

Illinois Department of Healthcare and Family Services

Healthcare and Quality of Life

Performance Measures Specifications

For the
Accountable Care Entities

August 18, 2014

HEDIS 2014

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Acronyms in **Green** indicate this is a HEDIS measure.

Acronyms in **Red** indicate this is an Illinois defined and developed measure **if** the first letter is "I".

- **Or** -

It is a state modified HEDIS measure if the first letter is "S" which will be followed by the HEDIS acronym for the appropriate base measure.

Medication Tables for Measures

All non-HEDIS measures have the medication tables included in the measure specifications, or included at the end of this document. These tables will be updated annually. The medication tables for HEDIS measures may be downloaded from the NCQA website at www.ncqa.org.

Access / Utilization of Care

AAP - Adults' Access to Preventive/Ambulatory Health Services

Description

The percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line.

- Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.
- Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year.

Eligible Population

Product lines Commercial, Medicaid, Medicare (report each product line separately).

Ages 20–65 years and older as of December 31 of the measurement year. Report three age stratifications and a total rate.

- 20–44 years
- 45–64 years.
- 65 years and older.
- Total.

The total is the sum of the age stratifications.

Continuous enrollment *Medicaid and Medicare:* The measurement year.

Commercial: The measurement year and the two years prior to the measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

**Event/
diagnosis** None.

Administrative Specification

Denominator The eligible population (report each age stratification separately).

Numerator *Medicaid and Medicare:* One or more ambulatory or preventive care visits during the measurement year.

Commercial: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year.

Use the following value sets to identify ambulatory or preventive care visits:

- Ambulatory Visits Value Set.
- Other Ambulatory Visits Value Set.

CAP - Children and Adolescents' Access to Primary Care Practitioners

Description

The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.

- Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year.
- Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	12 months–19 years as of December 31 of the measurement year. Report four age stratifications. <ul style="list-style-type: none">• 12–24 months as of December 31 of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 31, 2011, and December 1, 2010).• 25 months–6 years as of December 31 of the measurement year. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between November 30, 2010, and January 1, 2006).• 7–11 years as of December 31 of the measurement year.• 12–19 years as of December 31 of the measurement year.
Continuous enrollment	<i>For 12–24 months, 25 months–6 years:</i> The measurement year. <i>For 7–11 years, 12–19 years:</i> The measurement year and the year prior to the measurement year.
Allowable gap	<i>For 12–24 months, 25 months–6 years:</i> No more than one gap in enrollment of up to 45 days during the measurement year. <i>For 7–11 years, 12–19 years:</i> No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

CAP - Children and Adolescents' Access to Primary Care Practitioners

Administrative Specification

Denominator The eligible population.

Numerator *For 12–24 months, 25 months–6 years:* One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year.

For 7–11 years, 12–19 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year or the year prior to the measurement year.

Count all members who had an ambulatory or preventive care visit to *any* PCP.

Exclude specialist visits.

Note

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- *Refer to Appendix 3 for the definition of PCP.*

AMB – Ambulatory Care – ED Visits Only

Description

This measure summarizes utilization of Emergency Department care.

Calculations

Product	Medicaid.
Member months	For each product line and table, report all member months for the measurement year. IDSS automatically produces member year's data for the commercial and Medicare product lines. Refer to <i>Specific Instructions for Use of Services Tables</i> for more information.
ED visits	Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: <ul style="list-style-type: none">• An ED visit (<u>ED Value Set</u>)• A procedure code (<u>ED Procedure Code Value Set</u>) with an ED place of service code (<u>ED POS Value Set</u>).

Exclusions (required)

The measure does not include mental health or chemical dependency services. Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency.

Any of the following meet criteria:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set).
- Psychiatry (Psychiatry Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set).
- Alcohol or drug rehabilitation or detoxification (AOD Rehab and Detox Value Set).

Note

- *This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.*

IAPE – Ambulatory Care Follow-up with a Provider within 14 Days of Emergency Department (ED) Visit (Illinois)

Description

This measure determines if there was an ambulatory care follow-up with a provider after having an ED visit.

Eligible Population

Product lines	Medicaid.
Ages	All
Continuous enrollment	Date of ED discharge through 14 days after ED discharge.
Allowable gap	No gaps in enrollment.
Event/ diagnosis	Discharged alive from an ED on or between December 18 of the prior year and December 17 of the measurement year. This measure excludes ED visits with a principal diagnosis for mental illness. The denominator for this measure is based on ED visits, <u>not members</u> . Include all events for those members who have more than one ED visit on or between December 18 of the prior year and December 17 of the measurement year.
ED visits	Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following: <ul style="list-style-type: none"> • An ED visit (<u>ED Value Set</u>) • A procedure code (<u>ED Procedure Code Value Set</u>) with an ED place of service code (<u>ED POS Value Set</u>).

Administrative Specification

Denominator	The eligible population
Numerator	An ambulatory care follow-up visit with a provider within 14 days of the ED visit. Use the <u>Ambulatory Visits</u> and the <u>Nursing facility care; Domiciliary, rest home or custodial care services and Ophthalmology and optometry</u> portions of the <u>Other Ambulatory Visits Value Sets</u> to identify ambulatory care visits.

Note: Not all the codes from the Ambulatory Visits Value Sets are used since they do not apply to the IL ABD population (e.g., newborn codes). Plans should only use the above referenced codes.

Exclusions (required)

Exclude ED discharges in which the patient was transferred directly or readmitted within 14 days to an acute or non-acute facility. These ED discharges are excluded from the measure because the hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Exclude ED discharges with a principal diagnosis of mental health or chemical dependency as identified in Table IAPE-A.

Table IAPE-A: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis	WITH	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Note: This table does not have a value set.

IAP1 – Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge (Illinois)

Description

This measure determines if a member had an ambulatory care follow-up with a Provider after having an inpatient hospital stay.

Eligible Population

Product	Medicaid
Ages	All
Continuous enrollment	Date of discharge through 14 days after discharge.
Allowable gap	No gaps in enrollment.
Event/ diagnosis	<p>Discharged alive from an inpatient setting on or between December 18 of the prior year and December 17 of the measurement year.</p> <p>This measure excludes inpatient discharges with a principal diagnosis for mental illness or chemical dependency.</p> <p>The denominator for this measure is based on inpatient discharges, not members. Include all events for those members who have more than one discharge on or between December 18 of the prior year and December 17 of the measurement year.</p> <p>Identify qualifying discharges using any of the following Value Sets:</p> <ul style="list-style-type: none"> • <u>Maternity MS-DRG Value Set.</u> • <u>Surgery MS-DRG Value Set.</u> • <u>Medicine MS-DRG Value Set</u> • <u>Newborns/Neonates MS-DRG Value Set</u>

Note: If MS-DRGs are not captured, then plans should use table IAPI-A:

Table IAPI-A: Additional Codes to Identify Inpatient Discharges

Principal ICD-9-CM Diagnosis	
001-289, 317-999, V01-V29, V40-V90	
<i>WITH</i>	
UB Type of Bill	OR
11x, 12x, 41x, 84x	Any acute inpatient facility code

IAPI – Ambulatory Care Follow-up with a Provider within 14 Days of Inpatient Discharge (Illinois)

Administrative Specification

Denominator	The eligible population
Numerator	An ambulatory care follow-up visit with a provider within 14 days of the inpatient discharge. Use the <i>Ambulatory Visits</i> and the <i>Nursing facility care; Domiciliary, rest home or custodial care services and Ophthalmology and optometry</i> portions of the <u>Other Ambulatory Visits Value Sets</u> to identify ambulatory care visits.

Note: *Not all the codes from the Ambulatory Value Sets were used since it does not apply to the IL ABD population (e.g., newborn codes). Plans should only use the above referenced codes.*

Exclusions (required)

- Exclude inpatient hospitalizations for deliveries (births) using the Maternity Diagnosis Value Set, the Maternity Value Set and Table IAPI-B.

Table IAPI-B: Additional Codes to Identify Maternity-Related Inpatient Discharges

Principal ICD-9-CM Diagnosis	MS—DRG
V27.x, V30-V37, V39	765-770, 774-782

Note: This table does not have a value set.

- Exclude discharges in which the patient was transferred directly or readmitted within 14 days after discharge to an acute or non-acute facility. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- The measure does not include services for inpatient discharges with a principal diagnosis of mental health or chemical dependency. Exclude claims and encounters that contain any of the codes in either the Mental Health Diagnosis Value Set or IPU-C below.

Table IAPE-A: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis	WITH	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

Note: This table does not have a value set.

W15/W34 – Well-Child Visits in the First 15 Months and the Third, Fourth, Fifth and Sixth Years of Life (HEDIS Combined)

W15 - Well-Child Visits in the First 15 Months of Life

Description

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:

- No well-child visits.
- One well-child visit.
- Two well-child visits.
- Three well-child visits.
- Four well-child visits.
- Five well-child visits.
- Six or more well-child visits.

Note: This measure has the same structure as measures in the Effectiveness of Care domain. The organization should follow the Guidelines for Effectiveness of Care Measures when calculating this measure.

Eligible Population

Product lines	Medicaid.
Age	15 months old during the measurement year.
Continuous enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child’s date of birth. Calculate the 15-month birthday as the child’s first birthday plus 90 days. For example, a child born on January 9, 2012, and included in the rate of “six or more well-child visits” must have had six well-child visits by April 9, 2013.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Day the child turns 15 months old.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits (Well-Care Value Set), on different dates of service, with a PCP during their first 15 months of life. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

W15/W34 – Well-Child Visits in the First 15 Months and the Third, Fourth, Fifth and Sixth Years of Life (HEDIS Combined)

Hybrid Specification

Denominator	<p>A systematic sample drawn from the eligible population for the Medicaid product line. The organization may reduce its sample size using the current year's administrative rate for six or more visits, or the prior year's audited rate for six or more visits.</p> <p>Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing sample size.</p>
Numerators	<p>Seven separate numerators are calculated, corresponding to the number of members who had 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a PCP during their first 15 months of life.</p> <p>The well-child visit must occur with a PCP.</p>
Administrative	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from administrative data.</p>
Medical record	<p>Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of <i>all</i> of the following:</p> <ul style="list-style-type: none">• A health and developmental history (physical and mental).• A physical exam.• Health education/anticipatory guidance. <p>Do not include services rendered during an inpatient or ED visit.</p> <p>Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.</p> <p>The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.</p>

Note

- Refer to Appendix 3 for the definition of PCP.
- This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.brightfutures.org for more information about well-child visits.

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W15/W34 – Well-Child Visits in the First 15 Months and the Third, Fourth, Fifth and Sixth Years of Life (HEDIS Combined)

W34 – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Description

The percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. The organization should follow the Guidelines for Effectiveness of Care Measures when calculating this measure.*

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	3–6 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	At least one well-child visit (<u>Well-Care Value Set</u>) with a PCP during the measurement year. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for the Medicaid product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate. Refer to <i>Guidelines for Calculations and Sampling</i> for information on reducing sample size.
Numerator	At least one well-child visit with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

W15/W34 – Well-Child Visits in the First 15 Months and the Third, Fourth, Fifth and Sixth Years of Life (HEDIS Combined)

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

Medical record Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of *all* of the following:

- A health and developmental history (physical and mental).
- A physical exam.
- Health education/anticipatory guidance.

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.

The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

Note

- Refer to Appendix 3 for the definition of PCP.
- This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.brightfutures.org for more information about well-child visits.

AWC – Adolescent Well-Care Visits

Description

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Note: This measure has the same structure as measures in the Effectiveness of Care domain. Organizations should follow the Guidelines for Effectiveness of Care Measures when calculating this measure.

Eligible Population

Product lines	Medicaid .
Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	At least one comprehensive well-care visit (<u>Well-Care Value Set</u>) with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the member.

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for the Medicaid product line. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited rate. Refer to <i>Guidelines for Calculations and Sampling</i> for information on reducing sample size.
Numerator	At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The PCP does not have to be assigned to the member.

AWC – Adolescent Well-Care Visits

- Administrative** Refer to *Administrative Specification* to identify positive numerator hits from the administrative data.
- Medical record** Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of *all* of the following:
- A health and developmental history (physical and mental).
 - A physical exam.
 - Health education/anticipatory guidance.
- Do not include services rendered during an inpatient or ED visit.
- Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.
- Visits to school-based clinics with practitioners whom the organization would consider PCPs may be counted if documentation that a well-care exam occurred is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the member.
- The organization may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure

Note

- Refer to Appendix 3 for the definition of PCP and OB/GYN and other prenatal care practitioners.
- This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at www.brightfutures.org for more information about well-care visits

IIHR—Inpatient Hospital 30-Day Readmission Rates (Illinois)

Description

This measure determines if a member had an inpatient hospital readmission for the same discharge diagnosis after having an initial inpatient hospital stay. Two rates are reported.

- Non-Behavioral Health Hospital Inpatient Stays
- Behavioral Health Hospital Inpatient Stays

Eligible Population

Product	Medicaid.
Ages	All.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Event/ diagnosis	Discharged alive from an inpatient setting (Table IPU-A) on or between December 2 of the prior year and December 1 of the measurement year. The denominator for this measure is based on discharges, <u>not members</u> . Include all events for those members who have more than one discharge on or between December 2 of the prior year and December 1 of the measurement year.

Table IIHR-A: Codes to Identify Total Inpatient Discharges

Principal ICD-9-CM Diagnosis		MS—DRG
001-289, 317-999, V01-V29, V40-V90	OR	001-013, 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, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999
<i>WITH</i>		
UB Type of Bill	OR	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Administrative Specification

Report each rate separately.

Rate 1: *Non-Behavioral Health Hospital Inpatient Stays*

Additional eligible population criteria The eligible population
Exclude inpatient discharges with a principal diagnosis for mental illness (Mental Health Diagnosis Value Set) and for pregnancies / deliveries (Table IIHR-A)

Table IIHR-B: Codes to Identify Pregnancies / Deliveries (Exclusions)

DRG	ICD-9-CM Diagnosis
370 - 375	630 - 679

IIHR—Inpatient Hospital 30-Day Readmission Rates

Numerator An inpatient hospital readmission within 30 days from the initial discharge. **The inpatient diagnosis for the readmission must be the same as the discharge diagnosis from the initial hospitalization, at the 3-digit classification level for the ICD-9 code (e.g., 428 rather than 428.01).**

Exclude transfers to an *acute facility* following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.

Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the measurement year.

Exclude direct transfer to a *non-acute facility* within the 30-day follow-up period. Refer to the Codes to Identify Nonacute Care Value Set for codes to identify non-acute care.

Rate 2: Behavioral Health Hospital Inpatient Stays

Additional eligible population criteria

The eligible population.

Include inpatient care at either a hospital or a treatment facility with mental health as the principal diagnosis.

Use one of the following criteria to identify mental health inpatient services:

- An inpatient facility code in conjunction with a principal mental health diagnosis (Mental Health Diagnosis Value Set), **or**
- MS-DRGs.

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

Note: DSM-IV codes mirror ICD-9-CM codes. A health plan that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for ICD-9-CM codes.

Numerator An inpatient hospital readmission within 30 days from the initial discharge. **The inpatient diagnosis for the readmission must be the same as the discharge diagnosis from the initial hospitalization, at the 3 digit classification level for the ICD-9 code (e.g., 296 rather than 296.01).**

Exclude transfers to an *acute facility* following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.

Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the measurement year.

Exclude direct transfer to a *non-acute facility* within the 30-day follow-up period. Refer to Table FUH-B for codes to identify non-acute care.

Preventive / Screening Services

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ABA – Adult BMI Assessment

Description

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior the measurement year.

Definitions

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.

Eligible Population

Product lines	Medicaid.
Ages	18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/diagnosis	Members who had an outpatient visit (<u>Outpatient Value Set</u>) during the measurement year or the year prior to the measurement year.

Note: The plans are required to calculate this using the hybrid methodology, but for 2014 reporting, the administrative rate will also be required.

Administrative Specification

Denominator	The eligible population.
Numerator	BMI (<u>BMI Value Set</u>) during the measurement year or the year prior to the measurement year. For members younger than 19 years of age on the date of service, BMI percentile (<u>BMI Percentile Value Set</u>) also meets criteria.

Exclusions (optional)

Members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

ABA – Adult BMI Assessment

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate or the prior years audited, product line-specific rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.
Numerator	BMI during the measurement year or the year prior to the measurement year as documented through either administrative data or medical record review.
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
Medical record	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 members younger than 19 years on the date of service, the following documentation of BMI percentile also meets criteria: <ul style="list-style-type: none">• BMI percentile documented as a value (e.g., 85th percentile).• BMI percentile plotted on an age-growth chart. Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance.

Exclusions (optional)

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

Note

- 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 weight only.

WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Description

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation*.
- Counseling for nutrition.
- Counseling for physical activity.

* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Definitions

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 CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age. For adolescents 16–17 years of age on the date of service, a BMI value (<u>BMI Value Set</u>) also meets criteria.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	3–17 years as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators: <ul style="list-style-type: none">• 3–11 years.• 12–17 years.• Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	An outpatient visit (<u>Outpatient Value Set</u>) with a PCP or an OB/GYN during the measurement year.

WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Administrative Specification

Denominator The eligible population.

Numerators

BMI Percentile BMI percentile (BMI Percentile Value Set) during the measurement year.

Counseling for Nutrition Counseling for nutrition (Nutrition Counseling Value Set) during the measurement year.

Counseling for Physical Activity Counseling for physical activity (Physical Activity Counseling Value Set) during the measurement year.

Exclusions (optional)

Members who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year. The denominator for all rates must be the same. An organization that excludes these members must do so for all rates.

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line for the Total age band (3–17 years). The Total sample is stratified by age to report rates for the 3–11 and 12–17 age stratifications.

Organizations may reduce the sample size using current year's administrative rate or the prior year's audited, product line-specific rate for the lowest of the three indicator rates for the Total age band. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

BMI Percentile BMI percentile during the measurement year as identified by administrative data or medical record review.

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

Medical record Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile, or
- BMI percentile plotted on age-growth chart.

For members who are younger than 16 years of age on the date of service, only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria. A BMI value is not acceptable for this age range.

For adolescents 16–17 years on the date of service, documentation of a BMI value expressed as kg/m² is acceptable.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile or value, if applicable is required for numerator compliance.

WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Counseling for Nutrition Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

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

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors).
- Checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Anticipatory guidance for nutrition.
- Weight or obesity training

Counseling for Physical Activity Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

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

Medical record Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Member received educational materials on physical activity during a face-to-face visit.
- Anticipatory guidance for physical activity.
- Weight or obesity training

Exclusions (optional)

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

WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Note

- The following notations or examples of documentation do not count as numerator compliant:
 - **BMI**
 - No BMI or BMI percentile documented in medical record or plotted on age-growth chart.
 - Notation of height and weight only.
 - **Nutrition and Diet**
 - No counseling/education on nutrition and diet.
 - Counseling/education before or after the measurement year.
 - Notation of “health education” or “anticipatory guidance” without specific mention of nutrition.
 - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition.
 - **Physical Activity**
 - No counseling/education on physical activity.
 - Notation of “cleared for gym class” alone without documentation of a discussion.
 - Counseling/education before or after the measurement year.
 - Notation of “health education” or “anticipatory guidance” without specific mention of physical activity.
 - Notation solely related to screen time (computer or television) without specific mention of physical activity.
- Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit. Services specific to an acute or chronic condition do not count toward the Counseling for nutrition and Counseling for physical activity indicators.
- Refer to Appendix 3 for the definition of PCP and OB/GYN practitioner.

CIS - Childhood Immunization Status (HEDIS)

Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	Children who turn 2 years of age during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	<p>For MMR, hepatitis B, VZV and hepatitis A, count any of the following:</p> <ul style="list-style-type: none">• Evidence of the antigen or combination vaccine, or• Documented history of the illness, or• A seropositive test result for each antigen. <p>For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count <i>only</i>:</p> <ul style="list-style-type: none">• Evidence of the antigen or combination vaccine. <p>For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.</p>

CIS - Childhood Immunization Status (HEDIS)

<i>DTaP</i>	At least four DTaP vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
<i>IPV</i>	At least three IPV vaccinations, with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted.
<i>MMR</i>	At least one MMR vaccination, with a date of service falling on or before the child's second birthday.
<i>HiB</i>	At least three HiB vaccinations, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted.
<i>Hepatitis B</i>	At least three hepatitis B vaccinations, with different dates of service on or before the child's second birthday.
<i>VZV</i>	At least one VZV vaccination, with a date of service falling on or before the child's second birthday.
<i>Pneumococcal conjugate</i>	At least four pneumococcal conjugate vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.
<i>Hepatitis A</i>	At least one hepatitis A vaccination, with a date of service falling on or before the child's second birthday.
<i>Rotavirus</i>	<p>The child must receive the required number of rotavirus vaccinations on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth. The following vaccine combinations are compliant:</p> <ul style="list-style-type: none">• Two doses of the two-dose vaccine, <i>or</i>• One dose of the two-dose vaccine and two doses of the three-dose vaccine, <i>or</i>• Three doses of the three-dose vaccine. <p>The vaccines are identified by different CPT codes (Table CIS-A).</p>
<i>Influenza</i>	At least two influenza vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.
<i>Combination rates</i>	Calculate the following rates for Combination 2–Combination 10.

CIS - Childhood Immunization Status (HEDIS)

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 2	✓	✓	✓	✓	✓	✓				
Combination 3	✓	✓	✓	✓	✓	✓	✓			
Combination 4	✓	✓	✓	✓	✓	✓	✓	✓		
Combination 5	✓	✓	✓	✓	✓	✓	✓		✓	
Combination 6	✓	✓	✓	✓	✓	✓	✓			✓
Combination 7	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Combination 8	✓	✓	✓	✓	✓	✓	✓	✓		✓
Combination 9	✓	✓	✓	✓	✓	✓	✓		✓	✓
Combination 10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Exclusion (optional)

- Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.
- Exclude contraindicated children only if the administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

The exclusion must have occurred by the second birthday. Look for exclusions as far back as possible in the member's history and use the codes in Table CIS-B to identify allowable exclusions.

Any particular vaccine	<ul style="list-style-type: none"> Anaphylactic reaction to the vaccine or its components (<u>Anaphylactic Reaction Due To Serum Value Set</u>). Anaphylactic reaction to the vaccine or its components (<u>Anaphylactic Reaction Due To Vaccination Value Set</u>).
DTaP	<ul style="list-style-type: none"> Encephalopathy (<u>Encephalopathy Due To Vaccination Value Set</u>). With a vaccine adverse-effect code (<u>Vaccine Causing Adverse Effect Value Set</u>).
MMR, VZV and influenza	<ul style="list-style-type: none"> Immunodeficiency (<u>Immunodeficiency Value Set</u>). HIV (<u>HIV Value Set</u>). Lymphoreticular cancer (<u>Lymphoreticular Cancer Value Set</u>). Multiple myeloma (<u>Multiple Myeloma Value Set</u>). Leukemia (<u>Leukemia Value Set</u>). Anaphylactic reaction to neomycin
IPV	<ul style="list-style-type: none"> Anaphylactic reaction to streptomycin, polymyxin B or neomycin
Hepatitis B	<ul style="list-style-type: none"> Anaphylactic reaction to common baker's yeast

CIS - Childhood Immunization Status (HEDIS)

Hybrid Specification

Denominator A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year's administrative rate for the lowest rate or the prior years audited product line-specific results for the lowest rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing sample size.

Numerators For MMR, hepatitis B, VZV and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine, or
- Documented history of the illness, or
- A seropositive test result.

For DTaP, HiB, IPV, pneumococcal conjugate, rotavirus and influenza, count *only*:

- Evidence of the antigen or combination vaccine.

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the organization must find evidence of all the antigens.

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

Medical Record For immunization evidence obtained from the medical record, organizations may count members where there is evidence that the antigen was rendered from one of the following.

- A note indicating the name of the specific antigen and the date of the immunization, **or**
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.

Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator *only* for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

Exclusions (optional)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred by the member's second birthday.

Note

- *This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.*

IMA – Immunizations for Adolescents

Description

The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	Adolescents who turn 13 years of age during the measurement year.
Continuous enrollment	12 months prior to the member's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the member's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	For meningococcal and Tdap or Td, count <i>only</i> evidence of the antigen or combination vaccine.
<i>Meningococcal</i>	One meningococcal conjugate or meningococcal polysaccharide vaccine (<u>Meningoccal Value Set</u>) on or between the member's 11th and 13th birthdays.
<i>Tdap/Td</i>	Any of the following with a date of service on or between the member's 10 th and 13 th birthdays meet criteria: <ul style="list-style-type: none">• At least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) vaccine (<u>Tdap Value Set</u>).• At least one tetanus, diphtheria toxoids (TD) vaccine (<u>Td Value Set</u>).• At least one tetanus vaccine (<u>Tetanus Value Set</u>) and at least one diphtheria vaccine (<u>Diphtheria Value Set</u>) on the same date of service or on different dates of service.
<i>Combination 1 (Meningococcal, Tdap/Td)</i>	Adolescents who are numerator compliant for both indicators (meningococcal, Tdap/Td).

IMA – Immunizations for Adolescents

Exclusion (optional)

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Either of the following meet optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) with a date of service prior to October 1, 2011.

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate for the lowest rate or the prior year's audited, product line-specific results for the lowest rate. For information on reducing the sample size, refer to the <i>Guidelines for Calculations and Sampling</i> .
Numerators	For meningococcal conjugate or polysaccharide and Tdap or Td, count <i>only</i> the evidence of the antigen or combination vaccine.
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
Medical record	For immunization information obtained from the medical record, organizations may count members where there is evidence that the antigen was rendered from either of the following: <ul style="list-style-type: none">• A note indicating the name of the specific antigen and the date of the immunization, or• A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered.

Exclusion (optional)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred on or before the member's 13th birthday.

Note

- This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.

HPV – Human papillomavirus Vaccine for Female Adolescents

Description

The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	Female adolescents who turn 13 years of age during the measurement year.
Continuous enrollment	12 months prior to the member's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the member's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerator	At least three HPV vaccinations (HPV Value Set), with different dates of service, on or between the member's 9th and 13th birthdays.

Exclusion (optional)

Either of the following meet optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components ([Anaphylactic Reaction Due To Serum Value Set](#)) any time on or before the member's 13th birthday.
- Anaphylactic reaction to the vaccine or its components ([Anaphylactic Reaction Due To Vaccination Value Set](#)) with a date of service prior to October 1, 2011.

Hybrid Specification

Denominator	<p>A systematic sample drawn from the eligible population. Organizations that use the Hybrid Method to report the <i>Immunizations for Adolescents (IMA)</i> measure may use the female members from the IMA sample as a start for this measure and, using the sampling methodology in the <i>Guidelines for Calculations and Sampling</i>, may draw enough additional female members from the remaining eligible population of this measure until the full sample size and appropriate oversample is reached.</p> <p>Organizations may reduce the sample size using the current year's HPV administrative rate or the prior year's audited, product line-specific rate. Refer to the <i>Guidelines for Calculations and Sampling for information on reducing the sample size</i>.</p>
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HPV – Human papillomavirus Vaccine for Female Adolescents

- Numerators** At least three HPV vaccinations, with different dates of service, on or between the member's 9th and 13th birthdays.
- Administrative** Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.
- Medical record** For immunization evidence obtained from the medical record, the organization may count members where there is evidence that the antigen was rendered from either of the following:
- A note indicating the name of the specific antigen and the date of service, **or**
 - A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

Exclusions (optional)

Refer to *Administrative Specification* for exclusion criteria. The exclusion must have occurred by the member's 13th birthday.

Note

- This measure follows the CDC and ACIP guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years to account for the measure's look-back period and to allow the industry time to adapt to the new guidelines.

