

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

Technical Specifications and Resource Manual for  
Federal Fiscal Year 2017 Reporting

September 2017

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



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## CONTENTS

ACKNOWLEDGMENTS.....	iii
I THE CORE SET OF HEALTH CARE QUALITY MEASURES FOR MEDICAID HEALTH HOME PROGRAMS .....	1
Background .....	1
Identifying the Health Home Core Set.....	1
How the Health Home Core Set Will Be Used .....	2
Health Home Core Set Measures .....	2
II DATA COLLECTION AND REPORTING OF THE HEALTH HOME CORE SET.....	3
Data Collection and Preparation for Reporting .....	3
Definitions .....	7
Reporting and Submission .....	8
Technical Assistance.....	9
III TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME CORE SET MEASURES.....	10
Measure ABA-HH: Adult Body Mass Index Assessment .....	11
Measure CDF-HH: Screening for Clinical Depression and Follow-Up Plan .....	14
Measure PCR-HH: Plan All-Cause Readmissions.....	18
Measure FUH-HH: Follow-Up After Hospitalization for Mental Illness.....	24
Measure CBP-HH: Controlling High Blood Pressure .....	28
Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ...	37
Measure PQI92-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite.....	42
IV TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME UTILIZATION MEASURES .....	47
Measure AMB-HH: Ambulatory Care – Emergency Department Visits.....	48
Measure IU-HH: Inpatient Utilization .....	51
Measure NFU-HH: Nursing Facility Utilization .....	56
APPENDIX A: HEALTH HOME CORE SET HEDIS® VALUE SET DIRECTORY USER MANUAL.....	A-61
APPENDIX B: GUIDANCE FOR SELECTING SAMPLE SIZES FOR HEDIS® HYBRID MEASURES..	B-69
APPENDIX C: DEFINITION OF HEALTH HOME CORE SET PRACTITIONER TYPES .....	C-73

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## **I. THE CORE SET OF HEALTH CARE QUALITY MEASURES FOR MEDICAID HEALTH HOME PROGRAMS**

### **Background**

Section 1945 of the Social Security Act allows states to elect a new Health Homes service option to provide comprehensive care coordination for individuals with chronic conditions under the Medicaid state plan and to receive additional federal support for the first eight quarters of implementation to support the roll out of this new care model. States are responsible for designating qualified health home providers to coordinate primary, acute, behavioral health (mental health and substance use services), and long-term services and supports for Medicaid-eligible individuals with chronic illness. Overall, it provides an opportunity for states to build a person-centered care delivery model that focuses on improving outcomes and disease management for enrollees with chronic conditions and obtaining better value for state Medicaid programs.

For more information, refer to the following links:

Health Home Information Resource Center

<https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-information-resource-center.html>

Health Home Quality Reporting

<https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/health-home-quality-reporting.html>

Frequently Asked Questions about Health Homes

<https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-home-faq-1-21.pdf>

### **Identifying the Health Home Core Set**

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

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

The 2017 Health Home Core Set includes 7 Core Measures and 3 Utilization Measures. One measure was retired from the 2017 Health Home Core Set: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care).

## How the Health Home Core Set Is Used

The 2017 Health Home Core Set is used to evaluate the Health Homes model. The Core Set is used to assess quality outcomes and performance, as well as to inform ongoing quality monitoring of the Health Home program. Health Home providers are expected to report to the state Medicaid program, which reports the data in aggregate to CMS at the State Plan Amendment (SPA) level. States are expected to report the Health Home Core Set measures when their state plan amendment (SPA) has been in effect for six or more months of the measurement period. For SPA amendments, states are expected to include data affected by the amendment combined with data from the original SPA when the amendment is in effect for six or more months of the measurement period. More information on the states expected to report for FFY 2017 is available at <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-home-reporting-table.pdf>.

## Health Home Core Set Measures

The following table lists the 2017 Health Home Core Set measures, the National Quality Forum (NQF) number (when the measure is NQF-endorsed), and the measure steward and the types of data collection methods used to report the measure. As noted in the table, the data collection methods include administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), medical records (paper or electronic), or e-measure only. These measures are based on the Core Set of Adult Health Care Quality Measures for Medicaid, but have been modified to allow for Health Home program reporting, which may also include children. The technical specifications in Chapters III and IV of this manual provide additional details for each measure.

NQF #	Measure Steward <sup>a</sup>	Measure Name	Data Collection Method(s)
<b>Core Set Measures</b>			
0004	NCQA	<a href="#">Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-HH)</a>	Administrative or e-measure
0018	NCQA	<a href="#">Controlling High Blood Pressure (CBP-HH)</a>	Hybrid or e-measure
0418	CMS	<a href="#">Screening for Clinical Depression and Follow-Up Plan (CDF-HH)</a>	Hybrid or e-measure
0576	NCQA	<a href="#">Follow-Up After Hospitalization for Mental Illness (FUH-HH)</a>	Administrative
1768	NCQA	<a href="#">Plan All-Cause Readmissions (PCR-HH)</a>	Administrative
NA	NCQA	<a href="#">Adult Body Mass Index Assessment (ABA-HH)</a>	Administrative or Hybrid
NA	AHRQ	<a href="#">Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)</a>	Administrative
<b>Utilization Measures</b>			
NA	NCQA	<a href="#">Ambulatory Care – Emergency Department Visits (AMB-HH)</a>	Administrative
NA	CMS	<a href="#">Inpatient Utilization (IU-HH)</a>	Administrative
NA	CMS	<a href="#">Nursing Facility Utilization (NFU-HH)</a>	Administrative

AHRQ = Agency for Healthcare Research & Quality; CMS = Centers for Medicare & Medicaid Services; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

<sup>a</sup> The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

## II. DATA COLLECTION AND REPORTING OF THE HEALTH HOME CORE SET

To support consistency in reporting the Health Home Core Set measures, this chapter provides general guidelines for data collection, preparation, and reporting. Technical specifications, which provide detailed information on how to calculate each measure, are presented in Chapters III and IV. For technical assistance with calculating and reporting these measures, contact the TA mailbox at [MACqualityTA@cms.hhs.gov](mailto:MACqualityTA@cms.hhs.gov).

### Data Collection and Preparation for Reporting

- **Version of specifications.** This manual includes the most applicable version of the measure specifications available to CMS as of January 2017. For HEDIS measures, the manual follows HEDIS 2017 specifications (2016 measurement year). For non-HEDIS measures, the manual includes the most applicable version of the specifications available from the measure steward for reporting 2016 data.
- **Value sets.** Many of the Health Home Core Set measure specifications reference value sets that must be used for calculating the measures. A value set is the complete set of codes used to identify a service or condition included in a measure. The Value Set Directory (VSD) includes all value sets and codes needed to report all HEDIS measures included in the Health Home Core Set.
  - The HEDIS value set directory and the value set directory for the Utilization measures in Section IV are available at: <https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fstate-resource-center%2Fmedicaid-state-technical-assistance%2Fhealth-homes-technical-assistance%2Fdownloads%2F2017-Health-Homes-Directory.zip>. Value set references are underlined in the specifications (e.g., BMI Percentile Value Set). Refer to Appendix A for a HEDIS Value Set Directory User Manual.
  - Value sets for the PQI92-HH measure are available at <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>.
- **Data collection time frames for measures.** States should adhere to the measurement periods identified in the technical specifications for each measure. Some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a hospital discharge for a mental health condition. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2016 data should be reported for FFY 2017. For each measure, the measurement period used to calculate the denominator should be reported in the “Start Date” and “End Date” fields. For many measures, the denominator measurement period for FFY 2017 corresponds to calendar year 2016 (January 1, 2016 – December 31, 2016). Some measures, however, also require states to review utilization or enrollment prior to this period to identify the measure-eligible population. States should not include these review periods (sometimes referred to as “look-back” periods) in the Start and End date range. Further information regarding measurement periods is available at: <https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-core-set-measurement-period-table-2017.pdf>.
- **Continuous enrollment.** This refers to the time frame during which a Health Home enrollee must be eligible for Medicaid benefits and enrolled in a Health Home program to be included in the measure denominator. The technical specifications provide the continuous enrollment requirement for each measure, if applicable. Continuous enrollment ensures that

the Health Home has enough time to render services. To be considered continuously enrolled, an individual must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health). The continuous enrollment period and allowable gaps are specified in each measure. To determine continuous enrollment, states should identify the enrollment date for each Health Home enrollee. This date is defined by the policies of each state's Health Home program and does not need to match the Health Home SPA effective date. Health Home enrollees may see multiple Health Home providers while continuously enrolled in a single Health Home program.

- **Allowable gap.** Some measures specify an allowable gap that can occur during continuous enrollment. For example, the Controlling High Blood Pressure measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in enrollment of up to 45 days. Thus, a Health Home enrollee who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year, because this enrollee has one 38-day gap (January 1–February 7).
- **Anchor date.** Some measures include an anchor date, which is the date that an individual must be enrolled and have the required benefit to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure's FFY 2017 measurement period (December 31, 2016). For other measures, the anchor date is based on a specific event, such as a birthdate. States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.
- **Date specificity.** A date must be specific enough to determine that an event occurred during the time frame in the measure. There are instances when documentation of the year alone is adequate; for example, most optional exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable. For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure.
- **Reporting unit.** CMS defines the reporting unit for each measure as each state's Health Home program. This means that states reporting any of the Health Home Core Set measures should collect data across all Health Home providers<sup>1</sup> within a specific Health Home program, as defined by the approved SPA applicable to the program. States should aggregate data from all Health Home providers into one Health Home program-level rate before reporting data to CMS. States with more than one SPA should report separately for each Health Home program, as defined in their SPA. SPA amendments should be included with the original SPA and not as a separate report. For more guidance about developing a state-level rate, see the bullet on "aggregating information for Health Home program-level reporting" below.
- **Eligible population for measurement.** Health Home enrollees are Medicaid beneficiaries (adults and children) who are enrolled in a state Health Home program and assigned a Health Home provider. For all measures, the denominator includes Health Home enrollees who satisfy measure-specific eligibility criteria (e.g. age, continuous enrollment, benefit, event, and anchor date). Some measures require a period of

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

continuous enrollment for inclusion in the measure. No utilization measures require a period of continuous enrollment for inclusion.

