Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set)

Technical Specifications and Resource Manual for Federal Fiscal Year 2013

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

For NCQA measures in the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid:

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I. The Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set)

Background

On March 23, 2010, President Obama signed the Affordable Care Act (Public Law 111-148) which requires the Secretary of Health and Human Services (HHS) to identify and publish a core set of health quality measures for Medicaid-enrolled adults (Medicaid Adult Core Set). This legislation parallels the requirement under Title IV of the Children's Health Insurance Program Reauthorization Act (CHIPRA; Public Law 111-3) to identify and publish a recommended initial core set of quality measures for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

The Medicaid Adult Core Set was identified by the Centers for Medicare & Medicaid (CMS) in partnership with the Agency for HealthCare Research and Quality (AHRQ). To facilitate an evidence-based and transparent process for prioritizing measures, AHRQ's National Advisory Council created a Subcommittee for identifying and evaluating quality measures for adults enrolled in Medicaid. The Subcommittee consisted of state Medicaid representatives, health care quality experts, and representatives of health professional organizations and associations. In January 2012, the Secretary selected and published an initial core set of 26 adult health care quality measures for voluntary use by states. More information on the Medicaid Adult Core Set, including background reports outlining the steps undertaken to identify the measures can be found at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-%E2%80%93PM-Adult-Health-Care-Quality-Measures.html.

The following table provides a brief description of each Medicaid Adult Core Set measure, the measure steward(s), and data sources needed to report the measure. As noted in the table, the data sources for the measures are administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), medical records, and surveys. The technical specifications in Chapter III of this manual provide additional details for each measure.

Measure		Measure Steward[a] (web site)	Description	Data Source
1	Flu Shots for Adults Ages 50 to 64	NCQA/HEDIS (http://www.ncqa.org)	Rolling average represents the percentage of Medicaid enrollees ages 50 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 5.0H survey was completed	Survey
2	Adult Body Mass Index (BMI) Assessment	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees ages 18 to 74 that had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year	Administrative or hybrid

Measure		Measure Steward[a] (web site)	Description	Data Source
3	Breast Cancer Screening	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid-enrolled women ages 42 to 69 that received a mammogram in the measurement year or the year prior to the measurement year	Administrative or hybrid
4	Cervical Cancer Screening	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid-enrolled women ages 24 to 64 that received one or more PAP tests during the measurement year or the two years prior to the measurement year	Administrative
5	Medical Assistance With Smoking and Tobacco Use Cessation	NCQA/HEDIS (http://www.ncqa.org)	Rolling average represents the percentage of Medicaid enrollees age 18 and older that were current smokers or tobacco users and who received advice to quit, discussed or were recommended cessation medications, and discussed or were provided cessation methods or strategies during the measurement year	Survey
6	Screening for Clinical Depression and Follow-Up Plan	CMS (http://www.usqualitymeasures.org)	Percentage of patients age 18 and older screened for clinical depression using a standardized tool, and if positive, a follow-up plan is documented on the date of the positive screen	Administrative
7	Plan All-Cause Readmission Rate	NCQA/HEDIS (http://www.ncqa.org)	For Medicaid enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission	Administrative
8	PQI 01: Diabetes Short-Term Complications Admission Rate	AHRQ (http://www.qualityindicators.ahrq.gov)	Number of discharges for diabetes short-term complications per 100,000 Medicaid enrollees age 18 and older	Administrative

Measure		Measure Steward[a] (web site)	Description	Data Source
9	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	AHRQ (http://www.qualityindicators.ahrq.gov)	Number of discharges for COPD per 100,000 Medicaid enrollees age 18 and older	Administrative
10	PQI 08: Congestive Heart Failure (CHF) Admission Rate	AHRQ (http://www.qualityindicators.ahrq.gov)	Number of discharges for CHF per 100,000 Medicaid enrollees age 18 and older	Administrative
11	PQI 15: Adult Asthma Admission Rate	AHRQ (http://www.qualityindicators.ahrq.gov)	Number of discharges for asthma per 100,000 Medicaid enrollees age 18 and older	Administrative
12	Chlamydia Screening in Women Ages 21 to 24	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrolled women ages 21 to 24 that were identified as sexually active and that had at least one test for Chlamydia during the measurement year	Administrative
13	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS (http://www.ncqa.org)	Percentage of discharges for Medicaid enrollees age 21 and older that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge and within 30 days of discharge	Administrative
14	PC-01: Elective Delivery	The Joint Commission (http://www.jointcommission.org)	Percentage of Medicaid and CHIP enrolled females with elective vaginal deliveries or elective cesarean sections delivering newborns with >= 37 and < 39 weeks of gestation completed	Medical record
15	PC-03: Antenatal Steroids	The Joint Commission (http://www.jointcommission.org)	Percentage of Medicaid and CHIP enrolled females at risk of preterm delivery with a full course of antenatal steroids completed prior to delivery of a preterm infant	Laboratory, medical record, registry

Measure		Measure Steward[a] (web site)	Description	Data Source
16	Annual HIV/AIDS Medical Visit	NCQA (http://www.ncqa.org)	Percentage of Medicaid enrollees age 18 and older with a diagnosis of HIV/AIDS and with at least two medical visits during the measurement year, with a minimum of 90 and 180 days between each visit	Administrative or hybrid
17	Controlling High Blood Pressure	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees ages 18 to 85 that had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year	Hybrid
18	Comprehensive Diabetes Care: LDL-C Screening	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a LDL-C screening test	Administrative
19	Comprehensive Diabetes Care: Hemoglobin A1c Testing	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a Hemoglobin A1c test	Administrative or hybrid
20	Antidepressant Medication Management	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression, that were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days (12 weeks) and for at least 180 days (6 months)	Administrative
21	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees ages 19 to 64 with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period	Administrative

Measure		Measure Steward[a] (web site)	Description	Data Source
22	Annual Monitoring for Patients on Persistent Medications	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees age 18 and older that received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and that received annual monitoring for the therapeutic agent during the measurement year	Administrative
23	CAHPS Health Plan Survey 5.0H – Adult Questionnaire	AHRQ NCQA/HEDIS (http://www.ncqa.org)	Survey on adult Medicaid enrollees' age 18 and older experiences with care	Survey
24	Care Transition – Transition Record Transmitted to Health Care Professional	American Medical Association/Physician Consortium for Performance Improvement (PCPI) (http://www.ama-assn.org)	Percentage of Medicaid enrollees age 18 and older discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	Administrative and medical record
25	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS (http://www.ncqa.org)	Percentage of Medicaid enrollees age 18 and older with a new episode of alcohol or other drug (AOD) dependence who: (a) Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis (b) Initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Administrative or hybrid
26	Postpartum Care Rate	NCQA/HEDIS (http://www.ncqa.org)	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery	Administrative or hybrid

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

How the Medicaid Adult Core Set Will Be Used

Implementation of a standardized set of adult health care quality measures for Medicaid will help CMS and states move toward a national system for quality measurement, reporting, and improvement. The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, beginning in September 2014, state data on the adult quality measures will become part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

II. Data Collection and Reporting of the Medicaid Adult Core Set

To support consistency in reporting the adult core set measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapter III and provide detailed information on how to calculate each measure.

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 December 2012. For HEDIS measures, the manual follows HEDIS 2013 specifications for FFY 2013 reporting. For non-HEDIS measures, the manual includes the specifications available from the measure steward as of December 2012.
- 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 before the reporting year; for example, calendar year 2012 data should be reported in FFY 2013.
- Reporting unit. The reporting unit for each measure is the state Medicaid program as a whole. This means that states reporting any of the core measures should collect data across all of the health care delivery systems used in their adult Medicaid program (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care). If data are collected separately, states should aggregate data from all sources into one state-level rate before reporting the data to CMS. For more guidance about reporting a state-level rate, see the bullet below.
- Aggregating information for state-level reporting. To obtain a state-level rate for a measure that is developed from the rates of multiple units of measurement, such as across multiple managed care organizations (MCOs) or across managed care and FFS delivery systems, the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual MCOs) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid and administrative data from different sources can be combined to develop a state-wide rate as long as the specifications allow the use of both data sources to construct the measure.[1]

[1] Additional guidance on developing state-level rates for health care quality measures is available in a Technical Assistance brief, "Approaches to Developing State-level Rates for Children's Health Care Quality Measures Based on Data from Multiple Sources," at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/TA2-StateRates.pdf.

- Eligible population for measurement. For all measures, the denominator includes Medicaid enrollees who satisfy measure-specific eligibility criteria. For the maternity care measures only (Elective Delivery, Antenatal Steroids, Postpartum Care Rate), the eligible population also includes CHIP enrolled females who satisfy the measure-specific eligibility criteria.
- Age criteria for Medicaid Adult Core Set measures. The age criteria vary by measure. Some measures do not have an upper age limit, while others include an age range above age 64. For purposes of Medicaid Adult Core Set reporting, states should calculate and report such measures in two age groups (as applicable): Medicaid enrollees under age 65 and those age 65 and older.
- 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 Medicaid (and, for maternity measures, CHIP enrolled females who satisfy the measure-specific eligibility criteria) program. For a measure that uses administrative data, all enrollees who meet the eligible population requirements for the measure should be included. For a measure that uses a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire eligible population for the measure.
- Data collection methods and data sources. Several measures include two data collection methods, administrative and hybrid. The administrative method uses transaction data (for example, claims) or other administrative data to calculate the measure. These data can be used in cases in which the data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population is included in the denominator. The hybrid method uses both administrative data sources and medical record data to determine numerator compliance. The denominator consists of a sample of the measure's eligible population. The hybrid method, when available, should be used when administrative data are incomplete or may be of poor quality. A few measures rely on data from the Consumer Assessment and Healthcare Providers and Systems (CAHPS) survey administered to a sample of adults enrolled in Medicaid.
- Sampling. For measures reported using the hybrid method, the sample size should be 411, plus an oversample to allow for substitution. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion. For measures reported using the CAHPS survey, the sample size should be 1,350, plus an oversample based on the state's prior experience with survey response rates, to yield at least 411 completed surveys.
- Small numbers. If a measure has a denominator that is less than 30 and the state chooses not to report the measure due to small numbers, please note this in the field indicated in CMS's data reporting tool.
- Continuous enrollment. This refers to the time during which an enrollee must be eligible for benefits to be included in the measure denominator. The technical specifications provide the continuous enrollment requirement (if relevant), for each measure.

- Risk adjustment. One of the measures in the Medicaid Adult Core Set, Plan All-Cause Readmission, requires risk adjustment. However, this measure does not currently have a risk adjustor for the Medicaid population. Appendix A contains the current risk adjustment specifications for the measure, but these are not specific to Medicaid. States choosing to report this measure should describe the risk adjustment methods they used to calculate the measure. None of the other measures in the Medicaid Adult Core Set require risk adjustment.
- Inclusion of paid, suspended, pending, reversed, and denied claims. A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided regardless of who provided the service. For such measures, the inclusion of claims, regardless of whether they were paid or denied, would be appropriate. For each HEDIS measure that relies on claims as a data source, the manual provides specific guidance on which claims to include.

Reporting and Submission

CMS has developed a web-based data submission tool, MACPro. Medicaid Adult Core Set reporting into MACPro will begin late November 2013. Detailed instructions for reporting will be provided separately.

III. Technical Specifications

This chapter presents the technical specifications for each measure in the Medicaid Adult Core Set. Each specification includes a description of the measure and information about the eligible population, key definitions, data source(s), instructions for calculating the measure, and any other relevant measure information. These specifications represent the most applicable version available from the measure steward as of December 2012.

Measure 1: Flu Shots for Adults Ages 50 to 64

National Committee for Quality Assurance

A. DESCRIPTION

A rolling average represents the percentage of Medicaid enrollees ages 50 to 64 that received an influenza vaccination between September 1 of the measurement year and the date when the CAHPS 5.0H adult survey was completed.

Guidance for Reporting:
• This measure uses a rolling two-year average to achieve a sufficient number of respondents for reporting. First-year data collection will generally not yield enough responses to be reportable.

B. ELIGIBLE POPULATION

Age	50 to 64 years as of September 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap of enrollment of up to 45 days during the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

C. PROTOCOL AND SURVEY INSTRUMENT

Collected annually as part of the Adult CAHPS Health Plan Survey 5.0H using a rolling average methodology.

Measure Eligibility Flag

A Measure Eligibility Flag is assigned for each adult in the CAHPS 5.0H survey sample frame data file.

Flu Shots for Adults Ages 50 to 64 Eligibility Flag
1 = Eligible (was born on or between September 2, 1947 and September 1, 1962)
2 = Ineligible (was born before September 2, 1947 or after September 1, 1962)

The Eligibility Flag identifies the population eligible for the Flu Shots for Adults Ages 50 to 64 measure. The results are calculated by using responses from respondents with a flag of "1 = Eligible." The use of an eligibility flag protects confidentiality (using the date of birth could result in a breach of confidentiality).

D. QUESTIONS INCLUDED IN THE MEASURE

Table 1.1. Flu Shots for Adults Ages 50 to 64

Question		Response Choices
Q45	Have you had a flu shot since September 1, YYYY? [a]	Yes No Don't know

[a]YYYY = the measurement year (2012 for the survey fielded in 2013).

E. CALCULATION OF MEASURE

A rolling average is calculated using the following formula.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

If the denominator is less than 100, a measure result of NA is assigned.

If the denominator is 100 or more, a rate is calculated.

If the state did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more (Year 2), a rate is calculated; if the denominator is less than 100, the rate is not reported.

Denominator

The number of Medicaid enrollees with a Measure Eligibility Flag of “Eligible” who responded “Yes” or “No” to the question “Have you had a flu shot since September 1, YYYY?”

Numerator

The number of Medicaid enrollees in the denominator who responded “Yes” to the question “Have you had a flu shot since September 1, YYYY?”

Measure 2: Adult Body Mass Index (BMI) Assessment

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

- This measure applies to Medicaid enrollees ages 18 to 74. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and 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 data specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year.
- Include all paid, suspended, reversed, pending, and denied claims.

B. 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	The measurement year and the year prior to the measurement year.
Allowable gap	No more than a 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Medicaid enrollees who had an outpatient visit (Table 2.1) during the measurement year or the year prior to the measurement year.

Table 2.1. Codes to Identify Outpatient Visits

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

BMI (Table 2.2) during the measurement year or the year prior to the measurement year.

Table 2.2. Codes to Identify BMI

ICD-9-CM Diagnosis
V85.0 – V85.5

Exclusions (optional)

Enrollees who had a diagnosis of pregnancy (Table 2.3) during the measurement year or the year prior to the measurement year.

Table 2.3. Codes to Identify Exclusions

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

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Numerator

BMI during the measurement year or the year prior to the measurement year as documented through either administrative data or medical record review.

Administrative

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

Medical Record

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

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

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

Exclusions (optional)

Refer to 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.

E. ADDITIONAL NOTES

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

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

Measure 3: Breast Cancer Screening

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid-enrolled women ages 42 to 69 that received a mammogram to screen for breast cancer.

Guidance for Reporting:
• This measure applies to Medicaid enrollees ages 42 to 69. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 42 to 64 and ages 65 to 69. • Include all paid, suspended, reversed, pending, and denied claims.

B. ELIGIBLE POPULATION

Age	Women ages 42 to 69 as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than a 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

One or more mammograms during the measurement year or the year prior to the measurement year. A woman had a mammogram if a submitted claim/encounter contains any code in Table 3.1.