BCS – Breast Cancer Screening

Description

The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

Eligible Population

Product lines	Medicaid.
Ages	Women 52–74 years as of December 31 of the measurement year.
Continuous enrollment	October 1 two years prior to the measurement year through December 31 of the measurement year.
Allowable gap	<p>No more than one gap in enrollment of up to 45 days for each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year). To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each full calendar year of continuous enrollment (i.e., the measurement year and the year prior to the measurement year).</p> <p>No gaps in enrollment are allowed from October 1 two years prior to the measurement year through</p>
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	One or more mammograms (<u>Mammography Value Set</u>) any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Exclusion (optional)

Bilateral mastectomy any time during the member's history through December 31 of the measurement year. Any of the following meet criteria for bilateral mastectomy:

- Bilateral mastectomy (Bilateral Mastectomy Value Set).
- Unilateral mastectomy (Unilateral Mastectomy Value Set) **with** a bilateral modifier (Bilateral Modifier Value Set).
- Two unilateral mastectomies (Unilateral Mastectomy Value Set) on different dates of service.
- Both of the following (on the same or a different date of service):
 - Unilateral mastectomy (Unilateral Mastectomy Value Set) **with** a right-side modifier (Right Modifier Value Set) (same date of service).
 - Unilateral mastectomy (Unilateral Mastectomy Value Set) **with** a left-side modifier (Left Modifier Value Set) (same date of service).

Note: *The purpose of this measure is to evaluate primary screening. Do not count biopsies, breast ultrasounds or MRIs for this measure because they are not appropriate methods for primary breast cancer screening.*

CCS – Cervical Cancer Screening

Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Note: Due to significant specification changes, NCQA will not publicly report this measure for HEDIS 2014.

Eligible Population

Product lines	Medicaid.
Ages	Women 24–64 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	The number of women who were screened for cervical cancer, as identified in steps 1 and 2 below.
Step 1	Identify women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (<u>Cervical Cytology Value Set</u>) during the measurement year or the two years prior to the measurement year.
Step 2	From the women who did not meet step 1 criteria, identify women 30–64 years of age as of December 31 of the measurement year who had cervical cytology (<u>Cervical Cytology Value Set</u>) and a human papillomavirus (HPV) test (<u>HPV Tests Value Set</u>) with service dates four or less days apart during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of both tests.
Step 3	Sum the events from steps 1 and 2 to obtain the rate.

Exclusion (optional)

Hysterectomy with no residual cervix (Hysterectomy Value Set) any time during the member's history through December 31 of the measurement year.

CCS – Cervical Cancer Screening

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year’s administrative rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerator The number of women who were appropriately screened for cervical cancer as documented through either administrative data or medical record review.

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

Medical record

Step 1 Identify the number of women 24–64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology was performed.
- The result or finding.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

Step 2 From the women who did not meet step 1 criteria, identify the number of women 30–64 years of age as of December 31 of the measurement year who had cervical cytology and an HPV test on the same date of service during the measurement year or the four years prior to the measurement year **and** who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:

- A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
- The results or findings.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

In administrative data, there is flexibility in the date of service to allow for a potential lag in claims. In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.

Note: Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

CCS – Cervical Cancer Screening

Step 3 Sum the events from Steps 1–2 to obtain the rate.

Exclusion (*optional*)

Refer to *Administrative Specification* for exclusion criteria. Evidence of a hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.

Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

SCOL – Colorectal Cancer Screening (State Modified HEDIS)

Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Eligible Population

Product lines	Medicaid (For HEDIS, this measure applies to Commercial and Medicare)
Ages	51–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.

Administrative Specification

Denominator	The eligible population.
Numerator	One or more screenings for colorectal cancer. Any of the following meet criteria: <ul style="list-style-type: none">• Fecal occult blood test (<u>FOBT Value Set</u>) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type.• Flexible Sigmoidoscopy (<u>Flexible Sigmoidoscopy Value Set</u>) during the measurement year or the four years prior to the measurement year.• Colonoscopy (<u>Colonoscopy Value Set</u>) during the measurement year or the nine years prior to the measurement year.

Exclusion (optional)

- Members with a diagnosis of colorectal cancer or total colectomy. Look for evidence of colorectal cancer or total colectomy as far back as possible in the member's history. Either of the following any time during the member's history through December 31 of the measurement year:
 - Colorectal Cancer (Colorectal Cancer Value Set).
 - Total Colectomy (Total Colectomy Value Set).

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for each product line. The organization may reduce the sample size using the current year's administrative rate or the prior years audited, product line-specific rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.
Numerator	One or more screenings for colorectal cancer. Appropriate screenings are defined by one of the following criteria. <ul style="list-style-type: none">• FOBT during the measurement year.• Flexible Sigmoidoscopy during the measurement year or the four years prior to the measurement year.• Colonoscopy during the measurement year or the nine years prior to the measurement year.
Administrative	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.

SCOL – Colorectal Cancer Screening (State Modified HEDIS)

Medical record Documentation in the medical record must include a note indicating the date the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the “medical history” section of the record. If it is unclear whether the documentation is part of the medical history, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).

There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required for numerator compliance. Follow the instructions below to determine member compliance.

- If the medical record does not indicate the type of test and there is no indication as to how many samples were returned, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.
- If the medical record does not indicate the type of test and the number of returned samples is specified, the member would only meet the screening criteria if the number of samples specified is greater than or equal to three samples. If there are fewer than three samples, the member does not meet the screening criteria for inclusion.
- iFOBT tests may require fewer than three samples. If the medical record indicates that an iFOBT was done, the member meets the screening criteria regardless of how many samples were returned.
- If the medical record indicates that a gFOBT was done, follow the scenarios below.
 - *If the medical record does not indicate the number of returned samples, assume the required number was returned. The member meets the screening criteria for inclusion in the numerator.*
 - *If the medical record indicates that three or more samples were returned, the member meets the screening criteria for inclusion in the numerator.*
 - *If the medical record indicates that fewer than three samples were returned, the member does not meet the screening criteria.*

Do not count *digital rectal exam* as evidence of a colorectal screening because it is not specific or comprehensive enough to screen for colorectal cancer.

Medical Record Exclusion (*optional*)

Refer to *Administrative Specifications* for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating colorectal cancer or total colectomy any time during the members history through December 31 of the measurement year.

SDEV – Developmental Screening in the First Three Years of Life

Oregon Health and Science University (Modified applicable CPT codes)

A. Description

The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

Guidance for Reporting

- This measure included three age-specific indicators assessing whether children are screened by their first, second, or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C). The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications.

B. Eligible Population

Product lines	Medicaid
Ages	Children who turn 1, 2, or 3 years of age between January 1 and December 31 of the measurement year.
Continuous enrollment	Children who are enrolled continuously for 12 months prior to the child's 1 st , 2 nd , or 3 rd birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Benefit	Medical
Event/Diagnosis	None

C. Data Source

C.1 – Administrative Specifications

- | | |
|---------------------|---|
| Denominators | The eligible population. |
| 1 | The children in the eligible population who turned 1 during the measurement year. |
| 2 | The children in the eligible population who turned 2 during the measurement year. |
| 3 | The children in the eligible population who turned 3 during the measurement year. |
| 4 | All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3. |

SDEV – Developmental Screening in the First Three Years of Life

- Numerators** The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. The measure is based on three, age-specific indicators.
- 1 Children in Denominator 1 who had a claim with CPT code 96110 or 96111 by their first birthday.
 - 2 Children in Denominator 2 who had a claim with CPT code 96110 or 96111 after their first and before or on their second birthday.
 - 3 Children in Denominator 3 who had a claim with CPT code 96110 or 96111 after their second and before or on their third birthday.
 - 4 Children in the entire eligible population who had a claim with CPT code 96110 or 96111 in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2, and 3).

Claims Data: CPT code 96110 Developmental testing, with interpretation and report.
CPT code 96111 Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

Important note about Appropriate Use of Claims Data. This measure is anchored to standardized tools that meet four criteria specified below in the paragraph beginning with “Tools must meet the following criteria.” States who have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

Claims NOT included in This Measure: It is important to note that modified 96110 claims [e.g. modifiers added to claim indicating standardized screening for a specific domain of development (e.g. social emotional screening via the ASQ-SE, autism screening)] should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

C.2 – Medical Records Specifications

- Denominators** A systematic sample of 411 drawn from the eligible population stratified by age.
- 1 137 children from the sample who turned 1 during the measurement year.
 - 2 137 children from the sample who turned 2 during the measurement year.
 - 3 137 children from the sample who turned 3 during the measurement year
 - 4 The entire sample of 411 children.

Numerators

- 1 Children in Denominator 1 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their first birthday.
- 2 Children in Denominator 2 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their first and before or on their second birthday
- 3 Children in Denominator 3 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their second and before or on their third birthday
- 4 Children in Denominator 4 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2, and 3).

SDEV – Developmental Screening in the First Three Years of Life

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed, and
- The standardized tool used (see below), and
- Evidence of a screening result or screening score

Tools must meet the following criteria:

1. **Developmental domains:** The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2. **Established Reliability:** Reliability scores of approximately 0.70 or above.
3. **Established Findings Regarding the Validity:** Validity scores for the tool must be approximately 0.70 or above. Measures validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. **Established Sensitivity/Specificity:** Sensitivity and specificity scores of approximately 0.70 or above.

Current recommended tools that meet these criteria:

- Ages and Stages Questionnaire (ASQ) – 2 months to 5 years.
- Ages and Stages Questionnaire – 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months.
- Bayley Infant Neuro-developmental Screen (BINS) – 3 months to 2 years.
- Brigance Screens-II – Birth to 90 months.
- Child Development Inventory (CDI) – 18 months to 6 years.
- Infant Development Inventory - Birth to 18 months.
- Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years.
- Parent's evaluation of Developmental Status – Developmental Milestones (PEDS-DM).

Tools NOT included in This Measure: It is important to note that standardized tools specifically focused on one domain of development [e.g. child's socio-emotional development (ASQ-SE) or autism (M-CHAT)] are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

D. Exclusions

None

E. Calculation Algorithm

- Step 1** Determine the denominators.
From the total denominator, sort into three age cohorts: children who turned one, two or three years of age between January 1 and December 31 of the measurement year.
- Step 2** Determine the numerators.
For each age cohort., and for the total, identify children who had a screening for developmental, behavioral, and social delays performed by their birthday as found through claims data or documented in the medical chart.

SDEV – Developmental Screening in the First Three Years of Life

Claims data	Children for whom a claim of 96110 or 96111 was submitted for services in the 12 months preceding their birthday.
Medical Record	Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding their birthday. Documentation must include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.
Step 3	Calculate the age-specific indicators (ages 1-3) by dividing the age-specific numerator by the age-specific denominator and multiplying by 100 to get a percentage.
Step 4	Create the overall measure of screening based on the age-specific numerators and denominators. Total Numerator: Numerator 1 + Numerator 2 + Numerator 3 Total Denominator: Denominator 1 + Denominator 2 + Denominator 3
Sampling Methodology	If administrative data are used, the entire eligible population is used for the denominator. If using the hybrid method (administrative plus medical record data sources), a systematic sample can be drawn of 411, with 137 in each age group.

F. Optional Age-Specific Oversampling for the Denominator

A sample of 411 will provide sufficient statistical power for stated reporting a state-wide developmental screening rate for children ages 1 to 3. With smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. Because states will want to use this measure to improve screening rates, age-specific rates may help states to target their efforts. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 may be insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

The eligible population, from which the original sample was drawn, should be stratified by age, and the age-specific sample drawn from within each stratum. To oversample for any age group, the state should return to the original listing of eligible children in that age group, and continue adding children to the sample until the larger sample is complete. However, in order to maintain consistency of reporting and avoid having to weight the age groups to calculate the total, the state should only include the first 137 children samples in the age-specific and total rates reported to CMS.

Appropriate Care

CDC – Comprehensive Diabetes Care

Description

The percentage of members 18–75 years of age with diabetes who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- Medical attention for nephropathy
- LDL-C screening

Eligible Population

Product lines	Medicaid
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/ diagnosis	<p>There are two ways to identify members with diabetes: by pharmacy data and by claim/encounter data. The organization must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p><i>Claim/encounter data.</i> Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years):</p> <ul style="list-style-type: none">At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>) or nonacute inpatient encounters (<u>Nonacute Inpatient Value Set</u>) on different dates of service, with a diagnosis of diabetes (<u>Diabetes Value Set</u>). Visit type need not be the same for the two visits.At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>).At least one ED visit (<u>ED Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>). <p><i>Pharmacy data:</i> Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CDC-A).</p>

CDC – Comprehensive Diabetes Care (HEDIS)

Table CDC-A: Prescriptions to Identify Members With Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	• Acarbose • Miglitol
Amylin analogs	• Pramlintide
Antidiabetic combinations	<ul style="list-style-type: none"> <li style="width: 25%;">• Alogliptin-metformin <li style="width: 25%;">• Glyburide-metformin <li style="width: 25%;">• Metformin-saxagliptin <li style="width: 25%;">• Alogliptin-pioglitazone <li style="width: 25%;">• Linagliptin-metformin <li style="width: 25%;">• Metformin-sitagliptin <li style="width: 25%;">• Glimepiride-pioglitazone <li style="width: 25%;">• Metformin-pioglitazone <li style="width: 25%;">• Saxagliptin <li style="width: 25%;">• Glimepiride-rosiglitazone <li style="width: 25%;">• Metformin-rosiglitazone <li style="width: 25%;">• Sitagliptin-simvastatin <li style="width: 25%;">• Glipizide-metformin
Insulin	<ul style="list-style-type: none"> <li style="width: 50%;">• Insulin aspart <li style="width: 50%;">• Insulin isophane human <li style="width: 50%;">• Insulin aspart-insulin aspart protamine <li style="width: 50%;">• Insulin isophane-insulin regular <li style="width: 50%;">• Insulin detemir <li style="width: 50%;">• Insulin lispro <li style="width: 50%;">• Insulin glargine <li style="width: 50%;">• Insulin lispro-insulin lispro protamine <li style="width: 50%;">• Insulin glulisine <li style="width: 50%;">• Insulin regular human
Meglitinides	• Nateglinide • Repaglinide
Miscellaneous antidiabetic agents	<ul style="list-style-type: none"> <li style="width: 25%;">• Alogliptin <li style="width: 25%;">• Linagliptin <li style="width: 25%;">• Metformin-repaglinide <li style="width: 25%;">• Exenatide <li style="width: 25%;">• Liraglutide <li style="width: 25%;">• Sitagliptin
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin
Sulfonylureas	<ul style="list-style-type: none"> <li style="width: 25%;">• Chlorpropamide <li style="width: 25%;">• Glimepiride <li style="width: 25%;">• Glyburide <li style="width: 25%;">• Tolbutamide <li style="width: 25%;">• Glipizide <li style="width: 25%;">• Tolazamide
Thiazolidinediones	• Pioglitazone • Rosiglitazone

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.