- **Enrollees with partial benefits.** For each measure, states should include only the Health Home enrollees who are eligible to receive the services assessed in the numerator. If an enrollee is not eligible to receive the services assessed in the measure, the enrollee should not be included in the denominator for the measure. The technical specifications for some measures have guidance regarding which benefits an individual must be eligible for to be included, but each state should assess the specific benefit packages of the enrollees in their state.
- **Aggregating information for Health Home program-level reporting.** To obtain a Health Home program-level rate for a measure that is developed from the rates of multiple units of measurement (such as across Health Home providers), the state should calculate a weighted average of the individual rates. How much any one entity (e.g., each Health Home provider) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that Health Home providers serving larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid, administrative, electronic, and data from alternative data collection methods or sources, such as patient registries, can be combined to develop a Health Home program-level rate as long as the specifications allow the use of these data collection methods or sources to construct the measure. For additional guidance on developing a program-level rate, refer to the TA Brief titled, "Approaches to Developing State-Level Rates Using Data from Multiple Sources."<sup>2</sup> Although CMS encourages Health Home providers and states to use the methods and data sources listed in the specification for each measure, states and providers may use alternative methods and data sources, when necessary. When reporting an aggregated rate that uses alternative data sources or combines data from multiple sources and methods, states should report the data sources and methods used, and the combined rate.
- **Reporting a weighted rate.** When a state develops a weighted rate combining data across multiple reporting units (Health Home providers), the state should report the rate for the combined data in the "Rate" field. If the state has the numerator and denominator that were used to calculate the Health Home Program-Level rate, they should be entered in the Numerator and Denominator fields. If this information is not available, a state can enter "0" in the Numerator and Denominator fields, report the Health Home Program-Level rate in the "Rate" field, and explain the missing information in the "Additional Notes/Comments on Measure" section. If possible, the state should also provide the numerators, denominators, measure-eligible population, and rates for each Health Home provider in this section as well as a description of the method used to calculate the Health Home Program-Level rate (including the approach used for weighting).
- **Age criteria.** The age criteria vary by measure. Some measures have an upper age limit, while others include an age range above age 64 and/or under age 18. For the purpose of Health Home Core Set reporting, states should calculate and report such measures for three age groups where applicable: Health Home enrollees under age 18, enrollees between the ages of 18 and 64, and those age 65 and older. States should also report for the total population. States should note any deviations from the specifications in the "Deviations from Measure Specifications" field.
- **Exclusions.** Some measure specifications contain required or optional exclusions. A Health Home enrollee who meets required exclusion criteria should be removed from the

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<sup>2</sup> The TA Brief, "Approaches to Developing State-level Rates Using Data from Multiple Sources," is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf>.

measure denominator. Some exclusions are optional. States should note when reporting whether optional exclusions are applied.

- **Representativeness of data.** States should use the most complete data available and ensure that the rates reported are representative of the entire population enrolled in their Health Home program(s). For a measure based on administrative data, all Health Home enrollees who meet the eligible population requirements for the measure should be included. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire Health Home eligible population for the measure.
- **Data collection methods.** The measures in the Health Home Core Set have three possible data collection methods: administrative, hybrid, and medical records, including electronic medical records (e-Measures). Each measure specifies the data collection method(s) that must be used. If a measure includes a choice of methods, any of the listed methods may be used.
  - The administrative method uses transaction data (for example, claims) or other administrative data sources to calculate the measure. These data can be used in cases in which the data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population is included in the denominator.
  - The hybrid method uses both administrative data sources and medical record data (paper or EHR) to determine numerator compliance. Administrative data are reviewed to determine if enrollees in the systematic sample received the service, and medical record data are reviewed for enrollees who do not meet the numerator criteria through administrative data. The denominator consists of a systematic sample of the measure's eligible population. The hybrid method, when possible, should be used when administrative data and EHR data are incomplete or may be of poor quality or the data elements for the measure are not captured in administrative data (e.g., Controlling High Blood Pressure). More information on the use of the hybrid method for Health Home Core Set Reporting is available at <http://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf>.
  - The e-measure method uses EHRs only to calculate the measure.
- **Sampling.** For measures that use the hybrid method, sampling guidance is included in the technical specification if available from the measure steward. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.
  - For HEDIS measures that use the hybrid method, the sample size should be 411, unless special circumstances apply. If a Health Home Program has less than 411 enrollees, all enrollees should be included as the sample. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.
  - States should use the "Additional Notes/Comments" field to describe the sampling approach used for each measure. Additional guidance on sampling for hybrid measures is available in the following TA brief: Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets (October 2014).<sup>3</sup>

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<sup>3</sup> Technical Assistance briefs can be found at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>.

- **Alternative data collection methods and data sources.** States may choose to report on any of these measures using the methods listed in the specifications, or using an alternative method (e.g., medical record review without systematic sample) or data source (e.g., patient registry) if the administrative, hybrid, and medical record/e-measure methods are not feasible. The data collection method and data source should be explained in the "Deviations from Measure Specification" field.
- **Small numbers.** If a measure has a denominator that is less than 30 and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- **Risk adjustment.** One of the measures in the Health Home Core Set, Plan All-Cause Readmissions, requires risk adjustment. However, this measure does not currently have a risk adjustor for the Medicaid population. CMS suggests that states report unadjusted rates for this measure until a standardized risk adjustor is made available.
- **Inclusion of paid, suspended, pending, and denied claims.** A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided. For such measures, the inclusion of claims, regardless of whether they were paid, denied, or voided would be appropriate. For HEDIS measures that rely on claims as a data source, the HEDIS Volume 2 manual provides guidance on which claims to include: <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2017.aspx>.
- **ICD-9 / ICD-10 Conversion.** In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, measures should be calculated using ICD-10 codes for claims with a date of service or date of discharge on or after October 1, 2015.<sup>4</sup> ICD-10 codes are available in the specification or in the corresponding value set directory (see above).
  - For HEDIS measures in the Health Home Core Set, value sets included both ICD-9 and ICD-10 codes. ICD-9 codes will be removed from HEDIS measure specifications when the look-back period for the measure plus one additional year has passed. (The look-back period plus one year has not yet passed for any of the measures.) This is consistent with NCQA's policy for removing obsolete codes from HEDIS measures. After ICD-9 codes have been removed from a measure, only ICD-10 codes will be eligible for use in reporting.
  - For non-HEDIS measures in the Health Home Core Set, ICD-9 codes are retained in the measure specification or in the value sets in accordance with the measure steward's published specifications.

## Definitions

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

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

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<sup>4</sup> The following Health Home Core Set measures are affected by this conversion: ABA-HH, PCR-HH, PQI92-HH, FUH-HH, CBP-HH, IET-HH, AMB-HH, and IU-HH.

- Designated provider: May be physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other.
- Team of health professionals: May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, or other.
- Health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral healthcare providers, chiropractors, licensed complementary and alternative medical practitioners, and physician assistants.
- Health Home Enrollee: Medicaid beneficiary (adult or child) enrolled in a state Health Home program. Medicaid beneficiaries eligible for Health Home services:
  - Have two or more chronic conditions, or
  - Have one chronic condition and are at risk for a second, or
  - Have a serious and persistent mental health condition.

Health Home enrollees may include beneficiaries dually eligible for both Medicare and Medicaid. Medicaid/CHIP Core Set Practitioner Types are defined in Appendix C.

## Reporting and Submission

Procedures for reporting the Health Home Core Set are provided below.

- **Reporting eligibility.** States are expected to report the Health Home Core Set measures when their SPA has been in effect for six months or more of the measurement period. A health home program that had an effective date before July 2, 2016 or during a previous year is eligible to report for FFY 2017. While some measures may have a continuous enrollment requirement that exceeds the time that enrollees were in a health home, states should report as many measures as possible for which their enrollees meet the continuous enrollment requirements. The continuous enrollment requirements are specified in the eligible population section for each measure.
- **Submission deadline.** CMS will announce the deadline for submitting and certifying final data on the Health Home Core Set measures for FFY 2017. States can update data submitted after the submission deadline; however, updates made after the deadline are not guaranteed to be used in the development of reports by CMS and states are encouraged to submit data that are as complete as possible by the submission deadline.
- **Completing fields.** Specific fields are provided for each measure. States should complete every field for each measure submitted to ensure consistent and accurate reporting and comparability across states. States are encouraged to document the methods used to calculate the measures in order to improve CMS's understanding of variations across states.
- **Including attachments.** Supporting documents related to measures can be submitted with Health Home Core Set data.
- **Reasons for not reporting a measure.** Although reporting the Health Home Core Set is voluntary, states choosing not to report a measure are required to explain their reason for not reporting the measure. This information will assist CMS in understanding why each state or why all states as a group may not be reporting on specific measures.
- **Noting deviations from the measure technical specifications.** Although states are encouraged to report measures adhering to the methods provided in the specifications, this may not always be possible. It might also be necessary to provide additional information and context about the rates reported. Examples of deviations include eligible population definitions that differ from the specifications (age ranges, codes for

identifying the population, or missing population segments); differences in data sources used; differences in codes used (added, excluded, or substituted codes); differences in the version used; issues encountered in calculating the measure; and caveats not specified elsewhere.

- **Reporting by population.** For each Health Home Core Set measure reported to CMS, states should specify the population included in the measure: Medicaid, Medicare and Medicaid dual eligibles, and Other. Any populations excluded from the denominator should be noted in the “Deviations from Measure Specifications” field.
- **Data auditing.** For FFY 2017, CMS will not require certification or auditing of HEDIS or other measures. However, states are encouraged to do so when possible. If there are current state mechanisms for accreditation, certification, and managed care external quality review reporting, or if the state validates its Health Home Core Set rates, we ask that states describe these processes.
- **Reporting electronic health record (EHR) Medicaid Incentive Program measures.** For states voluntarily reporting on a core measure that is also an EHR Medicaid incentive program measure (CBP-HH, CDF-HH, IET-HH) we ask that states indicate whether any information was extracted from EHRs in the appropriate system reporting fields.