Table 3.1. Codes to Identify Breast Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue
77055-77057	G0202, G0204, G0206	87.36, 87.37	0401, 0403

Exclusions (optional)

Women who had a bilateral mastectomy. Look for evidence of a bilateral mastectomy as far back as possible in the enrollee's history through December 31 of the measurement year. Refer to Table 3.2 for codes to identify exclusions. Any of the following meet criteria for bilateral mastectomy:

- A bilateral mastectomy code
- A unilateral mastectomy code with a bilateral modifier

- Two unilateral mastectomy codes on different dates of service
- A unilateral mastectomy code with a right side modifier and a unilateral mastectomy code with a left side modifier (may be on the same date of service)

Table 3.2. Codes for Identifying Exclusions

Description	CPT	ICD-9-CM Procedure
Bilateral mastectomy		85.42, 85.44, 85.46, 85.48
Unilateral mastectomy	19180, 19200, 19220, 19240, 19303-19307	85.41, 85.43, 85.45, 85.47
Bilateral modifier (a bilateral procedure performed during the same operative session)	50, 09950	
Right side modifier	RT	
Left side modifier	LT	

D. ADDITIONAL NOTES

This measure evaluates primary screening. Do not count biopsies, breast ultrasounds, or MRIs because they are not appropriate methods for primary breast cancer screening.

Measure 4: Cervical Cancer Screening

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid-enrolled women ages 24 to 64 that received one or more Pap tests to screen for cervical cancer.

Guidance for Reporting:
• Include all paid, suspended, reversed, pending, and denied claims.

B. ELIGIBLE POPULATION

Age	Women ages 24 to 64 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than a 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

One or more Pap tests during the measurement year or the two years prior to the measurement year. A woman had a Pap test if a submitted claim/encounter contains any code in Table 4.1.

Table 4.1. Codes to Identify Cervical Cancer Screening

CPT	HCPCS	ICD-9-CM Procedure	UB Revenue	LOINC
88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Exclusions (optional)

Women who had a hysterectomy with no residual cervix. Look as far back as possible in the enrollee's history for evidence of hysterectomy through December 31 of the measurement year. Refer to Table 4.2 for codes to identify a hysterectomy.

Table 4.2. Codes to Identify Exclusions

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Hysterectomy	51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, 752.43, V67.01, V76.47, V88.01, V88.03	68.4-68.8

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Numerator

One or more Pap tests during the measurement year or the two years prior to the measurement year as documented through either administrative data or medical record review.

Administrative

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

Medical Record

Documentation in the medical record must include:

- A note indicating the date when the test was performed, and
- The result or finding

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

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

E. ADDITIONAL NOTES

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

Exclusions (optional)

Refer to Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix. The hysterectomy must have occurred by December 31 of the measurement year. Documentation of “complete,” “total,” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.

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

Measure 5: Medical Assistance with Smoking and Tobacco Use

National Committee for Quality Assurance

A. DESCRIPTION

A rolling average represents the percentage of Medicaid enrollees age 18 and older that were current smokers or tobacco users and who received medical assistance during the measurement year. The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation and are reported as three separate rolling averages:

- Advising Smokers and Tobacco Users to Quit – A rolling average represents the percentage of Medicaid enrollees age 18 and older who were current smokers or tobacco users and who received advice to quit during the measurement year
- Discussing Cessation Medications – A rolling average represents the percentage of Medicaid enrollees age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year
- Discussing Cessation Strategies – A rolling average represents the percentage of Medicaid enrollees age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report the three separate rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- This measure uses a rolling two-year average to achieve a sufficient number of respondents for reporting. First-year data collection will generally not yield enough responses to be reportable.

B. ELIGIBLE POPULATION

Age	Age 18 as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than 1-month gap in coverage.
Current enrollment	Currently enrolled at the time the survey is completed.

C. PROTOCOL AND SURVEY INSTRUMENT

Collected annually as part of the Adult CAHPS Health Plan Survey 5.0H using a rolling average methodology.

D. QUESTIONS INCLUDED IN THE MEASURE

Table 5.1. Medical Assistance With Smoking and Tobacco Use Cessation—Medicaid Product Line

Questions		Response Choices
Q38	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all. → If Not at all, Go to Question 42 Don't know. → If Don't know, Go to Question 42
Q39	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q40	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication	Never Sometimes Usually Always
Q41	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program	Never Sometimes Usually Always

E. CALCULATION OF MEASURE

Rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

- If the denominator is less than 100, the measure is not reported
- If the denominator is 100 or more, a rate is calculated
- If the state did not report results in the prior year (Year 1) but reports results for the current year and achieves a denominator of 100 or more, a rate is calculated; if the denominator is less than 100, the measure is not reported

COMPONENT 1: ADVISING SMOKERS AND TOBACCO USERS TO QUIT

Denominator

The number of Medicaid enrollees who responded to the survey and indicated that they were current smokers or tobacco users. Response choices must be as follows to be included in the denominator:

Q38 = "Every day" or "Some days." AND

Q39 = "Never" or "Sometimes" or "Usually" or "Always."

Numerator

The number of Medicaid enrollees in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to Q39.

COMPONENT 2: DISCUSSING CESSATION MEDICATIONS

Denominator

The number of Medicaid enrollees who responded to the survey and indicated that they were current smokers or tobacco users. Member response choices must be as follows to be included in the denominator:

Q38 = “Every day” or “Some days.”

Q40 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of Medicaid enrollees in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering “Sometimes” or “Usually” or “Always” to Q40.

COMPONENT 3: DISCUSSING CESSATION STRATEGIES

Denominator

The number of Medicaid enrollees who responded to the survey and indicated that they were current smokers or tobacco users. Response choices must follow one of the two paths to be included in the denominator:

Q38 = “Every day” or “Some days.”

Q41 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of Medicaid enrollees in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering “Sometimes” or “Usually” or “Always” to Q41.

PERCENTAGE OF CURRENT SMOKERS AND TOBACCO USERS – SUPPLEMENTAL CALCULATION

This calculation is provided to support analysis of Medical Assistance With Smoking and Tobacco Use Cessation rates and provides additional context unreportable results. A state with a small number of smokers or tobacco users may not be able to obtain a large enough denominator to achieve reportable rates.

The percentage of current smokers and tobacco users is calculated using data collected during the current reporting year only (not calculated as a rolling average).

Denominator

The number of Medicaid enrollees who responded “Every day,” “Some days,” “Not at all,” or “Don’t know” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Numerator

The number of Medicaid enrollees in the denominator who responded “Every day” or “Some days” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Measure 6: Screening for Clinical Depression and Follow-Up Plan

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Guidance for Reporting:

- In the original specification, this measure includes Medicaid enrollees 12 and older. For the purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- This measure uses administrative data, including G codes for the numerator.

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner's office that is filing the code
Standardized Tool	An assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. Some depression screening tools include: 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), Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver), and PRIME MD-PHQ2
Follow-Up Plan	Proposed outline of treatment to be conducted as a result of clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: • Additional evaluation • Suicide Risk Assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression

C. ADMINISTRATIVE SPECIFICATION

Denominator

Patient age = 18 years or older on date of encounter, AND

Patient encounter during the reporting period (CPT or HCPCS codes): CPT - 90791, 90792, 90832, 90834, 90837, 90839, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

G Codes – G0101, G0402, G0438, G0439, G0444

Numerator

Patients screening for clinical depression using a standardized tool AND follow-up plan is documented. This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period.

Code to identify positive screen for clinical depression; follow-up plan documented:

G8431 Positive screen for clinical depression using a standardized tool and a follow-up plan documented.

(Reporting this code will meet numerator criteria when calculating performance), or

Code to identify negative screen for clinical depression documented, patient not eligible/appropriate for follow-up plan:

G8510 Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented.

(Reporting this code will meet numerator criteria when calculating performance)

Exclusions

A patient is not eligible if one or more of the following conditions exist:

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

Measure 7: Plan All-Cause Readmission Rate

National Committee for Quality Assurance

A. DESCRIPTION

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

- Count of Index Hospital Stays (IHS) (denominator)
- Count of 30-Day Readmissions (numerator)
- Average Adjusted Probability of Readmission (rate)

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, and denied claims.
- This measure requires risk adjustment. Risk adjustment tables for Medicare and commercial populations are posted at http://www.ncqa.org. There are no standardized risk adjustment tables for Medicaid. States reporting this measure should describe the method they used for risk adjustment weighting and calculation of the adjusted probability of readmission. Appendix A provides additional information on risk adjustment methods in the non-Medicaid population.

B. DEFINITIONS

IHS	Index hospital stay. An acute inpatient stay with a discharge on or between January 1 and December 1 of the measurement year. Exclude stays that meet the exclusion criteria in the denominator section.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Classification Period	365 days prior to and including an Index Discharge Date.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the Index Discharge Date.
Continuous Enrollment	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 Medicaid enrollees. Include all acute inpatient discharges for Medicaid 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 stays with a discharge date on or between January 1 and December 1 of the measurement year.

Include acute admissions to behavioral healthcare facilities. Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.

Step 2

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

Step 3

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

Step 4

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

Step 5

Exclude stays for the following reasons:

- Inpatient stays with discharges for death
- Acute inpatient discharge with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period (Table 7.1).

Table 7.1. Codes to Identify Maternity Related Inpatient Discharges

Description	ICD-9-CM Diagnosis
Pregnancy	630-679, V22, V23, V28
Conditions originating in the perinatal period	760-779, V21, V29-39

Step 6

Calculate continuous enrollment.

Step 7

Assign each acute inpatient stay to one age and gender category. Refer to Table 7.2 and Table 7.3 below.

Numerator

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

Step 1

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

Step 2

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

Step 3

Exclude acute inpatient hospital discharges with a principal diagnosis using the codes listed in Table 7.1.

Step 4

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

Reporting: Denominator

Count the number of IHS for each age, gender and total combination and enter these values into the reporting table.

Reporting: Risk Adjustment

Note: See Appendix A for additional information on risk adjustment weighting in the non-Medicaid population and methods for calculating the adjusted probability of a readmission. There are no standardized risk adjustment tables for Medicaid. These steps require a Medicaid-specific risk assessment methodology. States reporting this measure should describe the method they used for calculation of the adjusted probability of admission.

Step 1

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

States must calculate the probability of readmission for each hospital stay within the applicable age and gender group to calculate the average. For the total age/gender

category, the probability of readmission for all hospital stays in the age/gender categories must be averaged together; organizations cannot take the average of the average adjusted probabilities reported for each age/gender.

Step 2

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

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

Example

For the “18 – 44” age category:

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

Repeat for each subsequent group.

Step 3

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

Step 4

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

Reporting: Numerator

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

Table 7.2. Plan All-Cause Readmission Rates by Age, Gender and Risk Adjustment

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

Table 7.3. Plan All-Cause Readmission Rates by Age, Gender and Risk Adjustment

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

E. ADDITIONAL NOTES

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

Measure 8: PQI 01: Diabetes Short-Term Complications Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

The number of discharges for diabetes short-term complications per 100,000 Medicaid enrollees age 18 and older.

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

Medicaid enrollees age 18 and older.

Numerator

All discharges with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma).

Include ICD-9-CM diagnosis codes:

25010 DM KETO T2, NT ST UNCNTRLD

25011 DM KETO T1, NT ST UNCNTRLD

25012 DM KETOACD UNCONTROLD

25013 DM KETOACD UNCONTROLD

25020 DMII HPRSM NT ST UNCNTRL

25021 DMI HPRSM NT ST UNCNTRLD

25022 DMII HPROSMLR UNCONTROLD

25023 DMI HPROSMLR UNCONTROLD

25030 DMII O CM NT ST UNCNTRLD

25031 DMI O CM NT UNCNTRLD

25032 DMII OTH COMA UNCONTROLD

25033 DMI OTH COMA UNCONTROLD

Exclusions

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

Measure 9: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

The number of discharges for chronic obstructive pulmonary disease (COPD) per 100,000 Medicaid enrollees age 18 and older.

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

B. ELIGIBLE POPULATION

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

C ADMINISTRATIVE SPECIFICATION

Denominator

Medicaid enrollees age 18 and older.

Numerator

All non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD. Select codes appearing in the primary diagnosis position must be accompanied by a secondary diagnosis of COPD.

Include ICD-9-CM COPD diagnosis codes:

4660 ACUTE BRONCHITIS*

490 BRONCHITIS NOS*

4910 SIMPLE CHR BRONCHITIS

4911 MUCOPURUL CHR BRONCHITIS

49120 OBST CHR BRONC W/O EXAC

49121 OBS CHR BRONC W(AC) EXAC

4918 CHRONIC BRONCHITIS NEC

4919 CHRONIC BRONCHITIS NOS

4920 EMPHYSEMATOUS BLEB

4928 EMPHYSEMA NEC

494 BRONCHIECTASIS

4940 BRONCHIECTAS W/O AC EXAC

4941 BRONCHIECTASIS W AC EXAC

496 CHR AIRWAY OBSTRUCT NEC

*Must be accompanied by a secondary diagnosis code of COPD.

ICD-9-CM Asthma diagnosis codes:

49300 EXTRINSIC ASTHMA NOS

49301 EXT ASTHMA W STATUS ASTH

49302 EXT ASTHMA W(ACUTE) EXAC

49310 INTRINSIC ASTHMA NOS

49311 INT ASTHMA W STATUS ASTH

49312 INT ASTHMA W (AC) EXAC

49320 CHRONIC OBST ASTHMA NOS

49321 CH OB ASTHMA W STAT ASTH

49322 CH OBST ASTH W (AC) EXAC

49381 EXDERCSE IND BRONCHOSPASM

49382 COUGH VARIANT ASTHMA

49390 ASTHMA NOS

49391 ASTHMA W STATUS ASTHMAT

49392 ASTHMA NOS W (AC) EXAC

Exclusions

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

Measure 10: PQI 08: Congestive Heart Failure (CHF) Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

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

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

Medicaid enrollees age 18 and older.

Numerators

All discharges with ICD-9-CM principal diagnosis code for CHF.