Administrative Specification

Denominator The eligible population.

Numerators

HbA1c Testing An HbA1c test ([HbA1c Tests Value Set](#)) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

LDL-C Screening An LDL-C test ([LDL-C Tests Value Set](#)) performed during the measurement year, as identified by claim/encounter or automated laboratory data.
The organization may use a calculated or direct LDL for LDL-C screening and control indicators.

Medical Attention for Nephropathy A nephropathy screening test **or** evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year:

- A nephropathy screening test ([Nephropathy Screening Tests Value Set](#)).
- Evidence of treatment for nephropathy or ACE/ARB therapy ([Nephropathy Treatment Value Set](#)).
- Evidence of stage 4 chronic kidney disease ([CKD Stage 4 Value Set](#)).

CDC – Comprehensive Diabetes Care (HEDIS)

- Evidence of ESRD ([ESRD Value Set](#)).
- Evidence of kidney transplant ([Kidney Transplant Value Set](#)).
- A visit with a nephrologist, as identified by the organization’s specialty provider codes (no restriction on the diagnosis or procedure code submitted).
- A positive urine macroalbumin test ([Positive Urine Macroalbumin Tests Value Set](#)).
- A urine macroalbumin test ([Urine Macroalbumin Tests Value Set](#)) where laboratory data indicates a positive result (“trace” urine macroalbumin test results are not considered numerator compliant).
- At least one ACE inhibitor or ARB dispensing event (Table CDC-L).

Table CDC-L: ACE Inhibitors/ARBs

Description	Prescription				
Angiotensin converting enzyme inhibitors	Benazepril Captopril	Enalapril Fosinopril	Lisinopril Moexipril	Perindopril Quinapril	Ramipril Trandolapril
Angiotensin II inhibitors	Azilsartan Candesartan	Eprosartan Irbesartan	Losartan Olmesartan	Telmisartan Valsartan	
Antihypertensive combinations	Aliskiren-valsartan Amlodipine-benazepril Amlodipine-hydrochlorothiazide-valsartan Amlodipine-hydrochlorothiazide-olmesartan Amlodipine-olmesartan Amlodipine-telmisartan Amlodipine-valsartan Azilsartan-chlorthalidone		Benazepril-hydrochlorothiazide Candesartan-hydrochlorothiazide Captopril-hydrochlorothiazide Enalapril-hydrochlorothiazide Eprosartan-hydrochlorothiazide Fosinopril-hydrochlorothiazide Hydrochlorothiazide-irbesartan Hydrochlorothiazide-lisinopril	Hydrochlorothiazide-losartan Hydrochlorothiazide-moexipril Hydrochlorothiazide-olmesartan Hydrochlorothiazide-quinapril Hydrochlorothiazide-telmisartan Hydrochlorothiazide-valsartan Trandolapril-verapamil	

Exclusions (optional)

Identify members who do not have a diagnosis of diabetes ([Diabetes Value Set](#)), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria:

- A diagnosis of polycystic ovaries ([Polycystic Ovaries Value Set](#)), in any setting, any time during the member’s history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes ([Gestational or Steroid-Induced Diabetes Value Set](#)), in any setting, during the measurement year or the year prior to the measurement year.

Hybrid Specification

Denominator A systematic sample of 411 members from the eligible population.

Numerators

HbA1c Testing An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding. The organization may count notation of the following in the medical record.

- A1c
- Hemoglobin A1c
- HgbA1c
- HbA1c
- Glycohemoglobin A1c

CDC – Comprehensive Diabetes Care (HEDIS)

LDL-C Screening An LDL-C test performed during the measurement year as identified by claim/ encounter or automated laboratory data or medical record review.
At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result or finding.
The organization may use a calculated or direct LDL for LDL-C screening and control indicators.

Medical Attention for Nephropathy A nephropathy screening test during the measurement year **or** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

Nephropathy screening test. At a minimum, documentation must include a note indicating the date when a urine microalbumin test was performed, and the result. Any of the following meet the criteria for a urine microalbumin test.

- 24-hour urine for microalbumin
- Timed urine for microalbumin
- Spot urine for microalbumin
- Urine for microalbumin/creatinine ratio
- 24-hour urine for total protein
- Random urine for protein/creatinine ratio

Is there documentation of ESRD, chronic or acute renal failure, renal insufficiency, diabetic nephropathy,

dialysis or renal transplant? *Evidence of nephropathy.* Any of the following meet the criteria for evidence of nephropathy.

- Documentation of a visit to a nephrologist.
- Documentation of a renal transplant.
- Documentation of medical attention for any of the following (no restriction on provider type).
 - Diabetic nephropathy
 - ESRD
 - Chronic renal failure (CRF).
 - Chronic kidney disease (CKD)
 - Renal insufficiency
 - Proteinuria
 - Albuminuria
 - Acute renal failure (ARF)
 - Dialysis, hemodialysis or peritoneal dialysis
- A positive urine macroalbumin test. At a minimum, documentation in the medical record must include a note indicating the date when the test was performed, and a positive result. Any of the following meet the criteria for a positive urine macroalbumin test.
 - Positive urinalysis (random, spot or timed) for protein
 - Positive urine (random, spot or timed) for protein
 - Positive urine dipstick for protein
 - Positive tablet reagent for urine protein
 - Positive result for albuminuria
 - Positive result for macroalbuminuria
 - Positive result for proteinuria
 - Positive result for gross proteinuria

Note: “Trace” urine macroalbumin test results are not considered numerator compliant.

-
- Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year.

CDC – Comprehensive Diabetes Care (HEDIS)

Exclusions (optional)

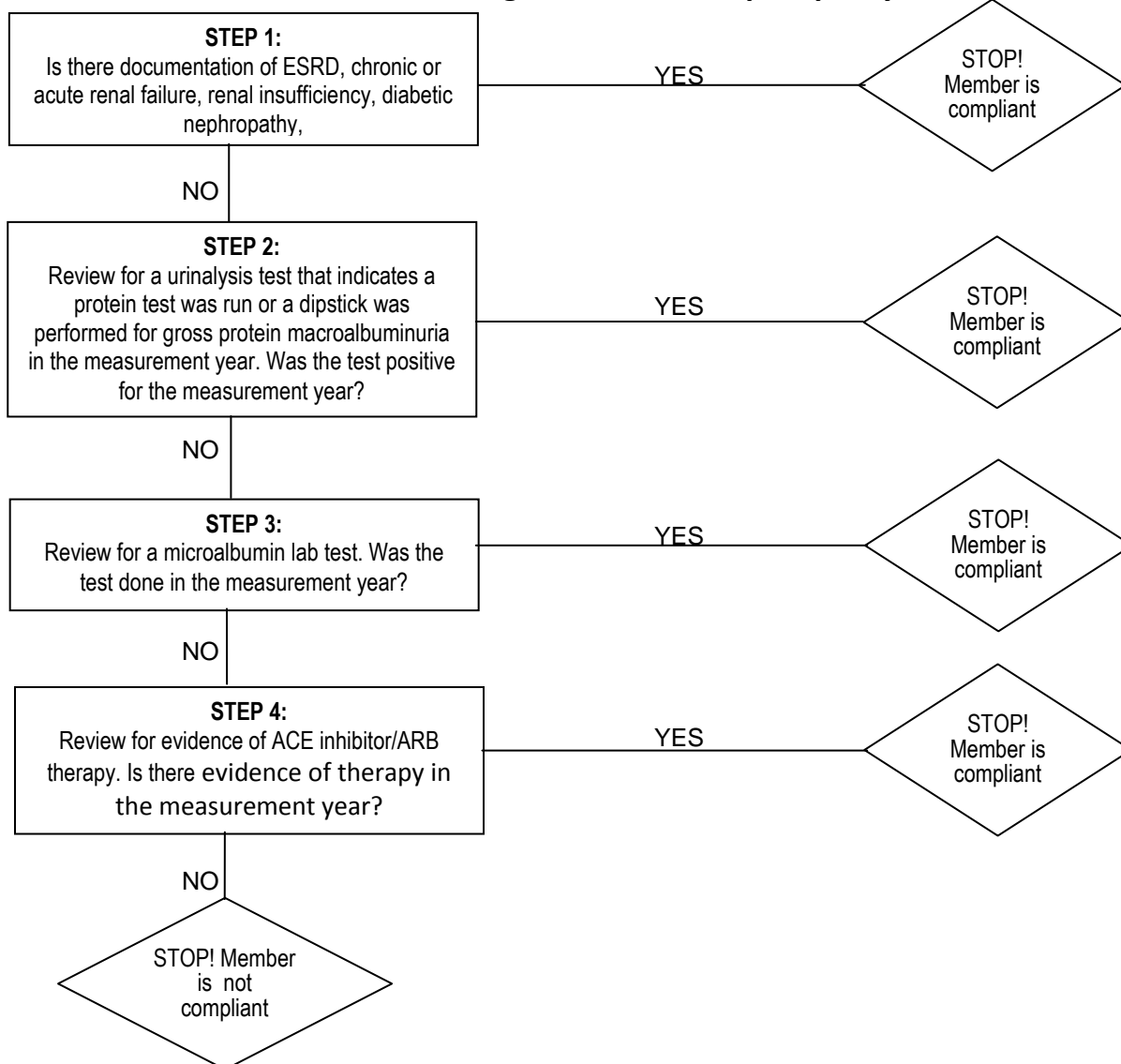
Refer to *Administrative Specification* for exclusion criteria. Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year, and who meet either of the following criteria:

- A diagnosis of polycystic ovaries, in any setting, any time during the member’s history through December 31 of the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Note

The organization may select data collection method (Administrative vs. Hybrid) at the indicator level, but the method for screening and control rates must be consistent.

Monitoring for Diabetic Nephropathy



PA1C – Annual Pediatric Hemoglobin A1c Testing (May 2013)

Description

The percentage of children ages 5 to 17 with diabetes (type 1 and type 2) that had a Hemoglobin A1c (HbA1c) test during the measurement year.

Guidance for Reporting:

- Include all paid, pending, reversed, and denied claims.

Eligible Population

Product lines	Medicaid
Ages	5-17 years old as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Event/ diagnosis	There are two ways to identify children with diabetes: by pharmacy data and by claim/ encounter data. The organization must use both methods to identify the eligible population, but a child only needs to be identified by one method to be included in the measure. Children may be identified as having diabetes during the measurement year or the year prior to the measurement year. <i>Pharmacy data:</i> Children who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table PA1C-A).

Table PA1C-A: Prescriptions to Identify Children With Diabetes

Description	Prescription			
Alpha-glucosidase inhibitors	Acarbose	Miglitol		
Amylin analogs	Pramlintide			
Antidiabetic combinations	Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin	Glyburide-metformin Metformin-pioglitazone	Metformin-rosiglitazone Metformin-sitagliptin	
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin inhalation Insulin zinc pork Insulin zinc beef-pork Insulin zinc human Insulin zinc extended human	Insulin isophane beef-pork Insulin isophane pork Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin regular beef-pork Insulin regular pork		
Meglitinides	Nateglinide	Repaglinide		
Miscellaneous antidiabetic agents	Exenatide	Liraglutide	Sitagliptin	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin			
Sulfonylureas	Acetohexamide Chlorpropamide	Glimepiride Glipizide	Glyburide Tolazamide	Tolbutamide
Thiazolidinediones	Pioglitazone	Rosiglitazone		

PA1C – Annual Pediatric Hemoglobin A1c Testing (May 2013)

Note

Glucophage/metformin is not included because it is used to treat conditions other than diabetes; enrollees with diabetes on these medications are identified through diagnosis codes only. A comprehensive list of medications and NDC codes can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDIS2013/HEDIS2013NDCLicense.aspx>.

Claim/encounter data. Children that had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table PA1C-B), or one face-to-face encounter in an acute inpatient or ED setting during the measurement year or the year prior to the measurement year. The organization may count services that occur over both years. Refer to Table PA1C-C for codes to identify visit type.

Table PA1C-B: Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Source: Refer to Table CDC-B in HEDIS specifications (2013 version).

Table PA1C-C: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217, 99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Source: Refer to Table CDC-C in HEDIS specifications (2013 version).

C. Data Source

C.1 – Administrative Specifications

Denominator The eligible population.

Numerator HbA1c Testing: An HbA1c test performed during the measurement year, as identified by claim/ encounter or automated laboratory data. Use any code listed in Table PA1C-D.

Table PA1C-D: Codes to Identify HbA1c Tests CPT

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8, 62388-4

Source: Refer to Table CDC-D in HEDIS specifications (2013 version).

PA1C – Annual Pediatric Hemoglobin A1c Testing (May 2013)

Exclusions (optional)

Children with a diagnosis of polycystic ovaries (Table PA1C-E) that did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table PA1C-B) during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the child's history, but must have occurred by December 31 of the measurement year.

Children with gestational or steroid-induced diabetes (Table PA1C-E) that did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table PA1C-B) during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year.

Table PA1C-E: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic ovaries	256.4
Steroid induced	249, 251.8, 962.0
Gestational diabetes	648.8

Source: Refer to Table CDC-O in HEDIS specifications (2013 version).

C.2 – Hybrid/EHR Data Specifications

Denominator A systematic sample of 411 drawn from the eligible population.