### Technical Assistance

To help states collect, report, and use the Health Home Core Set measures, CMS offers technical assistance. Please submit technical assistance requests specific to the Health Home Core Set to [MACqualityTA@cms.hhs.gov](mailto:MACqualityTA@cms.hhs.gov).<sup>5</sup>

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

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<sup>5</sup> States with technical questions about the Child Core Set, the Adult Core Set, and Maternal and Infant Health measures should also contact [MACqualityTA@cms.hhs.gov](mailto:MACqualityTA@cms.hhs.gov).

### **III. TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME CORE SET MEASURES**

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

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

These specifications represent the most applicable version available from the measure steward as of January 2017.

## MEASURE ABA-HH: ADULT BODY MASS INDEX ASSESSMENT

National Committee for Quality Assurance

### A. DESCRIPTION

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

Data Collection Method: Administrative or Hybrid

#### Guidance for Reporting:

- This measure applies to Health Home enrollees ages 18 to 74. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64 and ages 65 to 74.
- The height, weight, and BMI should be from the same data source.
- The height and weight measurement should be taken during the measurement year or the year prior to the measurement year.
- If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year or the year prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9-CM, ICD-10-CM, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

### B. 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 indicate the relative position of a patient's BMI number among those of the same sex and age.

### C. ELIGIBLE POPULATION

Age	Age 18 as of January 1 of the year prior to the measurement year to age 74 as of December 31 of the measurement year.
Continuous enrollment	Enrolled in a Medicaid Health Home program for 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 the continuous enrollment period. To determine continuous enrollment for a Health Home enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	Health Home enrollees who had an outpatient visit ( <u>Outpatient Value Set</u> ) during the measurement year or the year prior to the measurement year.

#### **D. ADMINISTRATIVE SPECIFICATION**

##### **Denominator**

The eligible population.

##### **Numerator**

For Health Home enrollees age 20 or older on the date of service, BMI (BMI Value Set) during the measurement year or the year prior to the measurement year.

For Health Home enrollees younger than age 20 on the date of service, BMI percentile (BMI Percentile Value Set) during the measurement year or the year prior to the measurement year.

##### **Exclusions (optional)**

Health Home enrollees who had a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

#### **E. HYBRID SPECIFICATION**

##### **Denominator**

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

##### **Numerator**

BMI value or percentile during the measurement year or the year prior to the measurement year, as documented through either administrative data or medical record review:

##### **Administrative Data**

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

**Medical Record Review**

For Health Home enrollees age 20 and older on the date of service, 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 value must be from the same data source.

For Health Home enrollees younger than age 20 on the date of service, documentation in the medical record must indicate the height, weight, and BMI percentile, dated during the measurement year or year prior to the measurement year. The weight and BMI percentile must be from the same data source.

For BMI percentile, the following documentation meets criteria:

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

Ranges and thresholds do not meet the criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance. Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).

**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.

**F. ADDITIONAL NOTES**

The following notations or examples of documentation are considered "negative findings" and do not count as numerator compliant:

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

## **MEASURE CDF-HH: SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN**

Centers for Medicare & Medicaid Services

### **A. DESCRIPTION**

Percentage of Health Home enrollees age 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Data Collection Method: Hybrid or e-measure

#### Guidance for Reporting:

- This measure applies to Health Home enrollees age 12 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 12 to 17, ages 18 to 64, and age 65 and older.
- This measure uses administrative data and medical record review to calculate the denominator exclusions for the measure. States may also choose to use medical record review to identify numerator cases. States should indicate deviations from the measure specifications if they choose to use the hybrid method to identify numerator cases.
- This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from CMS. States should describe their sampling methodology in the "Additional Notes/Comments" field.
- The measure steward does not provide diagnosis codes for the depression and bipolar disorder exclusions; medical record review is required to determine the exclusions.
- The original specification for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of Health Home Core Set reporting, there are two G codes included in the numerator to capture whether clinical depression screening was done and if the screen was positive, whether a follow-up plan was documented.
- The date of encounter and screening must occur on the same date of service; if a patient has more than one encounter during the measurement year, the patient should be counted in the numerator and denominator only once based on the most recent encounter.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- The denominator for this measure includes Health Home enrollees age 18 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  1. Those enrollees with a positive screen for clinical depression during an outpatient visit using a standardized tool with a follow-up plan documented.
  2. Those enrollees with a negative screen for clinical depression during an outpatient visit using a standardized tool.

The following coding systems are used in this measure: CPT and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

## B. DEFINITIONS

Screening	<p>Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.</p> <p>Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner's office that is filing the code.</p>
Standardized tool	<p>An assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.</p> <p>Examples of depression screening tools include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Adolescent Screening Tools (ages 12 to 17): Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2.</li> <li>• Adult Screening Tools (age 18 and older): Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening (this screening tool is used in situations where the patient has cognitive impairment and is administered through the caregiver), and PRIME MD-PHQ2.</li> </ul>
Follow-up plan	<p>Proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following:</p> <ul style="list-style-type: none"> <li>• Additional evaluation for depression</li> <li>• Suicide risk assessment</li> <li>• Referral to a practitioner who is qualified to diagnose and treat depression</li> <li>• Pharmacological interventions</li> <li>• Other interventions or follow-up for the diagnosis or treatment of depression</li> </ul> <p>The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."</p>

**C. ELIGIBLE POPULATION**

Age	Age 12 or older on date of encounter.
Continuous enrollment	Enrolled in a Medicaid Health Home program for at least 90 days during the measurement year during which an outpatient visit occurred (see Table CDF-A).
Allowable gap	None.
Event/diagnosis	Health Home enrollees age 12 and older who had an outpatient visit (Table CDF-A) during the measurement year.

**D. HYBRID SPECIFICATION****Denominator**

The eligible population with an outpatient visit during the measurement year (Table CDF-A).

Table CDF-A. Codes to Identify Outpatient Visits

CPT	HCPCS
90791, 90792, 90832, 90834, 90837, 90839, 92625, , 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	G0101, G0402, G0438, G0439, G0444

**Numerator**

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

Table CDF-B. Codes to Document Clinical Depression Screen

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

**Exclusions**

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

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

In addition, use the codes in Table CDF-C to identify other exclusions.

Table CDF-C. Codes to Identify Exclusions

Code	Description
G8433	Screening for clinical depression not documented, documentation stating the patient is not eligible
G8940	Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible

## E. E-MEASURE SPECIFICATION

For the FFY 2017 reporting cycle, refer to the eCQM specifications for 2016 reporting (published in 2015) for eligible professionals for complete value set and e-measure codes, available from [https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field\\_year\\_value=3&keys=&=Apply](https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field_year_value=3&keys=&=Apply).

### Guidance for Reporting:

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

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

### Denominator

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

### Numerator

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

### Exclusions

Refer to the Hybrid Specification for exclusion criteria.

## F. ADDITIONAL NOTES

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

## MEASURE PCR-HH: PLAN ALL-CAUSE READMISSIONS

National Committee for Quality Assurance

### A. DESCRIPTION

For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories:

- Count of Index Hospital Stays (IHS)
- Count of 30-Day Readmissions
- Readmission Rate

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

#### Guidance for Reporting:

- This measure applies to Health Home enrollees age 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64 and age 65 and older.
- This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, CMS suggests that states report unadjusted rates for this measure (Columns 1, 2, and 3 in Tables PCR-A and PCR-B) until a standardized risk adjustor is made available.
- Include paid claims only.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

### B. DEFINITIONS

Index hospital stay (IHS)	An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index admission date	The IHS admission date.
Index discharge date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index readmission stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index readmission date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the Eligible Population.
Classification period	365 days prior to and including an Index Discharge Date.

**C. ELIGIBLE POPULATION**

Age	Age 18 and older as of the Index Discharge Date.
Continuous enrollment	Enrolled in a Medicaid Health Home program for at least 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/diagnosis	An acute inpatient discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on Health Home enrollees. Include all acute inpatient discharges for Health Home enrollees who had one or more discharges on or between January 1 and December 1 of the measurement year. The state should follow the steps below to identify acute inpatient stays.

**D. ADMINISTRATIVE SPECIFICATION****Denominator**

The eligible population.

**Step 1**

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

To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Determine whether the discharge date for the stay falls on or between January 1 and December 1 of the measurement year.

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

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

**Step 2**

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

A direct transfer is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.

- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

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

### Step 3

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

### Step 4: Required exclusions

Exclude hospital stays for the following reasons:

- The Health Home enrollee died during the stay.
- A principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set).

**Note:** For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use both the original stay and the transfer stay to identify exclusions in this step.

### Step 5: Required exclusions for planned readmissions

For all acute inpatient discharges identified using steps 1–4, determine if there was a planned hospital stay within 30 days after the acute inpatient discharge. To identify planned hospital stays, identify all acute inpatient discharges on or between January 3 and December 31 of the measurement year:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.
4. Exclude any hospital stay as an Index Hospital Stay if the admission date of the first stay within 30 days meets any of the following criteria:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set).
  - A potentially planned procedure (Potentially Planned Procedure Value Set) without a principal acute diagnosis (Acute Condition Value Set).

**Note:** For hospital stays where there was an acute-to-acute direct transfer (identified in step 2), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the direct transfer stay).

### Example 1

For a Health Home enrollee with the following acute inpatient stays, exclude stay 1 as an Index Hospital Stay.

- Stay 1 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD
- Stay 2 (February 5–7 of the measurement year): Acute inpatient discharge with a principal diagnosis of maintenance chemotherapy

### Example 2

For a Health Home enrollee with the following acute inpatient stays, exclude stays 2 and 3 as Index Hospital Stays in the following scenario.

- Stay 1 (January 15–17 of the measurement year): Acute inpatient discharge with a principal diagnosis of diabetes
- Stay 2 (January 30–February 1 of the measurement year): Acute inpatient discharge with a principal diagnosis of COPD
- Stay 3 (February 5–7 of the measurement year): Acute inpatient discharge with an organ transplant
- Stay 4 (February 10–15 of the measurement year): Acute inpatient discharge with a principal diagnosis of rehabilitation

### Step 6

Calculate continuous enrollment.

### Step 7

Assign each acute inpatient stay to an age category. Refer to Table PCR-A and Table PCR-B below.

