medicaid and CHIP enrollees).
III. Technical Specifications for the Initial Core Set of Children's Health Care Quality Measures			
Measure 1: Timeliness of Prenatal Care	14	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims. • References to postpartum visits in the original HEDIS specifications have been removed because they are not relevant to reporting of the children's core set, which only focuses on the timeliness of prenatal care.
	16	Change	Updated source for Table 1.1 (Codes to Identify Deliveries and Verify Live Births): • Refer to Table PPC-B in HEDIS specifications (2012 version).

Section/Measure	Page(s)	Type	Change
	18-22	Change	Updated Table 1.2 (Markers for Early Prenatal Care Obtainable from Administrative Data): • Decision Rule 2: Moved CPT code 99500 from Part A to Part D. Added LOINC code 59838-3 for Part C Cytomegalo-virus. Added LOINC codes 972-0, 978-7, and 1305-2 for Part C Rubella Rh Marker Event. Added LOINC code 63462-6 for Part C Rubella. • Decision Rule 3: Removed CPT code 99500 and HCPCS codes H1000, H1004, and H1005 from Part A.; members with these codes are identified in Decision Rule 4. Added LOINC code 63462-6 for Part C Rubella. Added LOINC codes 972-0, 978-7, and 1305-2 for Part C Rubella Rh Marker Event. • Decision Rule 4: Moved CPT code 99500 from Part A to Part D.
	23	Change	Updated Table 1.3 (Markers for Prenatal Care Obtainable from Administrative Data): • Moved CPT code from Part C to Part A. • Updated table source: Harvard Pilgrim Health Care; refer to Table PPC-D in HEDIS specifications (2012 version).
	26	Change	Modified additional notes: • When counting prenatal visits, include visits with physician assistants (PA), nurse practitioners (NP), midwives and registered nurses (RN) if a physician co-signature is present, if required by state law. • A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate. A colposcopy alone is not numerator compliant.
	26	Addition	Added the following guidance to the additional notes: • If multiple estimated dates of delivery (EDD) are documented, the most recent date should be used. • The state must use one date (date of delivery or EDD) to define the start and end of the first trimester. • The intent of the measure is to assess whether prenatal and preventive care were rendered on a routine, outpatient basis rather than assessing treatment for emergent events. • If both Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care are collected using the Hybrid Method, the same sample for collection must be used. If the Hybrid Method is used, a combination of administrative data and medical record review may not be used to identify prenatal care visits for an individual in the denominator. For example, for one woman, two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) may not be counted for one woman, even if each visit shows a different date of service.

Section/Measure	Page(s)	Type	Change
Measure 2: Frequency of Ongoing Prenatal Care	27	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	28	Addition	Added clarification of the numerator definition and instructions to determine numerator: • Women who had an unduplicated count of <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. • For each delivery, follow the steps below to calculate each woman's ratio of observed-to-expected prenatal care visits.
	29	Change	Modified instructions for Step 4 of the administrative numerator specifications: • If a HCPCS code falls on the same date of service as a CPT or UB Revenue code, count it as a single visit.
	31	Change	Updated additional notes: • If both Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care are collected using the Hybrid Method, the same sample for collection must be used.
	32	Change	Updated Table 2.1 (Month of Pregnancy Woman Enrolled in Medicaid/CHIP): • Added 9th Month column. • Added 43rd Week column. • Added footnote: Dashes indicate no visit is expected. • Removed footnote: Members who enroll during their ninth month of pregnancy would not be eligible for this measure, given the continuous enrollment criterion of 43 days prior to delivery through 56 days after delivery.
Measure 3: Live Births Weighing Less than 2,500 Grams	33	Change	Modified eligible population: • Deliveries where the principal source of payment for delivery is Medicaid or CHIP.
Measure 4: Cesarean Rate for Nulliparous Singleton Vertex	34	Change	Modified Guidance for Reporting: • Risk adjustment is currently not required for purposes of reporting this measure.
	35	Change	Updated codes used to determine cesarean deliveries for the numerator using the Patient Discharge Data Set: • Changed DRG codes 370 to 375 and 371 to 766.

Section/Measure	Page(s)	Type	Change
	35-36	Change	Updated codes used to determine all deliveries for the denominator using the Patient Discharge Data Set: • Added ICD-9-CM code V27.0. • Changed DRG codes 370 to 765, 371 to 766, 372 to 774, 373 to 775, 374 to 767, and 375 to 768.
	36-38	Addition	Updated ICD-9-CM codes used to determine exclusions to include 65281.
	38	Change	Removed risk adjustment language and references.
Measure 5: Childhood Immunization Status	39	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
Measure 6: Adolescent Immunization Status	46	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	46	Addition	Added anchor date for eligible population: • Enrolled on the child's 13th birthday.
Measure 7: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents	49	Addition	Added Guidance for Reporting: • The height, weight, and BMI should be from the same data source. • The height and weight measurement should be taken during the measurement year. • If using hybrid data specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year. • Include all paid, suspended, pending, reversed, and denied claims.
	50	Change	Updated Table 7.1 (Codes to Identify Outpatient Visits): • Removed ICD-9-CM Diagnostic codes V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9.
	51	Change	Updated age criteria for BMI percentile requirement in hybrid numerator specifications: • For children who are younger than 16 years old on the date of service, only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.
Measure 8: Developmental Screening in the First Three Years	53	Change	Updated Guidance for Reporting: • This measure includes three age-specific indicators assessing whether children are screened by their first, second, or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.

Section/Measure	Page(s)	Type	Change
of Life	53	Addition	Added Guidance for Reporting: • The code 96110 used to identify the numerator for the administrative method has been shown to have questionable validity. The measure steward recommends that states conduct a validity assessment of the claims data, as compared to medical chart review, before using the administrative method to calculate this measure.
Measure 9: Chlamydia Screening	58	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	59-60	Change	Updated Table 9.2 (Codes to Identify Sexually Active Women): • Removed ICD-9-CM code V56.52. • Added LOINC codes 59263-4, 63464-2, 64088-8, and 64094-6.
	61	Change	Updated table reference in administrative numerator specifications: • A woman is counted as having had a test if she had a claim/ encounter with a service date during the measurement year with one or more of the codes in Table 9.3.
	61	Change	Updated Table 9.4 (Codes to Identify Exclusions): • Added LOINC code 45194-8 for pregnancy test.
	62	Change	Updated link to NDC list for isotretinoin: • An NDC list for isotretinoin is available at http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2012/HEDIS2012FinalNDCLists.aspx.
Measure 10: Well-Child Visits in the First 15 Months of Life	63	Addition	Added Guidance for Reporting: • Children should be listed in the numerator for their highest number of visits only. Thus, if a child has 5 visits, include the child only in the 5-visit numerator. The sum of all rates should equal 100 percent. • Include all paid, suspended, pending, reversed, and denied claims.
	64	Change	Updated Table 10.1 (Codes to Identify Well-Child Visits): • Added HCPCS codes G0438 and G0439.
Measure 11: Well-Child Visits in the Third, Fourth, Fifth, and Sixth	66	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	66	Change	Changed anchor date for the eligible population from “Date of delivery” to “December 31 of the measurement year.”

Section/Measure	Page(s)	Type	Change
Years of Life	67	Change	Updated Table 11.1 (Codes to Identify Well-Child Visits): • Added HCPCS codes G0438 and G0439.
	67	Change	Modified hybrid numerator specifications: • Visits to school-based clinics with practitioners who are considered PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified for the measure.
Measure 12: Adolescent Well-Care Visits	69	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	70	Change	Updated Table 12.1 (Codes to Identify Adolescent Well-Care Visits): • Added HCPCS codes G0438 and G0439.
	70	Addition	Added description for hybrid numerator: • At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The PCP does not have to be assigned to the adolescent.
Measure 13: Percentage of Eligibles that Received Preventive Dental Services	72	Addition	Added Guidance for Reporting: • CMS will calculate this measure for states based on data submitted as part of the EPSDT report (CMS-416). States will not be able to provide data for this measure in CARTS. Because the denominator for this measure includes only individuals enrolled in a Medicaid or CHIP Medicaid expansion program determined to be eligible for EPSDT services, states reporting data about a separate CHIP program should provide dental data in Section IIIG of the CARTS report.

Section/Measure	Page(s)	Type	Change
	72	Change	Removed Guidance for Reporting: • This measure includes one rate for individuals ages 1 to 20. • Listed below are key differences between the initial core set measure and the Form CMS-416 Annual EPSDT Participation Report: - The submission date for FFY 2011 reporting of the initial core set of measures is March 1, 2012, while the CMS 416 Report is due April 1, 2012. - The eligible population for Measure 13 includes individuals ages 1 to 20 that are eligible for Medicaid or CHIP Medicaid Expansion programs. The eligible population for the CMS-416 Report is the same; however, the CMS-416 report also includes individuals ages 0 to 1 years eligible for EPSDT services. • Services included are those provided within the Federal fiscal year measurement period. • The anchor date for the 90 consecutive days of enrollment should be within the Federal fiscal year measurement period.
Measure 14: Children and Adolescent Access to Primary Care Practitioners	74	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	75	Change	Updated Table 14.1 (Codes to Identify Ambulatory or Preventive Care Visits): • Added HCPCS codes G0438 and F0439 for Preventive Medicine.
Measure 15: Appropriate Testing for Children with Pharyngitis	76	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	79	Change	Updated Table 15.4 (Codes to Identify Group A Streptococcus Tests): • Added LOINC code 60489-2.
Measure 16: Otitis Media With Effusion (OME)	80	Addition	Added Guidance for Reporting: • Measure 16 is on hold for FFY 2012 reporting. States will not be able to provide data for this measure in CARTS.

Section/Measure	Page(s)	Type	Change
	80	Change	Removed Guidance for Reporting: • Because CPT II codes are required for this measure and are not commonly used by states, CMS is working with the measure steward to discuss alternative methodologies for calculating this measure. As a result, states will not be expected to report the measure until further guidance is available. • For states that choose to report this measure, please note the following guidance: - The eligible population for this measure should include patients aged 2 months as of the beginning of the measurement year through 12 years (the patient's 12th birthday) as of the end of the measurement year. - An episode of OME is defined as a 90-day period from onset of Otitis Media with Effusion (as indicated by the first occurrence of qualifying diagnosis and CPT codes). The absence of a prescription during the 90 days would meet the numerator requirement.
Measure 17: Percentage of Eligibles That Received Dental Treatment Services	83	Addition	Added Guidance for Reporting: • CMS will calculate this measure for states based on data submitted as part of the EPSDT report (CMS-416). States will not be able to provide data for this measure in CARTS. Because the denominator for this measure includes only individuals enrolled in a Medicaid or CHIP Medicaid expansion program determined to be eligible for EPSDT services, states reporting data about a separate CHIP program should provide dental data in Section IIIG of the CARTS report.
	83	Change	Removed Guidance for Reporting: • This measure includes one rate for individuals ages 1 to 20. • Listed below are key differences between this measure for reporting of the initial core set and that for the Form CMS-416 Annual EPSDT Participation Report: - The submission date for FFY 2011 reporting of the initial core set of measures is March 1, 2012, while the CMS 416 Report is due April 1, 2012. - The eligible population for Measure 17 includes individuals ages 1 to 20 that are eligible for Medicaid or CHIP Medicaid Expansion programs. The eligible population for the CMS 416 Report is the same; however, the CMS-416 report also includes individuals ages 0 to 1 years eligible for EPSDT services. • Services included are those provided within the Federal fiscal year measurement period. • The anchor date for the 90 consecutive days of enrollment should be within the Federal fiscal year measurement period.

Section/Measure	Page(s)	Type	Change
	83	Change	Updated description for numerator: • The unduplicated number of individuals receiving at least one dental treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (CDT codes D2000 –D9999).
Measure 18: Ambulatory Care – Emergency Department Visits	85	Change	Removed Guidance for Reporting: • For this measure, CARTS allows entry for one numerator, denominator, and rate for each year. The counts for the numerator and denominator for the Total population should be entered in the space provided for the numerator and denominator; the rate will be calculated automatically. The age-specific rates for <1, 1-9, and 10-19 should be reported in the CARTS field labeled "Additional Notes on Measure." • For this measures, CARTS calculates the rate per 100 member months rather than per 1,000 member months. CMS will adjust the measure after the data are submitted to CARTS.
	85	Addition	Added Guidance for Reporting: • Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason. If a child is enrolled retroactively, count all services for which the state paid or expects to pay.
Measure 19: Pediatric Central Line Associated Blood Stream Infections	88	Addition	Added Guidance for Reporting: • CMS will calculate this measure for states based on data submitted to the National Healthcare Safety Network. States will not be able to provide data for this measure in CARTS.
	88	Change	Removed Guidance for Reporting: • CMS is working to better understand how states can collect data needed for this measure. If a state chooses to collect and report this measure, CMS requests that the state provide a description of how the data were collected in the CARTS field labeled "Additional Notes of Measure."
	90	Change	Updated Step 3b of the denominator specifications: • In NICUs, the number of patients with one or more central lines is stratified by birth weight in five categories since risk of BSI varies by birthweight.
	90	Change	Updated Step 5 of the denominator specifications: • Divide the total number of observed CLABSI events ("2" above) by the "expected" number of CLABSI rates ("4.b." above).

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Measure 20: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit	92	Change	Removed Guidance for Reporting: • The entire measure specification was updated based on input from the measure steward. The revised measure specification removes the use of at least two short-acting beta adrenergic agents as a method for identifying asthmatics and clarifies the measurement period. States should indicate whether they used the February 2011 or the updated December 2011 version of the specifications for Measure 20 when reporting into CARTS in Other Comments on Measure box.
Measure 21: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication	94	Addition	Added Guidance for Reporting: • Many of the ADHD medications are also used in the treatment of narcolepsy. In order to have a precise ADHD measure, children with narcolepsy should be removed from the denominator and both indicators. • Include all paid, suspended, pending, reversed, and denied claims. • A comprehensive list of medications and NDC codes can be found at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2012/HEDIS2012FinalNDCLists.aspx.
	95	Change	Modified definition for the Continuation and Maintenance Phase: • The 31-300 days following the IPSD (10 months).
	98	Change	Removed outdated link to medications and NDC codes used to determine the denominator.
	98	Change	Modified table reference in Step 4 of the administrative denominator specifications for Rate 2: • Exclude children that had an acute inpatient claim/encounter with a principal diagnosis of mental health (Table 21.1) or substance abuse (Table 21.2) during the 300 days (10 months) after the IPSD.
Measure 22: Annual Pediatric Hemoglobin (ABA1C) Testing	100	Addition	Added Guidance for Reporting: • Include all paid, suspended, pending, reversed, and denied claims.
	100	Change	Removed Guidance for Reporting: • The entire measure specification was updated based on input from the measure steward. The revised measure follows the HbA1c indicator from the HEDIS Comprehensive Diabetes Care measure, with minor changes for age and identifying prescriptions.
Measure 23: Follow-Up After Hospitalization for	105	Change	Modified rate definitions in the measure description: • The percentage of discharges for which children received follow-up within 30 days of discharge. • The percentage of discharges for which children received follow-up within 7 days of discharge.

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Mental Illness	105-106	Addition	Added Guidance for Reporting: • Follow the detailed specifications to (1) include the appropriate discharge when the patient was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the patient was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis. • Include all paid, suspended, pending, reversed, and denied claims.
	109	Change	Updated Table 23.2 (Codes to Identify Visits): • Added POS code 24.
Measure 24: CAHPS	110	Addition	Added Guidance for Reporting: • The Agency for Healthcare Research and Quality's CAHPS Database will be unavailable to take submissions in 2012. For CARTS reporting, states should indicate if they have collected the CAHPS survey and the populations sampled. • CHIPRA requirement for CAHPS reporting: For FFY 2013 reporting, CHIPRA section 402 requires Title XXI programs to submit to CMS "data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality of care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey." • A technical assistance brief about CAHPS reporting results will be available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.
	110	Change	Updated Guidance for Reporting: • For purposes of reporting for the initial core set, CAHPS Health Plan Survey 4.0H, Child Version should be used. The inclusion of the Children with Chronic Conditions (CCC) supplemental items is encouraged by CMS. • The survey should be conducted by a third-party vendor certified by NCQA according to the HEDIS protocol. A current listing of NCQA-certified HEDIS survey vendors is available at **http://www.ncqa.org/LinkClick.aspx?fileticket=o1WCTrVjMI8%3d&tabid=170.** • Any deviations in the questionnaire, data collection or survey administration, sampling, or data analysis should be reported in the CARTS field labeled "Additional Notes/Comments on Measure."

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	110	Change	Removed Guidance for Reporting: • From the February 14, 2011 State Health Official Letter: "As required by CHIPRA section 402(a)(2), which amends reporting requirements in section 2108 of the Act, Title XXI programs are required to report results from AHRQ's CAHPS Child Medicaid Survey." • Reporting for this measure is required by December 2013 for Title XXI States only. • Additional guidance on preparing a questionnaire is available at https://www.cahps.ahrq.gov/cahpskit/files/1012_Preparing_Questionnaire_HP40.pdf • States should submit their raw CAHPS data to AHRQ's CAHPS Database and their summary results to CMS through CARTS. Submission of raw data to AHRQ is recommended; if States choose to submit results to CMS through CARTS, they should submit a summary of the results only (not raw data). • Combining results for Medicaid and CHIP enrollees would be preferred for this measure.
	111	Change	Modified Sample Size: • The sample needs to be large enough to yield 411 completed surveys per reporting unit (e.g., health plan, PCCM program, or state), a cost-effective method shown to produce statistically valid survey comparisons.
	111	Addition	Added Section C – Completion Criteria.
	111-112	Change	Updated Table 24.1 (Key Questions to Determine a Completed CAHPS Health Plan Survey): • Updated CAHPS Health Plan Survey 4.0 to CAHPS Health Plan Survey 4.0H.
	113	Addition	Added Section D – Data Analysis.
	114	Change	Modified CAHPS survey title: • CAHPS Health Plan Survey 4.0H.