Numerator HbA1c Testing: An HbA1c test performed during the measurement year as identified by administrative data or medical record review.

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

Medical Record: At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result or finding.

Organizations may count notation of the following in the medical record.

- A1c
- HbA1c
- Hemoglobin A1c
- Glycohemoglobin A1c
- HgbA1c

Exclusions (optional)

Refer to Administrative Data Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of polycystic ovaries at any time in the child's history, but must have occurred by December 31 of the measurement year. The child must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or year prior to the measurement year.

Refer to Administrative Data Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of gestational or steroid-induced diabetes during the measurement year or the year prior to the measurement year. The child must not have a face-to-face encounter in any setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year.

MMA – Medication Management for People with Asthma

Description

The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any asthma controller medication during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days that a member is covered by at least one asthma controller medication prescription, divided by the number of days in the treatment period.
Oral medication dispensing event	<p>One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.</p> <p>Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.</p> <p>Refer to the <i>Oral medication dispensing event</i> definition in ASM for examples.</p>
Inhaler dispensing event	<p>All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a member received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.</p> <p>Use the Drug ID field in the NDC list to determine if the medications are the same or different.</p>
Injection dispensing event	Injections count as one dispensing event. Multiple dispensing events of the same or different medication count as separate dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
Calculating number of days covered for multiple prescriptions	<p>If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication (for the numerator). For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller. Subtract any days supply that extends beyond December 31 of the measurement year</p> <p>Use the drug ID provided by the NDC to determine if the prescriptions are the same or different.</p>

MMA – Medication Management for People with Asthma

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	5–64 years by December 31 of the measurement year. Report four age stratifications and a total rate: <ul style="list-style-type: none">• 5–11 years.• 12–18 years.• 19–50 years.• 51–64 years.• Total. The total is the sum of the age stratifications.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment year.
Anchor date	December 31 of the measurement year.
Benefits	Medical. Pharmacy during the measurement year.
Event/ diagnosis	Follow the steps below to identify the eligible population for the measure. Step 1 Identify members as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. <ul style="list-style-type: none">• At least one ED visit (<u>ED Value Set</u>) with a principal diagnosis of asthma (<u>Asthma Value Set</u>).• At least one acute inpatient claim/encounter (<u>Acute Inpatient Value Set</u>) with a principal diagnosis of asthma (<u>Asthma Value Set</u>).• At least four outpatient asthma visits (<u>Outpatient Value Set</u>) or observation visits (<u>Observation Value Set</u>) on different dates of service, with any diagnosis of asthma (<u>Asthma Value Set</u>) and at least two asthma medication dispensing events (Table ASM-C). Visit type need not be the same for the four visits.• At least four asthma medication dispensing events (Table ASM-C). Step 2 A member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (<u>Asthma Value Set</u>), in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year). Step 3: Required exclusions Exclude members who met any of the following criteria. <ul style="list-style-type: none">• Members who had any diagnosis from any of the following value sets, any time during the member’s history through December 31 of the measurement year:<ul style="list-style-type: none">• <u>Emphysema Value Set</u>.• <u>Other Emphysema Value Set</u>.• <u>COPD Value Set</u>.• <u>Obstructive Chronic Bronchitis Value Set</u>.• <u>Chronic Respiratory Conditions Due to Fumes/Vapors Value Set</u>.• <u>Cystic Fibrosis Value Set</u>.• <u>Acute Respiratory Failure Value Set</u>.• Members who have no asthma controller medications (Table ASM-D) dispensed during the measurement year.

MMA – Medication Management for People with Asthma

Administrative Specification

Denominator The eligible population.

Numerators

Medication Compliance 50% The number of members who achieved a PDC of at least 50% for their asthma controller medications (Table ASM-D) during the measurement year.

Medication Compliance 75% The number of members who achieved a PDC of at least 75% for their asthma controller medications (Table ASM-D) during the measurement year.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication (Table ASM-D) during the measurement year.

Step 2 To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.

Step 3 Count the days covered by at least one prescription for an asthma controller medication (Table ASM-D) during the treatment period. To ensure that the days supply does not exceed the treatment period, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member’s PDC using the following equation. Round (using the .5 rule to two decimal places.

$$\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Medication Compliance 50% Sum the number of members whose PDC is ≥50% for their treatment period.

Medication Compliance 75% Sum the number of members whose PDC is ≥75% for their treatment period.

Note

- *The HEDIS age strata for asthma measures are designed to align with both clinical practice guidelines and reporting requirements for child health quality improvement programs. Clinical guidelines specify appropriate age cohorts for measuring use of asthma medications as 5–11 years of age and 12–50 years of age, to account for the differences in medication regimens for children vs. for adolescents and adults. Implementation requires further stratification of the age ranges, to enable creation of comparable cohorts that align with child health populations.*

PCE – Pharmacotherapy Management of COPD Exacerbation

Description

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid within 14 days of the event
2. Dispensed a bronchodilator within 30 days of the event

Note: *The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual*

Definitions

Intake Period	An 11-month period that begins on January 1 of the measurement year and ends on November 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any acute inpatient discharge or ED claim/encounter during the Intake Period with a principal diagnosis of COPD. <i>For an acute inpatient claim/encounter, the Episode Date is the date of discharge.</i> <i>For an ED claim/encounter, the Episode Date is the date of service.</i>
Active prescription	A prescription is considered active if the “days’ supply” indicates the date the member filled the prescription, which is the number of days or more between that date and the relevant date. <i>For an acute inpatient claim/encounter, the relevant date is the date of admission.</i> <i>For an ED claim/encounter, the relevant date is the date of service.</i>

Eligible Population

Product lines	Medicaid.
Ages	40 years or older as of January 1 of the measurement year.
Continuous enrollment	Episode Date through 30 days after the Episode Date.
Allowable gap	None.
Anchor date	Episode Date.
Event/ diagnosis	A COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD. Follow the steps below to identify the eligible population. Step 1 Identify all members who during the Intake Period had an acute inpatient discharge (<u>Acute Inpatient UB Revenue Value Set</u>) or an ED visit (<u>ED Value Set</u>) with a primary diagnosis of COPD (<u>COPD Value Set</u>), emphysema (<u>Emphysema Value Set</u>) or chronic bronchitis (<u>Chronic Bronchitis Value Set</u>). Do not include ED visits that result in an inpatient admission. Note: The denominator for this measure is based on acute inpatient discharges and ED visits, not on members. Only UB Revenue codes are used to identify acute inpatient discharges because using other codes could result in double-counting.

PCE – Pharmacotherapy Management of COPD Exacerbation

- Step 2** Identify all COPD Episode Dates. For each member identified in step 1, identify all acute inpatient discharges and ED visits. Do not include ED visits that result in an inpatient admission.
- Step 3** Test for transfers. Exclude Episode Dates on which the member was transferred directly to an acute or nonacute care facility for any diagnosis.
- Step 4** Test for readmission and additional ED visits. Exclude Episode Dates when the member was readmitted to an acute or nonacute care facility for any diagnosis within 14 days after the Episode Date. Exclude Episode Dates when the member had an ED visit for any diagnosis within 14 days after the Episode Date.
- Step 5** Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from the Episode Date through 30 days after the Episode Date.
- Note:** All Episode Dates that were not excluded should remain in the denominator. The denominator for this measure is based on acute inpatient discharges and ED visits, not members.

Administrative Specification

Denominator The eligible population.

Numerators

Systemic corticosteroid Dispensed prescription for systemic corticosteroid (Table PCE-C) on or 14 days after the Episode Date. The organization may count systemic corticosteroids that are active on the relevant date.

Table PCE-C: Systemic Corticosteroids

Description	Prescription			
Glucocorticoids	<ul style="list-style-type: none"> • Betamethasone • Dexamethasone 	<ul style="list-style-type: none"> • Hydrocortisone • Methylprednisolone 	<ul style="list-style-type: none"> • Prednisolone • Prednisone 	<ul style="list-style-type: none"> • Triamcinolone

Bronchodilator Dispensed prescription for a bronchodilator (Table PCE-D) on or 30 days after the Episode Date. The organization may count bronchodilators that are active on the relevant date.

Table PCE-D: Bronchodilators

Description	Prescription		
Anticholinergic agents	<ul style="list-style-type: none"> • Albuterol-ipratropium • Acclidinium-bromide 	<ul style="list-style-type: none"> • Ipratropium • Tiotropium 	
Beta 2-agonists	<ul style="list-style-type: none"> • Albuterol • Arformoterol • Budesonide-formoterol • Fluticasone-salmeterol 	<ul style="list-style-type: none"> • Fluticasone-vilanterol • Indacaterol • Levalbuterol • Mometasone-formoterol 	<ul style="list-style-type: none"> • Formoterol • Metaproterenol • Pirbuterol • Salmeterol
Methylxanthines	<ul style="list-style-type: none"> • Aminophylline • Dyphylline-guaifenesin 	<ul style="list-style-type: none"> • Dyphylline • Guaifenesin-theophylline 	<ul style="list-style-type: none"> • Theophylline

PBH – Persistence of Beta-Blocker Treatment After a Heart Attack

Description

The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge.

Definition

Treatment days (covered days) The actual number of calendar days covered with prescriptions within the specified 180-day measurement interval (i.e., a prescription of a 90-day supply dispensed on the 100th day will have 80 days counted in the 180-day interval).

Eligible Population

Product lines Medicaid

Ages 18 years and older as of December 31 of the measurement year.

Continuous enrollment Discharge date through 180 days after discharge.

Allowable gap No more than one gap in enrollment of up to 45 days within the 180 days of the event. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not continuously enrolled).

Anchor date Discharge date.

Benefit Medical and pharmacy

Event/diagnosis Discharged alive from an acute inpatient setting with an AMI (AMI Value Set) from July 1 of the year prior to the measurement year through June 30 of the measurement year. Use only facility claims to identify AMI. **Do not use diagnoses from professional claims to identify AMI.**

*An organization that does not have fifth-digit specificity must develop a methodology to ensure that only the first eligible episode of an AMI is included in the measure.

If a member has more than one episode of AMI from July 1 of the year prior to the measurement year through June 30 of the measurement year, the organization should only include the first discharge.

Transfers to acute facilities. Include hospitalizations in which the member was transferred directly to another acute inpatient facility for any diagnosis. Count the discharge from the subsequent acute inpatient facility, not the initial discharge. The discharge date from the facility to which the member was transferred must occur on or before June 30 of the measurement year.

Transfers to nonacute facilities. Exclude from the denominator, hospitalizations in which the member was transferred directly to a nonacute care facility for any diagnosis.

Readmissions. If the member was readmitted to an acute or nonacute care facility for any diagnosis, include the member in the denominator and use the discharge date from the original hospitalization.

PBH – Persistence of Beta-Blocker Treatment After a Heart Attack

Administrative Specification

Denominator The eligible population.

Numerator A 180-day course of treatment with beta-blockers (Table PBH-B).

Identify all members in the denominator population whose dispensed days supply is ≥ 135 days in the 180 days following discharge. Persistence of treatment for this measure is defined as at least 75 percent of the days' supply filled.

To determine continuity of treatment during the 180-day period, identify all prescriptions filled within 180 days of the Discharge Date, and add the number of allowed gap days to the number of treatment days for a maximum of 180 days (i.e., 135 treatment days + 45 gap days = 180 days);

To account for members who are on beta-blockers prior to admission, the organization should factor those prescriptions into adherence rates if the actual treatment days fall within the 180 days following discharge.

Table PBH-B: Beta-Blocker Medications

Description	Prescription		
Noncardioselective beta-blockers	<ul style="list-style-type: none"> • Carvedilol • Labetalol • Nadolol 	<ul style="list-style-type: none"> • Penbutolol • Pindolol • Propranolol 	<ul style="list-style-type: none"> • Timolol • Sotalol
Cardioselective beta-blockers	<ul style="list-style-type: none"> • Acebutolol • Atenolol 	<ul style="list-style-type: none"> • Betaxolol • Bisoprolol 	<ul style="list-style-type: none"> • Metoprolol • Nebivolol
Antihypertensive combinations	<ul style="list-style-type: none"> • Atenolol-chlorthalidone • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide 		<ul style="list-style-type: none"> • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-propranolol

Exclusion (optional)

Members identified as having an intolerance or allergy to beta-blocker therapy. Any of the following anytime during the member's history through the end of the continuous enrollment period meet criteria:

- Asthma ([Asthma Value Set](#)).
- COPD ([COPD Value Set](#)).
- Obstructive chronic bronchitis ([Obstructive Chronic Bronchitis Value Set](#)).
- Chronic respiratory conditions due to fumes and vapors ([Chronic Respiratory Conditions Due to Fumes/Vapors Value Set](#)).
- Hypotension, heart block >1 degree or sinus bradycardia ([Beta-Blocker Contraindications Value Set](#)).
- A medication dispensing event indicative of a history of asthma (Table PBH-D).
- Intolerance or allergy to beta-blocker therapy.

Table PBH-D: Medications to Identify Exclusions (History of Asthma)

Description	Prescription		
Bronchodilator combinations	<ul style="list-style-type: none"> • Albuterol-ipratropium • Budesonide-formoterol 	<ul style="list-style-type: none"> • Fluticasone-salmeterol • Mometasone-formoterol 	
Inhaled corticosteroids	<ul style="list-style-type: none"> • Beclomethasone • Budesonide • Ciclesonide 	<ul style="list-style-type: none"> • Flunisolide • Fluticasone • Fluticasone CFC free 	<ul style="list-style-type: none"> • Mometasone • Triamcinolone

PQI08 – Heart Failure Admission Rate

Agency for Healthcare Research and Quality

Description

The number of discharges for congestive heart failure (CHF) per 100,000 Medicaid enrollees age 18 and older.

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.