### **Numerator**

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

### Step 1

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

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay to determine whether it falls on or between January 3 and December 31 of the measurement year.

Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If an organization consolidates these stays into a single event (for any reason), the original distinct inpatient stays must be used.

### Step 2

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

A direct transfer is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.
- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.

Use the following method to identify acute-to-acute direct transfers:

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

### Step 3

Exclude acute inpatient hospital admissions with a principal diagnosis of pregnancy (Pregnancy Value Set) or a principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).

### Step 4

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

#### **Reporting: Denominator**

Count the number of IHS and enter these values into the table.

#### **Reporting: Numerator**

Count the number of IHS with a readmission within 30 days and enter these values into the table.

#### **Reporting: Readmission Rate**

This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. CMS suggests that states report unadjusted rates (columns 1, 2, and 3 in Tables PCR-A and PCR-B) for this measure until a standardized risk adjustor is made available.

**Note:** Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6 in Tables PCR-A and PCR-B.

Table PCR-A. Plan All-Cause Readmissions Rates by Age and Risk Adjustment: Ages 18 to 64

Age	Count of Index Stays (Denominator) (1)	Count of 30-Day Readmissions (Numerator) (2)	Observed Readmissions (Num/Den) (3)	Average Adjusted Probability (4)	Total Variance (5)	O/E Ratio (Observed Readmissions/ Average Adjusted Probability) (6)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
18–44	_____	_____	_____	_____	_____	_____	_____	_____
45–54	_____	_____	_____	_____	_____	_____	_____	_____
55–64	_____	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____	_____

Note: This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, CMS suggests that states report the unadjusted total rates for this measure (columns 1, 2, and 3) because Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6.

Table PCR-B. Plan All-Cause Readmissions Rates by Age and Risk Adjustment: Age 65 and Older

Age	Count of Index Stays (Denominator) (1)	Count of 30-Day Readmissions (Numerator) (2)	Observed Readmissions (Num/Den) (3)	Average Adjusted Probability (4)	Total Variance (5)	O/E Ratio (Observed Readmissions/ Average Adjusted Probability) (6)	Lower Confidence Interval (O/E Ratio)	Upper Confidence Interval (O/E Ratio)
65–74	_____	_____	_____	_____	_____	_____	_____	_____
75–84	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____
Total	_____	_____	_____	_____	_____	_____	_____	_____

Note: This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, CMS suggests that states report the unadjusted total rates for this measure (columns 1, 2, and 3) because Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6.

## MEASURE FUH-HH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

National Committee for Quality Assurance

### A. DESCRIPTION

Percentage of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

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

Data Collection Method: Administrative

#### Guidance for Reporting:

- This measure applies to Health Home enrollees age 6 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 6 to 17, ages 18 to 64, and age 65 and older.
- Follow the detailed specifications to (1) include the appropriate discharge when the patient was transferred directly or readmitted to an acute or nonacute care facility for a mental health diagnosis, and (2) exclude discharges in which the patient was transferred directly or readmitted to an acute or nonacute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow up rate should be greater than (or equal to) the 7-day follow-up rate.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or be found on the same date of service.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or same date of service).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of mental health practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9-CM, ICD-10-CM, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

**B. ELIGIBLE POPULATION**

Age	Age 6 and older as of the date of discharge.
Continuous enrollment	Enrolled in a Health Home program from the date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).
Event/diagnosis	<p>An acute inpatient discharge with a principal diagnosis of mental illness (<u>Mental Illness Value Set</u>) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the discharge date for the stay to determine whether it falls on or between January 1 and December 1 of the measurement year.</li> </ol> <p>The denominator for this measure is based on discharges, not on Health Home enrollees. If Health Home enrollees had more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p>
Acute facility readmission or direct transfer	<p>If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>To identify readmissions and direct transfers to an acute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the stays to determine whether they fall after December 1 of the measurement year.</li> </ol>

Exclusions	<p>Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.</p> <p>To identify readmissions to a nonacute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim.</li> <li>3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period.</li> </ol> <p>Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the <u>Mental Health Diagnosis Value Set</u>). To identify readmissions to an acute inpatient care setting:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>).</li> <li>3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period.</li> </ol> <p>These discharges are excluded from the measure because rehospitalization or direct transfers may prevent an outpatient follow-up visit from taking place.</p>
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### C. ADMINISTRATIVE SPECIFICATION

#### Denominator

The eligible population.

#### Numerators

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. Include visits that occur on the date of discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

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

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a mental health practitioner
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner
- A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set)
- A visit in a non-behavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner
- A visit in a non-behavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set)

- Transitional care management services (TCM 7 Day Value Set)

The following meets criteria for only the 30-Day Follow-Up indicator:

- Transitional care management services (TCM 14 Day Value Set)

Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is the date of the face-to-face visit.

#### **D. ADDITIONAL NOTES**

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the period specified (e.g., within 30 days after discharge or within 7 days after discharge).

## MEASURE CBP-HH: CONTROLLING HIGH BLOOD PRESSURE

National Committee for Quality Assurance

### A. DESCRIPTION

Percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:

- Health Home enrollees ages 18 to 59 whose BP was <140/90 mm Hg.
- Health Home enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Health Home enrollees ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg.

Data Collection Method: Hybrid or e-measure

#### Guidance for Reporting:

- This measure applies to Health Home enrollees ages 18 to 85. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64 and ages 65 to 85. The numerator for Health Home enrollees ages 18 to 64 will include enrollees ages 18 to 59 who meet the first criterion added to enrollees ages 60 to 64 who meet the second or third criteria. The rate for Health Home enrollees ages 65 to 85 will include all enrollees in that age group who meet the second or third criteria: diagnosis of diabetes with BP < 140/90 mm Hg or no diagnosis of diabetes with BP of <150/90 mm Hg.
- To identify the eligible population for this measure, states should use administrative data to select all enrollees who had an outpatient visit with a diagnosis of hypertension during the first six months of the measurement year (January 1, 2015- June 30, 2015). To identify the denominator, states should then review the enrollee's medical record to confirm the hypertension diagnosis, which can be recorded anytime during the enrollee's history on or before June 30 of the measurement year. If the enrollee's diagnosis cannot be confirmed then exclude the enrollee.
- This measure requires use of the hybrid method or e-measure.
- NCQA's list of NDC codes for insulin or oral hypoglycemic/antihyperglycemic medications can be found at <http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017/hedis-2017-ndc-license>.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

**B. DEFINITIONS**

Adequate control	<p>Adequate control is defined as meeting any of the following criteria:</p> <ul style="list-style-type: none"> <li>• Health Home enrollees ages 18 to 59 whose BP was &lt;140/90 mm Hg</li> <li>• Health Home enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was &lt;140/90 mm Hg</li> <li>• Health Home enrollees ages 60 to 85 without a diagnosis of diabetes whose BP was &lt;150/90 mm Hg</li> </ul>
Representative BP	<p>The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the Health Home enrollee is “not controlled.”</p>

**C. ELIGIBLE POPULATION**

Age	Ages 18 to 85 as of December 31 of the measurement year.
Continuous enrollment	Enrolled in a Medicaid Health Home program for the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Health Home enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Health Home enrollees are identified as hypertensive if there is at least one outpatient visit ( <u>Outpatient Without UBREV Value Set</u> ) with a diagnosis of hypertension ( <u>Essential Hypertension Value Set</u> ) during the first six months of the measurement year.

Diabetes flag for the numerator	<p>After the Eligible Population is identified, assign each Health Home enrollee a diabetic or not diabetic flag using only administrative data and the steps below. The flag is used to determine the appropriate BP threshold to use during numerator assessment (the threshold for Health Home enrollees with diabetes is different than the threshold for Health Home enrollees without diabetes).</p> <p>Step 1</p> <p>Assign a flag of diabetic to Health Home enrollees who were identified as diabetic using claims/encounter data or pharmacy data. The state must use both methods to assign the diabetes flag, but a Health Home enrollee only needs to be identified by one method. Health Home enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year.</p> <p>Claims/encounter data. Health Home enrollees 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"> <li>• At least two outpatient visits (<u>Outpatient Value Set</u>), observation visits (<u>Observation Value Set</u>), ED visits (<u>ED 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.</li> <li>• At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>) with a diagnosis of diabetes (<u>Diabetes Value Set</u>).</li> </ul> <p>Pharmacy data. Health Home enrollees who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (Table CBP-A).</p> <p>Step 2</p> <p>From the Health Home enrollees identified in Step 1, assign a flag of “not diabetic” to Health Home enrollees who do not have a diagnosis of diabetes (<u>Diabetes Value Set</u>), in any setting, during the measurement year or year prior to the measurement year AND who had a diagnosis of gestational diabetes or steroid-induced diabetes (<u>Diabetes Exclusions Value Set</u>), in any setting, during the measurement year or the year prior to the measurement year.</p> <p>Note: Health Home enrollees classified as diabetic in step 1 based on pharmacy data alone and who had a diagnosis of gestational or steroid-induced diabetes as specified above are re-classified as not diabetic in this step.</p> <ul style="list-style-type: none"> <li>• Step 3</li> <li>• For Health Home enrollees who were not assigned a flag in Step 1 or Step 2, assign a flag of “not diabetic.”</li> </ul>
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Table CBP-A: Prescriptions to Identify Health Home Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlintide
Antidiabetic combinations	Alogliptin-metformin Alogliptin-pioglitazone Canagliflozin-metformin Dapagliflozin-metformin Empagliflozin-linagliptin Empagliflozin-metformin Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-repaglinide Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Sitagliptin-simvastatin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin degludec Insulin detemir Insulin glargine Insulin glulisine Insulin human inhaled Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human
Meglitinides	Nateglinide Repaglinide
Glucagon-like peptide-1 (GLP1) agonists	Dulaglutide Exenatide Liraglutide Albiglutide

Description	Prescription
Sodium glucose cotransporter 2 (SGLT2) inhibitor	Canagliflozin Dapagliflozin Empagliflozin
Sulfonylureas	Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone
Dipeptidyl peptidase-4 (DDP-4) inhibitors	Alogliptin Linagliptin Saxagliptin Sitagliptin

Source: Refer to Table CDC-A in HEDIS specifications (2017 version).