ICD-9-CM Diagnosis Codes (Discharges after September 30, 2002):

39891 RHEUMATIC HEART FAILURE

4280 CONGESTIVE HEART FAILURE

4281 LEFT HEART FAILURE

42820 SYSTOLIC HRT FAILURE NOS OCT02-

42821 AC SYSTOLIC HRT FAILURE OCT02-

42822 CHR SYSTOLIC HRT FAILURE OCT02-

42823 AC ON CHR SYST HRT FAIL OCT02-

42830 DIASTOLC HRT FAILURE NOS OCT02-

42831 AC DIASTOLIC HRT FAILURE OCT02-

42832 CHR DIASTOLIC HRT FAIL OCT02-

42833 AC ON CHR DIAST HRT FAIL OCT02-

42840 SYST/DIAST HRT FAIL NOS OCT02-

42841 AC SYST/DIASTOL HRT FAIL OCT02-

42842 CHR SYST/DIASTL HRT FAIL OCT02-

42843 AC/CHR SYST/DIA HRT FAIL OCT02-

4289 HEART FAILURE NOS

ICD-9-CM Diagnosis Codes (Discharges before September 30, 2002):

40201 MAL HYPERT HRT DIS W CHF

40211 BENIGN HYP HRT DIS W CHF

40291 HYPERTEN HEART DIS W CHF

40401 MAL HYPER HRT/REN W CHF

40403 MAL HYP HRT/REN W CHF/RF

40411 BEN HYPER HRT/REN W CHF

40413 BEN HYP HRT/REN W CHF/RF

40491 HYPER HRT/REN NOS W CHF

40493 HYP HT/REN NOS W CHF/RF

Exclusions

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

With a cardiac procedure code

ICD-9-CM Cardiac Procedure Codes:

0050 IMPL CRT PACEMAKER SYS OCT02-

0051 IMPL CRT DEFIBRILLAT OCT02-

0052 IMP/REP LEAD LF VEN SYS OCT02-

0053 IMP/REP CRT PACEMKR GEN OCT02-

0054 IMP/REP CRT DEFIB GENAT OCT02-

0056 INS/REP IMPL SENSOR LEAD OCT06-

0057 IMP/REP SUBCUE CARD DEV OCT06-

0066 PTCA OCT06-

1751 IMPLANTATION OF RECHARGEABLE CARDIAC CONTRACTILITY MODULATION [CCM], TOTAL SYSTEM OCT09-

1752 IMPLANTATION OR REPLACEMENT OF CARDIAC CONTRACTILITY MODULATION [CCM] RECHARGEABLE PULSE, GENERATOR ONLY OCT09-

3500 CLOSED VALVOTOMY NOS

3501 CLOSED AORTIC VALVOTOMY
3502 CLOSED MITRAL VALVOTOMY
3503 CLOSED PULMON VALVOTOMY
3504 CLOSED TRICUSP VALVOTOMY
3510 OPEN VALVULOPLASTY NOS
3511 OPN AORTIC VALVULOPLASTY
3512 OPN MITRAL VALVULOPLASTY
3513 OPN PULMON VALVULOPLASTY
3514 OPN TRICUS VALVULOPLASTY
3520 REPLACE HEART VALVE NOS
3521 REPLACE AORT VALV-TISSUE
3522 REPLACE AORTIC VALVE NEC
3523 REPLACE MITR VALV-TISSUE
3524 REPLACE MITRAL VALVE NEC
3525 REPLACE PULM VALV-TISSUE
3526 REPLACE PULMON VALVE NEC
3527 REPLACE TRIC VALV-TISSUE
3528 REPLACE TRICUSP VALV NEC
3531 PAPILLARY MUSCLE OPS
3532 CHORDAE TENDINEAE OPS
3533 ANNULOPLASTY
3534 INFUNDIBULECTOMY
3535 TRABECUL CARNEAE CORD OP
3539 TISS ADJ TO VALV OPS NEC
3541 ENLARGE EXISTING SEP DEF
3542 CREATE SEPTAL DEFECT
3550 PROSTH REP HRT SEPTA NOS
3551 PROS REP ATRIAL DEF-OPN
3552 PROS REPAIR ATRIA DEF-CL
3553 PROST REPAIR VENTRIC DEF
3554 PROS REP ENDOCAR CUSHION
3555 PROS REP VENTRC DEF-CLOS OCT06-
3560 GRFT REPAIR HRT SEPT NOS
3561 GRAFT REPAIR ATRIAL DEF
3562 GRAFT REPAIR VENTRIC DEF
3563 GRFT REP ENDOCAR CUSHION

3570 HEART SEPTA REPAIR NOS
3571 ATRIA SEPTA DEF REP NEC
3572 VENTR SEPTA DEF REP NEC
3573 ENDOCAR CUSHION REP NEC
3581 TOT REPAIR TETRAL FALLOT
3582 TOTAL REPAIR OF TAPVC
3583 TOT REP TRUNCUS ARTERIOS
3584 TOT COR TRANSPOS GRT VES
3591 INTERAT VEN RETRN TRANSP
3592 CONDUIT RT VENT-PUL ART
3593 CONDUIT LEFT VENTR-AORTA
3594 CONDUIT ARTIUM-PULM ART
3595 HEART REPAIR REVISION
3596 PERC HEART VALVULOPLASTY
3598 OTHER HEART SEPTA OPS
3599 OTHER HEART VALVE OPS
3601 PTCA-1 VESSEL W/O AGENT
3602 PTCA-1 VESSEL WITH AGNT
3603 OPEN CORONRY ANGIOPLASTY
3604 INTRCORONRY THROMB INFUS
3605 PTCA-MULTIPLE VESSEL
3606 INSERT OF COR ART STENT OCT95-
3607 INS DRUG-ELUT CORONRY ST OCT02-
3609 REM OF COR ART OBSTR NEC
3610 AORTOCORONARY BYPASS NOS
3611 AORTOCOR BYPAS-1 COR ART
3612 AORTOCOR BYPAS-2 COR ART
3613 AORTOCOR BYPAS-3 COR ART
3614 AORTCOR BYPAS-4+ COR ART
3615 1 INT MAM-COR ART BYPASS
3616 2 INT MAM-COR ART BYPASS
3617 ABD-CORON ART BYPASS OCT96-
3619 HRT REVAS BYPS ANAS NEC
362 ARTERIAL IMPLANT REVASC
363 OTH HEART REVASCULAR
3631 OPEN CHEST TRANS REVASC

3632 OTH TRANSMYO REVASCULAR

3633 ENDO TRANSMYO REVASCULAR OCT06-

3634 PERC TRANSMYO REVASCULAR OCT06-

3639 OTH HEART REVASULAR

3691 CORON VESS ANEURYSM REP

3699 HEART VESSLE OP NEC

3731 PERICARDIECTOMY

3732 HEART ANEURYSM EXCISION

3733 EXC/DEST HRT LESION OPEN

3734 EXC/DEST HRT LES OTHER

3735 PARTIAL VENTRICULECTOMY

3736 EXCISION OR DESTRUCTION OF LEFT ATRIAL APPENDAGE (LAA) OCT08-

3741 IMPLANT PROSTH CARD SUPPORT DEV OCT06

375 HEART TRANSPLANTATION (NOT VALID AFTER OCT 03)

3751 HEART TRANPLANTATION OCT03-

3752 IMPLANT TOT REP HRT SYS OCT03-

3753 REPL/REP THORAC UNIT HRT OCT03-

3754 REPL/REP OTH TOT HRT SYS OCT03-

3755 REMOVAL OF INTERNAL BIVENTRICULAR HEART REPLACEMENT SYSTEM OCT08

3760 IMPLANTATION OR INSERTION OF BIVENTRICULAR EXTERNAL HEART ASSIST SYSTEM OCT08

3761 IMPLANT OF PULSATION BALLOON

3762 INSERTION OF NON-IMPLANTABLE HEART ASSIST SYSTEM

3763 REPAIR OF HEART ASSIST SYSTEM

3764 REMOVAL OF HEART ASSIST SYSTEM

3765 IMPLANT OF EXTERNAL HEART ASSIST SYSTEM

3766 INSERTION OF IMPLANTABLE HEART ASSIST SYSTEM

3770 INT INSERT PACEMAK LEAD

3771 INT INSERT LEAD IN VENT

3772 INT INSERT LEAD ATRI-VENT

3773 INT INSER LEAD IN ATRIUM

3774 INT OR REPL LEAD EPICAR

3775 REVISION OF LEAD

3776 REPL TV ATRI-VENT LEAD

3777 REMOVAL OF LEAD W/O REPL

3778 INSER TEAM PACEMAKER SYS
3779 REVIS OR RELOCATE POCKET
3780 INT OR REPL PERM PACEMKR
3781 INT INSERT 1-CHAM, NON
3782 INT INSERT 1-CHAM, RATE
3783 INT INSERT DUAL-CHAM DEV
3785 REPL PACEM W 1-CHAM, NON
3786 REPL PACEM 1-CHAM, RATE
3787 REPL PACEM W DUAL-CHAM
3789 REVISE OR REMOVE PACEMAK
3794 IMPLT/REPL CARDDEFIB TOT
3795 IMPLT CARDIODEFIB LEADS
3796 IMPLT CARDIODEFIB GENATR
3797 REPL CARDIODEFIB LEADS
3798 REPL CARDIODEFIB GENRATR

Measure 11: PQI 15: Adult Asthma Admission Rate

Agency for Healthcare Research and Quality

A. DESCRIPTION

The number of discharges for asthma in adults per 100,000 Medicaid enrollees age 18 and older.

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

Medicaid enrollees age 18 and older.

Numerator

All non-maternal discharges for enrollees age 18 and older with an ICD-9-CM principal diagnosis code of asthma. Include ICD-9-CM diagnosis codes:

49300 EXT ASTHMA W/O STAT ASTH

49301 EXT ASTHMA W STATUS ASTH

49302 EXT ASTHMA W ACUTE EXAC OCT00-

49310 INT ASTHMA W/O STAT ASTH

49311 INT ASTHMA W STAT ASTH

49312 INT ASTHMA W ACUTE EXAC OCT00-

49320 CH OB ASTH W/O STAT ASTH

49321 CH OB ASTHMA W STAT ASTH

49322 CH OBS ASTH W ACUTE EXAC OCT00-

49381 EXERCSE IND BRONCHOSPASM OCT03-

49382 COUGH VARIANT ASTHMA OCT03-

49390 ASTHMA W/O STATUS ASTHM

49391 ASTHMA W STATUS ASTHMAT

49392 ASTHMA W ACUTE EXACERBTN OCT00-

Exclusions

- Transfer from a hospital (different facility)
- Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
- Transfer from another health care facility
- With missing gender (SEX = missing), age (AGE = missing), quarter (DQTR = missing), year (YEAR = missing), principal diagnosis (DX1 = missing), or county (PSTCO = missing)
- MDC 14 (pregnancy, childbirth, and puerperium)With any diagnosis code of cystic fibrosis and anomalies of the respiratory system

ICD-9-CM Cystic Fibrosis and Anomalies of the Respiratory System Diagnosis Codes:

27700 CYSTIC FIBROS W/O ILEUS

27701 CYSTIC FIBROSIS W ILEUS

27702 CYSTIC FIBROS W PUL MAN

27703 CYSTIC FIBROSIS W GI MAN

27709 CYSTIC FIBROSIS NEC

51661 NEUROEND CELL HYPRPL INF

51662 PULM INTERSTITL GLYCOGEN

51663 SURFACTANT MUTATION LUNG

51664 ALV CAP DYSP W VN MISALIGN

51669 OTH INTRST LUNG DIS CHLD

7421 ANOMALIES OF AORTIC ARCH

7483 LARYNGOTRACH ANOMALY NEC

7484 CONGENITAL CYSTIC LUNG

7485 AGENESIS OF LUNG

74860 LUNG ANOMALY NOS

74861 CONGEN BRONCHIECTASIS

74869 LUNG ANOMALY NEC

7488 RESPIRATORY ANOMALY NEC

7489 RESPIRATORY ANOMALY NOS

7503 CONG ESOPH FISTULA/ATRES

7593 SITUS INVERSUS

7707 PERINATAL CHR RESP DIS

Measure 12: Chlamydia Screening in Women Ages 21 to 24

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid-enrolled women ages 21 to 24 that were identified as sexually active and that had at least one test for Chlamydia during the measurement year.

Guidance for Reporting:

- In the original HEDIS specification, this measure has two reportable rates for ages 16 to 20 and 21 to 24. For reporting of the Medicaid Adult Core Set measure, states will calculate the rate for ages 21 to 24 only.
- Include all paid, suspended, reversed, pending, and denied claims.

B. ELIGIBLE POPULATION

Age	Women ages 21 to 24 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The state must use both methods to identify the eligible population; however, a woman only needs to be identified in one method to be eligible for the measure. Pharmacy data. Women who were dispensed prescription contraceptives during the measurement year (Table 12.1). Claim/encounter data. Women who had at least one encounter during the measurement year with any code in Table 12.2.

Table 12.1. Prescriptions to Identify Contraceptives

Description	Prescriptions	
Contraceptives	Desogestrel-ethinyl estradiol Drospirenone-ethinyl estradiol Estradiol-medroxyprogesterone Ethinyl estradiol-ethynodiol Ethinyl estradiol-etonogestrel Ethinyl estradiol-levonorgestrel Ethinyl estradiol-norelgestromin Ethinyl estradiol-norethindrone	Ethinyl estradiol-norgestimate Ethinyl estradiol-norgestrel Etonogestrel Levonorgestrel Medroxyprogesterone Mestranol-norethindrone Norethindrone
Diaphragm	Diaphragm	
Spermicide	Nonxynol 9	

Note: NDC codes to identify these drugs are listed at http://www.ncqa.org.

Table 12.2. Codes to Identify Sexually Active Women

Description	Codes
CPT	11975-11977, 57022, 57170, 58300, 58301, 58600, 58605, 58611, 58615, 58970, 58974, 58976, 59000, 59001, 59012, 59015, 59020, 59025, 59030, 59050, 59051, 59070, 59072, 59074, 59076, 59100, 59120, 59121, 59130, 59135, 59136, 59140, 59150, 59151, 59160, 59200, 59300, 59320, 59325, 59350, 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622, 59812, 59820, 59821, 59830, 59840, 59841, 59850-59852, 59855-59857, 59866, 59870, 59871, 59897, 59898, 59899, 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 76941, 76945-76946, 80055, 81025, 82105, 82106, 82143, 82731, 83632, 83661-83664, 84163, 84702-84704, 86592, 86593, 86631-86632, 87110, 87164, 87166, 87270, 87320, 87490-87492, 87590-87592, 87620-87622, 87660, 87808, 87810, 87850, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175, 88235, 88267, 88269
HCPCS	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, G0450, H1000, H1001, H1003-H1005, P3000, P3001, Q0091, S0199, S4981, S8055
ICD-9-CM Diagnosis	042, 054.10, 054.11, 054.12, 054.19, 078.11, 078.88, 079.4, 079.51-079.53, 079.88, 079.98, 091-097, 098.0, 098.10, 098.11, 098.15-098.19, 098.2, 098.30, 098.31, 098.35-098.8, 099, 131, 302.76, 339.82, 614, 615, 622.3, 623.4, 625.0, 626.7, 628, 630-679, 795.0, 795.1, 796.7, 996.32, V01.6, V02.7, V02.8, V08, V15.7, V22-V25, V26.0-V26.4, V26.51, V26.8, V26.9, V27, V28, V45.5, V61.5-V61.7, V69.2, V72.3, V72.4, V73.81, V73.88, V73.98, V74.5, V76.2
ICD-9-CM Procedure	69.01, 69.02, 69.51, 69.52, 69.7, 72-75, 88.78, 97.24, 97.71, 97.73
UB Revenue	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724, 0729, 0923, 0925