Eligible Population

Member months	All member months for Medicaid enrollees ages 18 and older as of the 30th day of the month.
Continuous enrollment	There is no continuous enrollment requirement.
Allowable gap	There is no gap in coverage requirement.
Anchor date	There is no anchor date

ADMINISTRATIVE SPECIFICATION

Denominator	Medicaid enrollees age 18 and older.
Numerators	All discharges with ICD-9-CM principal diagnosis code for CHF. Qualifying codes below.
ICD-9-CM Diagnosis Codes (Discharges after September 30, 2002)	39891 RHEUMATIC HEART FAILURE 4280 CONGESTIVE HEART FAILURE 4281 LEFT HEART FAILURE 42820 SYSTOLIC HRT FAILURE NOS OCT02- 42821 AC SYSTOLIC HRT FAILURE OCT02- 42822 CHR SYSTOLIC HRT FAILURE OCT02- 42823 AC ON CHR SYST HRT FAIL OCT02- 42830 DIASTOLC HRT FAILURE NOS OCT02- 42831 AC DIASTOLIC HRT FAILURE OCT02- 42832 CHR DIASTOLIC HRT FAIL OCT02- 42833 AC ON CHR DIAST HRT FAIL OCT02- 42840 SYST/DIAST HRT FAIL NOS OCT02- 42841 AC SYST/DIASTOL HRT FAIL OCT02- 42842 CHR SYST/DIASTL HRT FAIL OCT02- 42843 AC/CHR SYST/DIA HRT FAIL OCT02- 4289 HEART FAILURE NOS
ICD-9-CM Diagnosis Codes (Discharges before September 30, 2002):	40201 MAL HYPERT HRT DIS W CHF 40211 BENIGN HYP HRT DIS W CHF 40291 HYPERTEN HEART DIS W CHF 40401 MAL HYPER HRT/REN W CHF 40403 MAL HYP HRT/REN W CHF/RF 40411 BEN HYPER HRT/REN W CHF 40413 BEN HYP HRT/REN W CHF/RF 40491 HYPER HRT/REN NOS W CHF 40493 HYP HT/REN NOS W CHF/RF

PQI08 – Heart Failure Admission Rate

- Exclusions**
- Transfer from a hospital (different facility)
 - Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
 - Transfer from another health care facility
 - With missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), principal diagnosis (DX1 = missing), or county (PSTCO = missing)
 - MDC 14 (pregnancy, childbirth, and puerperium)

With a cardiac procedure code (ICD-9-CM Cardiac Procedure Codes)

0050 IMPL CRT PACEMAKER SYS OCT02-
 0051 IMPL CRT DEFIBRILLAT OCT02-
 0052 IMP/REP LEAD LF VEN SYS OCT02-
 0053 IMP/REP CRT PACEMKR GEN OCT02-
 0054 IMP/REP CRT DEFIB GENAT OCT02-
 0056 INS/REP IMPL SENSOR LEAD OCT06-
 0057 IMP/REP SUBCUE CARD DEV OCT06-
 0066 PTCA OCT06-
 1751 IMPLANTATION OF RECHARGEABLE CARDIAC CONTRACTILITY MODULATION [CCM], TOTAL SYSTEM OCT09-
 1752 IMPLANTATION OR REPLACEMENT OF CARDIAC CONTRACTILITY MODULATION [CCM] RECHARGEABLE PULSE, GENERATOR ONLY OCT09-
 3500 CLOSED VALVOTOMY NOS3501 CLOSED AORTIC VALVOTOMY
 3501 CLOSED AORTIC VALVOTOMY
 3502 CLOSED MITRAL VALVOTOMY
 3503 CLOSED PULMON VALVOTOMY
 3504 CLOSED TRICUSP VALVOTOMY
 3510 OPEN VALVULOPLASTY NOS
 3511 OPN AORTIC VALVULOPLASTY
 3512 OPN MITRAL VALVULOPLASTY
 3513 OPN PULMON VALVULOPLASTY
 3514 OPN TRICUS VALVULOPLASTY
 3520 REPLACE HEART VALVE NOS
 3521 REPLACE AORT VALV-TISSUE
 3522 REPLACE AORTIC VALVE NEC
 3523 REPLACE MITR VALV-TISSUE
 3524 REPLACE MITRAL VALVE NEC
 3525 REPLACE PULM VALV-TISSUE
 3526 REPLACE PULMON VALVE NEC
 3527 REPLACE TRIC VALV-TISSUE
 3528 REPLACE TRICUSP VALV NEC
 3531 PAPILLARY MUSCLE OPS
 3532 CHORDAE TENDINEAE OPS
 3533 ANNULOPLASTY
 3534 INFUNDIBULECTOMY
 3535 TRABECUL CARNEAE CORD OP
 3539 TISS ADJ TO VALV OPS NEC
 3541 ENLARGE EXISTING SEP DEF
 3542 CREATE SEPTAL DEFECT
 3550 PROSTH REP HRT SEPTA NOS
 3551 PROS REP ATRIAL DEF-OPN
 3552 PROS REPAIR ATRIA DEF-CL
 3553 PROST REPAIR VENTRIC DEF
 3554 PROS REP ENDOCAR CUSHION
 3555 PROS REP VENTRC DEF-CLOS OCT06-
 3560 GRFT REPAIR HRT SEPT NOS

PQI08 – Heart Failure Admission Rate

3561 GRAFT REPAIR ATRIAL DEF
3562 GRAFT REPAIR VENTRIC DEF
3563 GRFT REP ENDOCAR CUSHION
3570 HEART SEPTA REPAIR NOS
3571 ATRIA SEPTA DEF REP NEC
3572 VENTR SEPTA DEF REP NEC
3573 ENDOCAR CUSHION REP NEC
3581 TOT REPAIR TETRAL FALLOT
3582 TOTAL REPAIR OF TAPVC
3583 TOT REP TRUNCUS ARTERIOS
3584 TOT COR TRANSPOS GRT VES
3591 INTERAT VEN RETRN TRANSP
3592 CONDUIT RT VENT-PUL ART
3593 CONDUIT LEFT VENTR-AORTA
3594 CONDUIT ARTIUM-PULM ART
3595 HEART REPAIR REVISION
3596 PERC HEART VALVULOPLASTY
3598 OTHER HEART SEPTA OPS
3599 OTHER HEART VALVE OPS
3601 PTCA-1 VESSEL W/O AGENT
3602 PTCA-1 VESSEL WITH AGNT
3603 OPEN CORONRY ANGIOPLASTY
3604 INTRCORONRY THROMB INFUS
3605 PTCA-MULTIPLE VESSEL
3606 INSERT OF COR ART STENT OCT95-
3607 INS DRUG-ELUT CORONRY ST OCT02-
3609 REM OF COR ART OBSTR NEC
3610 AORTOCORONARY BYPASS NOS
3611 AORTOCOR BYPAS-1 COR ART
3612 AORTOCOR BYPAS-2 COR ART
3613 AORTOCOR BYPAS-3 COR ART
3614 AORTCOR BYPAS-4+ COR ART
3615 1 INT MAM-COR ART BYPASS
3616 2 INT MAM-COR ART BYPASS
3617 ABD-CORON ART BYPASS OCT96-
3619 HRT REVAS BYPS ANAS NEC
362 ARTERIAL IMPLANT REVASC
363 OTH HEART REVASCULAR
3631 OPEN CHEST TRANS REVASC
3632 OTH TRANSMYO REVASCULAR
3633 ENDO TRANSMYO REVASCULAR OCT06-
3634 PERC TRANSMYO REVASCULAR OCT06-
3639 OTH HEART REVASULAR
3691 CORON VESS ANEURYSM REP
3699 HEART VESSLE OP NEC
3731 PERICARDIECTOMY
3732 HEART ANEURYSM EXCISION
3733 EXC/DEST HRT LESION OPEN
3734 EXC/DEST HRT LES OTHER
3735 PARTIAL VENTRICULECTOMY
3736 EXCISION OR DESTRUCTION OF LEFT ATRIAL APPENDAGE (LAA) OCT08-
3741 IMPLANT PROSTH CARD SUPPORT DEV OCT06
375 HEART TRANSPLANTATION (NOT VALID AFTER OCT 03)
3751 HEART TRANPLANTATION OCT03-
3752 IMPLANT TOT REP HRT SYS OCT03-

PQI08 – Heart Failure Admission Rate

3753 REPL/REP THORAC UNIT HRT OCT03-
3754 REPL/REP OTH TOT HRT SYS OCT03-
3755 REMOVAL OF INTERNAL BIVENTRICULAR HEART REPLACEMENT SYSTEM OCT08
3760 IMPLANTATION OR INSERTION OF BIVENTRICULAR EXTERNAL HEART ASSIST
SYSTEM OCT08
3761 IMPLANT OF PULSATION BALLOON
3762 INSERTION OF NON-IMPLANTABLE HEART ASSIST SYSTEM
3763 REPAIR OF HEART ASSIST SYSTEM
3764 REMOVAL OF HEART ASSIST SYSTEM
3765 IMPLANT OF EXTERNAL HEART ASSIST SYSTEM
3766 INSERTION OF IMPLANTABLE HEART ASSIST SYSTEM
3770 INT INSERT PACEMAK LEAD
3771 INT INSERT LEAD IN VENT
3772 INT INSERT LEAD ATRI-VENT
3773 INT INSEER LEAD IN ATRIUM
3774 INT OR REPL LEAD EPICAR
3775 REVISION OF LEAD
3776 REPL TV ATRI-VENT LEAD
3777 REMOVAL OF LEAD W/O REPL
3778 INSEER TEAM PACEMAKER SYS
3779 REVIS OR RELOCATE POCKET
3780 INT OR REPL PERM PACEMKR
3781 INT INSERT 1-CHAM, NON
3782 INT INSERT 1-CHAM, RATE
3783 INT INSERT DUAL-CHAM DEV
3785 REPL PACEM W 1-CHAM, NON
3786 REPL PACEM 1-CHAM, RATE
3787 REPL PACEM W DUAL-CHAM
3789 REVISE OR REMOVE PACEMAK
3794 IMPLT/REPL CARDDEFIB TOT
3795 IMPLT CARDIODEFIB LEADS
3796 IMPLT CARDIODEFIB GENATR
3797 REPL CARDIODEFIB LEADS
3798 REPL CARDIODEFIB GENRATR

Behavioral Health

ADD - Follow-Up Care for Children Prescribed ADHD Medication

Description

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

- *Initiation Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.
- *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Definitions

Intake Period	The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD when the member had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation Phase	The 30 days following the IPSD.
C&M Phase	The 300 days following the IPSD (10 months).
New Episode	The member must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous Medication Treatment	The number of medication treatment days during the 10-month follow-up period must be ≥ 210 days (i.e., 300 treatment days – 90 gap days).
Treatment days (covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

Eligible Population: Rate 1—Initiation Phase

Product lines	Medicaid.
Ages	Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year.

ADD - Follow-Up Care for Children Prescribed ADHD Medication

Continuous enrollment	Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and pharmacy.
Event	Follow the steps below to identify the eligible population for the Initiation Phase.
Step 1	Identify all children in the specified age range who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period.

Table ADD-A: ADHD Medications

Description	Prescription
CNS stimulants	<ul style="list-style-type: none"> • Amphetamine-dextroamphetamine • Dexmethylphenidate • Dextroamphetamine • Lisdexamfetamine • Methamphetamine • Methylphenidate
Alpha-2 receptor agonists	<ul style="list-style-type: none"> • Clonidine • Guanfacine
Miscellaneous ADHD medications	<ul style="list-style-type: none"> • Atomoxetine

- Step 2** Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.
- Step 3** Calculate continuous enrollment. Members must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.
- Step 4** Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. An acute inpatient encounter in combination with any of the following meet criteria:
- A principal mental health diagnosis (Mental Health Diagnosis Value Set).
 - A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Administrative Specification: Rate 1—Initiation Phase

Denominator	The Rate 1 eligible population.
Numerator	<p>An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:</p> <ul style="list-style-type: none"> • <u>ADD Stand Alone Value Set</u>. • <u>ADD Visits Group 1 Value Set</u> with <u>ADD POS Group 1 Value Set</u>. • <u>ADD Visits Group 2 Value Set</u> with <u>ADD POS Group 2 Value Set</u>. <p>Note: Do not count a visit on the IPSD as the Initiation Phase visit.</p>

ADD - Follow-Up Care for Children Prescribed ADHD Medication

Eligible Population: Rate 2-C&M Phase

Product lines	Medicaid.
Ages	Six years as of March 1 of the year prior to the measurement year to 12 years as of February 28 of the measurement year.
Continuous enrollment	<p>Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.</p> <p>Members who switch product lines between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1.</p>
Allowable gap	<p>One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).</p>
Anchor date	None.
Benefits	Medical and pharmacy.
Event	Follow the steps below to identify the eligible population for the C&M Phase.
Step 1	Identify all members who meet the eligible population criteria for Rate 1—Initiation Phase.
Step 2	Calculate continuous enrollment. Members must be continuously enrolled in the organization for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.
Step 3	<p>Calculate the continuous medication treatment. Using the members in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)</p> <p>Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).</p>
Step 4	<p>Exclude members who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSD. An acute inpatient encounter in combination with any of the following meet criteria:</p> <ul style="list-style-type: none">• A principal mental health diagnosis (Mental Health Diagnosis Value Set).• A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

ADD - Follow-Up Care for Children Prescribed ADHD Medication (HEDIS)

Administrative Specification: Rate 2—C&M Phase

Denominator The Rate 2 eligible population.

Numerator Identify all members who meet the following criteria:

- Numerator compliant for *Rate 1-Initiation Phase*, **and**
- At least two follow-up visits from 31–300 days (9 months) after the IPSP with any practitioner.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

- ADD Stand Alone Visits Value Set.
- ADD Visits Group 1 Value Set **with** ADD POS Group 1 Value Set.
- ADD Visits Group 2 Value Set **with** ADD POS Group 2 Value Set.
- Telephone Visits Value Set.

Exclusions (*optional*)

Exclude from the denominator for both rates, members diagnosed with narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

Note

- *Members who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).*
- *Refer to Appendix 3 for the definition of prescribing practitioner.*
- *Organizations may have 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. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSP).*

AMM – Antidepressant Medication Management

Description

The percentage of members 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.

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

Definitions

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the Intake Period.
Negative Medication History	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Eligible Population

Product lines	Medicaid.
Ages	18 years and older as of April 30 of the measurement year.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IPSD.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population, which should be used for both rates.
Step 1	Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table AMM-C) during the Intake Period.

AMM – Antidepressant Medication Management

Table AMM-C: Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	• Bupropion	• Vilazodone	
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine	
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone	
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine		• Fluoxetine-olanzapine
SSNRI antidepressants	• Desvenlafaxine • Duloxetine	• Venlafaxine	
SSRI antidepressants	• Citalopram • Escitalopram	• Fluoxetine • Fluvoxamine	• Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine	
Tricyclic antidepressants	• Amitriptyline • Amoxapine • Clomipramine	• Desipramine • Doxepin • Imipramine	• Nortriptyline • Protriptyline • Trimipramine

Step 2 Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient or partial hospitalization setting during the 60 days prior to the IPSD (inclusive) through 60 days after the IPSD (inclusive). Members who meet any of the following criteria remain in the eligible population:

- An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
 - AMM Stand Alone Visits Value Set **with** Major Depression Value Set.
 - AMM Visits Value Set **with** AMM POS Value Set and Major Depression Value Set.
- An ED visits (ED Value Set) with any diagnosis of major depression (Major Depression Value Set).
- An inpatient (acute or nonacute) encounter with any diagnosis of major depression (Major Depression Value Set).

For an inpatient (acute or nonacute) encounter, use the date of discharge.

For a direct transfer, use the discharge date from the facility where the member was transferred.

Step 3 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

AMM – Antidepressant Medication Management

Administrative Specification

Denominator The eligible population.

Numerators

Effective Acute Phase Treatment At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table AMM-C) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).

Effective Continuation Phase Treatment At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-C) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).

Note

-
- *Organizations may have 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. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the time frame specified (e.g., during the Intake Period).*

SAA – Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Description

The percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Definitions

IPSD	Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
Oral medication dispensing event	<p>One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events.</p> <p>Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.</p>
Long-acting injections dispensing event	Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.
Calculating number of days covered for oral medications	<p>If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.</p> <p>If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap).</p> <p>Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.</p>
Calculating number of days covered for long-acting injections	Calculate number of days covered (for the numerator) for long-acting injections using the days supply specified for the medication in Table SAA-A. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply. For multiple J Codes or NDCs for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

SAA – Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Eligible Population

Product lines	Medicaid.
Ages	19–64 years of age as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population.

Step 1 Identify members with schizophrenia as those who met at least one of the following criteria during the measurement year.

- At least one acute inpatient claim/encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:
 - BH Stand Alone Acute Inpatient Value Set **with** Schizophrenia Value Set.
 - BH Acute Inpatient Value Set **with** BH Acute Inpatient POS Value Set and Schizophrenia Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meets criteria:
 - BH Stand Alone Outpatient/PH/IOP Value Set **with** Schizophrenia Value Set.
 - BH Outpatient/PH/IOP Value Set **with** BH Outpatient/PH/IOP POS Value Set and Schizophrenia Value Set.
 - ED Value Set **with** Schizophrenia Value Set.
 - BH ED Value Set **with** BH ED POS Value Set and Schizophrenia Value Set.
 - BH Stand Alone Nonacute Inpatient Value Set **with** Schizophrenia Value Set.
 - BH Nonacute inpatient Value Set **with** BH Nonacute Inpatient POS Value Set and Schizophrenia Value Set.

Step 2: Required exclusions Exclude members who met at least one of the following during the measurement year.

- A diagnosis of dementia (Dementia Value Set).
- Did not have at least two antipsychotic medication dispensing events, With at least one of the events occurring on or between January 1 and September 30. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.
 - Claims/encounter data. An antipsychotic medication (Long-Acting Injections 14 Days Supply value Set or Long-Acting Injections 28 Days Supply Value Set).
 - Pharmacy data. Dispensed an antipsychotic medication (Table SAA-A) on an ambulatory basis.

SAA – Adherence to Antipsychotic Medications for Individuals With Schizophrenia

Table SAA-A: Antipsychotic Medications

Description	Prescription	Covered Days	
Miscellaneous antipsychotic agents	<ul style="list-style-type: none"> • Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone 	<ul style="list-style-type: none"> • Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone 	
Phenothiazine antipsychotics	<ul style="list-style-type: none"> • Chlorpromazine • Fluphenazine • Perphenazine • Perphenazine-amitriptyline 	<ul style="list-style-type: none"> • Prochlorperazine • Thioridazine • Trifluoperazine 	
Psychotherapeutic combinations	<ul style="list-style-type: none"> • Fluoxetine-olanzapine 		
Thioxanthenes	<ul style="list-style-type: none"> • Thiothixene 		
Long-acting injections	<ul style="list-style-type: none"> • Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate 	<ul style="list-style-type: none"> • Olanzapine • Paliperidone palmitate 	28 days supply
	<ul style="list-style-type: none"> • Risperidone 		14 days supply

Administrative Specification

Denominator The eligible population.

Numerator The number of members who achieved a PDC of at least 80% for their antipsychotic medications (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.

Follow the steps below to identify numerator compliance.

Step 1 Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the measurement year.

Step 2 To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.

Step 3 Count the days covered by at least one antipsychotic medication (see Table SAA-A; Long-Acting Injections 14 Days Supply Value Set; Long-Acting Injections 28 Days Supply Value Set) during the treatment period. To ensure that days supply that extend beyond the measurement year are not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4 Calculate the member's PDC using the following equation. Round to two decimal places, using the .5 rule.

$$\frac{\text{Total Days Covered by an Antipsychotic Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Step 5 Sum the number of members whose PDC is $\geq 80\%$ for their treatment period.

IET – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Description

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following.

- *Initiation of AOD Treatment.* The percentage of members who initiate 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 members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Definitions

Intake Period	January 1–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. <i>For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.</i>
IESD	Index Episode Start Date. 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. <i>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.</i> <i>For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge.</i> <i>For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge.</i> <i>For direct transfers, the IESD is the discharge date from the second admission.</i>
Negative Diagnosis History	A period of 60 days before the IESD, during which the member had no claims/encounters with a diagnosis of AOD dependence. <i>For an inpatient claim/encounter, use the admission date to determine the Negative Diagnosis History.</i> <i>For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.</i> <i>For direct transfers, use the first admission to determine the Negative Diagnosis History.</i>

IET – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Eligible Population

Product lines	Medicaid.
Age	<p>13 years and older as of December 31 of the measurement year. Report two age stratifications and a total rate.</p> <ul style="list-style-type: none">• 13 - 17 years• 18+ years• Total <p>The total is the sum of the two age stratifications.</p> <p>Note: This measure uses the HEDIS age stratifications – report on ages appropriate for your plan.</p>
Continuous enrollment	60 days (2 months) prior to the IESD through 44 days after the IESD (inclusive).
Allowable gap	None.
Anchor date	None.
Benefits	<p>Medical and chemical dependency (inpatient and outpatient).</p> <p>Note: <i>Members with detoxification-only chemical dependency benefits do not meet these criteria.</i></p>
Event/ diagnosis	<p>New episode of AOD during the Intake Period.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p> <p>Step 1 Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:</p> <ul style="list-style-type: none">• An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria:<ul style="list-style-type: none">– <u>IET Stand Alone Visits Value Set</u> with <u>AOD Dependence Value Set</u>.– <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and <u>AOD Dependence Value Set</u>.– <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and <u>AOD Dependence Value Set</u>.• A detoxification visit (<u>Detoxification Value Set</u>).• An ED visit (<u>ED Value Set</u>) with a diagnosis of AOD (<u>AOD Dependence Value Set</u>).• An inpatient discharge with a diagnosis of AOD as identified by either of the following:<ul style="list-style-type: none">– An inpatient facility code with a diagnosis of AOD (<u>AOD Dependence Value Set</u>).– An inpatient facility code with an AOD procedure code (<u>AOD Procedures Value Set</u>). <p><i>For members with more than one episode of AOD, use the first episode.</i></p> <p><i>For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.</i></p> <p>Select the IESD.</p>

IET – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Step 2 Test for Negative Diagnosis History. Exclude members who had a claim/encounter with a diagnosis of AOD (AOD Dependence Value Set) 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 encounter, use the ED date of service to determine the Negative Diagnosis History.

Step 3 Calculate continuous enrollment. Members must be continuously enrolled without any gaps, 60 days (2 months) before the IESD through 44 days after the IESD.

Administrative Specification

Denominator The eligible population.

Numerator

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 member is compliant.

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with a diagnosis of AOD, within 14 days of the IESD (inclusive). If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count. Any of the following code combinations meet criteria.

- IET Stand Alone Visits Value Set **with** AOD Dependence Value Set.
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** AOD Dependence Value Set.
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** AOD Dependence Value Set.

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 inpatient detoxification or detoxification codes (Detoxification Value Set) as initiation of treatment. Exclude members from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.

Engagement of AOD Treatment Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis 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 count. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set **with** AOD Dependence Value Set.
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **and** AOD Dependence Value Set.

IET – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **and** AOD Dependence Value Set.

For members 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 inpatient detoxification or detoxification codes (Detoxification Value Set).

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate (e.g., within 14 days of the IESD or within 30 days after the date of the initiation encounter).*

Maternity

PPC - Prenatal and Postpartum Care

Description

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester *or* within 42 days of enrollment in the organization.
- *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Eligible Population

Product lines Medicaid.

Age None specified.

Continuous enrollment 43 days prior to delivery through 56 days after delivery.

Allowable gap No allowable gap during the continuous enrollment period.

Anchor date Date of delivery.

Benefit Medical.

Event/ diagnosis *Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Include women who delivered in a birthing center.

Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1 Identify deliveries. Identify all women with a delivery between November 6 of the year prior to the measurement year and November 5 of the measurement year. Either of the following meets criteria:

- A delivery (Deliveries Value Set)
- A delivery on an infant claim (Deliveries Infant Record Value Set), where the organization can link infant and mother records.

Step 2 Exclude non-live births (Non-live Births Value Set).

Step 3 *Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.*

PPC - Prenatal and Postpartum Care

Administrative Specification

Denominator The eligible population.

Numerator

Timeliness of Prenatal Care A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and the gaps in enrollment during the pregnancy.
Include only visits that occur while the member was enrolled.

Follow the steps below to identify the numerator

- Step 1** Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, go to step 2.
For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3.
- Step 2** Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]) with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for *Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester*.
For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.
- Step 3** Determine the start date of the last enrollment segment (i.g., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).
For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4. For women whose last enrollment started less than 219 days before delivery proceed to step 5.
- Step 4** Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for *Identifying Prenatal Care For Women Not Continuously Enrolled During the First Trimester* and find a visit between the last enrollment start date and 176 days before delivery.
- Step 5** Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for *Identifying Prenatal Care For Women Not Continuously Enrolled During the First Trimester* and find a visit within 42 days after enrollment.

PPC - Prenatal and Postpartum Care

Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester

Decision Rule 1 Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria.

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).

Decision Rule 2 Any of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner, meet criteria:

- A prenatal visit (Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).
- A prenatal visit (Prenatal Visits Value Set) with all of the following:
 - Toxoplasma (Toxoplasma Antibody Value Set).
 - Rubella (Rubella Antibody Value Set).
 - Cytomegalovirus (Cytomegalovirus Antibody Value Set).
 - Herpes Simplex (Herpes Simplex Antibody Value Set).
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO (ABO Value Set).
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and Rh (Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set).

Decision Rule 3 Any of the following during the first trimester, where the practitioner type is a PCP, meet criteria:

- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an obstetric panel (Obstetric Panel Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and all of the following:
 - Toxoplasma (Toxoplasma Antibody Value Set).
 - Rubella (Rubella Antibody Value Set).

PPC - Prenatal and Postpartum Care

- Cytomegalovirus (Cytomegalovirus Antibody Value Set).
- Herpes Simplex (Herpes Simplex Antibody Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO (ABO Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and Rh (Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set).
- A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with an obstetrical history.
- A prenatal visit (Prenatal Visits Value Set) with any internal organization code for LMP or EDD with risk assessment and counseling/education.

Note: For criteria that require a prenatal visit code (Prenatal Visits Value Set) **and** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.