Note: Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; Health Home enrollees with diabetes on these medications are identified through diagnosis codes only. A complete list of medications and NDC codes is posted to <http://www.ncqa.org/hedis-quality-measurement/hedis-measures/hedis-2017/hedis-2017-ndc-license>.

## D. HYBRID SPECIFICATION

### Denominator

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

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For this measure, NCQA recommends that states use an oversample of 10 to 15 percent to ensure enough confirmed cases of hypertension.

To confirm the diagnosis of hypertension, there must be a notation of one of the following in the medical record anytime during the Health Home enrollee's history on or before June 30 of the measurement year:

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

- Hyperpiesis

It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents:

- Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis that is not part of the office visit note; see Note at the end of this section)
- Office note
- Subjective, Objective, Assessment, Plan (SOAP) note
- Encounter form
- Diagnostic report
- Hospital discharge summary

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

If the diagnosis of hypertension cannot be confirmed, the Health Home enrollee is excluded and replaced by the next Health Home enrollee from the oversample.

#### Identifying the Medical Record

States should use one medical record for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the record must be considered. If a state cannot find the medical record, the Health Home enrollee remains in the measure denominator and is considered noncompliant for the numerator.

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

#### Step 1

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

#### Step 2

- Use one medical record to both confirm the diagnosis for the denominator and identify the representative BP level for the numerator. There are circumstances in which the state may need to go to a second medical record to either confirm the diagnosis or obtain the BP reading, as in the following two examples:
- If a Health Home enrollee sees a PCP during the denominator confirmation period (on or before June 30 of the measurement year) and another PCP after June 30, the diagnosis of hypertension and the BP reading may be identified through two different medical records.
- If a Health Home enrollee has the same PCP for the entire measurement year, but it is clear from claims or medical record data that a specialist (e.g., cardiologist) manages the Health Home enrollee's hypertension after June 30, the state may use the PCP's

chart to confirm the diagnosis and use the specialist's chart to obtain the BP reading. For example, if all recent claims coded with a diagnosis of hypertension (Essential Hypertension Value Set) came from the specialist, the state may use this chart for the most recent BP reading. If the Health Home enrollee did not have any visit with the specialist prior to June 30 of the measurement year, the state must go to another medical record to confirm the diagnosis.

### **Numerator**

The number of Health Home enrollees in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year based on the following criteria:

- Health Home enrollees ages 18 to 59 as of December 31 of the measurement year whose BP was <140/90 mm Hg
- Health Home enrollees ages 60 to 85 as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Health Home enrollees ages 60 to 85 as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg
- To determine if an enrollee's BP is adequately controlled, the representative BP must be identified.

## **E. MEDICAL RECORD SPECIFICATION**

Follow the steps below to determine representative BP.

### Step 1

Identify the most recent BP reading noted in the medical record during the measurement year. The reading must occur after the date when the diagnosis of hypertension was confirmed. Do not include BP readings:

- Taken during an acute inpatient stay or an ED visit
- Taken on the same day as a diagnostic test or procedure that requires a change in diet or medication regimen on or one day before the day of the test or procedure, with the exception of fasting blood tests
- Reported by or taken by the Health Home enrollee

If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

### Step 2

Determine numerator compliance based on the following criteria:

- Health Home enrollees ages 18 to 59 as of December 31 of the measurement year whose BP was <140/90 mm Hg
- Health Home enrollees ages 60 to 85 as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg
- Health Home enrollees ages 60 to 85 as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg

The Health Home enrollee is not compliant if the BP reading does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

### Step 3

A single rate is reported for all three groups. Sum the numerator events from Step 2 to obtain the rate.

#### **Exclusions (optional)**

- Exclude from the eligible population all Health Home enrollees with evidence of end-stage renal disease (ESRD) (ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant, or dialysis.
- Exclude from the eligible population all Health Home enrollees with a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.
- Exclude from the eligible population all Health Home enrollees who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  3. Identify the admission date for the nonacute inpatient stay to determine whether it occurs during the measurement year.

## **F. E-MEASURE SPECIFICATION**

For the FFY 2017 reporting cycle, refer to the eCQM specifications for 2016 reporting (published in 2015) for eligible professionals for complete value set and e-measure codes, available from [https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field\\_year\\_value=3&keys=&=Apply](https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field_year_value=3&keys=&=Apply).

#### **Guidance for Reporting:**

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

#### **Denominator**

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

#### **Numerator**

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

#### **Exclusions**

Patients with evidence of end stage renal disease (ESRD), dialysis, or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period

**G. ADDITIONAL NOTES**

- When confirming the diagnosis of hypertension, the intent is to identify the date when the provider became aware of the hypertension diagnosis and documented the diagnosis of hypertension in the medical record (versus the time the enrollee acquired hypertension).
- Problem lists generally indicate established conditions; excluding undated entries might hinder confirmation of the denominator. If a problem list is found in an office visit note then it should be considered a dated problem list and the date of the visit must be used.
- Only administrative data should be used to assign the diabetes flag. The intent of the flag is to determine the appropriate BP threshold to use for the enrollee during numerator assessment. The only exception is if the enrollee is flagged as a diabetic but medical record evidence contains information that classifies the inclusion of the enrollee as a valid data error. To meet criteria as a valid data error, the medical record must contain no evidence of diabetes and include a notation that refutes the diagnosis. In this case, the diabetes flag may be changed to “not diabetic,” but the enrollee may not be removed from the sample.

## MEASURE IET-HH: INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT

National Committee for Quality Assurance

### A. DESCRIPTION

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

- Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
- Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Data Collection Method: Administrative or e-measure

#### Guidance for Reporting:

- Two rates are reported: initiation of AOD treatment and engagement of AOD treatment.
- This measure applies to Health Home enrollees age 13 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 13 to 17, ages 18 to 64, and age 65 and older.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9-CM, ICD-PCS, ICD-10-CM, ICD-10\_PCS, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

### B. DEFINITIONS

Intake period	January 1 to November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
Index episode	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department (ED) visit during the Intake Period with a diagnosis of AOD. For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.
IESD	Index Episode Start Date (IESD). The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED visit during the Intake Period with a diagnosis of AOD. For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service. For an inpatient (acute or nonacute) event, the IESD is the date of discharge. For an ED visit that results in an inpatient event, the IESD is the date of the inpatient discharge. An ED visit results in an inpatient stay when the

	<p>ED date of service and the admission date for the inpatient stay are one calendar day apart or less.</p> <p>For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer).</p>
Negative diagnosis history	<p>A period of 60 days (2 months) before the IESD when the enrollee had no claims/ encounters with a diagnosis of AOD dependence.</p> <p>For an inpatient event, use the admission date to determine the Negative Diagnosis History.</p> <p>For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History.</p> <p>For direct transfers, use the first admission to determine the Negative Diagnosis History.</p>
Direct transfer	<p>For direct transfers, use the first admission to determine the Negative Diagnosis History.</p> <p>A direct transfer is when the discharge date from one inpatient setting and the admission date to a second inpatient setting are one calendar day apart or less. For example:</p> <ul style="list-style-type: none"> <li>• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.</li> <li>• An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.</li> <li>• An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.</li> </ul> <p>Use the following method to identify admissions to and discharges from inpatient settings.</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Identify the admission and discharge dates for the stay.</li> </ol>

### C. ELIGIBLE POPULATION

Age	Age 13 and older as of December 31 of the measurement year.
Continuous enrollment	Enrolled in a Medicaid Health Home program for at least 60 days (2 months) prior to the IESD through 44 days after the IESD (105 total days).
Allowable gap	None.
Anchor date	None.
Benefits	<p>Medical and chemical dependency (inpatient and outpatient).</p> <p>Note: Health Home enrollees with detoxification-only chemical dependency benefits do not meet these criteria.</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</p> <p>Identify the Index Episode. Identify all Health Home enrollees in the specified age range who during the Intake Period had one of the following:</p> <ul style="list-style-type: none"> <li>• 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"> <li>• <u>IET Stand Alone Visits Value Set</u> with <u>AOD Dependence Value Set</u>.</li> <li>• <u>IET Visits Group 1 Value Set</u> with <u>IET POS Group 1 Value Set</u> and <u>AOD Dependence Value Set</u>.</li> <li>• <u>IET Visits Group 2 Value Set</u> with <u>IET POS Group 2 Value Set</u> and <u>AOD Dependence Value Set</u>.</li> <li>• A detoxification visit (<u>Detoxification Value Set</u>).</li> <li>• An ED visit (<u>ED Value Set</u>) with an AOD diagnosis (<u>AOD Dependence Value Set</u>).</li> </ul> </li> </ul> <p>An acute or nonacute inpatient discharge with either an AOD diagnosis (<u>AOD Dependence Value Set</u>) or an AOD procedure code (<u>AOD Procedures Value Set</u>). To identify acute and nonacute inpatient discharges:</p> <ol style="list-style-type: none"> <li>1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>).</li> <li>2. Determine whether the discharge date for the stay falls within the Intake Period (on or between January 1 and November 15 of the measurement year).</li> </ol> <p>For Health Home enrollees with more than one episode of AOD, use the first episode.</p> <p>For Health Home enrollees whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge. An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less. Select the IESD.</p> <p>Step 2</p> <p>Test for Negative Diagnosis History. Exclude Health Home enrollees who had a claim/encounter with a diagnosis of AOD (<u>AOD Dependence Value Set</u>) during the 60 days (2 months) before the IESD.</p> <p>For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.</p> <p>For an ED visit that results in an inpatient stay, use the ED date of service to determine the 60-day Negative Diagnosis History period. An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.</p> <p>Step 3</p>
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	Calculate continuous enrollment. Health Home enrollees must be continuously enrolled for 60 days (2 months) before the IESD through 44 days after the IESD (105 total days), with no gaps.
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## D. ADMINISTRATIVE SPECIFICATION

### Denominator

The eligible population.

### Numerator

#### Rate 1: Initiation of AOD Treatment

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

If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the Health Home enrollee is compliant.

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the Health Home enrollee must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization, with a diagnosis of AOD, on the IESD or in the 13 days after the IESD (14 total days). 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:

- An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Determine whether the admission date for the stay falls within 14 days of the IESD.
- 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

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying initiation of treatment.