Description	Codes
LOINC	557-9, 560-3, 660-1, 688-2, 690-8, 691-6, 692-4, 693-2, 698-1, 1832-5, 1834-1, 2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 4993-2, 5028-6, 5291-0, 5292-8, 5392-6, 5393-4, 5394-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 6487-3, 6488-1, 6489-9, 6510-2, 6511-0, 6514-4, 6516-9, 6561-5, 6562-3, 7975-6, 8041-6, 10524-7, 10705-2, 11083-3, 11084-1, 11481-9, 11597-2, 12222-6, 12223-4, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14499-8, 14500-3, 14502-9, 14503-7, 14504-5, 14506-0, 14509-4, 14510-2, 14513-6, 15019-3, 16280-0, 16600-9, 16601-7, 17398-9, 17399-7, 17400-3, 17401-1, 17402-9, 17403-7, 17404-5, 17405-2, 17406-0, 17407-8, 17408-6, 17409-4, 17410-2, 17411-0, 17412-8, 17723-8, 17724-6, 17725-3, 17726-1, 17727-9, 17728-7, 17729-5, 18500-9, 19080-1, 19171-8, 19176-7, 19177-5, 19180-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 20403-2, 20404-0, 20415-6, 20507-0, 20508-8, 20994-0, 21189-6, 21190-4, 21191-2, 21192-0, 21198-7, 21414-8, 21415-5, 21416-3, 21440-3, 21441-1, 21613-5, 22461-8, 22462-6, 22587-0, 22590-4, 22592-0, 22594-6, 23838-6, 24110-9, 24111-7, 24312-1, 25372-4, 25373-2, 26009-1, 29311-8, 30167-1, 31147-2, 31771-9, 31772-7, 31775-0, 31777-6, 31905-3, 31906-1, 31993-9, 32198-4, 32199-2, 32705-6, 33717-0, 33773-3, 34147-9, 34382-2, 34493-7, 34656-9, 34670-0, 34718-7, 35457-1, 36902-5, 36903-3, 38372-9, 40679-3, 40680-1, 41273-4, 41274-2, 42316-0, 42481-2, 42931-6, 43304-5, 43305-2, 43403-5, 43404-3, 43406-8, 43798-8, 44543-7, 44544-5, 44546-0, 44547-8, 44549-4, 44550-2, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 45194-8, 45327-4, 45331-6, 45332-4, 46731-6, 46989-0, 47211-8, 47212-6, 47236-5, 47237-3, 47238-1, 47387-6, 47527-7, 47528-5, 48030-1, 48039-2, 48560-7, 48781-9, 49096-1, 49246-2, 49318-9, 49891-5, 49896-4, 50387-0, 50388-8, 50690-7, 51838-1, 51839-9, 53605-2, 53762-1, 53879-3, 53925-4, 53926-2, 53927-0, 55299-2, 55869-2, 55870-0, 56497-1, 57032-5, 59263-4, 59264-2, 59420-0, 61390-1, 61391-9, 61392-7, 61393-5, 61394-3, 61395-0, 61396-8, 61372-9, 61373-7, 61374-5, 61375-2, 61376-0, 61377-8, 61378-6, 61379-4, 61380-2, 61381-0, 61382-8, 61383-6, 61384-4, 61385-1, 61386-9, 61387-7, 61388-5, 61389-3, 63464-2, 64088-8, 64094-6, 69002-4, 71793-4, 71431-1

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

At least one Chlamydia test during the measurement year as documented through administrative data. A woman is counted as having had a test if she had a claim/ encounter with a service date during the measurement year with one or more of the codes in Table 12.3.

Table 12.3. Codes to Identify Chlamydia Screening

CPT	LOINC
87110, 87270, 87320, 87490-87492, 87810	557-9, 560-3, 4993-2, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 14463-4, 14464-2, 14467-5, 14470-9, 14471-7, 14474-1, 14509-4, 14510-2, 14513-6, 16600-9, 16601-7, 21189-6, 21190-4, 21191-2, 21192-0, 21613-5, 23838-6, 31771-9, 31772-7, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43406-8, 44806-8, 44807-6, 45067-6, 45068-4, 45069-2, 45070-0, 45074-2, 45076-7, 45078-3, 45080-9, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 50387-0, 53925-4, 53926-2

Exclusions (optional)

Women who had a pregnancy test during the measurement year, followed within seven days (inclusive) by either a prescription for isotretinoin (Accutane) or an X-ray.

This exclusion does not apply to women who qualify for the denominator based on services other than the pregnancy test alone. Refer to Table 12.4 and Table 12.5 to identify exclusions.

Table 12.4. Codes to Identify Exclusions

Description	CPT	UB Revenue	LOINC
Pregnancy test	81025, 84702, 84703	0925	2106-3, 2107-1, 2110-5, 2111-3, 2112-1, 2113-9, 2114-7, 2115-4, 2118-8, 2119-6, 19080-1, 19180-9, 20415-6, 20994-0, 21198-7, 25372-4, 25373-2, 34670-0, 45194-8, 55869-2, 55870-0, 56497-1
With			
Diagnostic radiology	70010-76499	032x	

Table 12.5. Medications to Identify Exclusions

Description	Prescription
Retinoid	Isotretinoin

Measure 13: Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of discharges for Medicaid enrollees age 21 and older that were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:

- 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

Guidance for Reporting:

- In the original HEDIS specification, the eligible population for this measure includes patients age 6 and older as of the date of discharge. The Medicaid Adult Core Set measure has an eligible population of adults age 21 and older. States should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 21 to 64 and age 65 and older.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITION

Mental Health Practitioner	A practitioner who provides mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in his/her state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social 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.

C. ELIGIBLE POPULATION

Age	Age 21 and older as of date of discharge.
Continuous enrollment	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	Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (Table 13.1) on or between January 1 and December 1 of the measurement year. Use only facility claims to identify discharges with a principal mental health diagnosis. Do not use diagnoses from professional claims to identify discharges. The denominator for this measure is based on discharges, not enrollees. If enrollees had more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Mental health readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (Tables 13.1 and 13.2) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although re-hospitalization might not be for a selected mental health disorder, it is probably for a related condition. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility for a mental health principal diagnosis (Tables 13.1 and 13.2) within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table 13.3 for codes to identify nonacute care. Non-mental health readmission or direct transfer: Exclude discharges in which the enrollee was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables 13.1 and 13.2. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Table 13.1. Codes to Identify Mental Health Diagnosis

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

Table 13.2. Codes to Identify Inpatient Services

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

Table 13.3. Codes to Identify Nonacute Care

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

30-Day Follow-Up

An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table 13.4) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up

An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table 13.4) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Table 13.4. Codes to Identify Visits

CPT		HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner		
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510		G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
CPT		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner		
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53
UB Revenue		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table 13.1		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

E. ADDITIONAL NOTES

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

Measure 14: PC-01: Elective Delivery

The Joint Commission

A. DESCRIPTION

The percentage of Medicaid and CHIP enrolled females with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled females that meet the measurement eligibility criteria.

B. ADMINISTRATIVE SPECIFICATION

Denominator

Medicaid and CHIP enrollees delivering newborns with >= 37 and < 39 weeks of gestation completed.

Exclusions:

- ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for conditions possibly justifying elective delivery prior to 39 weeks gestation as defined in Table 14.1.
- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials

Table 14.1. Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation

Code	Shortened Description
042	HUMAN IMMUNO VIRUS DIS
641.01	PLACENTA PREVIA-DELIVER
641.11	PLACENTA PREV HEM-DELIV
641.21	PREM SEPAR PLACEN-DELIV
641.31	COAG DEF HEMORR-DELIVER
641.81	ANTEPARTUM HEM NEC-DELIV
641.91	ANTEPARTUM HEM NOS-DELIV
642.01	ESSEN HYPERTEN-DELIVERED
642.02	ESSEN HYPERTEN-DEL W P/P
642.11	RENAL HYPERTEN PG-DELIV
642.12	RENAL HYPERTEN-DEL P/P
642.21	OLD HYPERTEN NEC-DELIVER
642.22	OLD HYPERTEN-DELIV W P/P

Code	Shortened Description
642.31	TRANS HYPERTEN-DELIVERED
642.32	TRANS HYPERTEN-DEL W P/P
642.41	MILD/NOS PREECLAMP-DELIV
642.42	MILD PREECLAMP-DEL W P/P
642.51	SEVERE PREECLAMP-DELIVER
642.52	SEV PREECLAMP-DEL W P/P
642.61	ECLAMPSIA-DELIVERED
642.62	ECLAMPSIA-DELIV W P/P
642.71	TOX W OLD HYPERTEN-DELIV
642.72	TOX W OLD HYP-DEL W P/P
642.91	HYPERTENS NOS-DELIVERED
642.92	HYPERTENS NOS-DEL W P/P
645.11	POST TERM PREG-DEL
646.21	RENAL DIS NOS-DELIVERED
646.22	RENAL DIS NOS-DEL W P/P
646.71	LIVER/BIL TRCT DISR-DEL
648.01	DIABETES-DELIVERED
648.51	CONGEN CV DIS-DELIVERED
648.52	CONGEN CV DIS-DEL W P/P
648.61	CV DIS NEC PREG-DELIVER
648.62	CV DIS NEC-DELIVER W P/P
648.81	ABN GLUCOSE TOLER-DELIV
648.82	ABN GLUCOSE-DELIV W P/P
649.31	COAGULATION DEF-DELIV
649.32	COAGULATN DEF-DEL W P/P
651.01	TWIN PREGNANCY-DELIVERED
651.11	TRIPLET PREGNANCY-DELIV
651.21	QUADRUPLET PREG-DELIVER
651.31	TWINS W FETAL LOSS-DEL
651.41	TRIPLETS W FET LOSS-DEL
651.51	QUADS W FETAL LOSS-DEL
651.61	MULT GES W FET LOSS-DEL
651.71	MULT GEST-FET REDUCT DEL

Code	Shortened Description
651.81	MULTI GESTAT NEC-DELIVER
651.91	MULT GESTATION NOS-DELIV
652.01	UNSTABLE LIE-DELIVERED
652.61	MULT GEST MALPRES-DELIV
655.01	FETAL CNS MALFORM-DELIV
655.11	FETAL CHROMOSO ABN-DELIV
655.31	FET DAMG D/T VIRUS-DELIV
655.41	FET DAMG D/T DIS-DELIVER
655.51	FET DAMAG D/T DRUG-DELIV
655.61	RADIAT FETAL DAMAG-DELIV
655.81	FETAL ABNORM NEC-UNSPEC
656.01	FETAL-MATERNAL HEM-DELIV
656.11	RH ISOIMMUNIZAT-DELIVER
656.21	ABO ISOIMMUNIZAT-DELIVER
656.31	FETAL DISTRESS-DELIVERED
656.41	INTRAUTER DEATH-DELIVER
656.51	POOR FETAL GROWTH-DELIV
657.01	POLYHYDRAMNIOS-DELIVERED
658.01	OLIGOHYDRAMNIOS-DELIVER
658.11	PREM RUPT MEMBRAN-DELIV
658.21	PROLONG RUPT MEMB-DELIV
658.41	AMNIOTIC INFECTION-DELIV
659.71	ABN FTL HRT RATE/RHY-DEL
663.51	VASA PREVIA-DELIVERED
V08	ASYMP HIV INFECTN STATUS
V23.5	PREG W POOR REPRODUCT HX
V27.1	DELIVER-SINGLE STILLBORN

Numerator

Medicaid and CHIP enrollees with elective deliveries.

Include patients with ICD-9-CM Principal Procedure Code or ICD-9-CM Other Procedure Codes for one or more of the following:

- Medical induction of labor as defined in Table 14.2.

Cesarean section as defined in Table 14.3 while not in Active Labor or experiencing Spontaneous Rupture of Membranes.

Table 14.2. Codes to Identify Medical Induction of Labor

Code	Shortened Description
73.01	INDUCT LABOR-RUPT MEMB
73.1	SURG INDUCT LABOR NEC
73.4	MEDICAL INDUCTION LABOR

Table 14.3. Codes to Identify Cesarean Section

Code	Shortened Description
74.0	CLASSICAL C-SECTION
74.1	LOW CERVICAL C-SECTION
74.2	EXTRAPERITONEAL C-SECTION
74.4	CESAREAN SECTION NEC
74.99	CESAREAN SECTION NOS

C. ADDITIONAL NOTES

Additional information on the measure algorithm is available at https://manual.jointcommission.org/releases/TJC2012B/MIF0166.html.

Measure 15: PC-03: Antenatal Steroids

The Joint Commission

A. DESCRIPTION

The percentage of Medicaid and CHIP enrolled females at risk of preterm delivery at >=24 and <32 weeks gestation that received antenatal steroids prior to delivering preterm newborns.

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled females that meet the measurement eligibility criteria.

B. ADMINISTRATIVE SPECIFICATION

Denominator

Medicaid and CHIP enrolled females delivering live preterm newborns with >=24 and <32 weeks gestation completed.

Exclusions

- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials
- Documented Reason for Not Administering Antenatal Steroid Therapy
- ICD-9-CM Principal Diagnosis Code or ICD-9-CM Other Diagnosis Codes for fetal demise as defined in Table 15.1.

Table 15.1. Codes to Identify Fetal Demise

Code	Shortened Description
656.40	INTRAUTERINE DEATH-UNSP
656.41	INTRAUTER DEATH-DELIVER

Numerator

Medicaid and CHIP enrollees with a full course of antenatal steroids completed prior to delivering preterm newborns (Table 15.2).

Table 15.2. Antenatal Steroid Medications

Medication	Generic
Betamethasone	Betamethasone
Betamethasone Sodium Phosphate	Betamethasone Sodium Phosphate
Betamethasone Sodium Phosphate and Betamethasone Acetate	Betamethasone Sodium Phosphate and Betamethasone Acetate

Medication	Generic
Celestone	Betamethasone
Celestone Phosphate	Betamethasone Sodium Phosphate
Celestone Soluspan	Betamethasone Sodium Phosphate and Betamethasone Acetate
Cortastat	Dexamethasone Sodium Phosphate
Dalalone	Dexamethasone Sodium Phosphate
Dalalone DP	Dexamethasone Acetate
Dalalone LA	Dexamethasone Acetate
Decadron	Dexamethasone
Decadron LA	Dexamethasone Acetate
Decadron Phosphate	Dexamethasone Sodium Phosphate
Decadron w/Xylocaine	Dexamethasone Sodium Phosphate with Lidocaine HCL
Decaject	Dexamethasone Sodium Phosphate
Decaject LA	Dexamethasone Sodium Phosphate
Dexamethasone	Dexamethasone
Dexamethasone Acetate	Dexamethasone Acetate
Dexamethasone Intensol	Dexamethasone
Dexamethasone Sodium Phosphate	Dexamethasone Sodium Phosphate
Dexamethasone Sodium Phosphate with Lidocaine	Dexamethasone Sodium Phosphate with Lidocaine
Dexamethasone Sodium Phosphate with Lidocaine HCL	Dexamethasone Sodium Phosphate with Lidocaine HCL
Dexasone	Dexamethasone Sodium Phosphate
Dexasone LA	Dexamethasone Acetate
Dexone	Dexamethasone
Dexone LA	Dexamethasone Acetate
Hexadrol	Dexamethasone
Hexadrol Phosphate	Dexamethasone Sodium Phosphate
Solurex	Dexamethasone Sodium Phosphate
Solurex LA	Dexamethasone Acetate

C. ADDITIONAL NOTES

Additional information on the measure algorithm is available at https://manual.jointcommission.org/releases/TJC2012B/MIF0168.html.

Measure 16: Annual HIV/AIDS Medical Visit

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older with a diagnosis of HIV/AIDS and with at least two medical visits during the measurement year, with a minimum of 90 and 180 days between each visit.

Guidance for Reporting:

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

B. DEFINITION

Medical Visit	Any visit with a health care professional who provides routine primary care for the patient with HIV/AIDS (may be a primary care physician, OB/GYN, pediatrician or infectious diseases specialist).

C. ADMINISTRATIVE SPECIFICATION

Denominator

All enrollees age 18 and older with a diagnosis of HIV/AIDS (Table 16.1).

Table 16.1. Codes to Identify HIV/AIDS

Description	ICD-9-CM Diagnosis
HIV-AIDS	042, V08

Numerator

Numerator 1: Enrollees with at least two medical visits (Table 16.2) during the measurement year, with a minimum of 90 days between each visit.

Numerator 2: Enrollees with at least two medical visits (Table 16.2) during the measurement year, with a minimum of 180 days between each visit.

Table 16.2. Codes to Identify Medical Visits

Description	CPT
Medical Visits	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99241, 99242, 99243, 99244, 99245

Measure 17: Controlling High Blood Pressure

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.

Guidance for Reporting:

- This measure applies to Medicaid enrollees ages 18 to 85. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 85.
- This measure requires medical record review to assess the numerator.

B. DEFINITIONS

Adequate Control	Both a representative systolic BP < 140 mm Hg and a representative diastolic BP < 90 mm Hg (BP in the normal or high-normal range).
Representative BP	The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension was made). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. If no BP is recorded during the measurement year, assume that the member is “not controlled.”

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Medicaid enrollees are identified as hypertensive if there is at least one outpatient encounter (Table 17.1) with a diagnosis of hypertension (Table 17.2) during the first six months of the measurement year.

Table 17.1. Codes to Identify Outpatient Visits

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

Table 17.2. Codes to Identify Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

D. HYBRID SPECIFICATION

Denominator

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

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

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

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

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

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

Identifying the Medical Record

States should use only the medical records of one practitioner or provider team for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the records from one practitioner or provider team (even if obtained by a different practitioner) should be considered (e.g., from a consultation note or

other note relating to a BP reading from a health care practitioner or provider team). If a state cannot find the medical record, the enrollee remains in the measure denominator and is considered noncompliant for the numerator.

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

Step 1

- Identify the enrollee's PCP
- If the enrollee had more than one PCP for the time period, identify the PCP who most recently provided care to the adult
- If the 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 enrollee
- If a practitioner other than the enrollee's PCP manages the hypertension, the state may use the medical record of that practitioner

Step 2

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

Numerator

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

E. ADMINISTRATIVE SPECIFICATION

None.

F. MEDICAL RECORD SPECIFICATION

Follow the steps below to determine representative BP.

Step 1

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

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

Step 2

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

Exclusions (optional)

- Exclude from the eligible population all Medicaid enrollees with evidence of end-stage renal disease (ESRD) (Table 17.3) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD. Documentation of dialysis or renal transplant also meets the criteria for evidence of ESRD
- Exclude from the eligible population all Medicaid enrollees with a diagnosis of pregnancy (Table 17.3) during the measurement year
- Exclude from the eligible population all Medicaid enrollees who had an admission to a nonacute inpatient setting during the measurement year. Refer to Table 17.2 in Follow-Up after Mental Health Hospitalization measure specifications for codes to identify nonacute care

Table 17.3. Codes to Identify Exclusions

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

G. ADDITIONAL NOTES

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

Measure 18: Comprehensive Diabetes Care: LDL-C Screening

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a LDL-C screening test.

Guidance for Reporting:

- This measure is based on the original HEDIS specification that includes multiple diabetes care indicators. Only the LDL screening indicator is included in this measure.
- This measure applies to Medicaid enrollees ages 18 to 75. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Ages18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify Medicaid enrollees with diabetes: by pharmacy data and by claim/encounter data. The organization must use both methods to identify the eligible population, but an enrollee only needs to be identified by one method to be included in the measure. Medicaid enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data. Medicaid enrollees who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table 18.1). Claim/encounter data. Medicaid enrollees who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table 18.2), or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. The state may count services that occur over both years. Refer to Table 18.3 for codes to identify visit type.

Table 18.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlinitide
Antidiabetic combinations	Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metforminMetformin-pioglitazone Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Saxagliptin Sitagliptin-simvastatin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin inhalation Insulin isophane beef-pork Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin zinc human
Meglitinides	Nateglinide Repaglinide
Miscellaneous antidiabetic agents	Exenatide Linagliptin Liraglutide Metformin-repaglinide Sitagliptin
Sulfonylureas	Acetohexamide Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone

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

Table 18.2. Codes to Identify Diabetes

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

Table 18.3. Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

An LDL-C test performed during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in Table 18.4.

The state may use a calculated or direct LDL for LDL-C screening and control indicators.

Table 18.4. Codes to Identify LDL-C Screening

CPT	CPT Category II	LOINC
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0

Exclusions (optional)

- Medicaid enrollees with a diagnosis of polycystic ovaries (Table 18.5) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table 18.2) during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the enrollee's history, but must have occurred by December 31 of the measurement year
- Medicaid enrollees with gestational or steroid-induced diabetes (Table 18.5) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table 18.2) during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year

Table 18.5. Codes to Identify Exclusions

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

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Numerator

An LDL-C test performed during the measurement year as identified by claim/encounter or automated laboratory data or medical record review.

Administrative

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

Medical record

At a minimum, documentation in the medical record must include a note indicating the date when the LDL-C test was performed and the result. The state may use a calculated or direct LDL for LDL-C screening.

Exclusions (optional)

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

Measure 19: Comprehensive Diabetes Care: Hemoglobin A1c Testing

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test.

Guidance for Reporting:

- This measure is based on the original HEDIS specification that includes multiple diabetes care indicators. Only the HbA1c testing indicator is included in this measure.
- This measure applies to Medicaid enrollees ages 18 to 75. For purposes of Medicaid Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	There are two ways to identify Medicaid enrollees with diabetes: by pharmacy data and by claim/encounter data. The state must use both methods to identify the eligible population, but an enrollee only needs to be identified by one method to be included in the measure. Medicaid enrollees may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data. Medicaid enrollees who were dispensed insulin or oral hypoglycemics/antihyper-glycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Table 19.1). Claim/encounter data. Medicaid enrollees who had two face-to-face encounters, in an outpatient setting or nonacute inpatient setting, on different dates of service, with a diagnosis of diabetes (Table 19.2), or one face-to-face encounter in an acute inpatient or ED setting, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. The state may count services that occur over both years. Refer to Table 19.3 for codes to identify visit type.

Table 19.1. Prescriptions to Identify Medicaid Enrollees with Diabetes

Description	Prescription
Alpha-glucosidase inhibitors	Acarbose Miglitol
Amylin analogs	Pramlinitide
Antidiabetic combinations	Glimepiride-pioglitazone Glimepiride-rosiglitazone Glipizide-metformin Glyburide-metformin Linagliptin-metformin Metformin-pioglitazone Metformin-rosiglitazone Metformin-saxagliptin Metformin-sitagliptin Saxagliptin Sitagliptin-simvastatin
Insulin	Insulin aspart Insulin aspart-insulin aspart protamine Insulin detemir Insulin glargine Insulin glulisine Insulin inhalation Insulin isophane beef-pork Insulin isophane human Insulin isophane-insulin regular Insulin lispro Insulin lispro-insulin lispro protamine Insulin regular human Insulin zinc human
Meglitinides	Nateglinide Repaglinide
Miscellaneous antidiabetic agents	Exenatide Linagliptin Liraglutide Metformin-repaglinide Sitagliptin
Sulfonylureas	Acetohexamide Chlorpropamide Glimepiride Glipizide Glyburide Tolazamide Tolbutamide
Thiazolidinediones	Pioglitazone Rosiglitazone

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

Table 19.2. Codes to Identify Diabetes

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

Table 19.3. Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x,021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

An HbA1c test performed during the measurement year, as identified by claim/encounter or automated laboratory data. Use any code listed in Table 19.4.

Table 19.4. Codes to Identify HbA1c Tests

CPT	CPT Category II	LOINC
83036, 83037	3044F, 3045F, 3046F	4548-4, 4549-2, 17856-6, 59261-8, 62388-4, 71875-9

Exclusions (optional)

- Medicaid enrollees with a diagnosis of polycystic ovaries (Table 19.5) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table 19.2) during the measurement year or the year prior to the measurement year. Diagnosis may occur at any time in the enrollee's history, but must have occurred by December 31 of the measurement year
- Medicaid enrollees with gestational or steroid-induced diabetes (Table 19.5) who did not have a face-to-face encounter, in any setting, with a diagnosis of diabetes (Table 19.2) during the measurement year or the year prior to the measurement year. Diagnosis may occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year

Table 19.5. Codes to Identify Exclusions

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

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Numerator

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

Administrative

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

Medical Record

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

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

Exclusions (optional)

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

Measure 20: Antidepressant Medication Management

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older with a diagnosis of major depression that were newly treated with antidepressant medication, and remained on an antidepressant medication treatment. Two rates are reported:

- Effective Acute Phase Treatment. The percentage of newly diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 84 days (12 weeks)
- Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 180 days (6 months)

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITIONS

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IESD	Index Episode Start Date. The earliest encounter during the Intake Period with any diagnosis of major depression and a 90-day (3-month) Negative Medication History. For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge. For a direct transfer, the IESD is the discharge date from the facility to which the enrollee was transferred.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).
Negative Medication History	A period of 90 days (3 months) prior to the IPSD when the enrollee had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment Days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of April 30 of the measurement year.
Continuous enrollment	90 days (3 months) prior to the IESD through 245 days after the IESD.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	IESD.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population which should be used for both rates. Step 1 Identify all Medicaid enrollees who met at least one of the following criteria during the Intake Period: • At least one principal diagnosis of major depression (Table 20.1) in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table 20.2), or • At least two visits in an outpatient, ED, intensive outpatient or partial hospitalization setting (Table 20.2) on different dates of service with any diagnosis of major depression (Table 20.1), or • At least one inpatient (acute or nonacute) claim/encounter with any diagnosis of major depression (Table 20.1). Step 2 Determine the IESD. For each enrollee identified in step 1, identify the date of the earliest encounter during the Intake Period with any diagnosis of major depression. If the enrollee had more than one encounter during the Intake Period, include only the first encounter. Step 3 Identify the IPSD. The IPSD is the date of the earliest dispensing event for an antidepressant medication (Table 20.3) during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive). Exclude Medicaid enrollees who did not fill a prescription for an antidepressant medication during this period. Step 4 Test for Negative Medication History. Exclude Medicaid enrollees who filled a prescription for an antidepressant medication 90 days (3 months) prior to the IPSD. Step 5 Calculate continuous enrollment. Medicaid enrollees must be continuously enrolled for 90 days (3 months) prior to the IESD to 245 days after the IESD.

Table 20.1. Codes to Identify Major Depression

Description	ICD-9-CM Diagnosis
Major depression	296.20-296.25, 296.30-296.35, 298.0, 311

Table 20.2. Codes to Identify Visit Type

Description	CPT	HCPCS	UB Revenue
ED	99281-99285		045x, 0981
Outpatient, intensive outpatient and partial hospitalization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
	CPT		POS
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

Numerator 1: Effective Acute Phase Treatment

- At least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table 20.3) during the 114-day period following the IPSD (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication
- Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days)

Table 20.3. Antidepressant Medications

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

Numerator 2: Effective Continuation Phase Treatment

- At least 180 days (6 months) of continuous treatment with antidepressant medication (Table 20.3) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication
- Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days)

E. ADDITIONAL NOTES

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

Measure 21: Adherence to Antipsychotics for Individuals with Schizophrenia

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees ages 19 to 64 with schizophrenia that were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Guidance for Reporting:

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

B. DEFINITIONS

IPSD	Index prescription start date. The earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the measurement year.
Treatment Period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
Oral Medication Dispensing Event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.
Long-Acting Injections Dispensing Event	Injections count as one dispensing event. Multiple J codes or NDCs for the same or different medication on the same day are counted as a single dispensing event.

Calculating Number of Days Covered for Oral Medications	If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator . If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.
Calculating Number of Days Covered for Long-Acting Injections	Calculate number of days covered (for the numerator) for long-acting injections using the days-supply specified for the medication in Table 21.1. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply. For multiple J Codes or NDCs for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

C. ELIGIBLE POPULATION

Age	Ages 19 to 64 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population. Step 1 • Identify Medicaid enrollees with schizophrenia as those who met at least one of the following criteria during the measurement year • At least one acute inpatient claim/encounter (Table 21.2) with any diagnosis of schizophrenia (Table 21.3). • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting (Table 21.2) on different dates of service, with any diagnosis of schizophrenia (Table 21.3). Step 2: Required Exclusions • Medicaid enrollees with a diagnosis of dementia (Table 21.4) during the measurement year. • Medicaid enrollees who did not have at least two antipsychotic medication (Table 21.1) dispensing events during the measurement year.

Table 21.1. Antipsychotic Medications

Description	Prescription		J Codes	Covered Days
Miscellaneous antipsychotic agents	Aripiprazole Asenapine Clozapine Haloperidol Iloperidone Loxapine Lurasidone Molindone	Olanzapine Paliperidone Pimozide Quetiapine Quetiapine fumarate Risperidone Ziprasidone		
Phenothiazine antipsychotics	Chlorpromazine Fluphenazine Perphenazine Perphenazine-amitriptyline	Prochlorperazine Thioridazine Trifluoperazine		
Psychotherapeutic combinations	Fluoxetine-olanzapine			
Thioxanthenes	Thiothixene			
Long-acting injections	Fluphenazine decanoate Haloperidol decanoate	Olanzapine Paliperidone palmitate	J1631, J2358, J2426, J2680	28 days supply
	Risperidone		J2794	14 days supply

Table 21.2. Codes to Identify Visit Type

Description	UB Revenue		
Acute inpatient	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987		
	CPT		POS
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	WITH	21, 51
	CPT	HCPCS	UB Revenue
Outpatient, intensive outpatient, and partial hospital-lization	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0516, 0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

	CPT		POS
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
	CPT		UB Revenue
Emergency department	99281-99285		045x, 0981
	CPT		POS
	90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	WITH	23
	CPT	HCPCS	UB Revenue
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	H0017-H0019, T2048	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1000, 1001, 1003-1005
	CPT		POS
	90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291	WITH	31, 32, 56

Table 21.3. Codes to Identify Schizophrenia

ICD-9-CM Diagnosis
295

Table 21.4. Codes to Identify Dementia

ICD-9-CM Diagnosis
290, 291.2, 292.82, 294.0-294.2, 331.0, 331.1, 331.82

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

The number of Medicaid enrollees who achieved a PDC of at least 80 percent for their antipsychotic medications (Table 21.1) during the measurement year.

Follow the steps below to identify numerator compliance:

Step 1

Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (Table 21.1) during the measurement year.

Step 2

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

Step 3

Count the days covered by at least one antipsychotic medication (Table 21.1) during the treatment period. To ensure that the days supply does not exceed the treatment period, subtract any day's supply that extends beyond December 31 of the measurement year.

Step 4

Calculate the enrollee's PDC using the following equation:

$$\frac{\text{Total days covered by an Antipsychotic Medication in the Treatment Period (Step3)}}{\text{Total Days in Treatment Period (Step 2)}}$$

Step 5

Sum the number of beneficiaries whose PDC is > = 80 percent for their treatment period.

Measure 22: Annual Monitoring for Patients on Persistent Medications

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older that received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and that received annual monitoring for the therapeutic agent in the measurement year. Report each of the four rates separately and a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for members on digoxin
- Annual monitoring for members on diuretic
- Annual monitoring for members on anticonvulsants
- Total rate (the sum of the four numerators divided by the sum of the four denominators)

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate and report the four separate rates and the total rate listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1-month gap in coverage.
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Medicaid enrollees on persistent medications (i.e., Medicaid enrollees who received at least 180 treatment days of ambulatory medication in the measurement year). Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on December 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond December 31 of the measurement year. Note: Medications dispensed in the year prior to the measurement year must be counted toward the 180 treatment days.

C. ADMINISTRATIVE SPECIFICATION

Report each of the four rates separately and as a combined rate. The total rate is the sum of the four numerators divided by the sum of the four denominators.

Rate 1: Annual Monitoring for Medicaid Enrollees on ACE Inhibitors or ARBs

Additional eligible population criteria

Medicaid enrollees who received at least 180 treatment days of ACE inhibitors or ARBs, during the measurement year. Refer to Table 22.1 to identify ACE inhibitors and ARBs.

Medicaid enrollees may switch therapy with any medication listed in Table 22.1 during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., an enrollee who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).

Table 22.1. ACE Inhibitors/ARBs

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

Numerator

At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table 22.2). The enrollee must meet one of the following criteria to be compliant:

- A code for a lab panel test during the measurement year
- A code for a serum potassium and a code for serum creatinine during the measurement year
- A code for serum potassium and a code for blood urea nitrogen during the measurement year

The tests do not need to occur on the same service date, only within the measurement year.

Table 22.2. Codes to Identify Physiologic Monitoring Tests

Description	CPT	LOINC
Lab panel	80047, 80048, 80050, 80053, 80069	
Serum potassium (K+)	80051, 84132	2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 29349-8, 32713-0, 39789-3, 39790-1, 41656-0, 51618-7
Serum creatinine (SCr)	82565, 82575	2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 26752-6, 31045-8, 33558-8, 35203-9, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4, 39955-0, 39956-8, 39957-6, 39958-4, 39959-2, 39960-0, 39961-8, 39962-6, 39963-4, 39964-2, 39965-9, 39966-7, 39967-5, 39968-3, 39969-1, 39970-9, 39971-7, 39972-5, 39973-3, 39974-1, 39975-8, 39976-6, 40112-5, 40113-3, 40114-1, 40115-8, 40116-6, 40117-4, 40118-2, 40119-0, 40120-8, 40121-6, 40122-4, 40123-2, 40124-0, 40125-7, 40126-5, 40127-3, 40128-1, 40248-7, 40249-5, 40250-3, 40251-1, 40252-9, 40253-7, 40254-5, 40255-2, 40256-0, 40257-8, 40258-6, 40264-4, 40265-1, 40266-9, 40267-7, 40268-5, 40269-3, 40270-1, 40271-9, 40272-7, 40273-5, 44784-7, 50380-5, 50381-3, 51619-5, 51620-3, 59826-8, 59834-2, 62425-4
Blood urea nitrogen (BUN)	84520, 84525	3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 44734-2, 49071-4, 59570-2

Rate 2: Annual Monitoring for Medicaid Enrollees on digoxin

Additional eligible population criteria

Medicaid enrollees who received at least 180 treatment days of digoxin (Table 22.3) during the measurement year.

Table 22.3. Drugs to Identify Medicaid Enrollees on Digoxin

Description	Prescription
Inotropic agents	Digoxin

Numerator

At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table 22.2). The enrollee must meet one of the following criteria to be compliant:

- A code for a lab panel test during the measurement year

- A code for a serum potassium and a code for serum creatinine during the measurement year
- A code for serum potassium and a code for blood urea nitrogen during the measurement year

The two tests do not need to occur on the same service date, only within the measurement year.

Rate 3: Annual Monitoring for Medicaid Enrollees on Diuretics

Additional eligible population criteria

Medicaid enrollees who received at least 180 treatment days of a diuretic (Table 22.4), during the measurement year.

Medicaid enrollees may switch therapy with any medication listed in Table 22.4 during the measurement year and have the days supply for those medications count toward the total 180 treatment days.

Table 22.4. Drugs to Identify Medicaid Enrollees on Diuretics

Description	Prescription		
Antihypertensive combinations	Aliskiren-hydrochlorothiazide Aliskiren-hydrochlorothiazide-amlodipine Amiloride-hydrochlorothiazide Amlodipine-hydrochlorothiazide-olmesartan Amlodipine-hydrochlorothiazide-valsartan Atenolol-chlorthalidone Benazepril-hydrochlorothiazide Bendroflumethiazide-nadolol Bisoprolol-hydrochlorothiazide Candesartan-hydrochlorothiazide Captopril-hydrochlorothiazide Chlorthalidone-clonidine Enalapril-hydrochlorothiazide Eprosartan-hydrochlorothiazide		Fosinopril-hydrochlorothiazide Hydrochlorothiazide-irbesartan Hydrochlorothiazide-lisinopril Hydrochlorothiazide-losartan Hydrochlorothiazide-methyldopa Hydrochlorothiazide-metoprolol Hydrochlorothiazide-moexipril Hydrochlorothiazide-olmesartan Hydrochlorothiazide-propranolol Hydrochlorothiazide-quinapril Hydrochlorothiazide-spironolactone Hydrochlorothiazide-telmisartan Hydrochlorothiazide-triamterene Hydrochlorothiazide-valsartan
Loop diuretics	Bumetanide Ethacrynic acid		Furosemide Torsemide
Potassium-sparing diuretics	Amiloride Eplerenone		Spironolactone Triamterene
Thiazide diuretics	Chlorothiazide Chlorthalidone	Hydrochlorothiazide Indapamide	Methyclothiazide Metolazone

Numerator

At least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year (Table 22.2). The enrollee must meet one of the following criteria to be compliant:

- A code for a lab panel test during the measurement year
- A code for a serum potassium and a code for serum creatinine during the measurement year

- A code for serum potassium and a code for blood urea nitrogen during the measurement year

The two tests do not need to occur on the same service date, only within the measurement year.

Rate 4: Annual Monitoring for Medicaid Enrollees on Anticonvulsants

Additional eligible population criteria

Enrollees who received at least 180 treatment days for an anticonvulsant (Table 22.5) during the measurement year.

Enrollees who are on multiple anticonvulsant drugs count toward the denominator multiple times if they meet the persistent medications criteria for each drug taken during the measurement year (i.e., a member who received at least 180 days of phenytoin and 180 days of valproic acid is counted twice in the denominator for Rate 4, once for each drug).

Table 22.5. Drugs to Identify Adults on Anticonvulsants

Description	Drugs	
Barbiturate anticonvulsants	Phenobarbital	
Dibenzazepine anticonvulsants	Carbamazepine	
Hydantoin anticonvulsants	Phenytoin	
Miscellaneous anticonvulsants	Divalproex sodium	Valproic acid

Numerator

At least one drug serum concentration level monitoring test for the prescribed drug in the measurement year (Table 22.6).

If an enrollee received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication (i.e., an enrollee on phenytoin received a drug serum test for phenytoin).

If an enrollee persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., an enrollee on both phenytoin and valproic acid with at least 180 treatment days for each drug in the measurement year must separately show evidence of receiving drug serum concentration tests for each drug (Table 22.6) to be considered numerator-compliant for each drug).

Table 22.6. Codes to Identify Drug Serum Concentration Monitoring Tests

Description	CPT	LOINC
Drug serum concentration for Phenobarbital	80184	3948-7, 3951-1, 10547-8, 14874-2, 34365-7, 60468-6
Drug serum concentration for phenytoin	80185, 80186	3968-5, 3969-3, 14877-5, 32109-1, 40460-8, 65361-8
Drug serum concentration for valproic acid or divalproex sodium	80164	4086-5, 4087-3, 4088-1, 14946-8, 18489-5, 21590-5, 32119-0, 32283-4
Drug serum concentration for carbamazepine	80156, 80157	3432-2, 3433-0, 9415-1, 14056-6, 14639-9, 18270-9, 29147-6, 29148-4, 32058-0, 32852-6, 47097-1

Exclusions (optional)

Exclude enrollees from each eligible population rate who had an inpatient (acute or nonacute) claim/ encounter during the measurement year.

Measure 23: CAHPS Health Plan Survey 5.0H – Adult Questionnaire

Agency for Healthcare Research and Quality,
National Committee for Quality Assurance

A. DESCRIPTION

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey provides information on Medicaid enrollees' experiences with their health care and gives a general indication of how well the health care meets their expectations. Results summarize Medicaid enrollees' experiences through ratings, composites, and question summary rates.

Four global rating questions reflect overall satisfaction:

- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

Five composite scores summarize responses in key areas:

- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Shared Decision Making

Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

- Health Promotion and Education
- Coordination of Care

Guidance for Reporting:

- This measure applies to Medicaid enrollees age 18 and older. For purposes of Medicaid Adult Core Set reporting, states should calculate survey results for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- The survey should be conducted by a third-party vendor certified by NCQA according to the HEDIS protocol. A current listing of NCQA-certified HEDIS 5.0H survey vendors is available at http://www.ncqa.org/HEDISQualityMeasurement/NCQASurveyorsVendorsAuditors/HEDISSurveyVendorCertification/CAHPS50HSurvey.aspx.
- See Appendix B for additional guidance on conducting the CAHPS Survey. See Appendix C for the CAHPS 5.0H Adult Questionnaire.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than 1-month gap in coverage.
Current enrollment	Currently enrolled at the time the survey is completed.

C. ADDITIONAL NOTES

To conduct the CAHPS survey, states must contract with an NCQA Certified HEDIS Survey Vendor to administer HEDIS survey(s):

- Ascertain from the survey vendor the date when the sample frame is due. Dates are based on many factors, including the length of the survey protocol, the due date for member-level data file submission and the time needed to draw the random sample and generate the final member-level data file
- Generate a complete, unbiased sample frame that represents the reporting entity for each survey sample. A state that outsources sample frame generation to a survey vendor must provide the vendor with a membership file containing its entire population and, when necessary, claims and encounters data, from which the vendor generates the sample frame prior to sampling

NCQA Certified HEDIS Survey Vendors must:

- Follow the sampling protocols contained in HEDIS Volume 3
- Administer HEDIS surveys according to the data collection protocols

Sample Size

The survey vendor will work with the state to determine the number of enrollees to be surveyed in order to yield 411 completed surveys, and at least 100 valid responses on each question. The sample size will depend on prior survey experience. See Appendix B for additional guidance on determining the sample size.

Measure 24: Care Transition – Transition Record Transmitted to Health Care Professional

American Medical Association-Physician Consortium for Performance Improvement

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

Guidance for Reporting:

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

B. DEFINITIONS

Transition Record	A core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.
Transmitted	Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).
Primary Physician or Other Health Care Professional Designated for Follow-Up Care	May be designated primary care physician (PCP), medical specialist, or other physician or health care professional.

C. ADMINISTRATIVE SPECIFICATION

Denominator

All patients age 18 and older as of December 30 of the measurement year, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self care or any other site of care.

Identify patients discharged from inpatient facility using the following:

UB-04 (Form Locator 04 - Type of Bill):

0111 (Hospital, Inpatient, Admit through Discharge Claim)
0121 (Hospital, Inpatient - Medicare Part B only, Admit through Discharge Claim)
0114 (Hospital, Inpatient, Last Claim)
0124 (Hospital, Inpatient - Medicare Part B only, Interim-Last Claim)
0211 (Skilled Nursing-Inpatient, Admit through Discharge Claim)
0214 (Skilled Nursing-Inpatient, Interim, Last Claim)
0221 (Skilled Nursing-Inpatient, Medicare Part B only, Admit through Discharge Claim)
0224 (Skilled Nursing- Interim, Last Claim)

0281 (Skilled Nursing-Swing Beds, Admit through Discharge Claim)
0284 (Skilled Nursing-Swing Beds, Interim, Last Claim)

AND

Discharge Status (Form Locator 17):
01 (Discharged to home care or self care (routine discharge)
02 (Discharged/transferred to a short term general hospital for inpatient care)
03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
04 (Discharged/transferred to an intermediate care facility)
05 Discharged/transferred to a designated cancer center or children's hospital
06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)
43 (Discharged/transferred to a federal health care facility)
50 (Hospice – home)
51 (Hospice - medical facility (certified) providing hospice level of care)
61 (Discharged/transferred to hospital-based Medicare approved swing bed)
62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
66 (Discharged/transferred to a Critical Access Hospital (CAH))
70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

OR

UB-04 (Form Locator 04 - Type of Bill):
0131 (Hospital Outpatient, Admit through Discharge Claim)
0134 (Hospital Outpatient, Interim, Last Claim)

AND

UB-04 (Form Locator 42 - Revenue Code):
0762 (Hospital Observation)
0490 (Ambulatory Surgery)
0499 (Other Ambulatory Surgery)

AND

Discharge Status (Form Locator 17):
01 (Discharged to home care or self care (routine discharge)
02 (Discharged/transferred to a short term general hospital for inpatient care)
03 (Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care)
04 (Discharged/transferred to an intermediate care facility)
05 Discharged/transferred to a designated cancer center or children's hospital
06 (Discharged/transferred to home under care of organized home health service org. in anticipation of covered skilled care)
43 (Discharged/transferred to a federal health care facility)
50 (Hospice – home)
51 (Hospice - medical facility (certified) providing hospice level of care)
61 (Discharged/transferred to hospital-based Medicare approved swing bed)

62 (Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital)
63 (Discharged/transferred to a Medicare certified long term care hospital (LTCH))
64 (Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare)
65 (Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital)
66 (Discharged/transferred to a Critical Access Hospital (CAH))
70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list)

Numerator

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

Exclusions:

- Patients who died
- Patients who left against medical advice (AMA) or discontinued care

UB-04 (Form Locator 17 - Discharge Status):
07 – Left against medical advice or discontinued care
20 – Expired
40 – Expired at home
41 – Expired in a medical facility
42 – Expired-place unknown

Measure 25: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of Medicaid enrollees age 18 and older with a new episode of alcohol or other drug (AOD) dependence who received the following. Two rates are reported:

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

Guidance for Reporting:

- In the original HEDIS specification, this measure has two reportable age groups (ages 13 to 17 and age 18 and older). For Medicaid Adult Core Set reporting, the measure should be calculated for Medicaid enrollees age 18 and older. States should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITIONS

Intake Period	January 1 to November 15 of the measurement year. The Intake Period is used to capture new episodes of AOD.
Index Episode	The earliest inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD For ED visits that result in an inpatient stay, the inpatient stay is the Index Episode.
IESD	Index Episode Start Date. The earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or ED encounter during the Intake Period with a diagnosis of AOD. For an outpatient, intensive outpatient, partial hospitalization, detoxification or ED (not resulting in an inpatient stay) claim/encounter, the IESD is the date of service For an inpatient (acute or nonacute) claim/encounter, the IESD is the date of discharge. For an ED visit that results in an inpatient stay, the IESD is the date of the inpatient discharge. For direct transfers, the IESD is the discharge date from the second admission.
Negative Diagnosis History	A period of 60 days (2 months) before the IESD when the patient had no claims/ encounters with a diagnosis of AOD dependence. For an inpatient claim/encounter, use the admission date to determine the Negative Diagnosis History. For ED visits that result in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. For direct transfers, use the first admission to determine the Negative Diagnosis History.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	60 days (2 months) prior to the IESD through 44 days after the IESD (inclusive).
Allowable gap	None.
Anchor date	None.
Benefits	Medical and chemical dependency (inpatient and outpatient). Note: Medicaid enrollees with detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	Follow the steps below to identify the eligible population, which is the denominator for both rates. Step 1: Identify the Index Episode. Identify all Medicaid enrollees in the specified age range who during the Intake Period had one of the following: • An outpatient visit, intensive outpatient encounter or partial hospitalization (Table 25.2) with a diagnosis of AOD (Table 25.1) • A detoxification visit (Table 25.3) • An ED visit (Table 25.4) with a diagnosis of AOD (Table 25.1) • An inpatient discharge with a diagnosis of AOD as identified by either of the following: - An inpatient facility code in conjunction with a diagnosis of AOD (Table 25.1) - An inpatient facility code in conjunction with an AOD procedure code (Table 25.5) For Medicaid enrollees with more than one episode of AOD, use the first episode. For Medicaid enrollees whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge. Select the IESD. Step 2: Test for Negative Diagnosis History. Exclude Medicaid enrollees who had a claim/encounter with a diagnosis of AOD (Table 25.1) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service to determine the Negative Diagnosis History. Step 3: Calculate continuous enrollment. Medicaid enrollees must be continuously enrolled without any gaps 60 days (2 months) before the IESD through 44 days after the IESD.