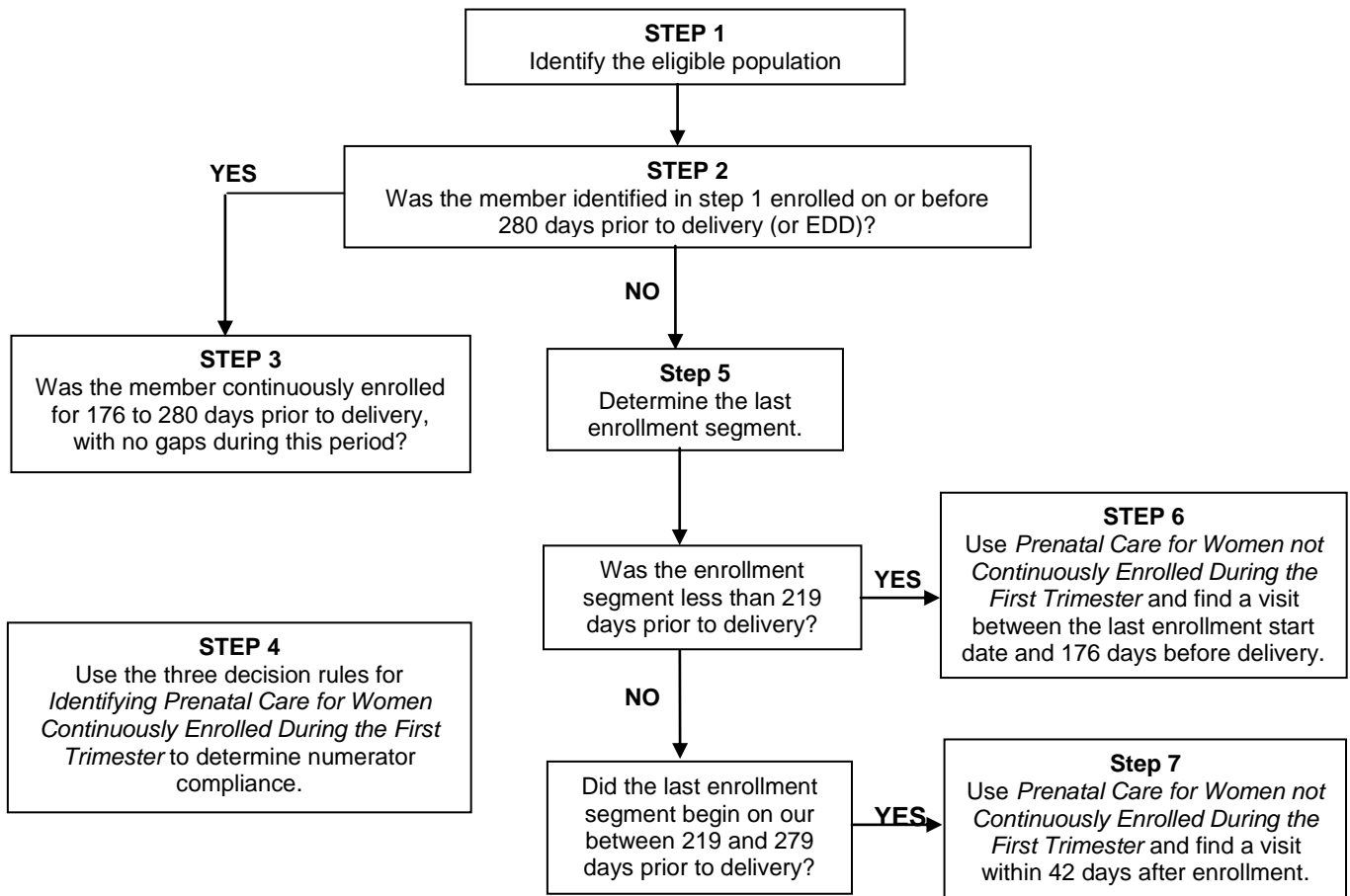
Identifying Prenatal Care For Women Not Continuously Enrolled During the First Trimester

Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:

- A bundled service (Prenatal Bundled Services Value Set) where the organization can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set).
- A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

Note: For criteria that require a prenatal visit code (Prenatal Visits Value Set) **and** a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.

PPC - Prenatal and Postpartum Care



Postpartum Care A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Visits Value Set).
- Cervical Cytology (Cervical Cytology Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Note: The practitioner requirement only applies to the Hybrid Specification. The member is compliant if any code from Table PPC-E is submitted.

PPC - Prenatal and Postpartum Care

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population for each product line. Organizations may reduce the sample size using the current year's lowest product line-specific administrative rate of these two indicators and the >81% indicator from <i>Frequency of Ongoing Prenatal Care</i> or the prior year's lowest audited product line-specific rate for these two indicators and the >81% indicator from <i>Frequency of Ongoing Prenatal Care</i> .
Numerator	
<i>Timeliness of Prenatal Care</i>	A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in the organization and gaps in enrollment during the pregnancy. Include only visits that occurred while the member was enrolled.
<u>Administrative</u>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.
<u>Medical record</u>	<p><i>Prenatal care visit to an OB/GYN practitioner or midwife, family practitioner or other PCP. For visits to a family practitioner or PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following.</i></p> <ul style="list-style-type: none">• A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).• Evidence that a prenatal care procedure was performed, such as:<ul style="list-style-type: none">– Screening test in the form of an obstetric panel (e.g., hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing), or– TORCH antibody panel alone, or– A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or– Echography of a pregnant uterus• Documentation of LMP or EDD in conjunction with <i>either</i> of the following.<ul style="list-style-type: none">– Prenatal risk assessment and counseling/education, or– Complete obstetrical history. <p>Note: For members whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery), count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principal diagnosis of pregnancy.</p>
<i>Postpartum Care</i>	A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.
<u>Administrative</u>	Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.

PPC - Prenatal and Postpartum Care

Medical record

Postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and *one* of the following.

- Pelvic exam.
- Evaluation of weight, BP, breasts and abdomen.
 - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including, but not limited to:
 - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
 - A preprinted “Postpartum Care” form in which information was documented during the visit.

Note

- For women continuously enrolled during the first trimester (176-280 days before delivery with no gaps), the organization has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.
- Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.
 - For women whose last enrollment segment started on or between 219 and 279 days before delivery, the organization has sufficient opportunity to provide prenatal care by the end of the first trimester.
 - For women whose last enrollment segment started less than 219 days before delivery, the organization has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- *When counting prenatal or postpartum visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses if a physician cosignature is present, if required by state law.*
- *Services that occur over multiple visits count toward this measure as long as all services are within the time frame established in the measure. Ultrasound and lab results alone should not be considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.*
- *The organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the organization must define a method to determine which EDD to use, and use that date consistently.*
- *A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for either rate.*
- *Refer to Appendix 3 for the definition of PCP and OB/GYN and other prenatal practitioners.*
- *The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.*
- *The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.*

FPC – Frequency of Ongoing Prenatal care

Description

The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:

- <21 percent of expected visits.
- 21 percent–40 percent of expected visits.
- 41 percent–60 percent of expected visits.
- 61 percent–80 percent of expected visits.
- ≥81 percent of expected visits.

This measure uses the same denominator as the Prenatal and Postpartum Care measure.

Eligible Population

Product line	Medicaid.
Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	<p>Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.</p> <p>Include women who delivered in a birthing center.</p> <p><i>Multiple births.</i> Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should count twice. Women who have multiple live births during one pregnancy should be counted once in the measure.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for both rates.</p> <p>Step 1 Identify deliveries. Identify all women with a delivery between November 6 of the year prior to the measurement year and November 5 of the measurement year. Either of the following meets criteria:</p> <ul style="list-style-type: none">• A delivery (<u>Delivery Value Set</u>). <p>Step 2 Exclude non-live births (<u>Non-live Births Value Set</u>).</p> <p>Step 3 Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.</p>

FPC – Frequency of Ongoing Prenatal care

Administrative Specification

Denominator The eligible population.

Numerator Women who had an unduplicated count of <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. For each delivery, follow the steps below to calculate each woman's ratio of observed-to-expected prenatal care visits.

Step 1 Identify the delivery date using hospital discharge data.

Step 2 Identify the date when the member enrolled in the organization and determine the stage of pregnancy at time of enrollment. If the member has gaps in enrollment during pregnancy, use the last enrollment segment to determine continuous enrollment in the organization. For members with a gap in enrollment any time during pregnancy (including a gap in the first trimester), the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date.

Use the following approach (or an equivalent method) to calculate the stage of pregnancy at time of enrollment. If gestational age is not available, assume a gestational age of 280 days (40 weeks).

- Convert gestational age into days.
- Subtract gestational age (in days) from the date of delivery (step 1).
- Subtract the date obtained above from the date when the member enrolled in the organization to determine the stage of pregnancy at time of enrollment.
- Divide the numbers of days the member was pregnant at enrollment (step 3) by 30. Round the resulting number according to the .5 rule to a whole number.

For example, delivery date is August 8, 2012; gestational age is 33 weeks; date of enrollment is May 6, 2012. Given these variables, the process is:

- Gestational age in days is *231 days* (33 weeks x 7 days/week).
- Date of delivery – gestational age (in days) is *December 20, 2012* (August 8, 2013 – 231 days).
- Date when the member enrolled in the organization – date obtained in step 2 is *137 days* (May 6, 2013 – December 20, 2012).
- Month in which prenatal care began is *4.56 months* (137 days/30 days) and then round up to *5 months* using the 0.5 rule.

This member's stage of pregnancy at time of enrollment is 5 months.

Step 3 Use Table FPC-A to find the number of recommended prenatal visits by gestational age and stage of pregnancy at time of enrollment per the American College of Obstetricians and Gynecologists (ACOG). The chart subtracts the number of missed visits prior to the date the member enrolled from the number of recommended visits for a given gestational age.

FPC – Frequency of Ongoing Prenatal care

ACOG recommends that women with an uncomplicated pregnancy receive visits every 4 weeks for the first 28 weeks of pregnancy, every 2–3 weeks until 36 weeks of pregnancy, and weekly thereafter. For example, ACOG recommends 14 visits for a 40-week pregnancy. If the member enrolled during her fourth month (3 missed visits prior to enrollment in the organization), the expected number of visits is $14 - 3 = 11$.

For deliveries with a gestational age <28 weeks or >43 weeks, calculate the expected number of prenatal care visits using the date when the member enrolled and ACOG's recommended schedule of visits. For example, if gestational age is 26 weeks and the member enrolled during her second month of pregnancy, the expected number of prenatal care visits is 5 (6 expected visits [1 visit every 4 weeks or 6 visits in 24 weeks], less 1 visit missed in the first month).

If gestational age is 44 weeks and the member enrolled during her third month of pregnancy, the expected number of prenatal care visits is 16 (14 expected visits for a 40-week gestation plus 1 visit each additional week [18 total expected prenatal care visits], less 2 visits missed in the first and second months).

Step 4 Identify the number of prenatal care visits the member received during the course of her pregnancy and while enrolled in the organization using claims and encounter data.

To identify prenatal visits that occurred during the first trimester, refer to the *Prenatal and Postpartum Care* measure decisions rules for *Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester*.

To identify prenatal visits that occurred during the second and third trimester, refer to the *Prenatal and Postpartum Care* measure instructions for *Identifying Prenatal Care For Women Not Continuously Enrolled During the First Trimester*. Visits that occur on the date of delivery and meet the prenatal visit criteria count toward the measure.

All criteria must be met for encounters to be counted as a discrete prenatal care visit. For example, Decision Rule 2 and 3 require multiple components (typically a visit combined with a diagnosis code or another prenatal service such as a lab test or an ultrasound). Ultrasound and lab results alone are not considered a discrete prenatal care visit unless they are combined with other criteria.

Services that occur over multiple visits can be combined to create a discrete prenatal care visit if all services occur within the time frame established in the measure and services are not double counted. Organizations must develop systems to avoid double counting. For example, a code from the Stand Alone Prenatal Visits Value Set on the same date of service as a code from the Prenatal Visits Value Set is interpreted to represent a single visit/encounter and should not be counted twice. If the member had a gap in enrollment, count only the visits received during the last enrollment segment.

Step 5 Calculate the ratio of observed visits (step 4) to expected visits (step 3).

Step 6 Report each woman in the appropriate category:

- <21 percent.
- 21 percent–40 percent.
- 41 percent–60 percent.
- 61 percent–80 percent.
- ≥81 percent of expected visits.

FPC – Frequency of Ongoing Prenatal care

Hybrid Specification

Denominator	<p>A systematic sample of members drawn from the eligible population. If the organization collects this measure and the <i>Prenatal and Postpartum Care</i> measure, it must use the same systematic sample for both. Organizations may reduce the sample size using the current year's lowest product-line-specific administrative rate for the rate of women who received ≥ 81 percent of expected prenatal care visits and the two rates from <i>Prenatal and Postpartum Care</i>. It may also use the prior year's lowest audited product-line-specific rates for the rate of women who received ≥ 81 percent of expected prenatal care visits and the two rates from <i>Prenatal and Postpartum Care</i>.</p> <p>Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing sampling size.</p>
Numerator	<p>Women who had an unduplicated count of the number of expected visits that was <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥ 81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. The visits may be identified through either administrative data or medical record review.</p> <p>The numerator is calculated retroactively from date of delivery or EDD.</p>
Administrative	<p>Refer to <i>Administrative Specification</i> to identify positive numerator hits from the administrative data.</p>
Medical record	<p>Use the medical record documentation requirements in the <i>Prenatal and Postpartum Care</i> measure to identify prenatal visits that occur during the first, second and third trimesters.</p> <p>Identify gestational age at birth from the hospital record (e.g., admission write-ups, histories and physicals, discharge summaries or labor and delivery records) or birth certificate. Gestational age is the number of completed weeks that elapsed between the first day of the last normal menstrual period and the date of delivery. If gestational age is not available, assume a gestational age of 280 days (40 weeks).</p> <p>Methods recommended to determine gestational age are as follows.</p> <ul style="list-style-type: none">• Physician ascertainment using ultrasound or Dubowitz assessment.• Last menstrual period (LMP) calculation (date of LMP – date of delivery) \div 7. If gestational age is recorded or calculated in fractions of a week, round down to the lower whole number.

Note

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- *This measure is based on deliveries. Members who have multiple deliveries from a single pregnancy should be counted once. Include each pregnancy for members who have multiple deliveries from different pregnancies.*
 - *When counting prenatal visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses if a physician cosignature is present, if required by state law.*
 - *Organizations that collect both Prenatal and Postpartum Care and Frequency of Ongoing Prenatal Care for reporting using the Hybrid Method must use the same sample for collection.*

FPC – Frequency of Ongoing Prenatal care

- If an organization uses the Hybrid Method, it may not use a combination of administrative data and medical record review to identify prenatal care visits for an individual in the denominator. For example, for one member, the organization may not count two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) for one member, even if each visit shows a different date of service.
- Refer to Appendix 3 for the definition of PCP and OB/GYN and other prenatal care practitioners.

Table FPC-A: Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Member Enrolled in the Organization

Gestational Age in Weeks	Month of Pregnancy Member Enrolled in the Organization*								
	0-1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month
28	6	5	4	3	1	1	—	—	—
29	6	5	4	3	1	1	—	—	—
30	7	6	5	4	2	1	1	—	—
31	7	6	5	4	2	1	1	—	—
32	8	7	6	5	3	2	1	—	—
33	8	7	6	5	3	2	1	—	—
34	9	8	7	6	4	3	2	1	—
35	9	8	7	6	4	3	2	1	—
36	10	9	8	7	5	4	3	1	—
37	11	10	9	8	6	5	4	2	—
38	12	11	10	9	7	6	5	3	—
39	13	12	11	10	8	7	6	4	1
40	14	13	12	11	9	8	7	5	1
41	15	14	13	12	10	9	8	6	2
42	16	15	14	13	11	10	9	7	3
43	17	16	15	14	12	11	10	8	4