Exclude Health Home enrollees from the denominator for both numerators (for Rate 1 and Rate 2) if the initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

#### Rate 2: Engagement of AOD Treatment

Identify all Health Home enrollees who meet the following criteria:

- Numerator compliant for the Initiation of AOD Treatment numerator and
- Two or more inpatient admissions, outpatient visits, intensive outpatient visits or partial hospitalizations with any AOD diagnosis, beginning on the day after the initiation encounter through 29 days after the initiation event (29 total days). 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:
  - An acute or nonacute inpatient admission with a diagnosis of AOD (AOD Dependence Value Set). To identify acute and nonacute inpatient admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Determine whether the admission date for the stay occurs the day after the initiation encounter through 29 days after the initiation event.
  - 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.

For Health Home enrollees who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.

Do not count events that include inpatient detoxification or detoxification codes (Detoxification Value Set) when identifying the engagement of AOD treatment.

The time frame for engagement, which includes the initiation event, is 30 total days.

## E. E-MEASURE SPECIFICATION

For the FFY 2017 reporting cycle, refer to the eCQM specifications for 2016 reporting (published in 2015) for eligible professionals for complete value set and e-measure codes, available from [https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field\\_year\\_value=3&keys=&=Apply..](https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms?field_year_value=3&keys=&=Apply..)

### Guidance for Reporting:

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

### Denominator

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

### Numerator

Numerator 1

Patients who initiated treatment within 14 days of the diagnosis.

Numerator 2

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

### Exclusions

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

## F. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required time frame for the rate.

## MEASURE PQI92-HH: PREVENTION QUALITY INDICATOR (PQI) 92: CHRONIC CONDITIONS COMPOSITE

Agency for Healthcare Research and Quality (AHRQ)

### A. DESCRIPTION

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

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

#### Guidance for Reporting:

- This measure applies to Health Home enrollees ages 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64 and age 65 and older.
- States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 Health Home enrollees.
- A two-step process should be used to determine whether enrollees should be counted in the measure:
  - For each enrollee month considered for the denominator, assess the enrollee's age at either the 15th or 30th of the month (or the 28th of the month in February). If the enrollee was age 18 or older by that date, the enrollee month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a member is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the enrollee's age on the date of admission. Only admissions for enrollees age 18 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers shown in Table PQI92-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure: <http://www.qualityindicators.ahrq.gov/Archive/Software.aspx>. These specifications are based on version 6.0 of the software. Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the “Deviations from Measurement Specifications” section.
- Include paid claims only.

The following coding systems are used in this measure: ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

## B. ELIGIBLE POPULATION

Enrollee months	All enrollee months for Medicaid Health Home enrollees age 18 and older as of the 15th or 30th of the month (or the 28th of the month in February). Date for counting member months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

## C. ADMINISTRATIVE SPECIFICATION

PQI 92: Chronic Conditions Composite

### Denominator

The total number of months of Health Home enrollment for enrollees age 18 and older during the measurement year.

### Numerator

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

- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 03: Diabetes Long-Term Complications Admission Rate
- PQI 05: COPD or Asthma in Older Adults Admission Rate
- PQI 07: Hypertension Admission Rate
- PQI 08: Heart Failure Admission Rate
- PQI 14: Uncontrolled Diabetes Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate
- PQI 16: Lower-Extremity Amputations Among Patients with Diabetes Rate

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

PQI 1: Diabetes Short-Term Complications Admission

All discharges of patients age 18 and older with an ICD-10-CM principal diagnosis code (Table PQI92-A, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>) for diabetes short-term complications (ketoacidosis, hyperosmolarity, and coma).

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

Table PQI92-B. Admission Codes for Transfers

SID ASOURCE Codes	2—Another hospital 3—Another facility, including long-term care
Point of Origin UB-04 Codes	4—Transfer from a hospital 5—Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6—Transfer from another health care facility

## PQI 3: Diabetes Long-Term Complications Admission

All discharges of patients age 18 and older with an ICD-10-CM principal diagnosis code (Table PQI92-C, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>) for diabetes long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified).

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

## PQI 5: COPD or Asthma in Older Adults Admission

All discharges of patients age 40 and older with an ICD-10-CM principal diagnosis code for COPD or asthma in adults age 40 and older (Table PQI92-D, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>).

Exclude patients with a diagnosis for cystic fibrosis and anomalies of the respiratory system (Table PQI92-E, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92-B, above). Patients with a missing principal diagnosis on admission are not included as numerator cases.

## PQI 7: Hypertension Admission

All discharges of patients age 18 and older with an ICD-10-CM principal diagnosis code for hypertension (Table PQI92-F, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>).

Exclude patients with a listed procedure code for cardiac procedure (Table PQI92-G, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>).

Exclude patients with a diagnosis for Stage I–IV kidney disease if the diagnosis is accompanied by a procedure code for dialysis (Table PQI92-H, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92-B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

#### PQI 8: Heart Failure Admission

All discharges of patients age 18 and older with an ICD-10-CM principal diagnosis code for heart failure (Table PQI92-I, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>).

Exclude patients with a listed procedure code for cardiac procedure (Table PQI92-G, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92-B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

#### PQI 14: Uncontrolled Diabetes Admission

All discharges of patients age 18 and older with an ICD-10-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication (Table PQI92-J, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>).

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

#### PQI 15: Asthma in Younger Adults Admission

All discharges of patients older than age 18 and younger than age 40 with an ICD-10-CM principal diagnosis code of asthma (Table PQI92-K, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>).

Exclude patients with a diagnosis for cystic fibrosis and anomalies of the respiratory system (Table PQI92-E, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92-B). Patients with a missing principal diagnosis on admission are not included as numerator cases.

#### PQI 16: Lower-Extremity Amputations Among Patients with Diabetes

All discharges of patients age 18 and older with an ICD-10-PCS procedure code for lower-extremity amputation and an ICD-10-CM diagnosis code for diabetes in any field (Table PQI92-L, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>).

Exclude patients with a diagnosis for traumatic amputation of the lower extremity or procedure codes for toe amputation (Table PQI92-M, available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2017-HH-ICD10-Codes.zip>). Patients who were transferred to the hospital from another hospital (different facility), SNF or ICF, or another health care facility are excluded from the numerator of the measure (Table PQI92-B,

above). Patients with a missing principal diagnosis on admission are not included as numerator cases.

#### **IV. TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME UTILIZATION MEASURES**

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

## MEASURE AMB-HH: AMBULATORY CARE – EMERGENCY DEPARTMENT (ED) VISITS

National Committee for Quality Assurance

### A. DESCRIPTION

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

Data Collection Method: Administrative

#### Guidance for Reporting:

- The measure applies to Health Home enrollees of all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 0 to 17, ages 18 to 64, and age 65 and older.
- Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason.
- Consider all inpatient stays, regardless of payment status (paid, suspended, pending, denied), when confirming that an ED visit did not result in an inpatient stay. For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and should not be included in the measure numerator.

The following codes are used in this measure: CPT, ICD-9-PCS, ICD-10-PCS, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

### B. DEFINITION

Enrollee months	Enrollee months are a “contribution” to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year. See Section D for guidance on calculating enrollee months.
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### C. ELIGIBLE POPULATION

Age	All Health Home enrollees.
Continuous enrollment	None.

### D. ADMINISTRATIVE DATA SPECIFICATION

#### Denominator

Number of enrollee months

#### Step 1

Determine enrollee months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The day selected must be consistent from person to person, month to month, and year to year.

For example, if the state tallies enrollment on the 15th of the month and an enrollee is enrolled in the Medicaid Health Home program on January 15, the enrollee contributes one enrollee month in January.

#### Step 2

Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if a the Health Home program tallies enrollment on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months (January, February, and March) to the ages 18 to 64 category and nine enrollee months to the age 65 and older category.

#### Numerator

Number of ED visits: To determine the number of ED visits, count the total number of visits, for Health Home enrollees, the state paid for during the measurement year. 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:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set).

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). An ED visit results in an inpatient stay when the ED date of service and the admission date for the inpatient stay are one calendar day apart or less.

Age of Enrollee: Report age as of the date of service.

Matching enrollment with utilization: Run enrollment reports used for enrollee month calculations to determine utilization rates (such as ED visits/1,000 enrollee months) within 30 days of the claims reports and for the same time period.

Counting Multiple Services: If a health home enrollee receives the same service two different times (e.g., ED visits six months apart), count them as two visits. Count services, not the frequency of procedure codes billed (e.g., if a physician and a hospital submit separate bills pertaining to the same ED visit with the same date of service, only one should be included). The state must develop its own systems to avoid double counting.

## E. CALCULATION OF THE ED VISITS RATES

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

$$\text{ED Visit Rate} = (\text{Number of ED visits/number of enrollee months}) \times 1,000$$

Table AMB-HH.A ED Visits per 1,000 Health Home Enrollee Months, by Age

Age	ED Visits	Enrollee Months	Visits per 1,000 Enrollee Months
0–17			
18–64			
65 and older			
Unknown			

Age	ED Visits	Enrollee Months	Visits per 1,000 Enrollee Months
Total			

Source: Refer to Table AMB-1 in HEDIS specifications (2017 version).

**F. ADDITIONAL NOTES**

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

## MEASURE IU-HH: INPATIENT UTILIZATION

Centers for Medicare & Medicaid Services

### A. DESCRIPTION

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

Data Collection Method: Administrative

#### Guidance for Reporting:

- This measure applies to Health Home enrollees of all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 0 to 17, ages 18 to 64, and age 65 and older.
- Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason.
- This measure includes discharges and days for total inpatient use and by type of use (maternity, mental and behavioral disorders, surgery, and medicine).

The following codes are used in this measure: ICD-9, ICD-10, and POS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

### B. DEFINITION

Enrollee months	Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year.
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### C. ELIGIBLE POPULATION

Age	All enrollees.
Continuous enrollment	None.

### D. ADMINISTRATIVE DATA SPECIFICATION

#### Denominator

Number of enrollee months

#### Step 1

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

## Step 2

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

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

**Numerator**

Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year.

Use the following steps to identify and categorize inpatient discharges:

## Step 1

Identify all acute inpatient discharges on or between January 1 and December 31 of the measurement year. To identify acute inpatient discharges:

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

## Step 2

Exclude discharges with a principal diagnosis of liveborn infants according to type of birth or multiple gestation/placenta status (Deliveries Infant Record Value Set).

Exclude newborn care (Newborns/Neonates MS-DRG Value Set) rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery discharge).

## Step 3

Report total inpatient, using all discharges identified after completing steps 1 and 2.

## Step 4

Report maternity, mental and behavioral disorders, surgery and medicine using MS-DRGs. Categorize discharges into maternity, mental and behavioral disorders, surgery, or medicine.

- Maternity (Maternity MS-DRG Value Set): A delivery is not required for inclusion in the Maternity category; any maternity-related stay is included. Include birthing center deliveries in this measure and count them as one day of stay.
- Mental and Behavioral Disorders (Mental and Behavioral Disorders MS-DRG Value Set)
- Surgery (Surgery MS-DRG Value Set)
- Medicine:
  - Medicine MS-DRG Value Set
  - Newborns/Neonates MS-DRG Value Set. Do not include newborn care rendered from birth to discharge home from delivery; only report newborn care rendered if the baby is discharged home from delivery and is subsequently rehospitalized.

**Note:** If reporting using MS-DRGs, Total Inpatient will not equal the sum of Maternity, Mental and Behavioral Disorders, Surgery and Medicine because DRGs for Principal

Diagnosis Invalid as Discharge Diagnosis and Ungroupable are included in Total Inpatient, but are not included in maternity, mental and behavioral disorders, surgery or medicine.

If the organization does not use MS-DRGs, follow steps 5–8 to categorize discharges.

#### Step 5

Report maternity. A delivery is not required for inclusion in the Maternity category; any maternity-related stay is included. Include birthing center deliveries and count them as one day of stay.

Starting with all discharges identified in step 3, identify maternity using either of the following:

- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).

#### Step 6

Report mental and behavioral disorders. From discharges remaining after removing maternity (step 5) from total inpatient (step 3), identify mental health and chemical dependency (Mental and Behavioral Disorders Value Set)

#### Step 7

Report surgery. From discharges remaining after removing maternity (step 5) and mental and behavioral disorders (step 6) from total inpatient (step 3), identify surgery (Surgery Value Set).

#### Step 8

Report medicine. Categorize as medicine the discharges remaining after removing maternity (step 5), mental and behavioral disorders (step 6) and surgery (step 7) from total inpatient (step 3).

#### Step 9

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

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

Step 10

Report tables IU-A and IU-BD and use the following guidelines to calculate the measures:

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

Table IU-A. Table for Reporting Enrollee Months, by Age

Age	Number of Enrollee Months
0–17	
18–64	
65 and older	
Unknown	
Total	

Table IU-B. Table for Reporting Inpatient Utilization per 1,000 Enrollee Months, by Age and Type of Inpatient Utilization

Age	Number of Discharges	Discharges/ 1,000 Enrollee Months	Number of Days	Days/ 1,000 Enrollee Months	Average Length of Stay
Inpatient					
0–17					
18–64					
65 and older					
Unknown					
Total Inpatient					
Maternity*					
18–64					
Unknown					
Total Maternity					

Age	Number of Discharges	Discharges/ 1,000 Enrollee Months	Number of Days	Days/ 1,000 Enrollee Months	Average Length of Stay
Mental and Behavioral Disorders					
0–17					
18–64					
65 and older					
Unknown					
Total Mental and Behavioral Disorders					
Surgery					
0–17					
18–64					
65 and older					
Unknown					
Total Surgery					
Medicine					
0–17					
18–64					
65 and older					
Unknown					
Total Medicine					

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

**E. ADDITIONAL NOTES**

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

## MEASURE NFU-HH: NURSING FACILITY UTILIZATION

Centers for Medicare & Medicaid Services

### A. DESCRIPTION

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

The following rates are reported:

- Nursing facility stay less than 101 days (short-term stay).
- Nursing facility stay greater than or equal to 101 days (long-term stay).

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to Health Home enrollees age 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report these measures for two age groups (as applicable) and a total rate: ages 18 to 64 and age 65 and older.

The following codes are used in this measure: POS and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

### B. DEFINITIONS

Enrollee months	Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year. See Section D for guidance on calculating enrollee months.
Community residence	Any residence that is not a Medicaid- or Medicare- certified nursing facility or Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF/IDD). Note: Individuals who were admitted to the nursing facility from the hospital setting and who lived in the community prior to the hospital admission are considered residing in the community.
Nursing facility	Medicaid- or Medicare- certified nursing facilities provide skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as "custodial care").
Short-term nursing facility stay	A nursing facility stay that results in a discharge <101 days after admission.
Long-term nursing facility stay	A nursing facility stay that does not result in a discharge less than 101 days after admission (i.e., no discharge in measurement year or discharge greater than or equal to 101 days after admission).

Admission	<p>An admission entry record is required when any one of the following occurs:</p> <ul style="list-style-type: none"> <li>• An enrollee has never been admitted to a nursing facility before, or</li> <li>• An enrollee has been in a nursing facility previously and was discharged with a return not anticipated, or</li> <li>• An enrollee has been in a nursing facility previously and was discharged with a return anticipated, and did not return within 30 days of discharge.</li> </ul>
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### C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	None.

### D. ADMINISTRATIVE SPECIFICATION

#### Steps to Calculate Enrollee Months for the Eligible Population.

##### Step 1

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

##### Step 2

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

#### Identify qualified index admissions (Figure NFU-A).

##### Step 1

Identify all admissions to nursing facilities (Nursing Facility Value Set) between September 1 of the year prior to the measurement year and August 31 of the measurement year.

States may alternatively use a state-defined residence classification system that indicates enrollee residence in a nursing facility.

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

##### Step 2

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

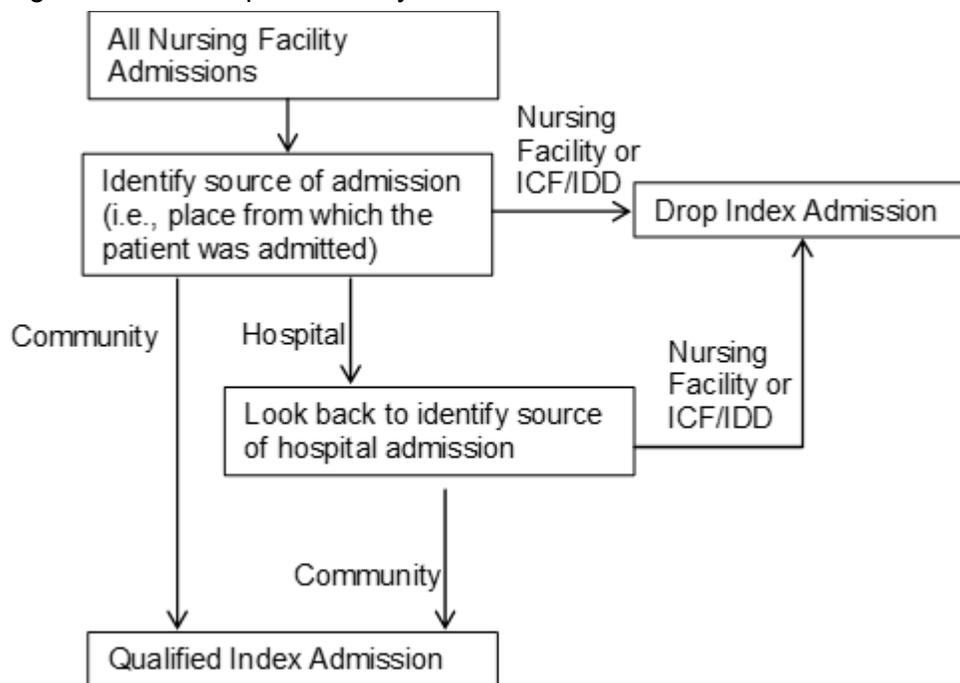
##### Step 3

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

## Step 4

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

Figure NFU-A. Steps to Identify Qualified Index Admissions



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

## Step 1

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

## Step 2

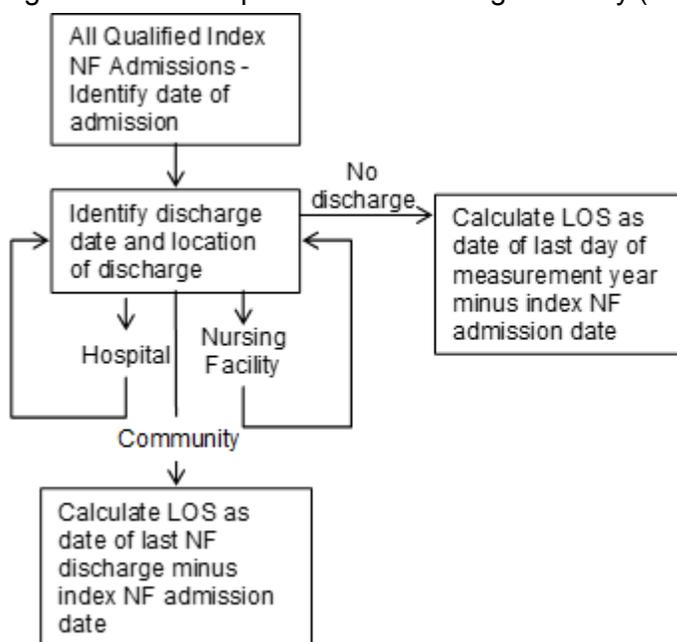
- Look for the location of the first discharge in the measurement year:
- If the enrollee is discharged to the community, calculate LOS as the date of nursing facility discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year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

- If the enrollee is discharged from the hospital to a nursing facility, repeat step 2 to look for next possible discharge from the nursing facility.
- If the enrollee is discharged to a different nursing facility (i.e., a transfer), repeat step 2 to look for the next possible discharge from the subsequent facility.

### Step 3

- Classify LOS as short-term or long-term.
- Short-term stay: The LOS is less than 101 days.
- Long-term stay: The LOS is greater than or equal to 101 days.
- When counting the duration of each stay in a measurement period, include the day of entry (admission) but not the day of discharge, unless the admission and discharge occurred on the same day. In this case, the number of days in the stay = 1.