Table 25.1. Codes to Identify AOD Dependence

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

Table 25.2. Codes to Identify Outpatient, Intensive Outpatient and Partial Hospitalization Visits

CPT	HCPCS	UB Revenue
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983

CPT		POS
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72
90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53

Table 25.3. Codes to Identify Detoxification Visits

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

Table 25.4. Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

Table 25.5. Codes to Identify AOD Procedures

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

Rate 1: Initiation of AOD Treatment

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

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

If the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification or ED visit, the Medicaid enrollee must have had an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization (Table 25.2) with an AOD diagnosis (Table 25.1) within 14 days of the IESD (inclusive).

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

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

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

Rate 2: Engagement of AOD Treatment

Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations (Table 25.2) with any AOD diagnosis (Table 25.1) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

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

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

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

Measure 26: Postpartum Care Rate

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a postpartum visit on or between 21 and 56 days after delivery.

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled females that meet the measurement eligibility criteria.
- Include all paid, suspended, pending, reversed, and denied claims.

B. DEFINITIONS

Pre-Term	A neonate whose birth occurs through the end of the last day of the 37th week (259th day) following the onset of the last menstrual period.
Post-Term	A neonate whose birth occurs from the beginning of the first day of the 43rd week (295th day) following the onset of the last menstrual period.
Start Date of the Last Enrollment Segment	For women with a gap in enrollment during pregnancy, the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date.

C. ELIGIBLE POPULATION

Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Event/diagnosis	Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in a birthing center. Refer to Tables 26.1 and 26.2 for codes to identify live births. Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Follow the first two steps below to identify the eligible population.

Step 1

Identify live births covered by Medicaid or CHIP. Use Method A and Method B below to identify all women with a live birth between November 6 of the year prior to the measurement year and November 5 of the measurement year. States must use both methods to identify the eligible population, but a woman only needs to be identified by one to be included in the measure.

Method A:

Codes listed in Table 26.1 identify a delivery and indicate the outcome of the delivery was a live birth. Women who are identified through the codes listed in Method A are automatically included in the eligible population and require no further verification of the outcome.

Table 26.1. Codes to Identify Live Births

Description	ICD-9-CM Diagnosis
Identify live births	650, V27.0, V27.2, V27.3, V27.5, V27.6, V30-V37[a], V39[a]

[a]These codes are assigned to the infant and should only be used if the state can link infant and mother records.

Method B:

Identify deliveries and verify live births. Codes in Table 26.2, Step A, identify deliveries but do not indicate the outcome. States must use Step B to eliminate deliveries that did not result in a live birth.

Table 26.2. Codes to Identify Deliveries and Verify Live Births

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Step A: Identify deliveries	59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.x1, 646.x1, 646.x2, 647.x1, 647.x2, 648.x1, 648.x2, 649.x1, 649.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.x2, 655.x1, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.x1, 665.x2, 666.x2, 667.x2, 668.x1, 668.x2, 669.x1, 669.x2, 670.02, 671.x1, 671.x2, 672.02, 673.x1, 673.x2, 674.x1, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2, 678.x1, 679.x1, 679.x2	72.0-73.99, 74.0-74.2, 74.4, 74.99
Step B: Exclude deliveries not resulting in a live birth		630-637, 639, 656.4, 768.0, 768.1, V27.1, V27.4, V27.7	

Step 2

Identify continuous enrollment. For women identified in step 1, determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

Numerator

Postpartum Care

A postpartum visit (Table 26.3) for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

The practitioner requirement only applies to the Hybrid Specification. The enrollee is compliant if any code from Table 26.3 is submitted.

Table 26.3. Codes to Identify Postpartum Visits

CPT	CPT Category II	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB Revenue	LOINC
57170, 58300, 59400*, 59410*, 59430, 59510*, 59515*, 59610*, 59614*, 59618*, 59622*, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175, 99501	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Note: Generally, these codes are used on the date of delivery, not on the date of the postpartum visit, so this code may be used only if the claim form indicates when postpartum care was rendered.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Numerator

Postpartum Care

A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery, as documented through either administrative data or medical record review.

Administrative

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

Medical record

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

- Pelvic exam, or
- Evaluation of weight, BP, breasts and abdomen, or
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component
- Notation of postpartum care, including, but not limited to:

- Notation of “postpartum care,” “PP care,” “PP check,” “6-week check”
- A preprinted “Postpartum Care” form in which information was documented during the visit

F. ADDITIONAL NOTES

When counting postpartum visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses if a physician cosignature is present, if required by state law.

Services that occur over multiple visits count toward this measure as long as all services are within the time frame established in the measure. Ultrasound and lab results alone should not be considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.

A Pap test alone is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for the rate.

The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.

Appendix A

Additional Information on Risk Adjustment Weighting for the Plan All-Cause Readmission Rate

This appendix provides additional information on risk adjustment weighting for the Plan All-Cause Readmission Rate. This measure requires risk adjustment. However, this measure does not currently have a risk adjustor for the Medicaid population. The methods described in this appendix apply to the Medicare and commercial populations. States choosing to report this measure should describe the risk adjustment methods they use to calculate the measure for the Medicaid population.

A. RISK ADJUSTMENT TABLES

Risk adjustment tables for Medicare and commercial populations are posted at http://www.ncqa.org. The specifications below refer to these tables. There are no standardized risk adjustment tables for the Medicaid population.

Table	Description
HCC-Surg	Surgery codes for Risk Adjustment Determination
PCR-DischCC	Discharge Clinical Condition category codes for Risk Adjustment Determination
CC-Comorbid	Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2
HCC –Rank	HCC rankings for Risk Adjustment Determination step 3
HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5
PCR-MA-DischCC-Weight-Under65	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages under 65
PCR-MA-DischCC-Weight-65plus	MA and SNP primary discharge weights for Risk Adjustment Weighting step 2 for ages 65 and older
PCR-Comm-DischCC-Weight	Commercial primary discharge weights for Risk Adjustment Weighting step 2
PCR-MA-ComorbHCC-Weight-Under65	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages under 65
PCR-MA-ComorbHCC-Weight-65plus	MA and SNP comorbidity weights for Risk Adjustment Weighting step 3 for ages 65 and older
PCR-Comm-ComorbHCC-Weight	Commercial comorbidity weights for Risk Adjustment Weighting step 3
PCR-MA-OtherWeights-Under65	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages under 65
PCR-MA-OtherWeights-65plus	MA and SNP base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5 for ages 65 and older
PCR-Comm-OtherWeights	Commercial base risk, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 4, 5

B. RISK ADJUSTMENT DETERMINATION

For each IHS, use the following steps to identify risk adjustment categories based on presence of surgeries, discharge condition, comorbidity, age, and gender.

Surgeries - Determine if the enrollee underwent surgery during the inpatient stay. Download the list of codes from the NCQA Web site (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-Surg is present from any provider between the admission and discharge dates.

Discharge Condition - Assign a discharge Clinical Condition (CC) category code to the IHS based on its primary discharge diagnosis, using Table DischCC. For acute-to-acute transfers, use the transfer's primary discharge diagnosis.

Exclude diagnoses that cannot be mapped to Table DischCC.

Comorbidities

Step 1

Identify all diagnoses for face-to-face encounters (Table A.1) during the classification period. Exclude the primary discharge diagnosis on the IHS.

Table A.1. Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	92002, 92004, 92012, 92014, 98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1001, 1002
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Step 2

Assign each diagnosis to one comorbid Clinical Condition (CC) category using Table CC—Comorbid.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3

Determine HCCs for each comorbid CC identified. Refer to Table HCC—Rank.

For each stay's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group
- The rank
- The HCC

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4

Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the Rank column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example

Assume a stay with the following comorbid CCs: CC-15, CC-19 and CC-80 (assume no other CCs).

- CC-80 does not have a map to the ranking table and becomes HCC-80
- HCC-15 is part of Ranking Group 1 and HCC-19 is part of Ranking Groups Diabetes 1–Diabetes 4. Because CC-15 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-15 for Ranking Group 1. Because CC-19 is ranked higher in Ranking Groups Diabetes 2–4, the comorbidity is assigned as HCC-19 for these ranking groups
- The final comorbidities for this discharge include HCC-15, HCC-19 and HCC-80

Example: Table HCC – Rank

Ranking Group	CC	Description	Rank	HCC
NA	CC-80	Congestive Heart Failure	NA	HCC-80
Diabetes 1	CC-15	Diabetes With Renal or Peripheral Circulatory Manifestation	1	HCC-15
	CC-16	Diabetes With Neurologic or Other Specified Manifestation	2	HCC-16
	CC-17	Diabetes With Acute Complications	3	HCC-17
	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	4	HCC-18
	CC-19	Diabetes Without Complications	5	HCC-19
Diabetes 2	CC-16	Diabetes With Neurologic or Other Specified Manifestation	1	HCC-16
	CC-17	Diabetes With Acute Complications	2	HCC-17
	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	3	HCC-18
	CC-19	Diabetes Without Complication	4	HCC-19
Diabetes 3	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	2	HCC-18
	CC-19	Diabetes Without Complication	3	HCC-19
Diabetes 4	CC-18	Diabetes With Ophthalmologic or Unspecified Manifestation	1	HCC-18
	CC-19	Diabetes Without Complication	2	HCC-19

Step 5

Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each stay's list of unique HCCs to those in the HCC column in Table HCC—Comb and assign any additional HCC conditions.

For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/CHF/renal combination), use only the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.

For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHR/ renal/diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted.

Based on the combinations, an enrollee can have none, one or more of these added HCCs.

Example

For a stay with comorbidities HCC-15, HCC-19 and HCC-80 (assume no other HCCs), assign HCC-901 in addition to HCC-15, HCC-19 and HCC-80. This does not replace HCC-15, HCC-19 or HCC-80.

Example: Table HCC – Comb

Combination: Diabetes and CHF			
Comorbid HCC	Comorbid HCC	Comorbid HCC	Combination HCC
HCC-15	HCC-80	NA	HCC-901
HCC-16	HCC-80	NA	HCC-901
HCC-17	HCC-80	NA	HCC-901
HCC-18	HCC-80	NA	HCC-901
HCC-19	HCC-80	NA	HCC-901

Risk Adjustment Weighting

For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age, and gender.

Note: The final weights table for commercial and Medicare reporting are available on NCQA's web site. There are no weights tables for Medicaid.

Step 1

For each IHS with a surgery, link the surgery weight.

- For ages 18 – 64: Use Table OtherWeights-Under65
- For age 65 and older: Use Table OtherWeights-65plus

Step 2

For each IHS with a discharge CC Category, link the primary discharge weights.

- For ages 18 – 64 : Use Table DischCC-Weight-Under65
- For age 65 and older: Use Table DischCC-Weight-65plus

Step 3

For each IHS with a comorbidity HCC Category, link the weights.

- For ages 18 – 64: Use Table ComorbHCC-Weight-Under65
- For age 65 and older: Use Table ComorbHCC-Weight-65plus

Step 4

Link the age and gender weights for each IHS.

- For ages 18 – 64: Use Table OtherWeights-Under65
- For age 65 and older: Use Table OtherWeights-65plus

Step 5

Identify the base risk weight.

- For ages 18 – 64: Use Table OtherWeights-Under65
- For age 65 and older: Use Table OtherWeights-65plus

Step 6

Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight).

Step 7

Use the formula below to calculate the adjusted probability of a readmission based on the sum of the weights for each IHS.

Adjusted probability of readmission = $\frac{e(\sum WeightsforIHS)}{1+e(\sum WeightsforIHS)}$

OR

Adjusted probability of readmission = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)]

Note: “Exp” refers to the exponential or antilog function.

Step 8

Use the formula below and the adjusted probability of readmission calculated in step 7 to calculate the variance for each IHS.

Variance = Adjusted probability of readmission x (1 – Adjusted probability of readmission)

Example: If the adjusted probability of readmission is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476.

Note: The variance is calculated at the IHS level. States must sum the variances for each age/gender and total category when populating the Total Variance cells in the reporting tables.

Sample Table: PCR—Risk Adjustment Weighting

Member ID[a]	Admiss. Counter	Base Risk Wt	Age	Gender	Age and Gender Wt.	Surgical Wt.	ICD-9-CM Diagnosis Code	Discharge CC		HCC-PCR		Sum of Weights	Adjusted Probability	Variance
								Category	Wt	Category	Wt			
1250	1	-1.08883	67	Female	0.1000	-0.2800	250.4	15	0.0700	20 25	0.1400 0.2000	-0.8600	0.2976	0.2090
4010	1	-1.08883	50.00	Male	0.1200	NA	007.4	5	0.0300	NA	NA	-0.9400	0.2811	0.2021
4010	2	-1.08883	50.00	Male	0.1200	NA	298.00	77	0.0600	5 47	0.0100 0.3300	-0.5700	0.3615	0.2308

[a]Each Member ID field with a value represents a unique IHS.

Appendix B

Guidance for Conducting the Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H (Medicaid)

Assessing patient experiences with health care is an important dimension of the quality of care. The Medicaid Adult Core Set includes a measure of experiences with health care based on the CAHPS® Survey.[2] This appendix provides additional guidance to states in carrying out CAHPS data collection, including selecting the survey instrument, contracting with a survey vendor, generating a sample frame, and conducting the survey using standard protocols.

Version of CAHPS for Initial Core Set Reporting

CAHPS is a family of surveys designed to assess consumer experiences with care. Different versions of the survey are available for use among various populations, payers, and settings. The version of the CAHPS Survey specified in Medicaid Adult Core Set is the CAHPS Health Plan Survey 5.0H (Medicaid). Appendix C contains the survey instrument.

Contracting with a Survey Vendor

In order to adhere to CAHPS 5.0H measure specifications, states must create a sample frame and contract with a National Committee for Quality Assurance (NCQA) certified HEDIS survey vendor that will administer the survey according to HEDIS protocols. The survey vendor draws the actual samples, fields the survey, and, if required, coordinates with other survey vendors to ensure samples are deduplicated and to combine results files.

- NCQA maintains a list of survey vendors that have been trained and certified by NCQA to administer the CAHPS 5.0H survey. Each survey vendor is assigned a maximum capacity of samples. The capacity reflects the firm's and NCQA's projection of resources available to be dedicated to administer the survey. A current listing of NCQA-certified HEDIS survey vendors is available at: http://www.ncqa.org/Portals/0/HEDISQM/Programs/SVC/2013%20HEDIS_CAHPS_Vendor_Web_List_12.20.12.pdf.

Generating a Sample Frame

States are responsible for generating a complete, accurate, and valid sample frame data file that is representative of the entire eligible population (Table B.1). If states choose to have their sample frame validated, they should arrange for an auditor to verify the integrity of the sample frame before the survey vendor draws the sample and administers the survey.

[2] CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table B.1. Eligible Population for Adult CAHPS 5.0H (Medicaid)

Ages	18 years and older as of December 31 of the measurement year
Continuous enrollment	The last six months of the measurement year
Allowable gap	For a Medicaid enrollee in a state where enrollment is verified monthly, the enrollee may not have more than a one-month gap in coverage (the enrollee must be enrolled for five of the last six months of the measurement year) For a Medicaid enrollee in a state where enrollment is verified daily, the enrollee may have no more than one gap in enrollment of up to 45 days during the last six months of the measurement year
Current enrollment	Currently enrolled at the time the survey is completed

Source: HEDIS 2013 Volume 3: Specifications for Survey Measures (http://www.ncqa.org/tabid/78/Default.aspx).

To enable the survey vendor to generate the random sample, states must generate a sample frame data file for each survey to be fielded. States are strongly encouraged to generate sample frames after eliminating disenrolled and deceased enrollees and updating eligibility files with address and telephone number corrections. When sampling, keep the following in mind:

- If each managed care plan carries out its own CAHPS survey, a separate sample frame must be generated for each plan.
- If a state has adults enrolled in multiple delivery systems (managed care, primary care case management, and/or fee for service), the sample frame(s) should be representative of all adults covered by the entire program. A state may generate one statewide sample frame that includes adults in all delivery systems or separate sample frames for each delivery system. The sample frame(s) should represent all adults that meet the eligibility criteria specified in Table B.1.

Drawing a Sample

The required sample size is 1,650 adults (Table B.2). A state should instruct its survey vendor to oversample if it has a prior history of low survey response rates, if it anticipates that a significant number of addresses or telephone numbers in the enrollment files are inaccurate, if it cannot eliminate disenrolled adults from eligibility files, or if it does not expect to achieve a denominator of 100 for most survey calculations. The required sample size is based on the average number of complete and valid surveys obtained by health plans during prior years; therefore, using the required sample size for a given survey does not guarantee that a state will achieve the goal of 411 completed surveys or the required denominator of 100 complete responses for each survey result. The state should work with its survey vendor to determine the number of complete and valid surveys it can expect to obtain without oversampling based on prior experience.

If its prior response rates or the number of completed surveys is expected to fall below the 411 completed surveys required, the survey vendor should oversample, in increments of 5 percent, to achieve the goal of 411 completed surveys. For example, if the vendor increases the sample by 5 percent, the final sample size would be 1,733. If the vendor increases the sample by 20 percent, the final sample size would be 1,980. Table B.2 displays final sample sizes at various oversampling rates. The survey vendor should work with the state to determine an appropriate sampling strategy. For a detailed discussion of oversampling, see “HEDIS 2013 Volume 3:

Specifications for Survey Measures," Appendix 7, "General Recommendations for Oversampling Survey Measures" (http://www.ncqa.org/tabid/78/Default.aspx).

Table B.2. Oversampling Rates and Final Sample Sizes for the CAHPS 5.0H Adult Survey

Sample	Required Sample Size	Oversampling Rate and Final Sample Size					
		5%	10%	15%	20%	25%	30%
CAHPS 5.0H Adult Sample	1,650	1,733	1,815	1,898	1,980	2,063	2,145

Source: Tables S-4 and CCC-5 in HEDIS 2013 Volume 3: Specifications for Survey Measures (http://www.ncqa.org/tabid/78/Default.aspx).

Deduplication

To reduce respondent burden, the survey vendor should deduplicate samples so that only one adult per household is included in the sample. If a survey is being collected and reported more than once for a given sample frame (for example, if a state is sponsoring a statewide survey and a managed care plan is also conducting its own survey), survey vendors may collaborate to deduplicate samples. With the approval of the state and other survey sponsor(s), vendors may do the following:

- One survey vendor may draw two deduplicated random samples and provide another survey vendor with one sample.
- One survey vendor may share the list of sampled adults with another survey vendor. The second survey vendor excludes these adults (as well as all other members of the household) from the sample frame before drawing the second random sample.

Survey Administration

The sampling and data collection procedures that the survey vendors have been trained and certified to carry out promote both the standardized administration of the survey instruments by different survey vendors and the comparability of resulting data. For results to comply with CAHPS 5.0H survey specifications, the state's survey vendor must follow one of the standard CAHPS 5.0H survey protocols. The state will have to work with its survey vendor to select one of two standard options for administering CAHPS 5.0H surveys:

1. The **mail-only methodology,** a three-wave mail protocol with three questionnaire mailings (81 days)
2. The **mixed methodology,** a two-wave mail protocol (two questionnaires) with telephone follow-up of at least three telephone attempts (70 days)

The basic tasks and time frames for the two protocol options are detailed in Tables B.3 and B.4. Regardless of the approach selected, the survey vendor is expected to maximize the final survey response rate and to pursue contacts with potential respondents until completing the selected data collection protocol. Achieving the targeted number of completed surveys does not justify ceasing the survey protocol.

Neither the state nor the survey vendor may offer incentives of any kind for completion of the survey. The vendor is expected to maintain the confidentiality of randomly sampled adults.

Table B.3. Survey Vendor Tasks and Time Frames for the Mail-Only Methodology

Vendor Tasks	Time Frame (Days)
Send first questionnaire and cover letter to the surveyed adult	0
Send a postcard reminder to nonrespondents 4–10 days after mailing the first questionnaire	4–10
Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire	35
Send a second postcard reminder to nonrespondents 4–10 days after mailing the second questionnaire	39–45
Send a third questionnaire and third cover letter to nonrespondents approximately 25 days after mailing the second questionnaire	60
Allow at least 21 days for the respondent to return the third questionnaire	81

Source: HEDIS 2013 Volume 3: Specifications for Survey Measures.

Table B.4. Survey Vendor Tasks and Time Frames for the Mixed Methodology

Vendor Tasks	Time Frame (Days)
Send first questionnaire and cover letter to the surveyed adult	0
Send a postcard reminder to nonrespondents 4–10 days after mailing the first questionnaire	4–10
Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire	35
Send a second postcard reminder to nonrespondents 4–10 days after mailing the second questionnaire	39–45
Initiate computer-assisted telephone interviews (CATI) for nonrespondents approximately 21 days after mailing the second questionnaire	56
Initiate systematic contact for all nonrespondents so that at least 3 telephone calls are attempted at different times of the day, on different days of the week, and in different weeks	56–70
Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all nonrespondents) approximately 14 days after initiation	70

Source: HEDIS 2013 Volume 3: Specifications for Survey Measures.

For Further Information

Information about the CAHPS family of surveys and the CAHPS Database is available at http://www.cahps.ahrq.gov/.

Information about the NCQA's HEDIS Survey Vendor Certification program can be found at http://www.ncqa.org/tabid/170/Default.aspx.

Information on "HEDIS 2012 Volume 3: Specifications for Survey Measures" is available at http://www.ncqa.org/tabid/78/Default.aspx.

Appendix C

CAHPS® 5.0H Adult Questionnaire (Medicaid)

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☑ Yes ➔If Yes, Go to Question 1

☐ No

{This box should be placed on the Cover Page}

Your privacy is protected. All information that would let someone identify you or your family will be kept private. {SURVEY VENDOR NAME} will not share your personal information with anyone without your OK. You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get.

You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call {SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

1. Our records show that you are now in {INSERT HEALTH PLAN NAME/ STATE MEDICAID PROGRAM NAME}. Is that right?

   [1] ☐ Yes →If Yes, Go to Question 3

   [2] ☐ No

2. What is the name of your health plan? (Please print)

   _____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

   [1] ☐ Yes

   [2] ☐ No →If No, Go to Question 5

4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

   [1] ☐ Never

   [2] ☐ Sometimes

   [3] ☐ Usually

   [4] ☐ Always

5. In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

   [1] ☐ Yes

   [2] ☐ No →If No, Go to Question 7

6. In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

   [1] ☐ Never

   [2] ☐ Sometimes

   [3] ☐ Usually

   [4] ☐ Always

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

   [0] ☐ None → If None, Go to Question 15

   [1] ☐ 1 time

   [2] ☐ 2

   [3] ☐ 3

   [4] ☐ 4

   [5] ☐ 5 to 9

   [6] ☐ 10 or more times

8. In the last 6 months, did you and a doctor or other health provider talk about specific things you could do to prevent illness?

   [1] ☐ Yes

   [2] ☐ No

9. In the last 6 months, did you and a doctor or other health provider talk about starting or stopping a prescription medicine?

   [1] ☐ Yes

   [2] ☐ No → If No, Go to Question 13

10. When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might want to take a medicine?

    [1] ☐ Not at all

    [2] ☐ A little

    [3] ☐ Some

    [4] ☐ A lot

11. When you talked about starting or stopping a prescription medicine, how much did a doctor or other health provider talk about the reasons you might not want to take a medicine?

    [1] ☐ Not at all

    [2] ☐ A little

    [3] ☐ Some

    [4] ☐ A lot

12. When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

    [1] ☐ Yes

    [2] ☐ No

13. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

    [00] ☐ 0 Worst health care possible

    [01] ☐ 1

    [02] ☐ 2

    [03] ☐ 3

    [04] ☐ 4

    [05] ☐ 5

    [06] ☐ 6

    [07] ☐ 7

    [08] ☐ 8

    [09] ☐ 9

    [10] ☐ 10 Best health care possible

14. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

YOUR PERSONAL DOCTOR

15. A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

    1☐ Yes

    2☐ No→If No, go to question 24

16. In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

    0☐ None → If None, go to question 23

    1☐ 1 time

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 to 9

    6☐ 10 or more times

17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

18. In the last 6 months, how often did your personal doctor listen carefully to you?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

19. In the last 6 months, how often did your personal doctor show respect for what you had to say?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

20. In the last 6 months, how often did your personal doctor spend enough time with you?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

21. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

    1☐ Yes

    2☐ No→If No, Go to Question 23

22. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

23. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

    00☐ 0 Worst personal doctor possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best personal doctor possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do not include dental visits or care you got when you stayed overnight in a hospital.

24. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments to see a specialist?

    1☐ Yes

    2☐ No→If No, go to question 28

25. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

26. How many specialists have you seen in the last 6 months?

    0☐ None → If none, go to question 28

    1☐ 1 specialist

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 or more specialists

27. We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

    00☐ 0 Worst specialist possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best specialist possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

28. In the last 6 months, did you look for any information in written materials or on the Internet about how your health plan works?

    1☐ Yes

    2☐ No→If No, Go to Question 30

29. In the last 6 months, how often did the written materials or the Internet provide the information you needed about how your health plan works?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

30. In the last 6 months, did you get information or help from your health plan's customer service?

    1☐ Yes

    2☐ No→If No, Go to Question 33

31. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

32. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

33. In the last 6 months, did your health plan give you any forms to fill out?

    1☐ Yes

    2☐ No→If No, Go to Question 35

34. In the last 6 months, how often were the forms from your health plan easy to fill out?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

35. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

    00☐ 0 Worst health plan possible
    01☐ 1
    02☐ 2
    03☐ 3
    04☐ 4
    05☐ 5
    06☐ 6
    07☐ 7
    08☐ 8
    09☐ 9
    10☐ 10 Best health plan possible

ABOUT YOU

36. In general, how would you rate your overall health?

    1☐ Excellent
    2☐ Very good
    3☐ Good
    4☐ Fair
    4☐ Poor

37. In general, how would you rate your overall mental or emotional health?

    1☐ Excellent
    2☐ Very good
    3☐ Good
    4☐ Fair
    4☐ Poor

38. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

    1☐ Every day
    2☐ Some days
    3☐ Not at all → If Not at all, go to question 42
    4☐ Don't know → If Don't know, go to question 42

39. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

    1☐ Never
    2☐ Sometimes
    3☐ Usually
    4☐ Always

40. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

    [1] ☐ Never

    [2] ☐ Sometimes

    [3] ☐ Usually

    [4] ☐ Always

41. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

    [1] ☐ Never

    [2] ☐ Sometimes

    [3] ☐ Usually

    [4] ☐ Always

42. Do you take aspirin daily or every other day?

    [1] ☐ Yes

    [2] ☐ No

    [3] ☐ Don't know

43. Do you have a health problem or take medication that makes taking aspirin unsafe for you?

    [1] ☐ Yes

    [2] ☐ No

    [3] ☐ Don't know

44. Has a doctor or health provider ever discussed with you the risks and benefits of aspirin to prevent heart attack or stroke?

    [1] ☐ Yes

    [2] ☐ No

45. Are you aware that you have any of the following conditions? Mark one or more.

    [a] ☐ High cholesterol

    [b] ☐ High blood pressure

    [c] ☐ Parent or sibling with heart attack before the age of 60

46. Has a doctor ever told you that you have any of the following conditions? Mark one or more.

    [a] ☐ A heart attack

    [b] ☐ Angina or coronary heart disease

    [c] ☐ A stroke

    [d] ☐ Any kind of diabetes or high blood sugar

47. In the last 6 months, did you get health care 3 or more times for the same condition or problem?

    [1] ☐ Yes

    [2] ☐ No→If No, Go to Question 49

48. Is this a condition or problem that has lasted for at least 3 months? Do not include pregnancy or menopause.

    [1] ☐ Yes

    [2] ☐ No

49. Do you now need or take medicine prescribed by a doctor? Do not include birth control.

    1☐ Yes

    2☐ No→If No, Go to Question 51

50. Is this medicine to treat a condition that has lasted for at least 3 months? Do not include pregnancy or menopause.

    1☐ Yes

    2☐ No

51. What is your age?

    1☐ 18-24

    2☐ 25-34

    3☐ 35-44

    4☐ 45-54

    5☐ 55-64

    6☐ 65-74

    7☐ 75 or older

52. Are you male or female?

    1☐ Male

    2☐ Female

53. What is the highest grade or level of school that you have completed?

    1☐ 8th grade or less

    2☐ Some high school, but did not graduate

    3☐ High school graduate or GED

    4☐ Some college or 2-year degree

    5☐ 4-year college graduate

    6☐ More than 4-year college degree

54. Are you of Hispanic or Latino origin or descent?

    1☐ Yes, Hispanic or Latino

    2☐ No, not Hispanic or Latino

55. What is your race? Mark one or more.

    a☐ White

    b☐ Black or African American

    c☐ Asian

    d☐ Native Hawaiian or other Pacific islander

    e☐ American Indian or Alaska Native

    f☐ Other

56. Did someone help you complete this survey?

    [1] ☐ Yes →If No, Go to Question 57

    [2] ☐ No → Thank you. Please return the completed survey in the postage-paid envelope.

57. How did that person help you? Mark one or more.

    [a] ☐ Read the questions to me

    [b] ☐ Wrote down the answers I gave

    [c] ☐ Answered the questions for me

    [d] ☐ Translated the questions into my language

    [e] ☐ Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope