Appendix 2 – Measure Dictionary (Technical Specifications)

Breast Cancer Screening

Administrative Specification Only: Numerator-compliant patients will have had one or more mammograms.

Key Elements:

- Admin-only – Mammogram coding

Time Frame:

- For Measurement Year 2022: 10/1/2020-12/31/2022

Advance Care Planning

Administrative Specification Only: Evidence of advance care planning must include either:

Key Elements:

- Admin-only – A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care.

Time Frame:

- Measurement Year (January – December)

***Note**: Medication review does not require the member to be present. Telephone visits, e-visits, or virtual check-ins meet the criteria.*

Care for Older Adults - Functional Status Assessment

Medical Record Hybrid Specification: Medical record documentation must include evidence of a complete functional status assessment and the assessment date. Note that a functional status assessment will not be deemed comprehensive if it is limited to an acute or single condition, event, or body system.

Key Elements (non-comprehensive):

- Functional status assessment
    - Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring, using toilet, walking
    - Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances

Time Frame:

- Measurement Year (January – December)

Care for Older Adults - Medication Review

Medical Record Hybrid Specification: Documentation must include one of the following, from the same medical record. A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Do not include medication lists or medication reviews performed in an acute inpatient setting.

Key Elements (same medical record):

- Medication list
- Evidence of a medication review by a prescribing practitioner or clinical pharmacist
- Review date
- Notation that the member is not taking any medication
- Notation date

Time Frame:

- Measurement Year (January – December)

Care for Older Adults - Pain Assessment

Medical Record Hybrid Specification: Medical record documentation must include evidence of a pain assessment and assessment date. Do not include pain assessments performed in an acute inpatient setting, and please note that notation of a pain management or pain treatment plan alone will not meet criteria. Pain assessment notation must include one of the following:

Key elements (non-comprehensive):

- Documentation that the patient was assessed for pain (positive or negative findings)
- Assessment result, using a standardized pain assessment tool including, but not limited to:
    - Numeric rating scales (verbal or written)
    - Face, Legs, Activity, Cry Consolability (FLACC) scale
    - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory)
    - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale)

Time Frame:

- Measurement Year (January – December)

Cervical Cancer Screening

Medical Record Hybrid Specification: Appropriate screenings will be in the medical records of:

- Women between the ages of 24-64 (in the measurement year), who had cervical cytology during that year or the two years prior. Medical record documentation must include both the result/finding and the date. Cervical cancer screening methods including collection and microscopic analysis of cervical cells count towards the measure
- Women between the ages of 30-64 (in the measurement year) with high-risk human papillomavirus (hrHPV) testing that year or the four years prior (if over 30 at time of the test). Medical record documentation must include both the result/findings and the date

  Note: Do not count biopsies for both screening types.

Key Elements:

- Testing performed
- Results
- Date

Time Frame:

- 3 years – Cervical Cytology
- 5 years – HrHPV (high-risk human papillomavirus)

Colorectal Screening

Medical Record Hybrid Specification: Medical record documentation must include the date of the colorectal cancer screening; a result is required if the documentation is not clearly part of the member's "medical history".

Pathology reports that indicate the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the screening date meet criteria. If the report does not indicate the type of screening, or for incomplete procedures, criteria can be met either by evidence that the scope advanced beyond the splenic flexure or evidence that the scope advanced into the sigmoid colon.

Do not count digital rectal exams (DRE), FOBT tests performed in an office setting, or FOBT tests performed on a sample collected via DRE.

Key Elements:

- Date of screening
- Result (as necessary)

Time Frame:

- Fecal Occult Blood Test: Measurement Year.
- Stool DNA Test: Measurement Year and 2 years prior.
- Flexible Sigmoidoscopy: Measurement Year and 4 years prior.
- Computed Tomography Colonography: Measurement Year and 4 years prior.
- Colonoscopy: Measurement Year and 9 years prior.

Eye Exam for Patients with Diabetes

Medical Record Hybrid Specification: The following items meet medical record documentation requirements, though are not an exhaustive list:

- Indication (note, letter, etc.) from a health care provider that an ophthalmoscopic exam was completed by an optometrist or ophthalmologist (eye care professional), the date the procedure was performed, and the results
- A chart or photograph indicating the date the fundus photography was performed and evidence of review by an eye care professional
- Evidence of bilateral eye enucleation or acquired absence of both eyes

Key Elements (non-comprehensive):

- Indication of ophthalmoscopic exam/fundus photography/bilateral eye enucleation/etc.
- Date
- Evidence of review by eye care professional
- Results

Time Frame:

- 1 year – retinal or dilated eye exam
- 2 years – negative retinal or dilated exam (negative for retinopathy)
- Any time during the member's history: bilateral eye enucleation

Hemoglobin A1c Control for Patients with Diabetes: Results (Including control and poor control)

Medical Record Hybrid Specification: To satisfy the measure, medical record documentation must include the date of the HbA1c test and the result. Ranges and thresholds will not meet criteria. Control is established if the member's most recent HbA1c level during the measurement year is <8.0%. Poor control is established if the most recent HbA1c level is >9.0%.

Key Elements:

- Testing performed
- Results
- Date

Time Frame:

- Measurement Year (January – December)

Kidney Health Evaluation for Patients with Diabetes

Administrative Specification Only: This measure, new in MY 2020, aims to evaluate members between 18-85 with type 1 and type 2 diabetes who received a kidney health evaluation. An evaluation is considered obtaining two lab tests during the measurement year: an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).

The uACR is defined as both a quantitative urine albumin test and a urine creatinine test. These two tests must have service dates no more than four days apart.

Key Elements:

- Admin-only – lab test coding

Time Frame:

- Measurement year (January – December)

Controlling High Blood Pressure < 140/90

Medical Record Hybrid Specification: For the measurement year, the most recent noted blood pressure (BP) reading must occur after the second diagnosis of hypertension at an outpatient visit, telephone visit, e-visit, or virtual check-in. BP readings from remote monitoring devices are allowed if they are digitally stored and both transmitted to and interpreted by the provider. Documentation must reflect that the reading is from an electronic device.

***Note** - Blood Pressure values can be captured via telehealth. Member self-reported BP reading exclusion removed, member reported BP readings taken by any digital device are acceptable. BP readings will not count if: taken during an acute inpatient stay or an ED visit; memberself-reported; or taken on the same day, or the day before, as a medical event requiring a change in diet/medication.*

Key Elements:

- Testing performed
- Results
- Date

Time Frame:

- Measurement year (January – December)

Osteoporosis Screening in Older Women

Administrative Specification Only: This measure evaluates the percentage of women 65-75 years of age who received osteoporosis screening. Numerator-compliant members will have had one or more osteoporosis screening tests on or between the member's 65th birthday and December 31 of the measurement year.

Key Elements:

- Measurement year
- Eligible population
- Numerator events by supplemental data

Time Frame:

- Measurement year (January – December)

Osteoporosis Management in Women Who Had a Fracture

Administrative Specification Only: This measure evaluates the percentage of women 65-85 years of age who had a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis in the six months after the fracture.

Key Elements:

- Continuous enrollment
- Medical and Pharmacy Benefit
- Exclude: Fractures of finger, toe, face and skull

Time Frame:

- Fracture Intake Period: 12-month window beginning July 1st of the year prior to the measurement year through June 30th of the measurement year.
- Measurement year (January – December)

Transitions of Care: Medication Reconciliation Post Discharge

Medical Record Hybrid Specification: Outpatient medical record documentation must include evidence of medication reconciliation and the reconciliation. The following, non-exhaustive, list exhibits some of the documentation types meeting criteria:

- Documentation of current medications, with a note that the provider reconciled the current and discharge medications
- Documentation of current medications with a note referencing the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, etc.)
- Documentation of the member's current medications with notation of discharge medication review
- Documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service

Key Elements:

- Medication documentation
- Notation of review/reconciliation

Time Frame:

January 1 through December 31 of the measurement year

Transitions of Care: Notification of Inpatient Admission

Medical Record Hybrid Specification: Outpatient medical record documentation must include evidence of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).The following, non-exhaustive, list exhibits some of the documentation types meeting criteria:

- Communication between emergency department or inpatient providers or staff and the member's PCP or ongoing care provider (e.g., phone call, email, fax).
- Communication about admission to the member's PCP or ongoing care provider through a health information exchange; an automated admission, or discharge and
- transfer (ADT) alert system.
- Communication about admission with the member's PCP or ongoing care provider through a shared electronic medical record (EMR) system. Evidence that the information was filed in the EMR and is accessible to the PCP or ongoing care provider on the day of admission through 2 days after the admission (3 total days) meets criteria.
- Communication about admission to the member's PCP or ongoing care provider from the member's health plan.
- Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay.
- Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The planned admission documentation or preadmission exam must clearly pertain to the denominator event.

Key Elements:

- ED or Inpatient admission documentation
- Notation of receipt on the day of admission through 2 days after the admission (3 total days)

Time Frame:

January 1 through December 31 of the measurement year

Transitions of Care: Receipt of Discharge Information

Medical Record Hybrid Specification: Outpatient medical record documentation must include evidence of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days) with evidence of the date when the documentation was received. At a minimum, the discharge information must include all of the following:

- The practitioner responsible for the member's care during the inpatient stay.
- Procedures or treatment provided.
- Diagnoses at discharge.
- Current medication list.
- Testing results, or documentation of pending tests or no tests pending.
- Instructions for patient care post-discharge.

Key Elements:

- Discharge information documentation to the outpatient provider
- Notation of receipt on the day of discharge through 2 days after the admission (3 total days)

Time Frame:

January 1 through December 31 of the measurement year

Transitions of Care: Patient Engagement After Inpatient Discharge

Administrative Specification Only: Patient engagement (outpatient follow-up visit) provided within 30 days after discharge.

- An outpatient visit.
- A telephone visit.
- Transitional care management services.
- An e-visit or virtual check-in.

Key Elements:

- Note: Patient Engagement on the date of discharge does not meet the criteria.
- Notation of receipt on the day of discharge through 2 days after the admission (3 total days)

Time Frame: January 1 through December 31 of the measurement year

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

Administrative Specification Only: This measure assesses the percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit. The following meet criteria for follow-up:

- An outpatient visit.
- A telephone visit.
- Transitional care management services.
- An outpatient or telehealth behavioral health visit.
- An intensive outpatient encounter or partial hospitalization.
- A community mental health center visit.

Time Frame:

- Measurement Year (January – December)