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



### Step 1

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

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

Report calculations in Table NFU-A.

Table NFU-A. Table for Reporting Nursing Facility Utilization

Age	Number of Short Term Admissions	Short Term Admissions/1,000 Enrollee Months	Number of Long Term Admissions	Long Term Admissions/ 1,000 Enrollee Months
18–64				
65 and older				
Total				

Appendix A  
Health Home Core Set  
HEDIS® Value Set Directory  
User Manual

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## A. WHAT IS THE VALUE SET DIRECTORY?

Measure specifications for HEDIS® measures included in the Health Home Core Set reference value sets. A “value set” is the complete set of codes used to identify a service or condition included in a measure. The Value Set Directory (VSD) includes all value sets and codes needed to report HEDIS measures included in the Health Home Core Set. This appendix describes how to use value sets in calculating measures in the Health Home Core Set.

## B. STRUCTURE OF THE VALUE SET DIRECTORY

The VSD (Excel workbook) contains the following spreadsheets:

- Measures to Value Sets
- Value Sets to Codes
- Summary of Changes – Codes
- Summary of Changes – Value Sets

The columns in the value sets are based on those included in the National Library of Medicine Value Set Authority Center (VSAC) standardized value set file. Not all columns will be needed for Health Home Core Set reporting, depending on how the state’s information systems are organized. All columns have been included in the value set to preserve consistency with the national standard.

## C. WHAT’S NEW IN THE VALUE SET DIRECTORY?

In the Summary of Changes – Codes spreadsheet, if every code from a specific code system is deleted from a value set then the Code column will indicate “All.”

Other specific code and value set changes are included in the Summary of Changes spreadsheets, as described in this manual.

## D. MEASURES TO VALUE SETS

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

Table A.1. Measures to Value Sets

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

Use the “Measures to Value Sets” spreadsheet to identify all value sets used for a particular measure or to identify all measures that use a specific value set. For example, setting the Measure ID filter to “ABA-HH” demonstrates that the Adult BMI Assessment measure uses the following value sets:

Measure ID	Measure Name	Value Set Name	Value Set OID
ABA-HH	Adult BMI Assessment	BMI	2.16.840.1.113883.3.464.1004.1037
ABA-HH	Adult BMI Assessment	BMI Percentile	2.16.840.1.113883.3.464.1004.1038
ABA-HH	Adult BMI Assessment	Outpatient	2.16.840.1.113883.3.464.1004.1202
ABA-HH	Adult BMI Assessment	Pregnancy	2.16.840.1.113883.3.464.1004.1219

Setting the Value Set Name filter to “Outpatient” demonstrates the measures that use the value set.

Measure ID	Measure Name	Value Set Name	Value Set OID
ABA-HH	Adult Body Mass Index Assessment	Outpatient	2.16.840.1.113883.3.464.1004.1202
CBP-HH	Controlling High Blood Pressure	Outpatient	2.16.840.1.113883.3.464.1004.1202
PCR-HH	Plan All-Cause Readmissions	Outpatient	2.16.840.1.113883.3.464.1004.1202

## E. VALUE SETS TO CODES

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

Table A.2. Value Sets to Codes

Element Name	Element Description
Value Set Name	The value set name
Value Set OID	Unique identifier for the value set
Value Set Version	The version date for the value set directory (2016-10-03 for federal fiscal year 2017 reporting)
Code	The code
Definition	The code definition Note: The definition is not included for Uniform Bill <sup>a</sup> or CPT <sup>b</sup> codes due to licensing restrictions.

Element Name	Element Description
Code System	The code system for the code. Code systems are labeled as: CPT            Current Procedural Terminology HCPCS        Healthcare Common Procedure Coding System Level II ICD10CM     International Classification of Diseases, 10th Revision, Clinical Modification (Diagnosis codes) ICD10PCS    International Classification of Diseases, 10th Revision, Procedure Coding System (Procedure codes) ICD9CM       International Classification of Diseases, 9th Revision, Clinical Modification (Diagnosis codes) ICD9PCS     International Classification of Diseases, 9th Revision, Procedure Coding System (Procedure codes) POS           CMS Place of Service UBREV        Uniform Bill (Revenue codes) UBTOB        Uniform Bill (Type of Bill codes)
Code System OID	Unique identifier for the code system
Code System Version	Code system version tracking number

<sup>a</sup> The American Hospital Association holds a copyright to the Uniform Bill Codes (“UB”) contained in the Adult Core Set measure specifications. The UB Codes in the Adult Core Set specifications are included with the permission of the AHA. The UB Codes contained in the Adult Core Set specifications may be used by states, health plans, and other health care delivery organizations for the purpose of calculating and reporting Adult Core Set measure results or using Adult Core Set measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate measure results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, please contact [ub04@healthforum.com](mailto:ub04@healthforum.com). <sup>b</sup> CPT codes copyright 2017 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Use the Value Sets to Codes spreadsheet to identify all codes in a value set or to identify all value sets that use a particular code. For example, setting the Value Set Name filter to “Essential Hypertension” demonstrates that the following codes are included in the value set.

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2016-10-03	I10	Essential (primary) hypertension [401]	ICD10CM	2.16.840.1.113883.6.90	2014.0.0.13AA
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2016-10-03	401.0	Malignant essential hypertension	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2016-10-03	401.1	Benign essential hypertension	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Essential Hypertension	2.16.840.1.113883.3.464.1004.1122	2016-10-03	401.9	Unspecified essential hypertension	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA

Setting the Code filter to “296.20” demonstrates that the code is included in the following value sets.

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Mental and Behavioral Disorders	2.16.840.1.113883.3.464.1004.1300	2016-10-03	296.20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Mental Health Diagnosis	2.16.840.1.113883.3.464.1004.1178	2016-10-03	296.20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Mental Illness	2.16.840.1.113883.3.464.1004.1179	2016-10-03	296.20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA

## F. SUMMARY OF CHANGES – CODES

The Summary of Changes – Codes spreadsheet lists code changes in FFY 2017 by value set and includes the elements in Table A.3.

Table A.3. Summary of Changes

Element Name	Element Description
Value Set	The name of the value set affected by the change
Change	The change (Added; Deleted)
Code System	The code system for the code
Code	The code

Use the Summary of Changes to identify codes added to or deleted from a concept. For example, setting the Value Set Name filter to “IET POS Group 1” will result in a list starting with the following four codes:

Value Set	Change	Code System	Code
IET POS Group 1	Added	POS	16
IET POS Group 1	Added	POS	17
IET POS Group 1	Added	POS	18
IET POS Group 1	Added	POS	19

Codes for value sets that are new to 2017 Health Home Core Set and value sets that are new to a specific Health Home Core Set measure are not listed individually in the “Summary of Changes – Codes” spreadsheet.

Codes for value sets that have been deleted from the 2017 Health Home Core Set or from a specific Health Home Core Set measure are not listed individually in the “Summary of Changes – Codes” spreadsheet.

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

## G. SUMMARY OF CHANGES – VALUE SETS

The Summary of Changes – Value Sets spreadsheet lists changes in FFY 2017 by value sets and includes the elements in Table A.3.

Table A.3. Summary of Changes – Value Sets

Element Name	Element Description
Health Home Core Set 2017	The name of the value set in the FFY 2017 manual (value sets that did not exist are labeled NA)
Change	The change (Added; Deleted; Revised)
Health Home Core Set 2017	The name of the value set in the FFY 2017 manual or the affected measures (for deleted value sets)

Use the Summary of Changes – Value Sets spreadsheet to identify revised, added or deleted value sets. For example, this spreadsheet demonstrates that the Inpatient Stay Value Set was added to the Ambulatory Care – Emergency Department Visits (AMB-HH) measure.

Health Home 2016	Change	Health Home 2017	Revised
Inpatient Stay	Added to measure	Added to AMB-HH	

## H. TECHNICAL ASSISTANCE

Please submit any requests for technical assistance to [MACqualityTA@cms.hhs.gov](mailto:MACqualityTA@cms.hhs.gov).

Appendix B  
Guidance for Selecting  
Sample Sizes for HEDIS® Hybrid Measures

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This appendix provides additional information on when it may be feasible to use a sample size of less than 411 when the hybrid method is used. The sample size is based on the current year's administrative rate or the prior year's reported rate. The guidance in the table below is designed to minimize the burden of medical record review, while providing an adequate sample size for calculating the measure.

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

Current Year's Administrative Rate or the Prior Year's Reported Rate	Minimum Sample Size
≤50%	411
51%	411
52%	410
53%	410
54%	409
55%	407
56%	405
57%	403
58%	401
59%	398
60%	395
61%	392
62%	388
63%	384
64%	380
65%	376
66%	371
67%	366
68%	360
69%	354
70%	348
71%	342
72%	335
73%	328
74%	321
75%	313
76%	305
77%	296

Current Year's Administrative Rate or the Prior Year's Reported Rate	Minimum Sample Size
78%	288
79%	279
80%	270
81%	260
82%	250
83%	240
84%	229
85%	219
86%	207
87%	196
88%	184
89%	172
90%	159
91%	147
92%	134
93%	120
94%	106
≥95%	100

Note: Truncate the decimal portion of the rate to obtain a whole number.

Appendix C  
Definition of Health Home  
Core Set Practitioner Types

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Practitioner type	Definition
Mental Health Practitioner	<p>A practitioner who provides mental health services and meets any of the following criteria:</p> <ul style="list-style-type: none"> <li>• An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice</li> <li>• An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice</li> <li>• An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice</li> <li>• A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice</li> <li>• An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy</li> <li>• An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC)</li> </ul>
Obstetrical/ Gynecological (OB/GYN) and Other Prenatal Care Practitioner	<p>Includes:</p> <ul style="list-style-type: none"> <li>• Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology</li> <li>• Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)</li> </ul>

Practitioner type	Definition
Primary Care Practitioner (PCP)	<ul style="list-style-type: none"><li>• A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services.</li><li>• Licensed practical nurses and registered nurses are not considered PCPs</li></ul>
Prescribing Practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications