Core Set of Health Care Quality Measures for Medicaid Health Home Programs

Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting

March 2014

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

ACKNOWLEDGMENTS

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I. Core Set of Health Care Quality Measures for Medicaid Health Home Programs

Background

Section 2703 of the Affordable Care Act (Public Law 111-148), entitled "State Option to Provide Health Homes for Enrollees with Chronic Conditions," creates a new opportunity for states to support improved integration of care for individuals with chronic conditions. Through the establishment of section 1945 of the Social Security Act, this provision allows states to elect a new Health Homes service option under the Medicaid state plan. This provision is an important opportunity for states to address and receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. Overall, it provides an opportunity for states to build a person-centered care delivery model that focuses on improving outcomes and disease management for enrollees with chronic conditions and obtaining better value for state Medicaid programs. For more information, refer to the following links:

Background on Health Homes, November 16, 2010
http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf

Background of Health Home Quality Measures, January 15, 2013
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-001.pdf

Frequently Asked Questions about Health Homes
http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/Health-Homes-FAQ-5-3-12_2.pdf

Identifying the Health Home Core Set

To support ongoing assessment of the effectiveness of the Health Home model, the Centers for Medicare & Medicaid Services (CMS) has established a recommended Core Set of health care quality measures that it intends to promulgate in the rulemaking process. These recommended Health Home quality measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for enrollees. This effort is aligned closely with the Department of Health and Human Services' (HHS) National Strategy for Quality Improvement in Health Care, as well as other quality initiatives.

CMS consulted with states considering Health Homes and conducted technical assistance calls, presentations, and webinars in order to identify the Core Set of Health Home quality measures for Medicaid-eligible children and adults. CMS also worked with federal partners, including the Office of the Assistant Secretary for Planning and Evaluation and the Substance Abuse and Mental Health Services Administration. The recommended Core Set of Health Home measures were chosen because they reflect key priority areas such as behavioral health and preventive care, and they align with the Core Set of health care quality measures for adults enrolled in Medicaid, the Medicaid Electronic Health Record (EHR) Incentive Program measures, and the National Quality Strategy.

Health Home Core Set Measures

The following table provides a brief description of each Core Set measure, the measure steward(s), and data sources needed to report the measure. As noted in the table, the data sources for the measures are administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), and medical records. These measures are based on the Core Set of health care quality measures for Medicaid-eligible adults, but have been modified to allow for Health Home program reporting, which may also include children. The technical specifications in Chapter III of this manual provide additional details for each measure.

Acronym	Measure	Measure Steward[a] (web site)	Description	Data Source
ABA-HH	Adult Body Mass Index (BMI) Assessment	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year	Administrative or hybrid
CDF-HH	Screening for Clinical Depression and Follow-Up Plan	CMS https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html	Percentage of Health Home enrollees age 12 and older screened for clinical depression using a standardized tool, and if positive, a follow-up plan is documented on the date of the positive screen	Hybrid
PCR-HH	Plan All-Cause Readmission Rate	NCQA/HEDIS http://www.ncqa.org	For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days of discharge and the predicted probability of an acute readmission	Administrative

Acronym	Measure	Measure Steward[a] (web site)	Description	Data Source
FUH-HH	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS http://www.ncqa.org	Percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative
CBP-HH	Controlling High Blood Pressure	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	Hybrid
CTR-HH	Care Transition – Timely Transmission of Transition Record	American Medical Association/ Physician Consortium for Performance Improvement (PCPI) http://www.ama-assn.org	Percentage of Health Home enrollees discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility, Health Home provider or primary physician, or other health care professional designated for follow-up care within 24 hours of discharge	Hybrid

Acronym	Measure	Measure Steward[a] (web site)	Description	Data Source
IET-HH	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS http://www.ncqa.org	Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who: (a) Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis (b) Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Administrative or hybrid
PQI92-HH	Chronic Condition Hospital Admission Composite—Prevention Quality Indicator	AHRQ http://www.qualityindicators.ahrq.gov/	The total number of hospital admissions for chronic conditions per 100,000 Health Home enrollees age 18 and older	Administrative

[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.

How the Health Home Core Set Will Be Used

The Health Home Core Set will be used to inform the required independent evaluation for the 2017 report to Congress. The Core Set will also be used to assess quality outcomes and performance, as well as to inform ongoing quality monitoring of the Health Home program. Health Home providers will be expected to report to the state Medicaid program, which will report the data in aggregate to CMS at the State Plan Amendment (SPA) level.

II. Data Collection and Reporting of the Health Home Core Set

To support consistency in reporting the Health Home 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 additional assistance with quality measures, contact the TA mailbox at MACqualityTA@cms.hhs.gov.

Data Collection and Preparation for Reporting

- Version of specifications. This manual includes the most applicable version of the measure specifications available to CMS as of May 2013. For HEDIS measures, the manual follows HEDIS 2013 specifications for federal fiscal year (FFY) 2013 reporting. For non-HEDIS measures, the manual includes the specifications available from the measure steward as of May 2013.
- 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 (CY) 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 measurement year (i.e., January 1–December 31 of the calendar year before the reporting year). For example, for the FFY 2013 reporting year, the measurement year would be CY 2012.
- Reporting unit. The reporting unit for each measure is the state Health Home program as a whole. States reporting the Health Home Core Set measures should collect data across all Health Home providers[1] within a specific Health Home program, as defined by the approved SPA applicable to the program. States should aggregate data from all Health Home providers into one Health Home program-level rate before reporting data to CMS. States with more than one SPA should report separately for each Health Home program, as defined in their SPA.
- Aggregating information for Health Home program-level reporting. To obtain a Health Home program-level rate for a measure developed from the rates of multiple units of measurement (such as across Health Home providers), the state should calculate a weighted average of the individual rates. How much an entity (e.g., each Health Home provider) contributes to the weighted average is based on the size of the enrollee population eligible for the measure. Health Home providers with larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid, administrative, electronic, and data from alternative data sources, such as patient registries, can be combined to develop a Health Home program-level rate.
- For assistance with developing a program-level rate, refer to the Technical Assistance Brief, Approaches to Developing State-Level Rates for Children's Health Care Quality Measures Based on Data from Multiple Sources, available at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/TA2-StateRates.pdf. Although CMS encourages Health Home providers and states to use the methods and data sources listed in the specification for each measure, states and providers may use alternative methods and data sources, when necessary. When reporting an aggregated rate that uses alternative

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[1] Section 1945(g) of the Social Security Act requires designated providers of Health Home services to report to the state on all applicable quality measures as a condition for receiving payment. When appropriate and feasible, quality measure reporting is to be done through the use of health information technology.

data sources or is combined from multiple data sources and methods, states should report the data sources and methods used, and the combined rate.

- Eligible population for measurement. Health Home enrollees are Medicaid beneficiaries (adults and children) who are enrolled in a state Health Home program and assigned a Health Home provider. For all measures, the denominator includes Health Home enrollees who satisfy measure-specific eligibility criteria. Some measures require a period of continuous enrollment for inclusion in the measure. No utilization measures require a period of continuous enrollment for inclusion.
- Age criteria for Health Home Core Set measures. The age criteria vary by measure. Some measures have an upper age limit, while others include an age range above age 64 (that is, Medicaid Health Home enrollees who may be dually eligible for Medicare) and/or under age 18. For the purpose of Core Set reporting, states should calculate and report such measures for three age groups where applicable: Health Home enrollees under age 18, enrollees between the ages of 18 and 64, and those age 65 and older. States should also report for the total population.
- Exclusions. Some measure specifications contain required or optional exclusions. A Health Home enrollee who meets exclusion criteria should be removed from the measure denominator. Some exclusions are optional. States should note when reporting in CARTS whether optional exclusions are applied.
- Representativeness of data. States should use the most complete data available for each Health Home program and ensure that the rates reported are representative of the entire population enrolled in their Health Home program(s). For a measure that uses administrative data, all Health Home enrollees who meet the eligible population requirements for the measure should be included. For a measure that uses a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire Health Home eligible population for the measure.
- Data collection methods and data sources. Several measures include more than one data collection method (e.g., administrative, hybrid, and medical records, including electronic medical records [e-measures]).
  - The administrative method uses transaction data (for example, claims) or other administrative data 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 e-measure method uses EHRs to calculate the measure. These data can be used in cases in which the Health Home provider participates in Meaningful Use and qualifies for Stage 1 Meaningful Use payment incentives.
  - The hybrid method uses both administrative data sources and medical record data to determine numerator compliance. The denominator consists of a sample of the measure's eligible population. The hybrid method, when available, should be used when administrative data and EHR data are incomplete or the data elements for the measure are not captured in administrative data (e.g., Controlling High Blood Pressure).
  - The medical record review method uses medical records only. States that choose to use this method may define their own sampling methodology; however, CMS encourages states to use a sampling methodology that ensures all individuals have an equal chance of inclusion.

- Sampling. For HEDIS measures reported using the hybrid method, the sample size should be 411, plus an oversample to allow for substitution. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.
- Alternative data collection methods and data sources. States may choose to report on any of these measures using the methods listed in the specifications, or using an alternative method (e.g., medical record review without systematic sample) or data source (e.g., patient registry) if the administrative, hybrid, and medical record/e-measure methods are not feasible. The method of data collection and data source should be reported with the reporting of the measure.
- Small numbers. If a measure has a denominator that is less than 30 and the state chooses not to report the measure due to small numbers, please note this in the field indicated in the data reporting tool.
- Continuous enrollment. This refers to the time during which a Medicaid enrollee must be eligible for Medicaid benefits and enrolled in a Health Home program to be included in the measure denominator. Continuous enrollment ensures that the Health Home has enough time to render services. The continuous enrollment period and allowable gaps are specified in each measure. To determine continuous enrollment, states should identify the enrollment date for each Health Home enrollee. This date is defined by the policies of each state's Health Home program and does not need to match the Health Home SPA effective date. Health Home enrollees may see multiple Health Home providers while continuously enrolled in a single Health Home program.
- Allowable gap. An allowable gap can occur any time during continuous enrollment. For example, the Controlling High Blood Pressure measure requires continuous enrollment throughout the measurement year (i.e., January 1–December 31) and allows one gap in enrollment of up to 45 days. An enrollee 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 enrollee has one 38-day gap (January 1–February 7).
- Risk adjustment. The Plan All-Cause Readmission measure requires risk adjustment. However, this measure does not currently have a risk adjustor for the Medicaid population. CMS suggests that states report unadjusted rates for this measure.
- Inclusion of paid, suspended, pending, reversed, and denied claims. A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided, regardless of who provided the service. For such measures, the inclusion of claims (whether paid or denied) is appropriate. For each HEDIS measure that relies on claims as a data source, the HEDIS Volume 2 manual provides specific guidance on which claims to include. The manual is available at http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013.aspx.

Definitions

Health Home Program. A state Medicaid program defined in an SPA that is responsible for comprehensive care management; care coordination and health promotion; comprehensive transitional care/follow-up; patient and family support; referral to community and social support services; and use of health information technology (HIT) to link services. A Health Home program may be made up of several Health Home providers.

Health Home Provider. An individual provider, team of health care professionals, or health team that provides the Health Home services and meets established standards. States can adopt a mix of these three types of providers identified in the legislation:

- Designated provider: May be physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, other.
- Team of health professionals: May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, or other.
- Health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral healthcare providers, chiropractors, licensed complementary and alternative medical practitioners, and physician assistants.

Health Home Enrollee. Medicaid beneficiary (adult or child) enrolled in a state Health Home program. Medicaid beneficiaries eligible for Health Home services:

- Have two or more chronic conditions, or
- Have one chronic condition and are at risk for a second, or
- Have a serious and persistent mental health condition.
  Health Home enrollees may include beneficiaries dually eligible for both Medicare and Medicaid.

Primary Care Provider. Physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses (RN) are not considered primary care providers.

Mental Health Practitioner. A practitioner who provides 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.
- 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.
- An 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 a licensed or 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 a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

Reporting and Submission

CMS has designated CARTS, a web-based data submission tool, as the vehicle for reporting the Health Home Core Set measures. Procedures for reporting into CARTS will be provided at a later date.

Technical Assistance

To help states collect, report, and use the Health Home Core Set measures, CMS offers technical assistance. Please submit technical assistance requests specific to the Health Home Core Set to: MACqualityTA@cms.hhs.gov.

For states needing further resources for integrating Medicare and Medicaid data for Medicare-Medicaid Dual-Eligible enrollees, please go to http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/State-Data-Resource-Center.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.

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III. Technical Specifications for the Health Home Core Set Measures

This chapter presents the technical specifications for each measure in the Health Home Core Set. Each specification includes a description of the measure and information about the eligible population, key definitions, data source(s), instructions for calculating the measure, and other relevant measure information.

These specifications have been modified from their original version for use in the Medicaid Health Home Core Set. They also differ slightly from the specifications used in the Medicaid Adult Core Set. The differences between the Health Home Core Set specifications and the original specifications provided by the measure steward are listed in the Notes section for each measure.

These specifications were developed based on the version available from the measure steward as of May 2013.

Measure ABA-HH: Adult Body Mass Index (BMI) Assessment

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Health Home enrollees ages 18 to 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year

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 or the year prior to 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, reversed, pending, and denied claims.
- This measure applies to Health Home enrollees ages 18 to 74. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable): 18 to 64 and ages 65 to 74. Age groups are based on age as of December 31 of the measurement year.
- For measurement year 2013, states may choose to report a BMI rate using a two-year look-back-period (as specified) or a one-year look-back period. States may use the one-year look-back period if an adequate sample size cannot be achieved using the two-year continuous enrollment criteria specified below. If a state reports a one-year look-back period, criteria apply to the denominator, numerator, and exclusions. Refer to instructions marked by an asterisk (*), below.

B. DEFINITIONS

Term	Definition
BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the Centers for Disease Control and Prevention's (CDC) BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among those of the same sex and age.

C. ELIGIBLE POPULATION

Criterion	Description
Age*	Ages 18 to 74. Report two age stratifications and a total rate: • 18 to 64 • 65 to 74 • Total The total is the sum of the age stratifications.
Continuous enrollment*	Enrolled in a Medicaid Health Home program for the measurement year and the year prior to the measurement year.

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Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Health Home enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (e.g., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Event/ diagnosis*	Health Home enrollees who had an outpatient visit (Table ABA.A) during the measurement year or the year prior to the measurement year.

*States that report using a one-year look-back period should include all Health Home enrollees who meet the following criteria: age 18 as of January 1 of the measurement year to age 74 as of December 31 of the measurement year; continuously enrolled in the Health Home Program for the measurement year; had an outpatient visit during the measurement year.

Table ABA.A. Codes to Identify Outpatient Visits

CPT	HCPCS	UB Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0402	051x, 0520-0523, 0526-0529, 0982, 0983

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

Health Home enrollees for whom BMI was documented (Table ABA.B) during the measurement year or the year prior to the measurement year.

*States that report using a one-year look-back period should include only BMI during the measurement year.

Table ABA.B. Codes to Identify BMI

ICD-9-CM Diagnosis
V85.0–V85.5

Exclusions (optional)

Health Home enrollees who had a diagnosis of pregnancy (Table ABA.C) during the measurement year or the year prior to the measurement year

*States that report using a one-year look-back period may exclude Health Home enrollees who had a diagnosis of pregnancy during the measurement year.

Table ABA.C. Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Pregnancy	630-679, V22, V23, V28

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E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population

Numerator

Health Home enrollees for whom BMI was documented during the measurement year or the year prior to the measurement year, as documented through either administrative data or medical record review.

*States that report using a one-year look-back period should include only BMI during the measurement year.

Administrative Data Source

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

Medical record data source

Documentation in the medical record must indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year. The weight and BMI must be from the same data source.

For Health Home enrollees younger than 19 on the date of service, the following documentation of BMI percentile also meets criteria:

- BMI percentile documented as a value (e.g., 85th percentile)
- BMI percentile plotted on an age-growth chart

Exclusions (optional)

Refer to the Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating diagnosis of pregnancy during the measurement year or the year prior to the measurement year.

*States that report using a one-year look-back period should exclude only Health Home enrollees with a diagnosis of pregnancy in the measurement year.

F. ADDITIONAL NOTES

The following notations or examples of documentation are considered “negative findings” and do not count as numerator compliant.

- No BMI or BMI percentile documented in medical record or plotted on age-growth chart
- Notation of height and weight only

The look-back period for this measure has been revised from the original 2013 HEDIS measure to allow states the option of reporting with only a one-year look-back period.

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Measure CDF-HH: Screening for Clinical Depression and Follow-Up Plan

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The percentage of Health Home enrollees age 12 and older who were screened for clinical depression using a standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen.

Guidance for Reporting:

- This measure applies to Health Home enrollees age 12 and older. For purposes of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): 12 to 17, 18 to 64, and 65 and older. Age groups should be based on age as of the date of encounter.
- This measure uses administrative data and medical record review to calculate the measure. States may also choose to use medical record review to identify numerator cases. CMS is currently working to develop hybrid specifications for this measure that may be included in a future version of the resource manual. States should indicate deviations from the measure specifications if they choose to use the hybrid method to identify numerator cases.
- The measure steward does not provide diagnosis codes for the depression and bipolar disorder exclusions; medical record review is required to determine the exclusions.
- The original specification included six G codes intended to capture whether individual providers reported on this measure. For the purpose of Health Home Core Set reporting, two G codes are included in the numerator to capture whether the clinical depression screening was done and if the screen was positive, whether a follow-up plan was documented.
- The screening and follow-up must occur on the same date of service; if a patient has more than one encounter during the measurement year, the patient should be counted in the numerator and denominator only once.

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. Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner’s office that is filing the code.

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Standardized tool	An assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. Examples of depression screening tools include, but are not limited to: • Adolescent Screening Tools (ages 12 to 17): Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire, Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD-PHQ2. • Adult Screening Tools (age 18 and older): Patient Health Questionnaire (PHQ9), 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 (SDS), Cornell Scale Screening and PRIME MD-PHQ2.
Follow-up plan	Proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: • Additional evaluation • Suicide Risk Assessment • 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 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 12 or older on date of encounter. Report three age stratifications and a total rate: • 12 to 17 • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	Enrolled in a Medicaid Health Home program for at least 90 days during the measurement year during which an outpatient visit occurred (see Table CDF.A).
Allowable gap	None.
Event/diagnosis	Health Home enrollees who had an outpatient visit (Table CDF.A) during the measurement year.

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D. HYBRID 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
90791, 90792, 90832, 90834, 90837, 90839, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	G0101, G0402, G0438, G0439, G0444

Numerator

Patients screened for clinical depression on the date of the encounter using an age-appropriate standardized tool and, if positive, a follow-up plan is documented on the date of the positive screen.

- G8431: Positive screen for clinical depression with a documented follow-up plan*

  OR
- G8510: Negative screen for clinical depression, follow-up not required.*

*Reporting this code meets numerator criteria when calculating performance.

Exclusions

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

- Patient refuses to participate.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court-appointed cases or cases of delirium.
- Patient has an active diagnosis of depression or bipolar disorder.

In addition, use the following codes to identify other exclusions:

- G8433: Screening for clinical depression not documented, patient not eligible/appropriate

  OR
- G8940: Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate.

E. E-MEASURE SPECIFICATION

Refer to 2014 ECQM specifications for eligible providers for complete value set and e-measure codes, available from http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/clinicalqualitymeasures.html.

Guidance for Reporting:

A clinical depression screen is complete on 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 positive screen.

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The documented follow up plan must be related to positive depression screening for example: “Patient referred for psychiatric evaluation due to positive depression screening”). Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used.

Denominator

All eligible enrollees age 12 and older before the beginning of the measurement period, with at least one eligible encounter during the measurement period.

Numerator

Patients screened for clinical depression on the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Exclusions

Refer to the Administrative Specification for exclusion criteria.

F. ADDITIONAL NOTES

The denominator of this measure has been modified from its original version to include only individuals with 90 days continuous enrollment in the Health Home program.

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Measure PCR-HH: Plan All-Cause Readmission Rate

National Committee for Quality Assurance

A. DESCRIPTION

For Health Home enrollees age 18 and older, the percentage of acute inpatient stays during the measurement year that were followed by an 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) (denominator).
- Count of 30-Day Readmissions (numerator).
- Average Adjusted Probability of Readmission (rate).

Guidance for Reporting:
• This measure applies to Health Home enrollees age 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable): age 18 to 64 and 65 and older. • Include all paid, suspended, pending, and denied claims. • This measure requires risk adjustment. However, this measure does not currently have a risk adjustor for the Medicaid population. CMS suggests that states report unadjusted rates for this measure.

B. DEFINITIONS

Term	Definition
Index hospital stay (IHS)	• An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
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 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.
Classification Period	• 365 days prior to and including an Index Discharge Date.

C. ELIGIBLE POPULATION

Criterion	Requirement
Age	Age 18 and older as of the Index Discharge Date. Report two age stratifications and a total rate: • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.

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Continuous enrollment	Enrolled in a Health Home program for at least 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.
Event/diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on Health Home enrollees. Include all acute inpatient discharges for Medicaid Health Home enrollees 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 stays.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Step 1

Identify all acute inpatient stays with a discharge date on or between January 1 and December 1 of the measurement year.

Include acute admissions to behavioral healthcare facilities.

Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.

Step 2

Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer’s discharge date as the Index Discharge Date.

Step 3

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

Step 4

Exclude any acute inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

Step 5

Exclude stays for the following reasons:

- Inpatient stays with discharges for death.
- Acute inpatient discharge with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period (Table PCR.A).

Table PCR.A. Codes to Identify Maternity Related Inpatient Discharges

Description	ICD-9-CM Diagnosis
Pregnancy	630-679, V22, V23, V28
Conditions originating in the perinatal period	760-779, V21, V29-V39

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Step 6

Calculate continuous enrollment.

Step 7

Assign each acute inpatient stay to one age and gender category. Refer to Table PCR.B and Table PCR.3 below.

Numerator

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

Step 1

Identify all acute inpatient stays with an admission date on or between January 2 and December 31 of the measurement year.

Step 2

Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3

Exclude acute inpatient hospital discharges with a principal diagnosis using the codes listed in Table PCR.A.

Step 4

For each IHS, determine if any of the acute inpatient stays had an admission date within 30 days after the Index Discharge Date.

Reporting denominator

Count the number of IHS for each age, gender and total combination and enter these values into the reporting table (see Table PCR.B and PCR.C).

Reporting risk adjustment (optional)

Step 1

Calculate the average adjusted probability for each IHS for each age, gender and total combinations and the overall total.

States must calculate the probability of readmission for each hospital stay within the applicable age and gender group to calculate the average. For the total age/gender category, the probability of readmission for all hospital stays in the age/gender categories must be averaged together; organizations cannot take the average of the average-adjusted probabilities reported for each age/gender.

Step 2

Enter these values into the reporting table and round to 4 decimal places.

Note: Do not take the average of the cells in the reporting table.

Example:

For the "18–44" age category:

- Identify all IHS by 18–44-year-old males and calculate the average adjusted probability.
- Identify all IHS by 18–44-year-old females and calculate the average adjusted probability.
- Identify all IHS by all 18–44-year-olds and calculate the average adjusted probability.

Repeat for each subsequent group.

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Step 3

Calculate the total (sum) variance for each age, gender and total combinations and the overall total.

Step 4

Enter these values into the reporting table and round to 4 decimal places.

Reporting numerator

Count the number of IHS with a readmission within 30 days for each age, gender, and total combination and enter these values into the reporting table.

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Table PCR.B. Plan All-Cause Readmission Rates by Age, Gender, and Risk Adjustment

Age	Sex	Count of Index Stays (Den)	Count of 30-Day Readmissions (Num)	Observed Readmission (Num/Den)	Average Adjusted Probability	Total Variance	O/E Ratio (Observed Readmission/ Average Adjusted Probability)
18–44	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.
45–54	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.
55–64	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.
Total	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.

Table PCR.C. Plan All-Cause Readmission Rates by Age, Gender, and Risk Adjustment

Age	Sex	Count of Index Stays (Den)	Count of 30-Day Readmissions (Num)	Observed Readmission (Num/Den)	Average Adjusted Probability	Total Variance	O/E Ratio (Observed Readmission/ Average Adjusted Probability)
65–74	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.
75–84	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.
85+	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.
Total	Male	.	.	.	.	.	.
.	Female	.	.	.	.	.	.
.	Total	.	.	.	.	.	.

F. ADDITIONAL NOTES

States may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for this measure. The Plan All-Cause Readmission measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification.

Measure FUH-HH: Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge.
- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Guidance for Reporting:
• Include all paid, suspended, pending, reversed, and denied claims. • This measure applies to Health Home enrollees age 6 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): ages 6 to 17, 18 to 64, and 65 and older. Age groups should be based on age as of the date of discharge.

B. DEFINITION

Mental health practitioner	A practitioner who provides 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. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Workers' 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.

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C. ELIGIBLE POPULATION

Age	Age 6 and older as of the date of discharge. Report three age stratifications and a total rate: • 6 to17 • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	Enrolled in a Health Home program from at least the date of discharge through 30 days after discharge
Allowable gap	No gaps in enrollment
Event/diagnosis	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Table FUH.A) on or between January 1 and December 1 of the measurement year. Use only facility claims to identify discharges with a principal mental health diagnosis. Do not use diagnoses from professional claims to identify discharges. The denominator for this measure is based on discharges, not patients. If patients had more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (Tables FUH.A and FUH.B) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the enrollee was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for a mental health principal diagnosis (Tables FUH.A and FUH.B) within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH.C for codes to identify nonacute care. Nonmental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables FUH.A and FUH.B. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place

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Table FUH.A. Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis
295–299, 300.3, 300.4, 301, 308, 309, 311–314

Table FUH.B. Codes to Identify Inpatient Services

MS—DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Table FUH.C. Codes to Identify Nonacute Care

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Hospice	.	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF	.	019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation	.	.	18x	.
Rehabilitation	.	0118, 0128, 0138, 0148, 0158	.	.
Respite	.	0655	.	.
Intermediate care facility	.	.	.	54
Residential substance abuse treatment facility	.	1002	.	55
Psychiatric residential treatment center	T2048, H0017-H0019	1001	.	56
Comprehensive inpatient rehabilitation facility	.	.	.	61
Other nonacute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)	.	.	.	.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

30-Day Follow-Up:

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An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table FUH.D) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up:

An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table FUH.D) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Table FUH.D. Codes to Identify Visits

CPT	.	HCPCS
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	.	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner	.	.
CPT	.	POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes	.	.
UB Revenue	.	.
0513, 0900-0905, 0907, 0911-0917, 0919	.	.
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH.A	.	.
UB Revenue	.	.
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983	.	.

NOTE: Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner.

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.

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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 (e.g., within 30 days after discharge or within 7 days after discharge).

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Measure CBP-HH: Controlling High Blood Pressure

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Guidance for Reporting:
• This measure requires use of the hybrid method. • This measure applies to Health Home enrollees ages 18 to 85. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable): 18 to 64 and 65 to 85. Age groups should be based on age as of December 31 of the measurement year.

B. DEFINITIONS

Adequate control	• Both a representative systolic BP <140 mm Hg and a representative diastolic BP <90 mm Hg (BP in the normal or high-normal range).
Representative BP	• The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension was made). 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 enrollee is "not controlled."
Primary care provider	• A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered primary care providers.

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 as of December 31 of the measurement year. Report two age stratifications and a total rate: • 18 to 64 • 65 to 85 • Total The total is the sum of the age stratifications.
Continuous enrollment	Enrolled in a Medicaid Health Home program for 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 Health Home enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled.
Anchor date	December 31 of the measurement year.

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Event/ diagnosis	Health Home enrollees are identified as hypertensive if there is at least one outpatient encounter (Table CBP.A) with a diagnosis of hypertension (Table CBP.B) during the first six months of the measurement year.

Table CBP.A. Codes to Identify Outpatient Visits

Description	CPT
Outpatient Visits	99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397

Table CBP.B. Codes to Identify Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population whose diagnosis of hypertension is confirmed by chart review.

To confirm the diagnosis of hypertension, there must be a notation of one of the following in the medical record on or before June 30 of the measurement year:

- HTN
- High BP (HBP)
- Elevated BP
- Borderline HTN
- Intermittent HTN
- History of HTN
- Hypertensive vascular disease (HVD)
- Hyperpiesia
- Hyperpiesis

The notation of hypertension may appear on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see Note at the end of this section)
- Office note
- Subjective, Objective, Assessment, Plan (SOAP) note
- Encounter form
- Telephone call record
- Diagnostic report
- Hospital discharge summary

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Statements such as “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm the diagnosis if such statements are the only notations of hypertension in the medical record.

Identifying the medical record

States should use only the medical records of one practitioner, Health Home provider, or provider team for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the records from one practitioner, Health Home provider, or provider team (even if obtained by a different practitioner) should be considered (e.g., from a consultation note or other note relating to a BP reading from a health care practitioner or provider team). If a state cannot find the medical record, the enrollee remains in the measure denominator and is considered noncompliant for the numerator.

States should use the following steps to find the appropriate medical record to review.

Step 1

- Identify the enrollee’s PCP (this may be a Health Home provider if the Health Home provider meets the definition of PCP outlined in the specification)
- If the enrollee had more than one PCP for the time period, identify the eligible practitioner who most recently provided care to the adult
- If the enrollee did not visit a PCP for the time period, identify the practitioner who most recently provided care to the enrollee
- If a practitioner other than the enrollee’s PCP manages the hypertension, the state may use the medical record of that practitioner

Step 2

- Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the state may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples:
- If an enrollee sees a PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.
- If an enrollee has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the adult’s hypertension after June 30, the state may use the PCP’s chart to confirm the diagnosis and use the specialist’s chart to obtain the BP reading. For example, if all recent claims coded with 401 came from the specialist, the state may use this chart for the most recent BP reading. If the enrollee did not have any visit with the specialist prior to June 30 of the measurement year, the state must go to another medical record to confirm the diagnosis.

Numerator

The number of Health Home enrollees in the denominator whose most recent BP is adequately controlled during the measurement year. For an enrollee’s BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if an enrollee’s BP is adequately controlled, the representative BP must be identified (see below).

Administrative data source

None.

Medical record data source

Follow the steps below to determine representative BP.

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Step 1

Identify the most recent BP reading noted during the measurement year. The reading must occur after the date when the diagnosis of hypertension was made or confirmed. Do not include BP readings that meet the following criteria:

- Taken during an acute inpatient stay or an ED visit.
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
- Reported by or taken by the enrollee.

Step 2

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.

Exclusions (optional)

- Exclude from the eligible population all Health Home enrollees with evidence of end-stage renal disease (ESRD) (Table CBP.C) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD.
- Exclude from the eligible population all Health Home enrollees with a diagnosis of pregnancy (Table CBP.C) during the measurement year.
- Exclude from the eligible population all Health Home enrollees who had an admission to a nonacute inpatient setting during the measurement year. Refer to Table CBP.C in Follow-Up After Mental Health Hospitalization measure specifications for codes to identify nonacute care.

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Table CBP.C. Codes to Identify Exclusions

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	UB Type of Bill	POS
Evidence of ESRD	36145, 36147, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0308-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339	585.5, 585.6, V42.0, V45.1	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.6	0367, 080x, 082x-085x, 088x	72x	65
Pregnancy	.	.	630-679, V22, V23, V28	.	.	.	.

E. E-MEASURE SPECIFICATION

See 2014 ECQM specifications for eligible providers for complete value set and e-measure codes: http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/clinicalqualitymeasures.html .

Guidance for Reporting:

In reference to the numerator element, only BP readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. BP readings from the patient's home (including readings directly from monitoring devices) are not acceptable. If no BP is recorded during the measurement period, the patient's BP is assumed "not controlled."

Denominator

Patients ages 18 to 85 who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.

Numerator

Patients whose most recent BP is adequately controlled (systolic <140 mmHg; diastolic <90 mmHg) during the measurement period.

Exclusions

Patients with evidence of ESRD, dialysis, or renal transplant before or during the measurement period.

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Patients with a diagnosis of pregnancy during the measurement period.

F. ADDITIONAL NOTES

States may use an undated notation of hypertension on problem lists. Problem lists generally indicate established conditions; to discount undated entries might hinder confirmation of the denominator. States generally require an oversample of 10 percent–15 percent to meet the Medical Record Systematic Sample (MRSS) for confirmed cases of hypertension.

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Measure CTR-HH: Care Transition – Timely Transmission of Transition Record

American Medical Association-Physician Consortium for Performance Improvement

A. DESCRIPTION

The percentage of Health Home enrollees of all ages discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility, Health Home provider or primary physician or other health care professional designated for follow-up care, within 24 hours of discharge.

Guidance for Reporting:

- This measure applies to Health Home enrollees of all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): 0 to 17, 18 to 64, and 65 and older. Age groups should be based on age as of December 31 of the measurement year.
- This measure includes discharges from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or other site of care.

B. DEFINITIONS

Term	Definition
Transition record	A core, standardized set of data elements related to the enrollee's diagnosis, treatment, and care plan that is discussed with and provided to the enrollee in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to the enrollee.
Transmitted	Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an EHR.
Primary physician or other health care professional designated for follow-up care	A Health Home provider, physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services, medical specialist or other health care professional.
Current medication list	All medications to be taken by enrollee after discharge, including all continued and new medications.
Advance directives	Written statement of enrollee wishes regarding future use of life-sustaining medical treatments.
Documented reason for not providing advance care plan	Documentation that advance care plan was discussed but enrollee did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR documentation as appropriate that the enrollee's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the enrollee's beliefs and thus harmful to the physician-enrollee relationship.

Contact information/plan for follow-up care	For enrollees discharged to an inpatient facility, the transition record may indicate that the three elements of: 24-hour/7-day contact information including physican for emergencies related to inpatient stay, contact information for optaining results of studies pending at discharge, and plan for follow-up care, are to be discussed between the discharging and the "receiving" facilities.
Plan for follow-up care	May include any post-discharge therapy needed (e.g., oxygen therapy, physical therapy, occupational therapy), any durable medical equipment needed, family/psychosocial resources available for enrollee support, etc.

C. ELIGIBLE POPULATION

Age	All ages as of December 31st of the measurement year. Report three age stratifications and a total rate: • 0 to17 • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	Enrolled in a Medicaid Health Home program on the date of discharge.
Allowable gap	None.
Event/diagnosis	Health Home enrollees who were discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care as of December 31st of the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

All enrollees discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care.

Identify enrollees discharged from inpatient facility using one of the following options:

- A code to identify Inpatient Facility (Table CTR.A) accompanied by a code to identify Discharge Status (Table CTR.B), OR
- A code to identify Outpatient Facilities (Table CTR.C) accompanied by a code to identify Locations (Table CTR.D) AND a code to identify Discharge Status (Table CTR.B).

Table CTR.A. Codes to Identify Inpatient Facilities Based on UB-04 (Form Locator 04—Type of Bill)

Code	Description
0111	Hospital, Inpatient, Admit through Discharge Claim
0121	Hospital, Inpatient—Medicare Part B only, Admit through Discharge Claim
0114	Hospital, Inpatient, Last Claim

Code	Description
0124	Hospital, Inpatient—Medicare Part B only, Interim-Last Claim
0211	Skilled Nursing—Inpatient, Admit through Discharge Claim
0214	Skilled Nursing—Inpatient, Interim, Last Claim
0221	Skilled Nursing—Inpatient, Medicare Part B only, Admit through Discharge Claim
0224	Skilled Nursing—Interim, Last Claim
0281	Skilled Nursing—Swing Beds, Admit through Discharge Claim
0284	Skilled Nursing—Swing Beds, Interim, Last Claim

Table CTR.B. Codes to Identify Discharge Status Based on UB-04 (Form Locator 17)

Code	Description
01	Discharged to home care or self-care (routine discharge)
02	Discharged/transferred to a short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care
04	Discharged/transferred to an intermediate care facility
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of organized Health Home service org. in anticipation of covered skilled care
43	Discharged/transferred to a federal health care facility
50	Hospice—home
51	Hospice—medical facility (certified) providing hospice level of care
61	Discharged/transferred to hospital-based Medicare approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Table CTR.C. Codes to Identify Outpatient Facilities Based on UB-04 (Form Locator 04—Type of Bill)

Code	Description
0131	Hospital Outpatient, Admit through Discharge Claim
0134	Hospital Outpatient, Interim, Last Claim

Table CTR.D. Codes to Identify Locations Based on UB-04 (Form Locator 42—Revenue Code)

Code	Description
0762	Hospital Observation
0490	Ambulatory Surgery
0499	Other Ambulatory Surgery

Numerator

Enrollees for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Medical record review is required to collect the numerator data elements. (Note: If a given element does not apply to the enrollee, the transition record should include documentation stating the element is not applicable, e.g., no pending studies at discharge).

The transition record must include the data elements specified in the Retrospective Data Collection Flowsheet (Figure CTR.A).

Figure CTR.A Retrospective Data Collection Flowsheet

Patient name:				
Medical record number or other patient identifier:				
Date of discharge:				
Numerator:				
		Yes	No	Instructions
Transition record with all of the specified elements	Did patient receive a Transition Record at discharge?			If yes, answer questions below to determine that all appropriate elements were included in the Transition Record
Are the following elements included in the transition record?		Yes	No	If a given element does not apply to the patient, the transition record should include documentation stating the element is not applicable (e.g., no pending studies at discharge)
Inpatient care	Reason for inpatient admission			
	Major procedures and tests, including summary of results			
Post-discharge/patient self-management	Current medication list			
	Studies pending at discharge (or documentation that no studies are pending)			
	Patient instructions			
Advance care plan	Advance directives or surrogate decision maker documented OR documented reason for not providing advance care plan			
Contact information/ plan for follow-up care	24-hour/7-day contact information including physician for emergencies related to inpatient stay			
	Contact information for obtaining results of studies pending at discharge			
	Plan for follow-up care			
	Primary physician, or other health care professional, or site designated for follow-up care			
Discharge information	Date and time patient was discharged from facility			
	Date and time transition record was transmitted to receiving facility, or physician, or other health care professional			
	Was transition record transmitted within 24 hours of discharge?			
Review responses above to determine if all elements were included in the transition record to be counted in the numerator for the measure.				

Exclusions

Refer to Table CTR.E:

- Enrollees who died prior to discharge.
- Patients who left against medical advice (AMA) or discontinued care.

Table CTR.E. Codes to Identify Exclusions Based on UB-04 (Form Locator 17—Discharge Status)

Code	Description
07	Left against medical advice or discontinued care
20	Expired
40	Expired at home
41	Expired in a medical facility
42	Expired-place unknown

E. ADDITIONAL NOTES

This measure has been modified from its original technical specification to allow for transmission of the transition record to the Health Home provider. The original measure specified transmission of the transition record only to the primary physician or other health care professional designated for follow-up care.

Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

- Initiation of AOD Treatment. The percentage of Health Home enrollees who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of Health Home enrollees who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Guidance for Reporting
• Include all paid, suspended, pending, reversed, and denied claims. • This measure applies to Health Home enrollees ages 13 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): 13 to 17, 18 to 64, and 65 and older. Age groups should be based on age as of December 31 of the measurement year.

B. DEFINITIONS

Intake Period	• January 1 to November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
Index Episode	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD • For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.
Index Episode Start Date (IESD)	The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD. For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED (not resulting in an inpatient stay) claim/encounter, the IESD is the date of service. For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge. For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge. • For direct transfers, the IESD is the discharge date from the second admission.

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Negative Diagnosis History	A period of 60 days (2 months) before the IESD when the patient had no claims/ encounters with a diagnosis of AOD dependence. For an inpatient claim/encounter, use the admission date to determine the Negative Diagnosis History. For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. • For direct transfers, use the first admission to determine the Negative Diagnosis History.

C. ELIGIBLE POPULATION

Age	Age 13 and older as of December 31 of the measurement year. Report three age stratifications and a total rate: • 13 to 17 • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	Enrolled in a Medicaid Health Home program for at least 60 days (2 months) prior to the IESD through 44 days after the IESD (inclusive).
Allowable gap	None.
Anchor date	None.

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Event/diagnosis	Follow the steps below to identify the eligible population, which is the denominator for both rates. Step 1 Identify the Index Episode. Identify all Health Home enrollees in the specified age range who during the Intake Period had one of the following: • An outpatient visit, intensive outpatient encounter or partial hospitalization (Table IET.B) with a diagnosis of AOD (Table IET.A). • A detoxification visit (Table IET.C). • An ED visit (Table IET.D) with a diagnosis of AOD (Table IET.A). • An inpatient discharge with a diagnosis of AOD as identified by either of the following: • An inpatient facility code in conjunction with a diagnosis of AOD (Table IET.A). • An inpatient facility code in conjunction with an AOD procedure code (Table IET.F). For Health Home enrollees with more than one episode of AOD, use the first episode. For Health Home enrollees whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge. Select the IESD. Step 2 Test for Negative Diagnosis History. Exclude Health Home enrollees who had a claim/encounter with a diagnosis of AOD (Table IET.A) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. Step 3 Calculate continuous enrollment. Health Home enrollees must be continuously enrolled without any gaps 60 days (2 months) before the IESD through 44 days after the IESD.

Table IET.A. Codes to Identify AOD Dependence

ICD-9-CM Diagnoses
291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

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Table IET.B. Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization Visits

CPT	HCPCS	UB Revenue
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983
CPT	.	POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53

Table IET.C. Codes to Identify Detoxification Visits

HCPCS	ICD-9-CM Procedure	UB Revenue
H0008-H0014	94.62, 94.65, 94.68	0116, 0126, 0136, 0146, 0156

Table IET.D. Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

Table IET.F. Codes to Identify AOD Procedures

ICD-9-CM Procedure
94.61, 94.63, 94.64, 94.66, 94.67, 94.69

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

Rate 1: Initiation of AOD Treatment

Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the adolescent or adult is compliant.

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If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification, or ED visit, the Health Home enrollee must have had an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization (Table IET.B) with an AOD diagnosis (Table IET.A) within 14 days of the IESD (inclusive).

If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).

Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment.

Exclude Health Home enrollees from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Rate 2 :Engagement of AOD Treatment

Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations (Table IET.B) with any AOD diagnosis (Table IET.A) within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

For Health Home enrollees who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period.

If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive).

Do not count engagement encounters that include detoxification codes (including inpatient detoxification).

E. E-MEASURE SPECIFICATION

See 2014 ECQM specifications for eligible providers for complete value set and e-measure codes: http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/clinicalqualitymeasures.html).

F. DEFINITION

Initiation visit	• The first visit for alcohol or other drug dependence treatment within 14 days after a diagnosis of alcohol or other drug dependence. • Treatment includes inpatient AOD admissions, outpatient visits, intensive outpatient encounters or partial hospitalization.

Guidance for Reporting:

The new episode of alcohol and other drug dependence should be the first episode of the measurement period that is not preceded in the 60 days prior by another episode of alcohol or other drug dependence.

Denominator

Patients age 13 and older who were diagnosed with a new episode of AOD dependency during a visit in the first 11 months of the measurement period.

Numerator

Numerator 1

Patients who initiated treatment within 14 days of the diagnosis.

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Numerator 2

Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Exclusions

Patients with a previous active diagnosis of AOD dependence in the 60 days prior to the first episode of alcohol or drug dependence.

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Measure PQI92-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

Agency for Healthcare Research and Quality (AHRQ)

A. DESCRIPTION

The total number of hospital admissions for ambulatory care sensitive chronic conditions per 100,000 Health Home enrollees age 18 and older. This measure includes adult hospital admissions for diabetes with short-term complications; diabetes with long-term complications; uncontrolled diabetes without complications; diabetes with lower-extremity amputation; chronic obstructive pulmonary disease; asthma; hypertension; heart failure; or angina without a cardiac procedure.

Guidance for Reporting:

- Free software is available from the AHRQ Web site for calculation of this measure: http://www.qualityindicators.ahrq.gov/Software/Default.aspx. These specifications are based on version 4.5 of the software.
- The numerator for this measure is specified to exclude transfers from other institutions, but the variables contained in the software to identify transfers (Table PQI92.B) may not exist in all data sources. In this case, states should note how transfers were identified and excluded.
- This measure applies to Health Home enrollees ages 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable): 18 to 64 and 65 and older. Age groups should be based on age as of December 31 of the measurement year.
- To calculate the measure per 100,000 Health Home enrollees, use the following steps: (1) calculate the numerator and denominator; (2) determine the rate (numerator/denominator); and (3) multiply the rate by 100,000.
- Age is based on the date of admission (hospital setting) or date of service (outpatient setting).
- Risk adjustment covariates and coefficients for the general population are available at http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx. The risk adjustment for this measure accounts for age and sex of the population and does not consider health conditions; therefore, states should use caution when comparing Health Home populations with different levels of comorbidity.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year. Report two age stratifications and a total rate: • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	None.
Allowable gap	None.

C. ADMINISTRATIVE SPECIFICATION

PQI 92: Chronic Conditions Composite

Denominator

The eligible population enrolled in a Health Home program during the measurement year.

Numerator

Discharges for patients ages 18 and older, who meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQIs):

- PQI 1: Diabetes Short-Term Complications Admission
- PQI 3: Diabetes Long-Term Complications Admission
- PQI 5: COPD or Asthma in Older Adults Admission
- PQI 7: Hypertension Admission
- PQI 8: Heart Failure Admission
- PQI 13: Angina without Procedure Admission
- PQI 14: Uncontrolled Diabetes Admission
- PQI 15: Asthma in Younger Adults Admission
- PQI 16: Lower-Extremity Amputations Among Patients with Diabetes

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

PQI 1: Diabetes Short-Term Complications Admission

All discharges of patients age 18 and older with an ICD-9-CM principal diagnosis code (Table PQI92.A) for diabetes short-term complications (ketoacidosis, hyperosmolarity, and coma).

Patients who were transferred to the hospital from another hospital (different facility), Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.A. Codes to Identify Diabetes Short-Term Complications

ICD-9-CM Codes	25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033

Table PQI92.B . Admission Codes for Transfers

SID ASOURCE Codes	2—Another hospital 3—Another facility, including long-term care
POINTOFORIGINUB04 Codes	4—Transfer from a hospital 5—Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6—Transfer from another health care facility

PQI 3: Diabetes Long-Term Complications Admission

All discharges of patients age 18 and older with an ICD-9-CM principal diagnosis code (Table PQI92.C) for diabetes long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified).

Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.C. Codes to Identify Diabetes Long-Term Complications

ICD-9-CM Codes	25040, 25041, 25042 25043, 25050, 25051, 25052, 25053, 25060, 25061, 25062, 25063, 25070, 25071, 25072, 25073, 25080, 25081, 25082, 25083, 25090, 25091, 25092, 25093

PQI 5: COPD or Asthma in Older Adults Admission

All discharges of patients age 40 and older with an ICD-9-CM principal diagnosis code for COPD or asthma in adults age 40 and older (Table PQI92.D).

Exclude patients with a diagnosis for cystic fibrosis and anomalies of the respiratory system (Table PQI92.E). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.D. Codes to Identify COPD and Asthma in Older Adults

ICD-9-CM COPD Codes	4910, 4911, 49120, 49121, 4918. 4919, 4920, 4928, 494, 4940, 4941, 496
ICD-9-CM Acute Bronchitis Codes*	4660, 490
ICD-9-CM Asthma (Older Adults) Codes	49300, 49301, 49302, 49310, 49311, 49312, 49320, 49321, 49322, 49381, 49382, 49390, 49391, 49392

*Must be accompanied by a secondary diagnosis code of COPD

Table PQI92.E. Codes to Identify Cystic fibrosis and anomalies of the respiratory system

ICD-9-CM Codes	27700, 27701, 27702, 27703, 27709, 51661, 51662, 51663, 51664, 51669, 74721, 7483, 7484, 7485, 74860, 74861, 74869, 7488, 7489, 7503, 7593, 7707

PQI 7: Hypertension Admission

All discharges of patients age 18 and older with an ICD-9-CM principal diagnosis code for hypertension (Table PQI92.F).

Exclude patients with a listed procedure code for cardiac procedure (Table PQI92.G). Exclude patients with a diagnosis for Stage I–IV kidney disease if the diagnosis is accompanied by a procedure code for dialysis (Table PQI92.H). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.F. Codes to Identify Hypertension

ICD-9-CM Codes	4010, 4019, 40200, 40210, 40290, 40300, 40310, 40390, 40400, 40410, 40490

Table PQI92.G. Codes to Identify Cardiac Procedures

ICD-9-CM Procedure Codes	0050, 0051, 0051, 0052, 0053, 0054, 0056, 0057, 0066, 1751, 1752, 1755, 3500, 3501, 3502, 3503, 3504, 3505, 3506, 3507, 3508, 3509, 3510, 3511, 3512, 3513, 3514, 3520, 3521, 3522, 3523, 3524, 3525, 3526, 3527, 3528, 3531, 3532, 3533, 3534, 3535, 3539, 3541, 3542, 3550, 3551, 3552, 3553, 3554, 3555, 3560, 3561, 3562, 3563, 3570, 3571, 3572, 3573, 3581, 3582, 3583, 3584, 3591, 3592, 3593, 3594, 3595, 3596, 3597, 3598, 3599, 3601, 3602, 3603, 3604, 3605, 3606, 3607, 3609, 3610, 3611, 3612, 3613, 3614, 3615, 3616, 3617, 3619, 3631, 3632, 3633, 3634, 3639, 3691, 3699, 3731, 3732, 3733, 3734, 3735, 3736, 3737, 3741, 3751, 3752, 3753, 3754, 3755, 3760, 3761, 3762, 3763, 3764, 3765, 3766, 3770, 3771, 3772, 3773, 3774, 3775, 3776, 3777, 3778, 3779, 3780, 3781, 3782, 3783, 3785, 3786, 3789, 3794, 3795, 3796, 3797, 3798, 3826

Table PQI92.H. Codes to Identify Stage I-IV Kidney Disease and Dialysis

ICD-9-CM Stage I-IV Kidney Disease Diagnosis Codes*	40300, 40310, 40390, 40400, 40410, 40490
ICD-9-CM Dialysis Access Procedure Codes	3895, 3927, 3929, 3942, 3943, 3993, 3994

*Must be accompanied by a dialysis access procedure code.

PQI 8: Heart Failure Admission

All discharges of patients age 18 and older with an ICD-9-CM principal diagnosis code for heart failure (Table PQI92.I).

Exclude patients with a listed procedure code for cardiac procedure (Table PQI92.G). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.I. Codes to Identify Heart Failure

ICD-9-CM Codes	39891, 4280, 4281, 42820, 42821, 42822, 42823, 42830, 42831, 42832, 42833, 42840, 42841, 42842, 42843, 4289

PQI 13: Angina Without Procedure Admission

All discharges of patients age 18 and older with an ICD-9-CM principal diagnosis code for angina (Table PQI92.J).

Exclude patients with a listed procedure code for cardiac procedure (Table PQI92.G). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another

health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.J. Codes to Identify Angina

ICD-9-CM Codes	4111, 41181, 41189, 4130, 4131, 4139

PQI 14: Uncontrolled Diabetes Admission

All discharges of patients age 18 and older with an ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication (Table PQI92.K).

Exclude patients with a diagnosis for cystic fibrosis and anomalies of the respiratory system (Table PQI92.E). Patients who were transferred to the hospital from another hospital (different facility), SNF, ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.K. Codes to Identify Uncontrolled Diabetes Without Mention of a Short-Term or Long-Term Complication

ICD-9-CM Codes	25002, 25003

PQI 15: Asthma in Younger Adults Admission

All discharges of patients older than age 18 and younger than age 40 with an ICD-9-CM principal diagnosis code of asthma (Table PQI92.L).

Exclude patients with a diagnosis for cystic fibrosis and anomalies of the respiratory system (Table PQI92.E). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.L . Codes to Identify Asthma in Young Adults

ICD-9-CM Codes	49300, 49301, 49302, 49310, 49311, 49312, 49320, 49321, 49322, 49381, 49382, 49390, 49392

PQI 16: Lower-Extremity Amputations Among Patients With Diabetes

All discharges of patients age 18 and older with an ICD-9-CM procedure code for lower-extremity amputation and diagnosis code of diabetes in any field (Table PQI92.M).

Exclude patients with a diagnosis for traumatic amputation of the lower extremity or procedure codes for toe amputation (Table PQI92.N). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92.B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

Table PQI92.M. Codes to Identify Lower Extremity Amputation and Diabetes

ICD-9-CM Lower-Extremity Amputation Procedure Codes	8410, 8411, 8412, 8413, 8414, 8415, 8416, 8417, 8418, 8419
ICD-9-CM Diabetes Diagnosis Codes	25000, 25001, 25002, 25003, 25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033, 25040, 25041, 25042, 25043, 25050, 25051, 25052, 25053, 25060, 25061, 25062, 25063, 25070, 25071, 25072, 25073, 25080, 25081, 25082, 25083, 25090, 25091, 25092, 25093

Table PQI92.N. Codes to Identify Traumatic Amputation of the Lower Extremity and Toe

ICD-9-CM Traumatic amputation of the lower extremity diagnosis codes	8950, 8951, 8960, 8961, 8962, 8963, 8970, 8971, 8972, 8973, 8974, 8975, 8976, 8977
ICD-9-CM Toe amputation procedure code	8411

Risk adjustment (optional)

States are encouraged to use the free AHRQ PQI software to calculate an age-gender risk-adjusted rate of admissions: http://www.qualityindicators.ahrq.gov/Software/Default.aspx

The AHRQ PQI risk adjustment model includes age, gender, and interaction of age and gender. A detailed description of the coefficients and the risk adjustment methodology is available on the AHRQ PQI web site.

Risk Adjustment Coefficients:

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V45/Parameter_Estimates_PQI_45.pdf

Empirical Methods for Risk Adjustment:

http://qualityindicators.ahrq.gov/Downloads/Resources/Publications/2011/QI_Empirical_Methods_05-03-11.pdf

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IV. Technical Specifications for the Health Home Utilization Measures

As part of the 2017 evaluation of the Health Home program, CMS requests that states submit information about Health Home enrollee utilization of inpatient, emergency, and nursing home care. These measures will be used in the evaluation to compare utilization between Health Home enrollees and non-Health Home Medicaid enrollees.

Acronym	Measure	Measure Steward[a] (web site)	Description	Data Source
AMB-HH	Ambulatory Care—Emergency Department Visits	NCQA/HEDIS http://www.ncqa.org	The rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.	Administrative
IU-HH	Inpatient Utilization	CMS	The rate of all acute inpatient care and services per 1,000 enrollee months among Health Home enrollees.	Administrative
NFU-HH	Nursing Facility Utilization	CMS	The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months.	Administrative

[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.

Measure AMB-HH: Ambulatory Care—Emergency Department Visits

National Committee for Quality Assurance

A. DESCRIPTION

The rate of emergency department (ED) visits per 1,000 enrollee months among Health Home enrollees.

Guidance for Reporting:
• The measure applies to Health Home enrollees of all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): 0 to 17, 18 to 64, and 65 and older. • 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. • Report age-stratified rates in total and separately by enrollee type: – Total Medicaid – Medicaid/Medicare Dual-Eligible – Medicaid—Disabled – Medicaid—Other Low Income • Individuals may be counted in more than one category. Health Home enrollees who have a restricted benefit package are not reported separately, but are included in the Total Medicaid population; therefore, the sum of the Medicaid/Medicare Dual-Eligible, Medicaid-Disabled, and Medicaid-Other Low Income may not equal the Total Medicaid.

B. DEFINITION

Enrollee months	• An enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year. See Section D for guidance on calculating enrollee months.

C. ELIGIBLE POPULATION

Age	Report three age stratifications and a total rate: • 0 to 17 • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	None.

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D. CALCULATING ENROLLEE MONTHS

Step 1

Determine enrollee months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The day selected must be consistent from person to person, month to month, and year to year. For example, if the state tallies enrollment on the 15th of the month and an enrollee is enrolled in the Medicaid Health Home program on January 15, the enrollee contributes one enrollee month in January.

Step 2

Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if an organization tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months to the 18 to 64 age group category and nine enrollee months to the 65-and-older age category.

E. CALCULATION OF ED VISIT RATES

Step 1

Count the total number of ED visits for Health Home enrollees that Medicaid (or Medicare for Dual Eligible beneficiaries) paid for, or expects to pay for, during the measurement year.

Identify ED visits (Table ABA.A). Count each visit to an ED that does not result in an inpatient stay once, regardless of the intensity or duration of the visit. Do not count ED visits that result in an inpatient stay. Categorize the visit into an age category based on the age as of the date of the ED visit.

Counting Multiple Services: The same service received on two different dates (e.g., ED visits six months apart) counts as two visits. Count visits, not the number of services or procedure codes billed (e.g., if a physician and a hospital submit separate bills for the same ED visit with the same date of service, only one should be counted). The state must develop its own system to avoid double counting.

Table ABA.A. Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

OR

CPT	.	POS
10040-69979	WITH	23

Step 2

Calculate the ED visit rate by dividing the number of ED visits by the number of enrollee months and multiply by 1,000, as follows:

ED Visit Rate = (Number of ED visits/number of enrollee months) x 1,000

Report Table ABA.B for the total Health Home population and by enrollee type (e.g., Medicaid/Medicare, Disabled, Low Income).

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Table ABA.B. ED Visits per 1,000 Health Home Enrollee Months, by Age

Age	ED Visits	Enrollee Months	Visits per 1,000 Enrollee Months
0–17	.	.	.
18–64	.	.	.
65+	.	.	.
Unknown	.	.	.
Total	.	.	.

F. ADDITIONAL NOTES

This measure has been adapted from the NCQA HEDIS measure AMB. Adaptations included the removal of outpatient visits from the original HEDIS measure; inclusion of additional language in the specification from the HEDIS section, “Guidelines for Utilization Measures;” and changes in age stratifications.

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Measure IU-HH: Inpatient Utilization

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The rate of acute inpatient care and services (total, maternity, mental health, surgery, and medicine) per 1,000 enrollee months among Health Home enrollees.

Guidance for Reporting:

- This measure applies to Health Home enrollees of all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): 0 to 17, 18 to 64, and 65 and older.
- Report all services the state (Medicaid) or Medicare (for Dual-Eligible beneficiaries) paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason. This measure includes discharges and days for total inpatient use and by type of use (medical/surgical, maternity, mental health).
- Age-stratified rates should be reported in total and separately by enrollee type:
  - Total Medicaid
  - Medicaid/Medicare Dual-Eligible
  - Medicaid—Disabled
  - Medicaid—Other Low Income
- Medicaid enrollees who have a restricted benefit package are not reported separately, but are included in the Total Medicaid population; therefore, the sum of the Medicaid/Medicare Dual-Eligible, Medicaid-Disabled and Medicaid-Other Low Income may not equal the Total Medicaid.

B. DEFINITION

Enrollee months	• An enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year. See Section D for guidance on calculating enrollee months.

C. ELIGIBLE POPULATION

Age	Report three age stratifications and a total rate: • 0 to 17 • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	None.

D. CALCULATING ENROLLEE MONTHS

Step 1

Determine enrollee months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The day selected must be consistent from person to person, month to month, and year to year. For example, if the state tallies enrollment on the 15th of the month and an enrollee is enrolled in the Medicaid Health Home program on January 15, the enrollee contributes one enrollee month in January.

Step 2

Use the enrollee's age on the specified day of each month to determine which age group the enrollee months will be contributed. For example, if an organization tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months to the 18–64 age group category.

Note: Maternity rates are reported per 1,000 female total enrollee months in order to capture deliveries as a percentage of the total inpatient discharges.

E. CALCULATING INPATIENT UTILIZATION

Step 1

Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year. Refer to the codes in Table IU.A to identify total inpatient discharges. Use the guidelines and formulas outlined below to report inpatient discharges:

- Coding: The use of DRGs is preferred to report discharges in all categories. Categorize DRGs by the hierarchy described below (i.e., Maternity, then Surgery, then Medicine). If DRGs are unavailable, use the other specified codes (e.g., ICD-9-CM codes) and categorize these codes by hierarchy (i.e., Maternity, then Surgery, then Medicine).
- Age of enrollees: Report Health Home enrollee age as of the date of discharge.
- Counting multiple services: The same procedure or service received on two different dates (e.g., CABG procedures six months apart) counts as two procedures. Multiple procedures on the same date of service count as one inpatient stay (e.g., if a surgeon and a hospital submit separate bills pertaining to the same surgical episode with the same date of service, only one should be counted). States must develop their own system to avoid double counting.
- Counting transfers: Treat transfers between institutions as separate admissions. Base transfer reports within an institution on the type and level of services provided. Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency services and non-mental health/chemical dependency services.
- Count only one admission when the transfer takes place within the same service category but to a different level of care; for example, from intensive care to a lower level of care or from a lower level of care to intensive care.
- Mental health and chemical dependency transfers: Count as a separate admission when the transfer is within the same institution, but to a different level of care (e.g., a transfer between inpatient and residential care). Each level should appropriately include discharges and length of stay.

Table IU.A. Codes to Identify Total Inpatient Discharges

Principal ICD-9-CM Diagnosis	.	MS—DRG
001-302, 306-999, V01-V29, V40-V90	OR	001-008, 010-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 876, 880-887, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill	.	.
11x, 12x, 41x, 84x	OR	Any acute inpatient facility code

Step 2

Categorize discharges into maternity, mental/behavioral health, surgery, and medicine. Use Table IU.B to identify discharges in categories using the following guidelines:

- Total Inpatient: Use Table IU.A to identify all acute inpatient discharges. The Total Inpatient should be the sum of the four categories (Maternity, Mental Health, Surgery, Medicine) and any MS-DRGs defined as “principal diagnosis invalid as discharge diagnosis or ungroupable.” Categorize each inpatient discharge using the hierarchy below.
- Maternity: Refer to Table IU.B for ICD-9-CM Principal Diagnosis codes, UB Revenue, UB Type of Bill, and DRG codes. A delivery is not required for inclusion of an inpatient stay in the Maternity category; any maternity-related stay is included. Include birthing center deliveries in this measure and count them as one day of stay.
- Mental/Behavioral Health: Include inpatient care at either a hospital or a treatment facility with mental health as the principal diagnosis. Include discharges associated with residential care and rehabilitation. Refer to Table IU.B for the ICD-9-CM Principal Diagnosis codes, UB Revenue, UB Type of Bill, and DRG codes.
- Surgery: Organizations that use ICD-9-CM Diagnosis codes must identify total inpatient, remove maternity-related and mental-health discharges, and include the remaining discharges accompanied by UB revenue code 036X.
- Medicine: Organizations that use ICD-9-CM Diagnosis codes must identify total acute inpatient discharges, remove maternity and mental health related discharges, and remove all discharges accompanied by UB revenue code 036X.
- Do not include newborn care rendered from birth to discharge home from delivery; only report newborn care rendered if the baby is discharged home from delivery and is subsequently rehospitalized (see MS-DRGs 789–795 under Medicine in Table U2.2).

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Table IU.B. Codes to Identify Inpatient Discharges by Type (Maternity, Mental Health, Surgery, and Medicine)

Description	Principal ICD-9-CM Diagnosis	UB Revenue	UB Type of Bill	MS—DRG
Maternity	630-676, 678-679, V24.0	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	765-770, 774-782
Mental Health	290, 293-302, 306-316	.	.	876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319
Surgery	Total minus (Maternity and Mental Health)*	036x	.	001-008, 010-013, 020-042, 113-117, 129-139, 163-168, 215-264, 326-358, 405-425, 453-517, 573-585, 614-630, 652-675, 707-718, 734-750, 799-804, 820-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-989
Medicine	Total minus (Maternity, Mental Health, and Surgery)	.	.	052-103, 121-125, 146-159, 175-208, 280-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-700, 722-730, 754-761, 789-795, 808-816, 834-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977

*If the organization uses ICD-9-CM Diagnosis codes to report this measure, all discharges reported in the Surgery group must be in conjunction with UB revenue code 036X.

Step 3

Calculate the average length of stay and total days for each category using the following guidelines.

- Length of Stay (LOS): All approved days from admission to discharge. The last day of the stay is not counted unless the admission and discharge date are the same.
- LOS = (discharge date – admit date) – denied days
- Note: When an inpatient revenue code (i.e., UB or equivalent code) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admission date are the same, then the discharge date minus the admission date equals one day, not zero days.
- Average Length of Stay (ALOS): Total days/total discharges
- Total days: The sum of the length of stay for all discharges during a measurement year. The total does not include the last day of the stay (unless the last day of stay is also the admit day) or denied days.
- Total days incurred includes days before January 1 of the measurement year for discharge dates occurring during the measurement year.
- Total days incurred does not include days during the measurement year that are associated with discharge dates in the year after the measurement year.
- Total days incurred = Sum of LOS for each discharge during the measurement year.

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Step 4

Report tables IU.C and IU.D separately for total Medicaid, Medicaid/Medicare Dual-Eligible, Medicaid—Disabled, and Medicaid—Other Low Income. Use the following guidelines to calculate the measures:

- Discharge: Total number of discharges for each group.
- Discharge rate (discharges/1,000 enrollee months): Calculate the discharge rate for total inpatient, maternity, mental health, surgery, and medicine by dividing the number of discharges by the number of enrollee months and multiply by 1,000, as follows:
- Discharge rate = (Number of discharges/number of enrollee months) x 1,000
- Days: Total number of days incurred for each group.
- Days rate (days/1,000 enrollee months): Calculate the days rate for total inpatient, maternity, mental health, surgery, and medicine by dividing the total number of days incurred by the number of enrollee months and multiply by 1,000 as follows:
- Days rate = (Total days incurred/enrollee months) × 1,000
- Average Length of Stay: Total days/total discharges.

Table IU.C. Table for Reporting Enrollee Months, by Age

Age	Number of Enrollee Months
0-17	.
18-64	.
65+	.
Unknown	.
Total	.

Table IU.D. Table for Reporting Inpatient Utilization Per 1,000 Enrollee Months, by Age and Type of Inpatient Utilization

Age	Number of Discharges	Discharges/ 1,000 Enrollee Months	Number of Days	Days/1,000 Enrollee Months	Average Length of Stay
Inpatient	.	.	.	.	.
0-17	.	.	.	.	.
18-64	.	.	.	.	.
65+	.	.	.	.	.
Unknown	.	.	.	.	.
Total Inpatient	.	.	.	.	.

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Age	Number of Discharges	Discharges/ 1,000 Enrollee Months	Number of Days	Days/1,000 Enrollee Months	Average Length of Stay
Maternity*					
18-64					
Unknown					
Total Maternity					
Mental Health					
0-17					
18-64					
65+					
Unknown					
Total Mental Health					
Surgery					
0-17					
18-64					
65+					
Unknown					
Total Surgery					
Medicine					
0-17					
18-64					
65+					
Unknown					
Total Medicine					

*The Maternity category is calculated using enrollee months for females ages 18 to 64.

F. ADDITIONAL NOTES:

This measure was adapted from the NCQA HEDIS measure Inpatient Utilization—General Hospital/Acute Care. Codes for behavioral and mental health-related inpatient care were added; language was added in the specification from the HEDIS section, Guidelines for Utilization Measures; changes were made to age stratifications.

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Measure NFU-HH: Nursing Facility Utilization

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months.

The following rates are reported:

- Nursing facility stay <101 days (short-term stay).
- Nursing facility stay ≥101 days (long-term stay).

Guidance for Reporting:
• This measure applies to Health Home enrollees age 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable): 18 to 64 and 65 and older.

B. DEFINITIONS

Enrollee months	• An enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year. See Section D for guidance on calculating enrollee months.
Community residence	Any residence that is not a Medicaid- or Medicare- certified nursing facility or ICF for Individuals with Intellectual or Developmental Disabilities (IDD). • Note: Individuals who were admitted to the nursing facility from the hospital setting and who lived in the community prior to the hospital admission are considered residing in the community.
Nursing facility	• Medicaid- or Medicare- certified nursing facilities provide skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as "custodial care").
Short-term nursing facility stay	• A nursing facility stay that results in a discharge <101 days after admission.
Long-term nursing facility stay	• A nursing facility stay that does not result in a discharge <101 days after admission (i.e., no discharge in measurement year or discharge ≥101 days after admission).
Admission	An admission entry record is required when any one of the following occurs: • An enrollee has never been admitted to a nursing facility before, or • An enrollee has been in a nursing facility previously and was discharged with a return not anticipated, or • An enrollee has been in a nursing facility previously and was discharged with a return anticipated, and did not return within 30 days of discharge.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year. Report two age stratifications and a total rate: • 18 to 64 • 65+ • Total The total is the sum of the age stratifications.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Steps to Calculate Enrollee Months for the Eligible Population.

Step 1

Determine enrollee months between September 1 of the year prior to the measurement year and August 31 of the measurement year using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The day selected must be consistent from person to person, month to month, and year to year. For example, if the state tallies enrollment on the 15th of the month and an enrollee is enrolled in the Health Home program on January 15, the enrollee contributes one enrollee month in January.

Step 2

Age stratification. Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if the state tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months to the 18–64 age group category and nine enrollee months to the 65-and-older age category.

Identify qualified index admissions (Figure NFU.A).

Step 1

Identify all admissions to nursing facilities between September 1 of the year prior to the measurement year and August 31 of the measurement year.

Refer to Table NFU.A for codes to identify nursing facilities. States may alternatively use a state-defined residence classification system that indicates enrollee residence in a nursing facility.

Note: The numerator for this measure is based on number of admissions. An enrollee may be counted more than once in the numerator if the individual had more than one admission to a nursing facility followed by a discharge to the community during the measurement year.

Step 2

Exclude admissions that are transfers from a nursing facility or ICF/IDD.

Step 3

Exclude admissions from the hospital where the hospital admission originated from a nursing facility or ICF/IDD.

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Step 4

All admissions directly from the community or from the hospital (where the hospital admission originated in the community) are considered qualified index admissions.

Figure NFU.A. Steps to Identify Qualified Index Admissions

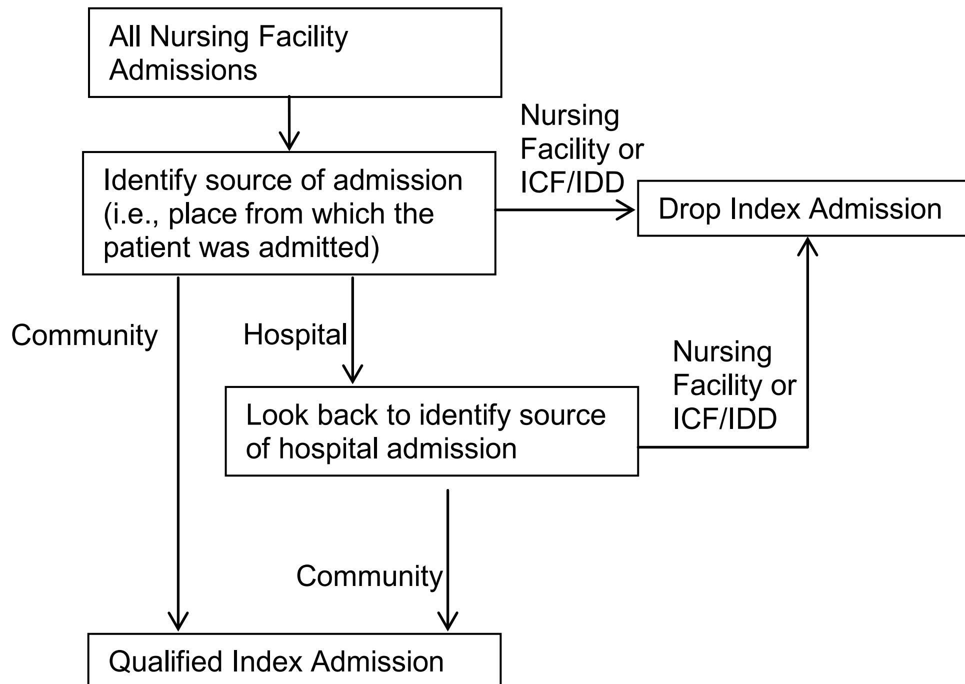

Table NFU.A.. Codes to Identify Nursing Facilities

UB -04 Type of Bill	Place of Service Codes	UB-04 Revenue Codes
021x, 022x, 023x, 028x	31, 32, 33	019x, 055x

Calculate length of stay (LOS) for qualified index admissions (Figure NFU.B).

Step 1

- Identify all qualified index admissions.
- If the enrollee dies in the nursing facility, exclude the admission from the qualified index admission.
- If the enrollee is transferred from the nursing facility to an ICF/IDD, exclude the nursing facility admission from the qualified index admission.

Step 2

Look for the location of the first discharge in the measurement year:

- If the enrollee is discharged to the community, calculate LOS as the date of nursing facility discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus the index admission date.
- If the enrollee is discharged to the hospital, look for the hospital discharge and location of discharge:
- If the enrollee dies in the hospital, exclude the admission from the qualified index admission.

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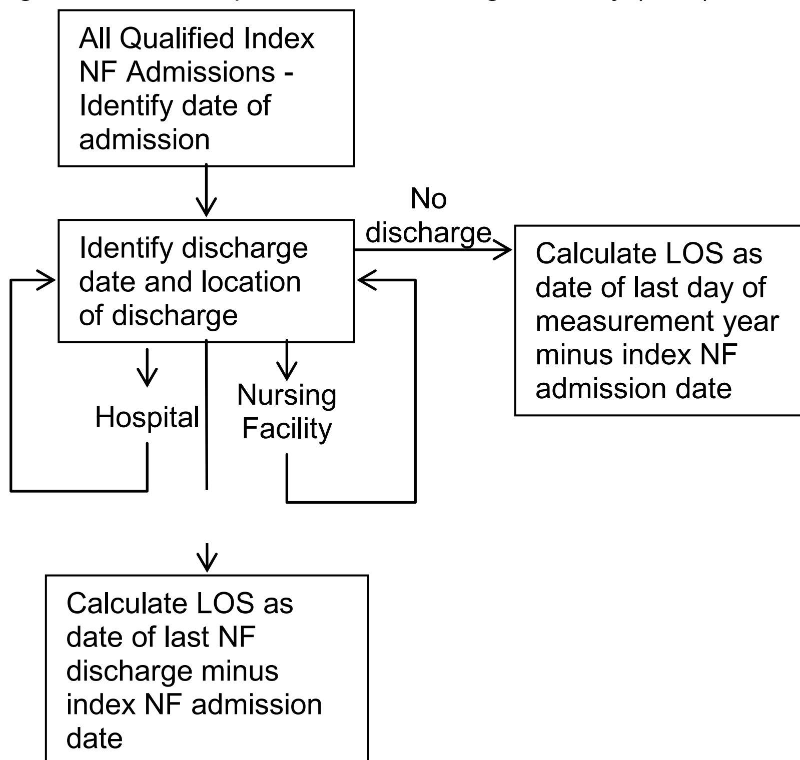
- If the enrollee remains in the hospital at the end of the measurement year, exclude the admission from the qualified index admission.
- If the enrollee is discharged from the hospital to the community, calculate LOS as the date of nursing facility discharge minus the index nursing facility admission date.
- If the enrollee is discharged from the hospital to a nursing facility, repeat step 2 to look for next possible discharge from the nursing facility.
- If the enrollee is discharged to a different nursing facility (i.e., a transfer), repeat step 2 to look for the next possible discharge from the subsequent facility.

Step 3

Classify LOS as short-term or long-term.

- Short-term stay: The LOS is <101 days.
- Long-term stay: The LOS is ≥101 days.
- When counting the duration of each stay in a measurement period, include the day of entry (admission) but not the day of discharge, unless the admission and discharge occurred on the same day. In this case, the number of days in the stay = 1.

Figure NFU.B. Steps to Calculate Length of Stay (LOS)



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Step 1

Calculate the admission rate by dividing the number of admissions by the number of enrollee months and multiply by 1,000 as follows:

- Short Term Admission Rate = (Number of short term admissions/number of enrollee months) x 1,000
- Long Term Admission Rate = (Number of long term admissions/number of enrollee months) x 1,000

Report calculations in Table NFU.B.

Table NFU.B. Table for Reporting Nursing Facility Utilization

Age	Number of Short Term Admissions	Short Term Admissions/1,000 Enrollee Months	Number of Long Term Admissions	Long Term Admissions/ 1,000 Enrollee Months
18-64				
65+				
Total				

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