Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set):

Technical Specifications and Resource Manual for Federal Fiscal Year 2013 Reporting

Updated May 2013

Center for Medicaid and CHIP Services

Centers for Medicare & Medicaid Services

For National Committee for Quality Assurance (NCQA) measures in the Child Core Set:

CONTENTS

The “Core Set of Children’s Health Care Quality Measures Technical Specifications and Resource Manual” is for use by states that seek to voluntarily report the core set of quality measures for children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). Although reporting the child core set measures is voluntary, the Centers for Medicare & Medicaid Services (CMS) encourages states to report on as many of the measures as feasible. The more states that collect and report the child core set of measures, the greater the potential for states and others to benefit from this information. CMS is developing data information systems to standardize reporting and make access to quality data more available to states for comparison purposes. States will be able to use these quality data in designing and implementing their quality improvement initiatives.

This manual consists of three chapters. The first chapter provides background information about the child core set of measures. The second chapter provides guidance for collecting, calculating, and reporting the child core set measures. The third chapter includes the technical specifications for each of the measures. To get a full sense of what is needed to report the child core set measures to CMS, states should familiarize themselves with the technical specifications as well as with the process for submitting data to CMS via the CHIP Annual Reporting Template System (CARTS).

I. The Core Set of Children's Health Care Quality Measures

Background

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Pub.L. 111-3) added Section 1139A(a) to the Social Security Act and included broad mandates to strengthen the quality of care for and health outcomes of children in Medicaid and CHIP. Section 401 of CHIPRA called for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish an initial core set of children's health care quality measures for voluntary use by state programs administered under Titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP. The legislation required the HHS Secretary to identify measures applicable to the duration of enrollment and health care coverage, preventive and health promotion services, and the treatment and management of acute and chronic conditions in children. The legislation also called for measures that could be used to assess families' experiences with health care, the availability of services, and care in the most integrated health settings. Ultimately, the goals of the core measure set are to provide a national estimate of the quality of health care for children; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

Information about the initial core set measures can be found in a February 2011 State Health Official letter (http://www.cms.gov/smdl/downloads/SHO11001.pdf). The initial core set included measures of prevention and health promotion services, management of acute and chronic conditions, oral health, and family experiences of care.

CHIPRA, which added Section 1139A (b)(5) of the Social Security Act, required the Secretary to publish recommended changes to the core set measures beginning in January 2013. Three measures were added to the Child Core Set in 2103 and one measure was retired. Additional information on the 2013 Children's Core Set of Health Care Quality measures can be found in a January 2013 State Health Official Letter (http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf).

Child Core Set Measures

The following table provides a general description of each core set measure (including the measure acronym), the measure steward(s), and method/data source. The methods and data sources include administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), electronic health records, and surveys, as noted in the table. The technical specifications in Chapter III of this manual provide additional details for each measure.

Population/Community Health

Acronym	Measure	Measure Steward[a] (Web site)	Description	Method/Data Source
HPV	Human Papillomavirus (HPV) Vaccine for Female Adolescents	National Committee for Quality Assurance (NCQA)/Healthcare Effectiveness Data and Information Set (HEDIS) (http://www.ncqa.org)	Percentage of female adolescents that turned 13 years old during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday	Administrative or hybrid
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender	Administrative or hybrid

Clinical Care

Acronym	Measure	Measure Steward[a] (Web site)	Description	Method/Data Source
CAP	Child and Adolescent Access to Primary Care Practitioners	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children and adolescents ages 12 months to 19 years that had a visit with a PCP, including four separate percentages: Children ages 12 to 24 months and 25 months to 6 years that had a visit with a PCP during the measurement year Children ages 7 to 11 years and adolescents ages 12 to 19 years that had a visit with a PCP during the measurement year or the year prior to the measurement year	Administrative

Acronym	Measure	Measure Steward[a] (Web site)	Description	Method/Data Source
CIS	Childhood Immunization Status	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday	Administrative or hybrid
IMA	Immunization Status for Adolescents	NCQA/HEDIS (http://www.ncqa.org)	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday	Administrative or hybrid
FPC	Frequency of Ongoing Prenatal Care	NCQA/HEDIS (http://www.ncqa.org)	Percentage of deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: < 21 percent of expected visits 21 percent – 40 percent of expected visits 41 percent – 60 percent of expected visits 61 percent – 80 percent of expected visits ≥ 81 percent of expected visits	Administrative or hybrid
PPC	Timeliness of Prenatal Care	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 received a prenatal care visit in the first trimester or within 42 days of enrollment	Administrative or hybrid

Acronym	Measure	Measure Steward[a] (Web site)	Description	Method/Data Source
LBW	Live Births Weighing Less Than 2,500 Grams	Centers for Disease Control and Prevention (CDC) (http://www.cdc.gov/nchs)	Percentage of live births that weighed less than 2,500 grams in the state during the reporting period	State vital records
CSEC	Cesarean Rate for Nulliparous Singleton Vertex	California Maternal Quality Care Collaborative (http://www.cmqcc.org)	Percentage of women that had a cesarean section among women with first live singleton births (also known as nulliparous term singleton vertex [NTSV] births) at 37 weeks of gestation or later	State vital records alone or merged with discharge diagnosis data
BHRA	Behavioral Health Risk Assessment (for Pregnant Women)	American Medical Association (AMA) – Physician Consortium for Performance Improvement (PCPI) (http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement.page)	Percentage of women, regardless of age, that gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence	Electronic health records
DEV	Developmental Screening In the First Three Years of Life	Oregon Health and Science University (http://www.oregon-pip.org/focus/CHIPRA%20Core%20Measures.html)	Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday	Administrative or hybrid
PA1C	Annual Pediatric Hemoglobin A1C Testing	NCQA (http://www.ncqa.org)	Percentage of children ages 5 to 17 with diabetes (type 1 and type 2) that had a Hemoglobin A1c (HbA1c) test during the measurement year	Administrative or hybrid

Acronym	Measure	Measure Steward[a] (Web site)	Description	Method/Data Source
W15	Well-Child Visits in the First 15 Months of Life	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a PCP during their first 15 months of life	Administrative or hybrid
W34	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year	Administrative or hybrid
AWC	Adolescent Well-Care Visit	NCQA/HEDIS (http://www.ncqa.org)	Percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Administrative or hybrid
CHL	Chlamydia Screening in Women	NCQA/HEDIS (http://www.ncqa.org)	Percentage of women ages 16 to 20 that were identified as sexually active and had at least one test for Chlamydia during the measurement year	Administrative
PDENT	Percentage Of Eligibles That Received Preventive Dental Services	CMS (http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp)	Percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received preventive dental services	Administrative (Form CMS-416)
TDENT	Percentage Of Eligibles That Received Dental Treatment Services	CMS (http://www.cms.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp)	Percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for EPSDT services, and that received dental treatment services	Administrative (Form CMS-416)

Acronym	Measure	Measure Steward[a] (Web site)	Description	Method/Data Source
MMA	Medication Management for People with Asthma	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children ages 5 to 20 that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period Two rates are reported: Percentage of children that remained on an asthma controller medication for at least 50 percent of their treatment period Percentage of children that remained on an asthma controller medication for at least 75 percent of their treatment period. This measure is reported using the following age ranges: 5 to 11 years; 12 to 18 years; 19 to 20 years; and total	Administrative

Care Coordination

Acronym	Measure	Measure Steward[a] (Web site)	Description	Data Source
FUH	Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS (http://www.ncqa.org)	Percentage of discharges for children ages 6 to 20 that were hospitalized for treatment of selected mental health disorders and that 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

Acronym	Measure	Measure Steward[a] (Web site)	Description	Data Source
ADD	Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children newly prescribed ADHD medication that had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispensed, including two rates: one for the initiation phase and one for the continuation and maintenance phase	Administrative

Safety

Acronym	Measure	Measure Steward[a] (Web site)	Description	Data Source
CLABSI	Pediatric Central Line-Associated Blood Stream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit	Centers for Disease Control and Prevention (www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf)	Rate of central line-associated blood stream infections (CLABSI) in the pediatric and neonatal intensive care units during periods selected for surveillance	Medical records (CDC's National Healthcare Safety Network)

Efficiency and Cost Reduction

Acronym	Measure	Measure Steward[a] (Web site)	Description	Data Source
CWP	Appropriate Testing for Children with Pharyngitis	NCQA/HEDIS (http://www.ncqa.org)	Percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus test for the episode	Administrative

Acronym	Measure	Measure Steward[a] (Web site)	Description	Data Source
ASMER	Annual Percentage of Asthma Patients 2 Through 20 Years Old with One or More Asthma-Related Emergency Room Visits	Alabama Medicaid (http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.7.0_Health_Information_Technology/4.7.1_Together_for_Quality/4.7.1.4_Asthma_Measures.aspx)	Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits	Administrative
AMB	Ambulatory Care – Emergency Department (ED) Visits	NCQA/HEDIS (http://www.ncqa.org)	Rate of ED visits per 1,000 enrollee months among children up to age 19	Administrative

Person and Caregiver Centered Experience

Acronym	Measure	Measure Steward[a] (Web site)	Description	Data Source
CPC	Consumer Assessment of Healthcare Providers and Systems® (CAHPS) 5.0H (Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items)	NCQA/HEDIS (http://www.ncqa.org) (https://www.cahps.ahrq.gov/content/ncbd/ncbd_intro.asp)	Survey on parents' experiences with their children's care	Survey

[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 Child Core Set Will Be Used

Implementation of a standardized set of children's health care quality measures 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 children receive through Medicaid and CHIP programs. As per the CHIPRA legislation, state data derived from the core measures will become part of the Secretary's annual report on the quality of care for children in Medicaid and CHIP. The Secretary's annual report summarizes state-specific and national measurement information on the quality of health care furnished to children enrolled in Medicaid and CHIP programs. Annual reports for 2010, 2011, and 2012 are available on the CHIPRA Core Set of Children's Health Care Quality Measures website:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html.

II. Data Collection and Reporting of the Child Core Set

To support consistency in reporting the child 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 the Centers for Medicare & Medicaid Services (CMS) as of spring 2013. For HEDIS measures, this manual follows HEDIS 2013 specifications for FFY 2013 reporting. For non-HEDIS measures, the manual includes the most applicable version of the specifications for reporting 2012 data available from the measure steward.
- 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 child's birthday or diagnosis. 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 for FFY 2013. For all measures, states should indicate start and end dates for the measurement period using the "Date Range" field in CARTS.
- Reporting unit. The reporting unit for each measure is the state 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 state Medicaid and CHIP programs (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care [MC]). If data are collected separately, states should aggregate data from all these sources into one state-level rate before reporting the data to CMS. For more guidance about developing 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 multiple managed care organizations [MCOs] or across MC 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/program-wide rate as long as the specifications allow use of both data sources to construct the measure. For additional guidance on developing state-level rates, refer to the TA Brief titled "Approaches to Developing State-level Rates for Children's Health Care Quality Measures Based on Data from Multiple Sources." [1]

[1] The TA Brief, Approaches to Developing State-level Rates for Children's Health Care Quality Measures Based on Data from Multiple Sources, is available at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/TA2-StateRates.pdf.

- Reporting a weighted rate in CARTS. When a state develops a weighted rate combining data across multiple reporting units, the state should enter zeroes in the "Numerator" and "Denominator" fields. In these cases, it should report the state-level rate in the "Rate" field and, when possible, include individual reporting unit numerators, denominators, and rates in the field labeled "Additional Notes/Comments on Measure," along with a description of the method used to derive the state-level rate.
- Eligible population for measurement. For all measures, the denominator includes Medicaid and CHIP enrollees who satisfy measure-specific eligibility criteria. The eligible Medicaid and CHIP population should include Title XIX and Title XXI populations, but not populations funded only by states (such as, state-covered children that are above the Medicaid/CHIP eligibility levels). If a denominator for a measure specifies an age range beyond that eligible for a state's Medicaid and CHIP programs, the state should include only the ages eligible for the program in the denominator and note any deviations from the specifications in the "Deviations from Measure Specifications" field in CARTS. 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 CHIP programs. For a measure based on administrative data, all beneficiaries who meet the eligible population requirements for the measure should be included. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire eligible population requirements 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.
- Sampling. For measures reported using the hybrid method, the sample size should be 411, plus an oversample to allow for substitution. (For Developmental Screening In the First Three Years of Life, the sample is 411 divided across three age strata, or 137 in each age group.) Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion. Additional guidance on sampling for hybrid measures and CAHPS is available in the following TA briefs: Developing State-level Rates for Children's Health Care Quality Measures Based on Data from Multiple Sources (June 2012) and Guidance for Conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Child Survey (December 2012). [2]
- Small numbers. If a measure has a denominator that is less than 30 and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field in CARTS and specify the denominator size. Keep in mind that aggregating data to the state level minimizes the chances for small numbers in the denominator.

[2] Technical Assistance briefs can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

- Continuous enrollment. This refers to the time frame during which an enrollee must be eligible for benefits to be included in the measure denominator. The technical specifications provide the continuous enrollment requirement for each measure.
- Risk adjustment. No child core set measure requires 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. For such measures, the inclusion of claims, regardless of whether they were paid, denied, or voided, would be appropriate.[3] For each measure that relies on claims as a data source, the manual provides specific guidance on which claims to include.

Reporting and Submission

CMS has designated CARTS, a web-based data submission tool, as the vehicle that states choosing to report the child core set measures should use. Procedures for reporting into CARTS are provided below.

- Submission deadline. States are asked to submit and certify final data on the core set measures for FFY 2013 in Section IIA of CARTS by December 31, 2013. CARTS allows data to be updated after the submission deadline. However, updates after the deadline are not guaranteed to be used in the development of reports by CMS. States are encouraged to submit data that are as complete as possible by the submission deadline.
- Completing fields. Specific fields for each measure are provided. States should complete every field for each measure submitted to ensure consistent reporting across states. Details on how to enter data on the child core set measures can be found in the CARTS instructions.
- Including attachments. CARTS includes an attachment facility to upload additional information about a particular measure or to report on a state-specific quality measure developed as part of a CHIPRA Quality Demonstration Grant. Document titles uploaded as an attachment in CARTS must be 100 characters or less. More information about submitting attachments can be found in the CARTS instructions.
- Reasons for not reporting a measure. Although reporting the core set of measures is voluntary, states choosing not to report a measure are required to explain their reason for not reporting the measure. This information will assist CMS in understanding why each state or why all states as a group may not be reporting on specific measures.

[3] The measures for which these types of claims should be included are the timeliness of prenatal care, frequency of ongoing prenatal care, childhood immunization status, immunization status for adolescents, weight assessment, Chlamydia screening, well child visits, adolescent well-care visits, children and adolescent access to primary care, appropriate testing for children with pharyngitis, follow-up care for children prescribed ADHD medication, annual pediatric HbA1c testing, and follow-up after hospitalization for mental illness.

- Noting deviations and additional information. Although states are encouraged to report measures adhering to the methods provided in the specifications, this may not always be possible. It might also be necessary to provide additional information and context about the rates reported. Any deviations and clarifications should be recorded in the "Deviations from Measure Specifications" field in CARTS. Examples of deviations include eligible population definitions that differ from the specifications (age ranges, codes for identifying the population, or missing population segments); differences in data sources used; differences in codes used (added, excluded, or substituted codes); issues encountered in calculating the measure; difference in version of HEDIS used; and caveats not specified elsewhere.
- Options for reporting by Medicaid and CHIP programs. For each child core set measure reported in CARTS, states should specify if the data reported are for the state's Medicaid program only; CHIP program only; or Medicaid and CHIP programs combined. CMS prefers that states report Medicaid and CHIP data combined whenever possible.[4] States choosing to report a combined Medicaid and CHIP rate should coordinate internally between the two programs (and among CARTS users within the state) when reporting.
- Data auditing. For FFY 2013, CMS will not expect certification or auditing of HEDIS or other measures. However, if there are current state mechanisms for accreditation, certification, and managed care external quality review reporting, or if the state validates its core set rates, we ask that you note these processes in the "Additional Notes/Comments on Measure" field in CARTS.
- Reporting additional components of measures. CARTS provides states with the space needed to enter data for the components of the measures that are part of the child core set. For example, the HEDIS Prenatal and Postpartum Care measure is composed of one rate for timeliness of prenatal care and another rate for postpartum care. Because the child core set includes only the timeliness of prenatal care, CARTS will ask you only to report data on this particular rate. You may report the additional rate if you would like in the "Additional Notes/Comments on Measure" field in CARTS.
- Reporting Electronic Health Record (EHR) Incentive Program measures. For states reporting to CMS through CARTS on a core measure that is also an EHR incentive measure, we ask that you indicate whether any information was extracted from EHRs in the "Additional Notes/Comments on Measure" field in CARTS.
- Further assistance with CARTS. For more information about obtaining a CARTS user-name and password, please contact Shambrekia Wise (Shambrekia.Wise@cms.hhs.gov).

[4] Note: Title XXI programs are required by CHIPRA to collect and separately sample CAHPS survey data beginning in December 2013. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSFactSheet.pdf

Technical Assistance

To help states collect, report, and use the core measures to drive quality improvement at the state level, CMS offers technical assistance and analytic support. The overarching goals for providing technical assistance and analytic support are to increase the number of states reporting the core measures; increase the number of measures reported by each state; and improve the completeness of the data reported (that is, reporting for both Medicaid and CHIP enrollees). As part of the technical assistance effort, CMS will share promising practices for collecting the core measures with states. Please submit technical assistance requests specific to the core set of children's health care quality measures (Section IIA of CARTS only) to: CMSCHIPRAQualityTA@cms.hhs.gov.

III. Technical Specifications for the Core Set of Children's Health Care Quality Measures

This chapter presents the technical specifications for each measure in the child 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 March 2013.

Measure HPV: Human Papillomavirus (HPV) Vaccine for Female Adolescents

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

Percentage of female adolescents that turned 13 years of age during the measurement year and had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Guidance for Reporting:

- Include all paid, suspended, pending, reversed, and denied claims.
- Specifications for this measure refer to tables included in the Immunization Status for Adolescents (IMA) specifications. Please refer to the IMA measure specifications for additional detail.

B. ELIGIBLE POPULATION

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

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The eligible population

Numerator

At least three HPV vaccinations, with different dates of service, on or between the beneficiary's 9th and 13th birthdays. HPV vaccines administered prior to a beneficiary's 9th birthday cannot be counted.

Table HPV-A: Codes to Identify HPV Immunization for Female Adolescents

Immunization	CPT
HPV	90649, 90650

Exclusions (optional)

Adolescents who had a contraindication for the HPV vaccine may be excluded from the denominator. The exclusion must have occurred by the beneficiary's 13th birthday. Look for exclusions as far back as possible in the beneficiary's history and use the codes in Table IMA-B to identify exclusions.

C.2 – Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population.

Numerator

At least three HPV vaccinations, with different dates of service, on or between the beneficiary's 9th and 13th birthdays. HPV vaccines administered prior to a beneficiary's 9th birthday cannot be counted.

Administrative

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

Medical Record

For immunization evidence obtained from the medical record, the organization may count beneficiaries where there is evidence that the antigen was rendered from one of the following:

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

HPV vaccines administered prior to a beneficiary's 9th birthday cannot be counted.

Exclusions (optional)

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

D. ADDITIONAL NOTES

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

Measure WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index Assessment for Children/Adolescents

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of children ages 3 to 17 that had an outpatient visit with a PCP or OB/GYN and whose weight is classified based on body mass index (BMI) percentile for age and gender.

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

Guidance for Reporting:

- Only the BMI percentile component is included in the child core set measure; the physical activity/nutrition counseling measure components are not included in the measure.
- The eligible population (denominator) for this measure includes children ages 3 to 17 who have an outpatient visit and meet the continuous enrollment criteria.
- A BMI percentile is included in the numerator count if the specified documentation is present, regardless of the primary intent of the visit. A BMI without percentile is not acceptable for inclusion in the numerator count.
- For states reporting a core set measure that is also an Electronic Health Record (EHR) Incentive Program measure, please indicate whether any information was extracted from electronic health records. Please report this information in the "Other Comments on Measure" field in CARTS.
- The height, weight, and BMI must be from the same data source.
- The height and weight measurement should be taken during 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, pending, reversed, and denied claims.

B. DEFINITION

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI Percentile	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

PCP	Primary Care Physician. Includes physicians or non-physicians (e.g., nurse practitioner, physician assistant) who offer primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
OB/GYN	Obstetrics and Gynecology. Includes physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology, and certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).

C. ELIGIBLE POPULATION

Age	3 to 17 years old as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators. - 3 to 11 years - 12 to 17 years - Total - The total is the sum of the two age stratifications.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid/CHIP beneficiary for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year.
Benefit	Medical.
Event/Diagnosis	An outpatient visit (Table WCC-A) with a PCP or an OB/GYN during the measurement year.

Table WCC-A: Codes to Identify Outpatient Visits

CPT	UB Revenue
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 0982, 0983

Source: Refer to Table WCC-A in HEDIS specifications (2013 version).

D. DATA SOURCE

D.1 – Administrative Data Specifications

Denominator

The eligible population

Numerator

BMI percentile (Table WCC-B) during the measurement year.

Table WCC-B: Codes to Identify BMI Percentile

Description	CPT	ICD-9-CM Diagnosis	HCPCS
BMI Percentile	-	V85.5	-

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

Exclusions (optional)

Children who have a diagnosis of pregnancy during the measurement year.

Table WCC-C: Codes to Identify Exclusions

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

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

D.2 – Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population for the Total age band (Ages 3 to 17). The Total sample is stratified by age to report rates for ages 3 to 11 and ages 12 to 17.

Numerator

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

Administrative

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

Medical Record

Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source. Either of the following meets criteria for BMI percentile.

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

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

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

Exclusions (optional)

Refer to the Administrative Data Specification for exclusion criteria (Table WCC-C). Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year.

E. ADDITIONAL NOTES

The following notations or examples of documentation do not count as numerator compliant:

- Notation of height and weight only
- BMI or BMI percentile noted before or after the measurement year

Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit.

Measure CAP: Children and Adolescent Access to Primary Care Practitioners (PCP)

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of children ages 12 months to 19 years that had a visit with a PCP, including four separate percentages:

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

Guidance for Reporting:

- A PCP is defined as a physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	12 months to 19 years old as of December 31 of the measurement year. Report four age stratifications. 12 to 24 months old as of December 31 of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 31, 2010, and December 1, 2009). 25 months to 6 years old as of December 31 of the measurement year. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between November 30, 2009, and January 1, 2005). 7 to 11 years old as of December 31 of the measurement year. 12 to 19 years old as of December 31 of the measurement year.
Continuous Enrollment	For ages 12 to 24 months, ages 25 months to 6 years: The measurement year. For ages 7 to 11 years, ages 12 to 19 years: The measurement year and the year prior to the measurement year.

Allowable Gap	For ages 12 to 24 months, ages 25 months to 6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For ages 7 to 11 years, ages 12 to 19 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the child/adolescent may not have more than a 1-month gap in coverage (i.e., a child/adolescent whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.
Anchor Date	December 31 of the measurement year.
Benefit	Medical.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The eligible population.

Numerators

For ages 12 to 24 months, ages 25 months to 6 years: One or more visits with a PCP during the measurement year.

For ages 7 to 11 years, ages 12 to 19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year.

The following children/adolescents should be counted: those that had an ambulatory or preventive care visit to any PCP, with a CPT or ICD-9-CM code listed in Table CAP-A. Exclude specialist visits.

Table CAP-A: Codes to Identify Ambulatory or Preventive Care Visits

Description	CPT	HCPCS	ICD-9-CM Diagnosis
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	-	-
Home services	99341-99345, 99347-99350	-	-
Preventive medicine	99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429	G0438, G0439	-
General medical examination	-	-	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Source: Refer to Table CAP-A in HEDIS specifications(2013 version).

Measure CIS: Childhood Immunization Status

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

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

Guidance for Reporting:

- States should report a separate rate for each vaccine, as well as 9 combination rates.
- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all Medicaid and CHIP-enrolled children who turned 2 years old during the reporting year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, any immunizations missing from claims or registry data must be sought from medical records.
- For states reporting a child core set measure that is also an Electronic Health Record (EHR) Incentive Program measure, please indicate whether any information was extracted from electronic health records. Please report this information in the "Other Comments on Measure" field in CARTS.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Children who turn 2 years old during the measurement year.
Continuous Enrollment	12 months prior to the child's second birthday.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid/CHIP beneficiary for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor Date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/Diagnosis	None.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The eligible population

Numerators

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

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

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

- Evidence of the antigen or combination vaccine.

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

DTaP

At least four DTaP vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

IPV

At least three IPV vaccinations, with different dates of service on or before the child's second birthday. IPV administered prior to 42 days after birth cannot be counted.

MMR

At least one MMR vaccination, with a date of service falling on or before the child's second birthday.

HiB

At least three HiB vaccinations, with different dates of service on or before the child's second birthday. HiB administered prior to 42 days after birth cannot be counted.

Hep B

At least three Hep B vaccinations, with different dates of service on or before the child's second birthday.

VZV

At least one VZV vaccination, with a date of service falling on or before the child's second birthday.

PCV

At least four PCV vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hep A

At least one Hep A vaccination, with a date of service falling on or before the child's second birthday.

RV

The child must receive the required number of RV vaccinations on different dates of service on or before the second birthday. Do not count a vaccination administered prior to 42 days after birth. The following vaccine combinations are compliant:

- Two doses of the two-dose vaccine, or
- One dose of the two-dose vaccine and two doses of the three-dose vaccine, or
- Three doses of the three-dose vaccine.

The vaccines are identified by different CPT codes (Table CIS-A).

Influenza

Two influenza vaccinations, with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.

Combination rates

Calculate the following rates for Combination 2–Combination 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 2	x	x	x	x	x	x	-	-	-	-
Combination 3	x	x	x	x	x	x	x	-	-	-
Combination 4	x	x	x	x	x	x	x	x	-	-
Combination 5	x	x	x	x	x	x	x	-	x	-
Combination 6	x	x	x	x	x	x	x	-	-	x
Combination 7	x	x	x	x	x	x	x	x	x	-
Combination 8	x	x	x	x	x	x	x	x	-	x
Combination 9	x	x	x	x	x	x	x	-	x	x
Combination 10	x	x	x	x	x	x	x	x	x	x

Source: Refer to HEDIS specifications (2013 version).

Table CIS-A: Codes to Identify Childhood Immunizations

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
DTaP	90698, 90700, 90721, 90723	-	-	99.39
IPV	90698, 90713, 90723	-	-	99.41
MMR	90707, 90710	-	-	99.48
Measles and rubella	90708	-	-	-
Measles	90705	-	055	99.45

Immunization	CPT	HCPCS	ICD-9-CM Diagnosis*	ICD-9-CM Procedure
Mumps	90704	-	072	99.46
Rubella	90706	-	056	99.47
HiB	90645-90648, 90698, 90721, 90748	-	-	-
Hepatitis B**	90723, 90740, 90744, 90747, 90748	G0010	070.2, 070.3, V02.61	-
VZV	90710, 90716	-	052, 053	-
Pneumococcal conjugate	90669, 90670	G0009	-	-
Hepatitis A	90633	-	070.0, 070.1	-
Rotavirus (two dose schedule)	90681	-	-	-
Rotavirus (three dose schedule)	90680	-	-	-
Influenza	90655, 90657, 90661, 90662	G0008	-	99.52

Source: Refer to Table CIS-A in HEDIS specifications (2013 version).

* ICD-9-CM Diagnosis codes indicate evidence of disease.

** The two-dose Hep B antigen Recombivax is recommended for children between ages 11 and 14 only and is not included in this table.

Exclusion (optional)

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

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

Table CIS-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.42*
DTaP	Encephalopathy	323.51 with (E948.4 or E948.5 or E948.6)
IPV	Anaphylactic reaction to streptomycin, polymyxin B or neomycin	-

Immunization	Description	ICD-9-CM Diagnosis
MMR, VZV and influenza	Immunodeficiency, including genetic (congenital) immuno-deficiency syndromes	279
MMR, VZV and influenza	HIV disease; asymptomatic HIV	042, V08
MMR, VZV and influenza	Cancer of lymphoreticular or histiocytic tissue	200-202
MMR, VZV and influenza	Multiple myeloma	203
MMR, VZV and influenza	Leukemia	204-208
MMR, VZV and influenza	Anaphylactic reaction to neomycin	-
Hepatitis B	Anaphylactic reaction to common baker's yeast	-

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

*Use ICD-9-CM Diagnosis code 999.4 (without fifth digit) to identify anaphylactic reaction prior to October 1, 2011; the date of service must be before October 1, 2011.

C.2 – Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population for each product line.

Numerators

For MMR, Hep B, VZV, and Hep A, count any of the following.

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

For DTaP, HiB, IPV, PCV, RV, and influenza, count only:

- Evidence of the antigen or combination vaccine.

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

Administrative

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

Medical Record

For immunization evidence obtained from the medical record, children may be counted where there is evidence that the antigen was rendered from one of the following.

- A note indicating the name of the specific antigen and the date of the immunization, or

- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.

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

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

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

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

Exclusion (Optional)

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

D. ADDITIONAL NOTES

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

Measure IMA: Immunization Status for Adolescents

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of adolescents that turned 13 years old during the measurement year and had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Guidance for Reporting:

- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all Medicaid and CHIP-enrolled adolescents who turned 13 years old during the reporting year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, seek any immunizations missing from claims or registry data from medical records.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Adolescents who turn 13 years old during the measurement year.
Continuous Enrollment	12 months prior to the child's 13th birthday.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid/CHIP beneficiary for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months (60 days) is not continuously enrolled.
Anchor Date	Enrolled on the child's 13th birthday.
Benefit	Medical.
Event/Diagnosis	None.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The eligible population.

Numerators

For meningococcal and Tdap or Td, count only evidence of the antigen or combination vaccine.

- Meningococcal: One meningococcal conjugate or meningococcal polysaccharide vaccine on or between the child's 11th and 13th birthdays.
- Tdap/Td: One tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the child's 10th and 13th birthdays.
- Combination 1 (Meningococcal, Tdap/Td): Children who received one meningococcal vaccine on or between their 11th and 13th birthday and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) on or between the child's 10th and 13th birthdays.

Table IMA-A: Codes to Identify Adolescent Immunizations

Immunization	CPT	ICD-9-CM Procedure
Meningococcal	90733, 90734	-
Tdap	90715	99.39
Td	90714, 90718	-
Tetanus	90703	99.38
Diphtheria	90719	99.36

Source: Refer to Table IMA-A in HEDIS specifications (2013 version).

Exclusion (optional)

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

The exclusion must have occurred by the child's 13th birthday. Look for exclusions as far back as possible in the child's history and use the codes in Table IMA-B to identify exclusions.

Table IMA-B: Codes to Identify Exclusions

Immunization	Description	ICD-9-CM Diagnosis
Any particular vaccine	Anaphylactic reaction to the vaccine or its components	999.42*

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

*Use ICD-9-CM Diagnosis code 999.4 (without fifth digit) to identify anaphylactic reaction prior to October 1, 2011; the date of service must be before October 1, 2011.

C.2 – Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population.

Numerators

For meningococcal conjugate or polysaccharide and Tdap or Td, count only the evidence of the antigen or combination vaccine.

Administrative

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

Medical Record

For immunization information obtained from the medical record, children may be counted where there is evidence that the antigen was rendered from:

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

Exclusion (optional)

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

D. ADDITIONAL NOTES

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

Measure FPC: Frequency of Ongoing Prenatal Care

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

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

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

This measure uses the same denominator as the Timeliness of Prenatal Care measure.

Guidance for Reporting:

- Include all paid, suspended, pending, reversed, and denied claims.
- Specifications for this measure reference tables included in Measure PPC (Timeliness of Prenatal Care). Please refer to the PPC measure specifications for additional detail.

B. 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.
Benefit	Medical.
Event/Diagnosis	Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Women who delivered in a birthing center should be included in this measure. Refer to Table PPC-A 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. Women for whom a prenatal visit is not indicated should be excluded. These exclusions are indicated by a dash (–) in Table FPC-A.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The Eligible Population

Numerator

Women who had an unduplicated count of <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent, or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age.

For each delivery, follow the steps below to calculate each woman's ratio of observed-to-expected prenatal care visits.

Step 1

Identify the delivery date using hospital discharge data.

Step 2

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

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

- Convert gestational age into days.
- Subtract gestational age (in days) from the date of delivery (step 1).
- Subtract the date obtained above from the date when the woman enrolled in Medicaid/CHIP to determine the stage of pregnancy at time of enrollment.
- Divide the numbers of days the woman was pregnant at enrollment (step 3) by 30. Round the resulting number according to the .5 rule to a whole number.
- For example, delivery date is August 8, 2012; gestational age is 33 weeks; date of enrollment is May 6, 2012. Given these variables, the process is:
- Gestational age in days is 231 days (33 weeks x 7 days/week).
- Date of delivery – gestational age (in days) is December 22, 2011 (August 8, 2012 – 231 days).
- Date when the woman enrolled in Medicaid/CHIP– date obtained in Step 2 is 137 days (May 6, 2012– December 22, 2011).
- Month in which prenatal care began is 4.5 months (137 days/30 days) and then round up to 5 months using the 0.5 rule.
- This woman's stage of pregnancy at time of enrollment is 5 months.

Step 3

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

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

For deliveries with a gestational age <28 weeks or >42 weeks, calculate the expected number of prenatal care visits using the date when the woman enrolled and ACOG's recommended schedule of visits. For example, if gestational age is 26 weeks and the woman enrolled during her second month of pregnancy, the expected number of prenatal care visits is 5 (6 expected visits [1 visit every 4 weeks or 6 visits in 24 weeks], less 1 visit missed in the first month).

If gestational age is 43 weeks and the woman enrolled during her third month of pregnancy, the expected number of prenatal care visits is 15 (14 expected visits for a 40-week gestation plus 1 visit each additional week [17 total expected prenatal care visits], less 2 visits missed in the first and second months).

Step 4

Identify the number of prenatal care visits the woman received during the course of her pregnancy and while enrolled in Medicaid/CHIP using claims and encounter data. Use Table PPC-C to identify prenatal visits that occurred during the first trimester. Any of the four rules presented in the table may be used to search for evidence of prenatal care; a woman's record only needs to satisfy one rule.

Use Table PPC-D to identify prenatal visits that occurred during the second and third trimester. Visits that occur on the date of delivery and meet the prenatal visit criteria count toward the measure.

If a HCPCS code falls on the same date of service as a CPT or UB Revenue code, count it as a single visit. Using Table PPC-C, Decision Rule 2 as an example, count as a single visit, HCPCS H1004, CPT 99201 and ICD-9-CM Diagnosis code 651.03 that fall on the same date of service.

If the woman had a gap in enrollment, count only the visits received during the last enrollment segment.

Step 5

Calculate the ratio of observed visits (step 4) over expected visits (step 3).

Step 6

Report each woman in the appropriate category.

- <21 percent
- 21 percent–40 percent

- 41 percent–60 percent
- 61 percent–80 percent
- ≥81 percent of expected visits

Note

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.

C.2 – Hybrid Data Specifications

Denominator

A systematic sample of women drawn from the eligible population. If this measure and the Prenatal and Postpartum Care measure are collected, the same systematic sample must be used for both.

Numerator

Women who had an unduplicated count of the number of expected visits that was <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. The visits may be identified through either administrative data or medical record review.

The numerator is calculated retroactively from date of delivery or early elective delivery (EDD).

Administrative Data

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

Medical Records

Use the medical record documentation requirements in the Prenatal and Postpartum Care measure to identify prenatal visits that occur during the first, second and third trimesters.

Identify gestational age at birth from the hospital record (e.g., admission write-ups, histories and physicals, discharge summaries or labor and delivery records) or birth certificate. Gestational age is the number of completed weeks that elapsed between the first day of the last normal menstrual period and the date of delivery. If gestational age is not available, assume a gestational age of 280 days (40 weeks).

Methods recommended to determine gestational age are as follows.

Physician ascertainment using ultrasound or Dubowitz assessment.

LMP calculation (date of LMP – date of delivery) ÷ 7.

If gestational age is recorded or calculated in fractions of a week, round down to the lower whole number.

For visits after 219 days prior to delivery, count any documentation of a visit to an OB/GYN practitioner or midwife, family practitioner or other PCP with a principal diagnosis of pregnancy.

D. ADDITIONAL NOTES

This measure is based on deliveries. Women who have multiple deliveries from a single pregnancy should be counted once. Include each pregnancy for women who have multiple deliveries from different pregnancies.

When counting prenatal visits, include visits with physician assistants, nurse practitioners, midwives and registered nurses if a physician co signature is present, if required by State law.

If both Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care are collected using the Hybrid Method, the same sample for collection must be used. If the Hybrid Method is used, a combination of administrative data and medical record review may not be used to identify prenatal care visits for an individual in the denominator. For example, for one woman, two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) may not be counted for one woman, even if each visit shows a different date of service.

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

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

Source: Guidelines for Perinatal Care, Fifth Edition. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Refer to Table FPC-A in HEDIS specifications (2013 version).

Note: Dashes indicate no visit is expected.

Measure PPC: Timeliness of Prenatal Care

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of Medicaid/CHIP 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 prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid/CHIP.

Guidance for Reporting:

- Include all paid, suspended, pending, reversed, and denied claims.
- References to postpartum visits in the original HEDIS specifications have been removed because they are not relevant to reporting of the child core set, which only focuses on the timeliness of prenatal care.

B. 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.
Benefit	Medical.
Event/ Diagnosis	Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Women who delivered in a birthing center should be included in this measure. Refer to Table PPC-A 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.

C. DEFINITIONS

Preterm*	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 (295th day) of the 43rd week 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.

* These definitions are from the Guidelines for Perinatal Care, Fifth Edition. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

D. DATA SOURCE

D.1. – Administrative Data Specifications

Denominator

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

Step 1

Identify live births. 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. Both methods must be used to identify the eligible population, but a woman only needs to be identified by one method to be included in the measure.

Method A

Codes listed 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.

Denominator Criteria

Table PPC-A: 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*, V39*

*These codes are from the infant's records and are optional if infant and mother records are unable to be linked.

Method B

Identify deliveries and verify live births. Codes in Table PPC-B step A, identify deliveries but do not indicate the outcome. Step B must be used to eliminate deliveries that did not result in a live birth.

Table PPC- B: 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	-

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

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

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in Medicaid/CHIP and the gaps in enrollment during the pregnancy. Include only visits that occur while the woman was enrolled.

Step 3

Determine enrollment status during the first trimester. Determine if women identified in step 2 were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, go to step 4. For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 6.

Step 4

Determine continuous enrollment for the first trimester. Determine if women identified in step 3 were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]) with no gaps in enrollment. For these women, use one of the four decision rules in Table PPC-C to determine if there was a prenatal visit during the first trimester. [5] For women who were not continuously enrolled during the first trimester, proceed to step 5.

Step 5

For women who had a gap between 176 and 280 days before delivery, proceed to step 6.

Step 6

For women identified in step 3 and step 5, determine the start date of the last enrollment segment. [6] For women not enrolled in Medicaid/CHIP on or before 280 days before delivery (or EDD) and for women who had a gap between 176 and 280 days before delivery (step 5), determine the start date of the last enrollment segment.

For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 7. For women whose last enrollment started less than 219 days before delivery proceed to step 8.

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[5] If the woman identified in step 3 was continuously enrolled for the first trimester (176–280 days before delivery with no gaps during this period), there is sufficient opportunity to provide prenatal care in the first trimester. Table PPC-C must be used. Any enrollment gaps in the second and third trimesters are incidental.

[6] For women with a gap in enrollment during pregnancy, the last enrollment segment is the enrollment date during the pregnancy that is closest to the delivery date.

Step 7

Determine numerator compliance if enrollment started on or between 219 and 279 days before delivery. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the numerator criteria in Table PPC-D and find a visit between the last enrollment start date and 176 days before delivery. [7]

Step 8

Determine numerator compliance if enrollment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery). If the last enrollment segment started less than 219 days before delivery, determine numerator compliance using Table PPC-D numerator criteria for a visit within 42 days after enrollment.

Table PPC-C: Markers for Early Prenatal Care Obtainable From Administrative Data

DECISION RULE 1
Marker Event
Any prenatal care visit to an OB practitioner, a midwife or family practitioner or other primary care practitioner (PCP) with documentation of when prenatal care was initiated.
Administrative
Any one code: CPT: 59400*, 59425*, 59426*, 59510*, 59610*, 59618* CPT Category II: 0500F, 0501F, 0502F

DECISION RULE 2
Marker Event
Any visit to an OB practitioner or midwife with one of the following: Obstetric panel TORCH antibody panel Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing) Ultrasound (echocardiography) of pregnant uterus Pregnancy-related diagnosis code
Administrative
The woman must meet criteria in [Part A and (Part B or Part C)] or Part D. Part A: Any one code. CPT: 99201-99205, 99211-99215, 99241-99245 UB Revenue: 0514 Part B: Any one code. CPT: 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 80055 ICD-9-CM Diagnosis: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3,

[7] The 176 days before delivery includes the 42-day period after enrollment. For example, a woman who had a last enrollment segment 225 days before delivery would have until the end of the first trimester (176 days before delivery) instead of the 183 days before delivery under the 42-day criteria. Table PPC-D allows more flexibility for identifying prenatal care visits occurring later in the pregnancy.

DECISION RULE 2
649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28 ICD-9-CM Procedure: 88.78 Part C: One of the following.TORCH: A code for each of the four infections must be present for this component. Cytomegalo-virus: CPT: 86644 LOINC: 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6, 47307-4, 45326-6, 47363-7, 47430-4, 49539-0, 52976-8, 52984-2, 59838-3 Herpes simplex: CPT: 86694, 86695, 86696 LOINC: 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6, 25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4, 43180-9, 44008-1, 44480-2, 44494-3, 44507-2, 45210-2, 47230-8, 48784-3, 49848-5, 50758-2, 51915-7, 51916-5, 52977-6, 52981-8, 53377-8, 53560-9, 57321-2 Rubella: CPT: 86762 LOINC: 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7, 63462-6 Toxoplasma: CPT: 86777 LOINC: 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23485-6, 23486-4, 23784-2, 24242-0, 25300-5, 25542-2, 33336-9, 34422-6, 35281-5, 35282-3, 40677-7, 40678-5, 40697-5, 40785-8, 40786-6, 41123-1, 41124-9, 42949-8, 47389-2, 47390-0, 56990-5, 56991-3
Marker Event
Rubella/ABO/Rh: A code for Rubella and (ABO or Rh) must be present for this component Rubella: CPT: 86762 LOINC: 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7, 63462-6 ABO: CPT: 86900 LOINC: 883-9, 57743-7 Rh: CPT: 86901 LOINC: 972-0, 978-7, 10331-7, 1305-2, 34961-3

DECISION RULE 2
ABO and Rh: LOINC: 882-1, 884-7 Part D: Any one code. HCPCS: H1000-H1004, H1005* CPT: 99500

DECISION RULE 3
Marker Event
Any visit to a family practitioner or other PCP with a pregnancy related ICD-9-CM Diagnosis code AND one of the following: Obstetric panel TORCH antibody panel Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing) Ultrasound of the pregnant uterus
**When using a visit to a family practitioner or other PCP, it is necessary to determine that prenatal care was rendered and that the woman was not merely diagnosed as pregnant and referred to another practitioner for prenatal care.
Administrative
The woman must meet criteria in Part A and (Part B or Part C). Part A: Any CPT or UB revenue code with a ICD-9-CM Diagnosis code: (CPT with ICD-9-CM) or (UB with ICD-9-CM). The ICD-9-CM Diagnosis code must be on the same claim as the CPT or UB revenue code. Alternatively, an HCPCS code does not require a diagnosis code. CPT: 99201-99205, 99211-99215, 99241-99245 UB Revenue: 0514 ICD-9-CM Diagnosis: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28 Part B: Any one code: CPT: 76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 80055 ICD-9-CM Procedure: 88.78 Part C: One of the following: TORCH: A code for each of the four infections must be present for this component. Cytomegalovirus: CPT: 86644 LOINC: 5121-9, 5122-7, 5124-3, 5125-0, 5126-8, 5127-6, 7851-9, 7852-7, 7853-5, 9513-3, 13225-8, 13949-3, 15377-5, 16714-8, 16715-5, 16716-3, 22239-8, 22241-4, 22244-8, 22246-3, 22247-1, 22249-7, 24119-0, 30325-5, 32170-3, 32791-6, 32835-1, 34403-6, 47307-4, 45326-6, 47363-7, 47430-4, 49539-0, 52976-8, 52984-2, 59838-3 Herpes simplex: CPT: 86694, 86695, 86696 LOINC: 5202-7, 5203-5, 5204-3, 5205-0, 5206-8, 5207-6, 5208-4, 5209-2, 5210-0, 7907-9, 7908-7, 7909-5, 7910-3, 7911-1, 7912-9, 7913-7, 9422-7, 10350-7, 13323-1, 13324-9, 13501-2, 13505-3, 14213-3, 16944-1, 16949-0, 16950-8, 16954-0, 16955-7, 16957-3, 16958-1, 17850-9, 17851-7, 19106-4, 21326-4, 21327-2, 22339-6, 22341-2, 22343-8, 24014-3, 25435-9, 25837-6,

DECISION RULE 3
25839-2, 26927-4, 27948-9, 30355-2, 31411-2, 32687-6, 32688-4, 32790-8, 32831-0, 32834-4, 32846-8, 33291-6, 34152-9, 34613-0, 36921-5, 40466-5, 40728-8, 40729-6, 41149-6, 41399-7, 42337-6, 42338-4, 43028-0, 43030-6, 43031-4, 43111-4, 43180-9, 44008-1, 44480-2, 44494-3, 44507-2, 45210-2, 47230-8, 48784-3, 49848-5, 50758-2, 51915-7, 51916-5, 52977-6, 52981-8, 53377-8, 53560-9, 57321-2 Rubella: CPT: 86762 LOINC: 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7, 63462-6 Toxoplasma: CPT: 86777 LOINC: 5387-6, 5388-4, 5389-2, 5390-0, 5391-8, 8039-0, 8040-8, 11598-0, 12261-4, 12262-2, 13286-0, 17717-0, 21570-7, 22577-1, 22580-5, 22582-1, 22584-7, 23485-6, 23486-4, 23784-2, 24242-0, 25300-5, 25542-2, 33336-9, 34422-6, 35281-5, 35282-3, 40677-7, 40678-5, 40697-5, 40785-8, 40786-6, 41123-1, 41124-9, 42949-8, 47389-2, 47390-0, 56990-5, 56991-3 Rubella/ABO/Rh: A code for Rubella and (ABO or Rh) must be present for this component. Rubella: CPT: 86762 LOINC: 5330-6, 5331-4, 5332-2, 5333-0, 5334-8, 5335-5, 8013-5, 8014-3, 8015-0, 13279-5, 13280-3, 17550-5, 22496-4, 22497-2, 24116-6, 25298-1, 25420-1, 25514-1, 31616-6, 34421-8, 40667-8, 41763-4, 43810-1, 49107-6, 50694-9, 51931-4, 52986-7, 63462-6 ABO: CPT: 86900 LOINC: 883-9, 57743-7 Rh: CPT: 86901 LOINC: 972-0, 978-7, 10331-7, 1305-2, 34961-3 ABO and Rh: LOINC: 882-1, 884-7

DECISION RULE 4
Marker Event
Any visit to a family practitioner or other PCP with diagnosis-based evidence of prenatal care in the form of a documented last menstrual period (LMP) or EDD with either a completed obstetric history or risk assessment and counseling/education.
Administrative
The woman must meet criteria in (Part A and Part B) or Part C. Part A: Any one code: CPT: 99201-99205, 99211-99215, 99241-99245 UB Revenue: 0514 Part B: Any internal organization code for LMP or EDD with an obstetrical history Any internal organization code for LMP or EDD with risk assessment and counseling/education Part C: Any one code: CPT: 99500 HCPCS: H1000-H1004, H1005*

Sources: Harvard Pilgrim Health Care; Refer to Table PPC-C in HEDIS specifications (2013 version).

*Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

**H1005 is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

Table PPC-D: Markers for Prenatal Care Obtainable From Administrative Data

Marker Event
Any visit to an OB/GYN, family practitioner or other PCP with either an ultrasound or a principal diagnosis of pregnancy.
Administrative
The woman must meet criteria in Part A or (Part B and Part C). Part A: Any one code: CPT: 59400*, 59425*, 59426*, 59510*, 59610*, 59618*, 99500 HCPCS: H1000-H1004, H1005** CPT Category II: 0500F, 0501F, 0502F Part B: Any one code: CPT: 76801, 76805, 76811, 76813, 76815-76821, 76825-76828 ICD-9-CM Diagnosis: 640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28 ICD-9-CM Procedure: 88.78 Part C: Any one code: CPT: 99201-99205, 99211-99215, 99241-99245 UB Revenue: 0514

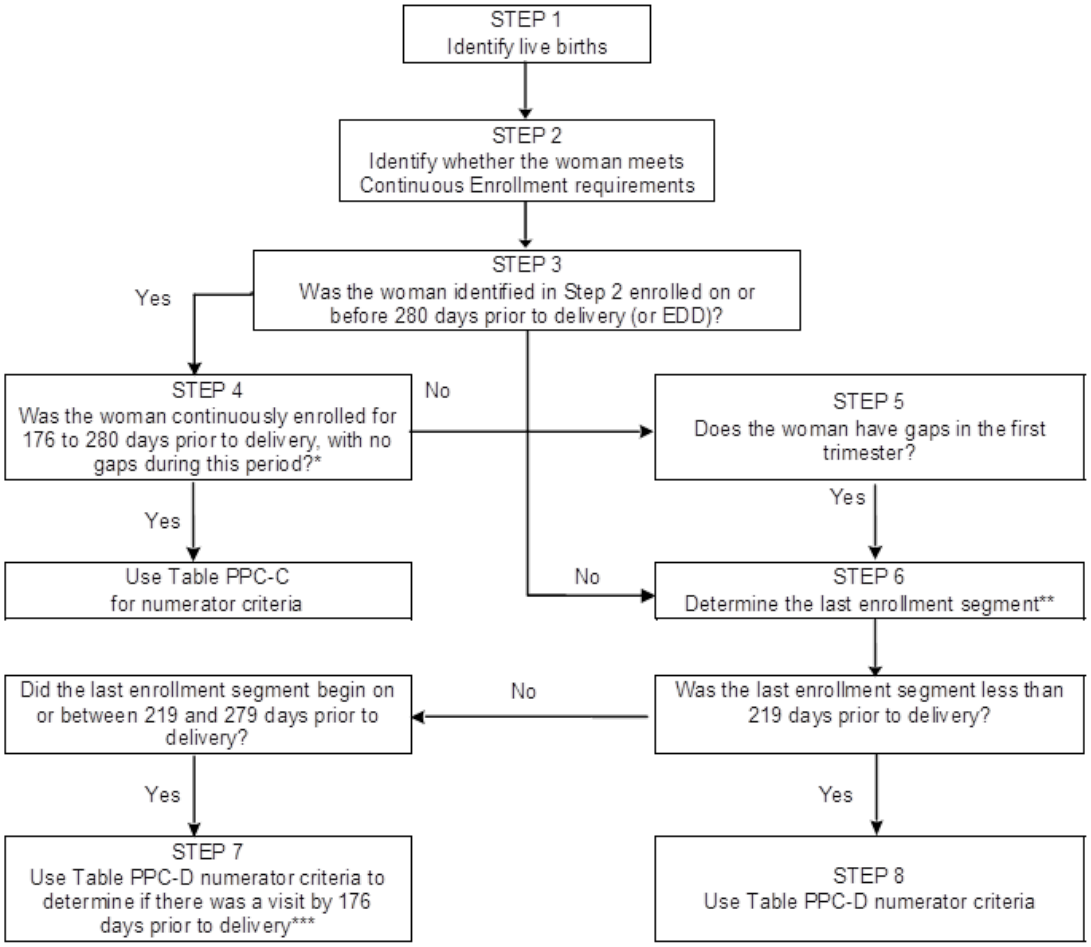
Source: Harvard Pilgrim Health Care; refer to Table PPC-D in HEDIS specifications (2013 version).

Note: If using an ICD-9-CM Diagnosis code from Part B with a CPT or UB revenue code from Part C, the ICD-9-CM Diagnosis code must be on the same claim as the CPT or UB revenue code.

*Generally, these codes are used on the date of delivery, not the first date for OB care, so this code is useful only if the claim form indicates when prenatal care was initiated.

**H1005 is a code that indicates bundled services and is useful only if the claim form indicates when prenatal care was initiated.

Timeliness of Prenatal Care Numerator



*If the woman identified in step 3 was continuously enrolled for the first trimester (176–280 days before delivery), there is no need to look for gaps occurring during other times in the pregnancy. Use the criteria in Table PPC-C to determine numerator compliance. For example, if a woman was enrolled during the first trimester, 176–280 days before delivery with a gap between the 125–150 days before delivery, the Table PPC-C first trimester criteria for numerator compliance must still be met. The gap and last enrollment segment are incidental because the woman meets the first trimester enrollment test.

**See the definition of last enrollment segment.

***The 176 days before delivery includes the 42-day period following enrollment. For example, a woman who had a last enrollment segment 225 days before delivery has until the end of the first trimester (176 days before delivery), instead of the 183 days before delivery under the 42-day criteria. Table PPC-D also has greater flexibility to identify a prenatal care visit.

D.2 - Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population.

Numerator

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in Medicaid/CHIP and gaps in enrollment during the pregnancy. Include only visits that occurred while the woman was enrolled.

Administrative Data

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

Medical Records

Prenatal care visit to an OB/GYN practitioner or midwife, family practitioner or other PCP. For visits to a family practitioner or PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:

A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used)

Evidence that a prenatal care procedure was performed, such as:

Screening test in the form of an obstetric panel (e.g., hematocrit, differential white blood cell [WBC] count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh[D] and ABO blood typing), or

- TORCH antibody panel alone or
- A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
- Echography of a pregnant uterus
- Documentation of LMP or EDD in conjunction with either of the following:
- Prenatal risk assessment and counseling/education, or
- Complete obstetrical history

Note: For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery), count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principal diagnosis of pregnancy.

E. ADDITIONAL NOTES

When counting prenatal visits, include visits with physician assistants (PA), nurse practitioners (NP), midwives and registered nurses (RN) if a physician co-signature is present, if required by state law.

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

The organization must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple estimated dates of delivery (EDD) are documented, the organization must define a method to determine which EDD to use, and use that date consistently.

A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate. A colposcopy alone is not numerator compliant.

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

The intent of the measure is to assess whether prenatal and preventive care were rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

If both Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care are collected using the Hybrid Method, the same sample for collection must be used. If the Hybrid Method is used, a combination of administrative data and medical record review may not be used to identify prenatal care visits for an individual in the denominator. For example, for one woman, two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) may not be counted for one woman, even if each visit shows a different date of service.

Measure LBW: Live Births Weighing Less Than 2,500 Grams

Centers for Disease Control and Prevention
(National Center for Health Statistics)

A. DESCRIPTION

The percentage of live births that weighed less than 2,500 grams in the state during the reporting period.

Guidance for Reporting:

- The denominator should include the number of Medicaid and CHIP resident live births in the state for the measurement period regardless of the length of enrollment for women with these births.

B. ELIGIBLE POPULATION

Deliveries where principal source of payment for delivery is Medicaid or CHIP.

C. DATA SOURCE

State vital records

Numerator

Number of resident live births less than 2,500 grams with Medicaid and/or CHIP as the payer source.

Denominator

Number of resident live births in the state in the reporting period with Medicaid and/or CHIP as the payer source.

Units

Report as a percentage.

Measure CSEC: Cesarean Rate for Nulliparous Singleton Vertex

(Also known as Cesarean Rate for Low-Risk First Birth Women)
California Maternal Quality Care Collaborative

A. DESCRIPTION

The percentage of women that had a cesarean section among women with first live singleton births (also known as nulliparous term singleton vertex [NTSV] births) at 37 weeks of gestation or later.

This measure identifies the portion of cesarean births that has the most variation among practitioners, hospitals, regions, and states and focuses attention on the proportion of cesarean births affected by elective medical practices such as induction and early labor admission. Furthermore, management of the first labor directly impacts the remainder of the woman's reproductive life especially given the current high rate of repeat cesarean births. This measure is used in Healthy People 2010 (Objective 16.9a, USDHHS, 2000) and previously received endorsement from the American College of Obstetricians and Gynecologists (American College of Obstetricians and Gynecologists: Task Force on Cesarean Delivery, 2000).

Guidance for Reporting:

- Risk adjustment is currently not required for purposes of reporting this measure.

B. ELIGIBLE POPULATION

Medicaid and CHIP Births

C. DATA SOURCE

Vital Records (Birth Certificate) either alone or merged with discharge diagnosis data set (see below)

Numerator

The proportion of the denominator that had a cesarean birth

Denominator

Live births at or beyond 37 (37.0) weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions). Parameters are available in administrative data sets.

C.1 – Discharge Data Set Specifications

Numerator

Those in the denominator with a Cesarean Delivery

Denominator

Parity=0

Fetal Presentation= Vertex or cephalic

Gestational age at delivery =/> 37.0

Plurality (number of fetuses) =1 (i.e. a singleton)

C.2 – Patient Discharge Data Set (ICD9)

Primary Cesarean Delivery Rate (IQI 33) methodology below uses patient discharge data (ICD9), and can be used as a start but lacks the ability to identify parity=0 (i.e. first pregnancy). This is the most important risk factor for initial cesarean birth. This data is found in the birth certificate (vital statistics) data and may be linked to the discharge data files. It is easier to use vital records (see above) as is done in many states and by NCHS.

Numerator

Number of cesarean deliveries, identified by DRG, or by ICD-9-CM procedure codes if they are reported without a 7491 hysterectomy procedure.

Table CSEC-A: Cesarean Delivery DRGs

Code	Description
765	CESAREAN SECTION W CC
766	CESAREAN SECTION W/O CC

Table CSEC-B: ICD-9-CM Cesarean Delivery Procedure Codes

Code	Description
740	CLASSICAL C-SECTION
741	LOW CERVICAL C-SECTION
742	EXTRAPERITONEAL C-SECT
744	CESAREAN SECTION NEC
7499	CESAREAN SECTION NOS

Exclusions

Table CSEC-C: ICD-9-CM Procedure Codes

Code	Description
7491	HYSTEROTOMY TO TERMIN PG

Denominator

All Deliveries.

Table CSEC-D: All Delivery ICD-9-CM Code

Code	Description
V27.0	DELIVER-SINGLE LIVEBORN

Table CSEC-E: All Delivery DRGs

Code	Description
765	CESAREAN SECTION W CC
766	CESAREAN SECTION W/O CC

Code	Description
774	VAGINAL DELIVERY W COMPL
775	VAG DELIVERY W/O COMPL
767	VAG DELIV W STERIL OR DC
768	VAG DELIV W OTH OR PROC

Exclusions:

Patients with abnormal presentation, preterm delivery, fetal death, multiple gestation diagnosis codes, breech procedure codes, or a previous Cesarean delivery diagnosis in any diagnosis field.

Table CSEC-F: ICD-9-CM Abnormal Presentation, Preterm, Fetal Death and Multiple Gestation Diagnosis Codes

Code	Description
65130	TWINS W FETAL LOSS-UNSP
65131	TWINS W FETAL LOSS-DEL
65133	TWINS W FETAL LOSS-ANTE
65140	TRIPLETS W FET LOSS-UNSP
65141	TRIPLETS W FET LOSS-DEL
65143	TRIPLETS W FET LOSS-ANTE
65150	QUADS W FETAL LOSS-UNSP
65151	QUADS W FETAL LOSS-DEL
65153	QUADS W FETAL LOSS-ANTE
65160	MULT GES W FET LOSS-UNSP
65161	MULT GES W FET LOSS-DEL
65163	MULT GES W FET LOSS-ANTE
65180	MULTI GESTAT NEC-UNSPEC
65181	MULTI GESTAT NEC-DELIVER
65183	MULTI GEST NEC-ANTEPART
65190	MULTI GESTAT NOS-UNSPEC
65191	MULT GESTATION NOS-DELIV
65193	MULTI GEST NOS-ANTEPART
65220	BREECH PRESENTAT-UNSPEC
65221	BREECH PRESENTAT-DELIVER
65223	BREECH PRESENT-ANTEPART
66960	BREECH EXTR NOS-UNSPEC
66961	BREECH EXTR NOS-DELIVER

Code	Description
65230	TRANSV/OBLIQ LIE-UNSPEC
65231	TRANSVER/OBLIQ LIE-DELIV
65233	TRANSV/OBLIQ LIE-ANTEPAR
65240	FACE/BROW PRESENT-UNSPEC
65241	FACE/BROW PRESENT-DELIV
65243	FACE/BROW PRES-ANTEPART
65260	MULT GEST MALPRESEN-UNSP
65261	MULT GEST MALPRES-DELIV
65263	MULT GES MALPRES-ANTEPAR
65281	MALPOSITION NEC-DELIVER
64420	EARLY ONSET DELIV-UNSPEC
64421	EARLY ONSET DELIVERY-DEL
65640	INTRAUTERINE DEATH-UNSP
65641	INTRAUTER DEATH-DELIVER
65643	INTRAUTER DEATH-ANTEPART
V271	DELIVER-SINGLE STILLBORN
V273	DEL-TWINS, 1 NB, 1 SB
V274	DELIVER-TWINS, BOTH SB
V276	DEL-MULT BRTH, SOME LIVE
V277	DEL-MULT BIRTH, ALL SB
65100	TWIN PREGNANCY-UNSPEC
65101	TWIN PREGNANCY-DELIVERED
65103	TWIN PREGNANCY-ANTEPART
65110	TRIPLET PREGNANCY-UNSPEC
65111	TRIPLET PREGNANCY-DELIV
65113	TRIPLET PREG-ANTEPARTUM
65120	QUADRUPLET PREG-UNSPEC
65121	QUADRUPLET PREG-DELIVER
65123	QUADRUPLET PREG-ANTEPART
66050	LOCKED TWINS-UNSPECIFIED
66051	LOCKED TWINS-DELIVERED
66053	LOCKED TWINS-ANTEPARTUM
66230	DELAY DEL 2ND TWIN-UNSP
66231	DELAY DEL 2ND TWIN-DELIV

Code	Description
66233	DELAY DEL 2 TWIN-ANTEPAR
7615	MULT PREGNANCY AFF NB
V272	DELIVER-TWINS, BOTH LIVE
V275	DEL-MULT BIRTH, ALL LIVE

Table CSEC-G: ICD-9-CM Breech Procedure Codes

Code	Description
7251	PART BRCH EXTRAC W FORCP
7252	PART BREECH EXTRACT NEC
7253	TOT BRCH EXTRAC W FORCEP
7254	TOT BREECH EXTRAC NEC

Table CSEC-H: ICD-9-CM Previous Cesarean Delivery Diagnosis Codes

Code	Description
65420	PREV C-SECT NOS-UNSPEC
65421	PREV C-SECT NOS-DELIVER
65423	PREV C-SECT NOS-ANTEPART]

Measure BHRA: Behavioral Health Risk Assessment (for Pregnant Women)

American Medical Association – Physician Consortium for Performance Measurement

A. DESCRIPTION

Percentage of women, regardless of age, that gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression, alcohol use, tobacco use, drug use, and intimate partner violence.

Guidance for Reporting:

- This measure is specified for calculation using electronic health records.

B. SUMMARY OF E-SPECIFICATION

Clinical Topic	Maternity Care.
Measure Title	Behavioral Health Risk Assessment.
Measure #	MC-3
Measurement Period	12 consecutive months.
Initial Patient Population	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care.
Denominator Statement	Equals Initial Patient Population.
Denominator Exclusions	None.
Numerator Statement	Patients who received the following behavioral health screening risk assessments at the first prenatal visit. Depression screening Patients who were screened for depression at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)). Alcohol use screening Patients who were screened for any alcohol use at the first visit. Tobacco use screening Patients who were screened for tobacco use* at the first visit.

Numerator Statement (continued)	Drug use (illicit and prescription, over the counter) screening Patients who were screened for any drug use at the first visit. Intimate partner violence screening Patients who were screened for intimate partner violence/abuse at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Intimate partner violence screening may include a self-reported validated depression screening tool (e.g., Hurt, Insult, Threaten, and Scream (HITS), Woman Abuse Screening Tool (WAST), Partner Violence Screen (PVS), Abuse Assessment Screen (AAS)). To satisfactorily meet the numerator – ALL screening components must be performed.
Denominator Exceptions	None.

C. MATERNITY CARE DATA REQUIREMENTS FOR HEALTH RISK ASSESSMENT E-SPECIFICATION

Table BHRA-A: Maternity Care Data Requirements: Supplemental Data Elements Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Individual Characteristic	Patient Characteristic	Age at Delivery	LOINC	2.16.840.1.113883.3.526.2.1434	During [Attribute, stop date time: Date of Delivery]	There are no restrictions on age for inclusion in the measure. This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Gender	HL7 (2.16.840.1.113883.5.1)	2.16.840.1.113883.1.111.1	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Race	CDC	2.16.840.1.114222.4.111.836	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Individual Characteristic	Patient Characteristic	Ethnicity	CDC	2.16.840.1.114222.4.11.837	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Preferred Language	CDC	2.16.840.1.114222.4.11.831	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Payer	Source of Payment Typology	2.16.840.1.113883.221.5	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

Table BHRA-B: Maternity Care Data Requirements: Initial Patient Population Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Measure Timing	n/a	Measure-ment Start Date	n/a	n/a	TBD by measure implementer	-
Measure Timing	n/a	Measure-ment End Date	n/a	n/a	TBD by measure implementer	-
Procedure	Procedure, Performed	Vaginal Delivery	GROUPING CPT SNOMED-CT	2.16.840.1.113883.3.526.3.1341 2.16.840.1.113883.3.526.2.1411 2.16.840.1.113883.3.526.2.1412	During measurement period	-

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Procedure	Procedure, Performed	Cesarean Section Delivery	GROUPING CPT SNOMED-CT	2.16.840.1.113883.3.526.3.1342 2.16.840.1.113883.3.526.2.1413 2.16.840.1.113883.3.526.2.1414	During measurement period	-
Attribute	Attribute: stop datetime	Date of Delivery	n/a	n/a	n/a	This data element is the date associated with "Procedure, Performed: Vaginal Delivery" or "Procedure, Performed: Cesarean Section Delivery" collected for the purpose of a 'look back period'. The delivery is the trigger for the measure and the numerator quality actions will be limited to 44 weeks prior to delivery to associate the action with the reporting pregnancy.
Encounter	Encounter, Performed	Prenatal Visit	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.03.1264 2.16.840.1.113883.3.526.02.338	Starts before start of [Procedure, Performed: Vaginal Delivery] <= 44 weeks; starts before start of [Procedure, Performed: Cesarean Section Delivery] <= 44 weeks	-

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

n/a = not applicable

Table BHRA-C: Maternity Care Data Requirements: Denominator and Denominator Exclusions Measure Component

Measure Component	QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Denominator	-	-	-	-	-	-	Equals Initial Patient Population
Denominator Exclusions	-	-	-	-	-	-	None

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

Table BHRA-D: Maternity Care Data Requirements: Numerator Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Risk Category/ Assessment	Risk Category/ Assessment	Depression Screening Tools Related to Maternity Care	GROUPING LOINC	2.16.840.1.113883.3.526.3.1359 2.16.840.1.113883.3.526.2.1441	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	Depression screening may include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)).
Intervention	Intervention, Result	Depression Screening-Procedure	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1360 2.16.840.1.113883.3.526.2.1442	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	-

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Risk Category/ Assessment	Risk Category/ Assessment	Alcohol Use Screening	GROUPING LOINC	2.16.840.1.113883.3.526.3.1361 2.16.840.1.113883.3.526.2.1443	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	-
Risk Category/ Assessment	Risk Category/ Assessment	Tobacco Use Screening	GROUPING LOINC	2.16.840.1.113883.3.526.3.1362 2.16.840.1.113883.3.526.2.1444	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	For the purposes of this measure a 'positive' tobacco use screen will be admittance by patient of ANY use.
Risk Category/ Assessment	Risk Category/ Assessment	Illicit, Prescription and Over the Counter Drug Use Screening	GROUPING LOINC	2.16.840.1.113883.3.526.3.1363 2.16.840.1.113883.3.526.2.1445	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	This data element includes screening for illicit drug use, prescription drug use, and over the counter drug use.
Risk Category/ Assessment	Risk Category/ Assessment	Intimate Partner Violence Screening-Tool	GROUPING LOINC	2.16.840.1.113883.3.526.3.1364 2.16.840.1.113883.3.526.2.1446	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	Intimate partner violence screening may include a self-reported validated screening tool (e.g., Hurt, Insult, Threaten, and Scream (HITS), Woman Abuse Screening Tool (WAST), Partner Violence Screen (PVS), Abuse Assessment Screen (AAS)).

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Attribute	Attribute: Result	Present "X"	n/a	n/a	n/a	This attribute can be applied to the value sets titled: 'Depression Screening Tools Related to Maternity Care,' 'Depression Screening-Procedure,' 'Alcohol Use Screening,' 'Tobacco Use Screening,' 'Drug Use Screening,' 'Intimate Partner Violence Screening-Tool.'

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

Table BHRA-E: Maternity Care Data Requirements: Denominator Exception Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Denominator Exception	-	-	-	-	-	No Valid Denominator Exceptions

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

Measure Performance Rate Calculation:

Performance Rate = N / (D – EXCL – EXCEP)

The PCPI strongly recommends that exception rates also be computed and reported alongside performance rates as follows:

Measure Exception Rate Calculation:

Exception Rate = EXCEP / (D – EXCL)

Exception types:

EXCEP= E1 (Medical Exceptions) + E2 (Patient Exceptions) + E3 (System Exceptions)

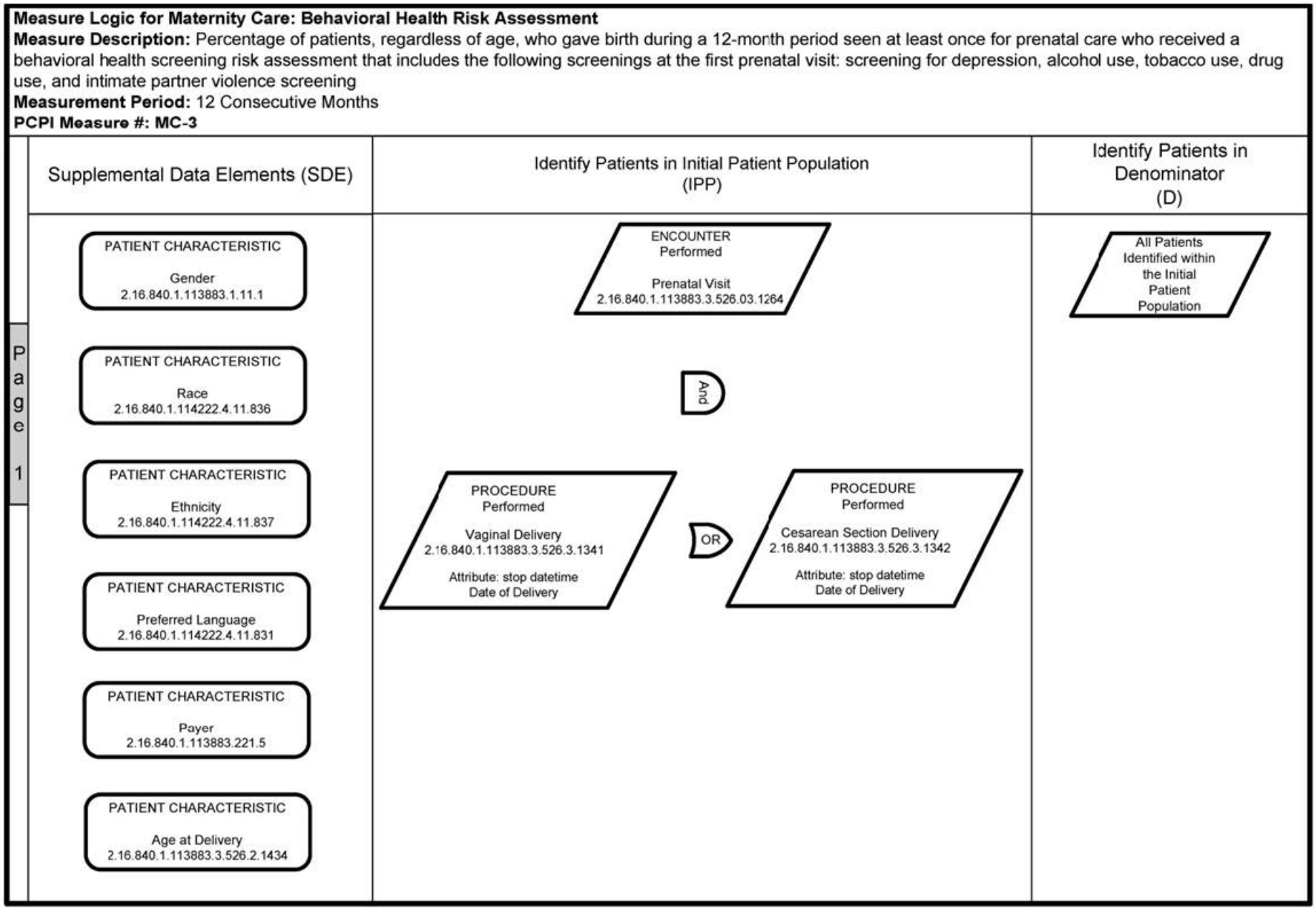
For patients who have more than one valid exception, only one exception should be counted when calculating the exception rate.

C. DEFINITIONS

Initial Patient Population (IPP)	Denominator (D)	Exclusions (EXCL)	Numerator (N)	Exceptions (EXCEP)
Definition: The group of patients that a set of performance measures is designed to address; usually focused on a specific clinical condition (e.g., coronary artery disease, asthma). For example, a patient age 18 and older with a diagnosis of CAD who has at least 2 visits during the measurement period.	Definition: The specific group of patients for inclusion in a specific performance measure based on specific criteria (e.g., patient's age, diagnosis, prior MI). In some cases, the denominator may be identical to the initial patient population.	Definition: The specific group of patients who should be subtracted from the measure population and denominator before determining if the numerator criteria are met.	Definition: The group of patients in the denominator for whom a process or outcome of care occurs (e.g., flu vaccine received).	Definition: The valid reasons why patients who are included in the denominator population did not receive a process or outcome of care (described in the numerator). Patients may have Exceptions for medical reasons (e.g., patient has an egg allergy so did not receive flu vaccine); patient reasons (e.g., patient declined flu vaccine); or system reasons (e.g., patient did not receive flu vaccine due to vaccine shortage). These cases are subtracted from the denominator population for the performance calculation; however, the number of patients with valid exceptions should be calculated and reported. This group of patients constitutes the Exception reporting population – patients for whom the numerator was not achieved and there is a valid Exception.

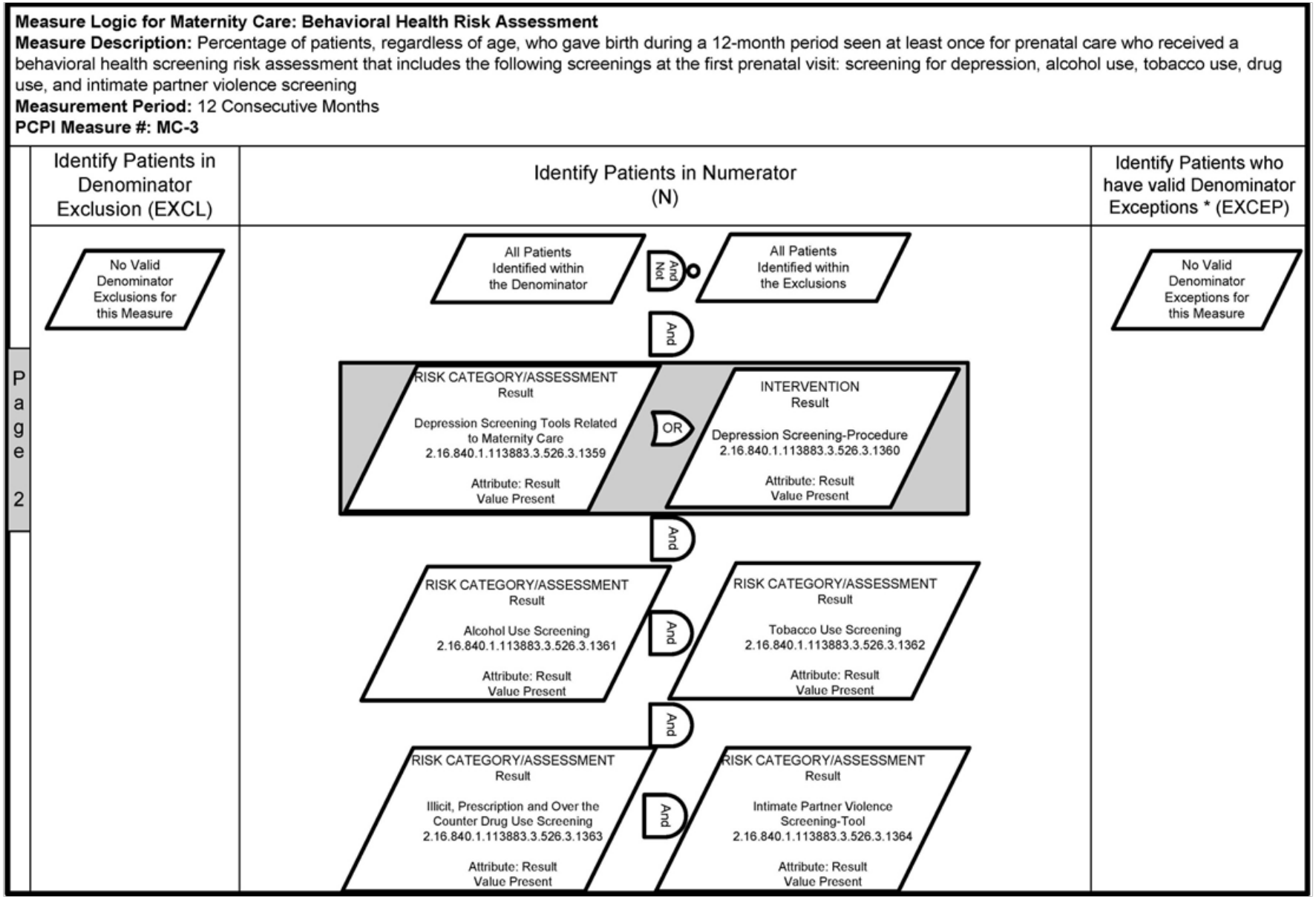
Initial Patient Population (IPP)	Denominator (D)	Exclusions (EXCL)	Numerator (N)	Exceptions (EXCEP)
Find the patients who meet the Initial Patient Population criteria (IPP)	Find the patients who qualify for the Denominator (D): From the patients within the Patient Population Criteria (IPP), select those people who meet Denominator selection criteria. (In some cases the IPP and D are identical).	Find the patients who qualify for the Exclusion (EXCL): From the patients within the Denominator criteria, select those patients who meet Exclusion criteria. The patients meeting exclusion criteria should be removed from the Denominator.	Find the patients who qualify for the Numerator (N): From the patients within the Denominator (D) criteria, select those people who meet Numerator selection criteria. Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.	From the patients who did not meet the Numerator criteria, determine if the patient meets any criteria for the Exception (E1 +E2 +E3). If they meet any criteria, they should be removed from the Denominator for performance calculation. As a point of reference, these cases are removed from the denominator population for the performance calculation, however the number of patients with valid exceptions should be calculated and reported.

Figure BHRA-A: PCPI E-Specification



See Data Requirements Table for timing constraints and relationship between data elements.

Figure BHRA-B: PCPI E-Specification



See Data Requirements Table for timing constraints and relationship between data elements.

*Coded examples for exceptions are NOT intended to be an exhaustive list. Exceptions will vary for each patient and situation.

Measure DEV: Developmental Screening in the First Three Years of Life

Oregon Health and Science University

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

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

C. DATA SOURCE

C.1 – Administrative Specifications

Denominator

Denominator 1: The children in the eligible population who turned 1 during the measurement year.

Denominator 2: The children in the eligible population who turned 2 during the measurement year.

Denominator 3: The children in the eligible population who turned 3 during the measurement year.

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

Numerators

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. The measure is based on three, age-specific indicators.

Numerator 1: Children in Denominator 1 who had a claim with CPT code 96110 by their first birthday

Numerator 2: Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays

Numerator 3: Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays

Numerator 4: Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data: CPT code 96110 (Developmental testing, with interpretation and report)

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

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

C.2 – Medical Record Specifications

Denominator

A systematic sample of 411 drawn from the eligible population stratified by age.

Denominator 1: 137 children from the sample who turned 1 during the measurement year.

Denominator 2: 137 children from the sample who turned 2 during the measurement year.

Denominator 3: 137 children from the sample who turned 3 during the measurement year.

Denominator 4: The entire sample of 411 children.

Numerators

Numerator 1: Children in Denominator 1 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their first birthday.

Numerator 2: Children in Denominator 2 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their first and before or on their second birthday.

Numerator 3: Children in Denominator 3 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their second and before or on their third birthday.

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

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

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

Tools must meet the following criteria:

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

Current recommended tools that meet these criteria:

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

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

D. EXCLUSIONS

None.

E. CALCULATION ALGORITHM

Step 1:

Determine the denominators.

From the total denominator, sort into three age cohorts: children who turned one, two or three years of age between January 1 and December 31 of the measurement year.

Step 2:

Determine the numerators.

For each age cohort, and for the total, identify children who had a screening for developmental, behavioral, and social delays performed by their birthday as found through claims data or documented in the medical chart.

Claims Data:

Children for whom a claim of 96110 was submitted for services in the 12 months preceding their birthday.

Medical Record:

Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding their birthday.

Documentation must include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.

Step 3:

Calculate the age-specific indicators (ages 1 to 3) by dividing the age-specific numerator by the age-specific denominator and multiplying by 100 to get a percentage.

Step 4:

Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

If administrative data are used, the entire eligible population is used for the denominator. If using the hybrid method (administrative plus medical record data sources), a systematic sample can be drawn of 411, with 137 in each age group.

F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

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

data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

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

Measure PA1C: Annual Pediatric Hemoglobin (HbA1c) Testing

National Committee for Quality Assurance

A. DESCRIPTION

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

Guidance for Reporting:

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

B. ELIGIBLE POPULATION

Insurance Coverage	Enrolled in Medicaid or CHIP.
Age	5 to 17 years old as of December 31 of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., a enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year.
Benefit	Medical.
Event/Diagnosis	There are two ways to identify children with diabetes: by pharmacy data and by claim/ encounter data. The organization must use both methods to identify the eligible population, but a child only needs to be identified by one method to be included in the measure. Children may be identified as having diabetes during the measurement year or the year prior to the measurement year. Pharmacy data. Children 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 PA1C-A).

Table PA1C-A: Prescriptions to Identify Children With Diabetes

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

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

Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; enrollees with diabetes on these medications are identified

through diagnosis codes only. A comprehensive list of medications and NDC codes can be found at http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013NDCLicense.aspx.

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

Table PA1C-B: Codes to Identify Diabetes

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

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

Table PA1C-C: Codes to Identify Visit Type

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

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

C. DATA SOURCE

C.1 – Administrative Specifications

Denominator

The eligible population.

Numerator

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

Table PA1C-D: Codes to Identify HbA1c Tests

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

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

Exclusions (optional)

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

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

Table PA1C-E: Codes to Identify Exclusions

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

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

C.2 – HYBRID/EHR Data Specifications

Denominator

A systematic sample of 411 drawn from the eligible population.

Numerator

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

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

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

A1c

HbA1c

Hemoglobin A1c

Glycohemoglobin A1c

HgbA1c

Exclusions (optional)

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

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

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

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of children that turned 15 months old during the measurement year and had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life:

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

Guidance for Reporting:

- A PCP is defined as a physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
- Children should be listed in the numerator for their highest number of visits only. Thus if a child has 5 visits, include the child only in the 5-visit numerator. The sum of all rates should equal 100 percent.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	15 months old during the measurement year.
Continuous Enrollment	31 days to 15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2011, and included in the rate of "six or more well-child visits" must have had six well-child visits by April 8, 2012.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	Day the child turns 15 months old.
Benefit	Medical.
Event/Diagnosis	None.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The eligible population

Numerators

Seven separate numerators are calculated, corresponding to the number of children who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a PCP during their first 15 months of life.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. A child who had a claim/encounter with a code listed in Table W15-A is considered to have received a well-child visit.

Table W15-A: Codes to Identify Well-Child Visits

CPT	HCPCS	ICD-9-CM Diagnosis
99381, 99382, 99391, 99392, 99461	G0438, G0439	V20.2, V20.3, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Source: Refer to Table W15-A in HEDIS specifications (2013 version).

C.2 – Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population for the Medicaid/CHIP product lines.

Numerator

Seven separate numerators are calculated, corresponding to the number of children who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a PCP during their first 15 months of life.

The well-child visit must occur with a PCP.

Administrative Data

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

Medical Records

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following.

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

Do not include services rendered during an inpatient or emergency department (ED) visit.

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

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

D. ADDITIONAL NOTES

This measure is based on the CMS and American Academy of Pediatrics guidelines for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at http://www.aap.org and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at http://www.Brightfutures.org for more information about well-child visits.

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

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of children ages 3 to 6 that had one or more well-child visits with a primary care practitioner (PCP) during the measurement year.

Guidance for Reporting:

- A PCP is defined as a physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	3 to 6 years old as of December 31 of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year.
Benefit	Medical.
Event/Diagnosis	None.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The eligible population

Numerator

At least one well-child visit with a PCP during the measurement year.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. A child who had a claim/encounter with a code listed in Table W34-A is considered to have received a well-child visit.

Table W34-A: Codes to Identify Well-Child Visits

CPT	HCPCS	ICD-9-CM Diagnosis
99382, 99383, 99392, 99393	G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Source: Refer to Table W34-A in HEDIS specifications (2013 version).

C.2 – Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population.

Numerator

At least one well-child visit with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

Administrative Data

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

Medical Records

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

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

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

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

Visits to school-based clinics with practitioners who are considered PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified for the measure. The PCP does not have to be assigned to the child.

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified for the measure.

D. ADDITIONAL NOTES

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

Measure AWC: Adolescent Well-Care Visits

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of enrolled adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year.

Guidance for Reporting:

- A PCP is defined as a physician or non-physician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
- An OB/GYN practitioner is defined as (1) physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology, and (2) certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Ages	12 to 21 years old as of December 31 of the measurement year
Continuous Enrollment	The measurement year.
Allowable Gap	Adolescents who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the adolescent may not have more than a 1-month gap in coverage (i.e., an adolescent whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year.
Benefit	Medical.
Event/Diagnosis	None.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

The eligible population.

Numerator

At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

The PCP does not have to be assigned to the adolescent. Adolescents who had a claim/encounter with a code listed in Table AWC-A are considered to have received a comprehensive well-care visit.

Table AWC-A: Codes to Identify Adolescent Well-Care Visits

CPT	HCPCS	ICD-9-CM Diagnosis
99383-99385, 99393-99395	G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Source: Refer to Table AWC-A in HEDIS specifications (2013 version).

C.2 – Hybrid Data Specifications

Denominator

A systematic sample drawn from the eligible population.

Numerator

At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The PCP does not have to be assigned to the adolescent.

Administrative Data

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

Medical Records

Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following.

A health and developmental history (physical and mental)

A physical exam

Health education/anticipatory guidance

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

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

Visits to school-based clinics with practitioners who are considered PCPs may be counted if documentation that a well-care exam occurred is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the adolescent.

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

D. ADDITIONAL NOTES

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

Measure CHL: Chlamydia Screening in Women

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of women ages 16 to 20 that were identified as sexually active and had at least one test for Chlamydia during the measurement year.

Guidance for Reporting:

- For HEDIS, this measure has 3 reportable rates—ages 16 to 20 and 21 to 24 cohorts and a total (ages 16 to 24). For reporting of the initial core set measure, include the rate for ages 16 to 20 only.
- For states reporting an initial core set measure that is also an Electronic Health Record (EHR) Incentive Program measure, please indicate whether any information was extracted from electronic health records. Please report this information in the "Other Comments on Measure" field in CARTS.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Age	Women ages 16 to 20 as of December 31 of the measurement year.
Continuous Enrollment	The measurement year.
Allowable Gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid/CHIP beneficiary for whom enrollment is verified monthly, the woman may not have more than a 1-month gap in coverage (i.e., a woman whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	December 31 of the measurement year.
Benefit	Medical.
Event/Diagnosis	Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. Both methods must be used 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 CHL-A).

Table CHL-A: Prescriptions to Identify Contraceptives

Description	Prescription
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

Source: Refer to Table CHL-A in HEDIS specifications (2013 version).

Notes: A comprehensive list of medications and NDC codes can be found at http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013NDCLicense.aspx .

Claim/encounter data. Women who had at least one encounter during the measurement year with any code in Table CHL-B.

Table CHL-B: 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

Description	Codes
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
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

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

C. DATA SOURCE

C.1 – Administrative Data Specifications

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 CHL-C.

Table CHL-C: 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

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

Exclusion (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 CHL-D and Table CHL-E to identify exclusions.

Table CHL-D: 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

Description	CPT	UB Revenue
Diagnostic radiology	70010-76499	032x

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

Table CHL-E: Medications to Identify Exclusions

Description	Prescription
Retinoid	isotretinoin

Source: Refer to Table CHL-E in HEDIS specifications (2013 version).

Note: An NDC list for isotretinoin is available at http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013FinalNDCLists.aspx.

Measure PDENT: Percentage Of Eligibles That Received Preventive Dental Services

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and that received preventive dental services.

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted as part of the EPSDT report (CMS-416). States will not be able to provide data for this measure in CARTS. The denominator for this measure includes only individuals enrolled in a Medicaid or CHIP Medicaid expansion program determined to be eligible for EPSDT services. States reporting data about a separate CHIP program should provide dental data in Section IIIG of the CARTS report.

B. ELIGIBLE POPULATION

Age	Individuals ages 1 to 20.
Continuous Enrollment	Eligible for EPSDT services for at least 90 continuous days.

C. DEFINITIONS

Unduplicated	An individual may only be counted once for each line of data.

D. DATA SOURCE

D.1 – Administrative Data Specifications

Numerator

The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (CDT codes D1000 - D1999).

Denominator

The total unduplicated number of individuals ages 1 to 20 that have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days and are eligible to receive EPSDT services.

Services may be provided under both fee-for-service and managed care arrangements and through any other private health plans that contract with the state.

Exclusions

Do not include in this count the following groups of individuals:

- Medically needy individuals ages 1 to 20 if you do not provide EPSDT services for the medically needy population

- Individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available
- Undocumented aliens who are eligible only for emergency Medicaid services
- Children in separate state CHIP programs
- Groups of individuals ages 1 to 20 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services)

Measure TDENT: Percentage of Eligibles That Received Dental Treatment Services

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The percentage of individuals ages 1 to 20 that are enrolled in Medicaid or CHIP Medicaid Expansion programs, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and that received dental treatment services.

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted as part of the EPSDT report (CMS-416). States will not be able to provide data for this measure in CARTS. The denominator for this measure includes only individuals enrolled in a Medicaid or CHIP Medicaid expansion program determined to be eligible for EPSDT services. States reporting data about a separate CHIP program should provide dental data in Section IIIG of the CARTS report.

B. ELIGIBLE POPULATION

Age	Individuals ages 1 to 20.
Continuous Enrollment	Eligible for EPSDT services for at least 90 continuous days.

C. DEFINITIONS

Unduplicated	An individual may only be counted once for each line of data.

D. DATA SOURCE

D.1 – Administrative Data Specifications

Numerator

The unduplicated number of individuals receiving at least one dental treatment service by or under the supervision of a dentist, as defined by HCPCS codes D2000 - D9999 (CDT codes D2000 - D9999).

Denominator

The total unduplicated number of individuals ages 1 to 20 that have been continuously enrolled in Medicaid or a CHIP Medicaid Expansion program for at least 90 days and are eligible to receive EPSDT services.

Services may be provided under both fee-for-service and managed care arrangements and through any other private health plans that contract with the state.

Exclusions

Do not include in this count the following groups of individuals:

- Medically needy individuals ages 1 to 20 if you do not provide EPSDT services for the medically needy population

- Individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available
- Undocumented aliens who are eligible only for emergency Medicaid services
- Children in separate state CHIP programs
- Groups of individuals ages 1 to 20 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services)

Measure MMA: Medication Management for People with Asthma

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of children ages 5 to 20 that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

1. Percentage of children who remained on an asthma controller medication for at least 50 percent of their treatment period.
2. Percentage of children who remained on an asthma controller medication for at least 75 percent of their treatment period.

Guidance for Reporting:

- For HEDIS, this measure has 5 reportable rates – ages 5 to 11, 12 to 18, 19 to 50 and 51 to 64 and a total (ages 5 to 64). For reporting of the initial core set measure, include the rates for ages 5 to 11, 12 to 18 and 19 to 20.

B. DEFINITIONS

IPSD	Index prescription start date. The earliest prescription dispensing date for any asthma controller medication during the measurement year.
Treatment Period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days that a beneficiary is covered by at least one asthma controller 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 (100/30 = 3.33, rounded down to 3). The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled. Multiple prescriptions for different medications dispensed on the same day are assessed separately. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different. Refer to the Oral medication dispensing event definition in ASM for examples.

Inhaler Dispensing Event	Each inhaler (i.e., canister) counts as one dispensing event. Multiple dispensing events of the same or different medication are assessed separately (even if medications were filled on the same date of service). The organization should allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
Injection Dispensing Event	Injections count as one dispensing event. Multiple dispensing events of the same or different medication are assessed separately. The organization should allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
Calculating Number of Days Covered for Multiple Prescriptions	If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication (for the numerator) using the prescriptions with the longest days supply. For multiple different prescriptions dispensed on different days with overlapping days supply, count each day within the treatment period only once toward the numerator. If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days supply and use the total to calculate the number of days covered by a controller medication (for the numerator). For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days supply for a total of 90 days covered by a controller. Use the drug ID provided by the NDC to determine if the prescriptions are the same or different.

C. ELIGIBLE POPULATION

Ages	5 years by December 31 of the measurement year. Report four age stratifications and a total rate: 5 to 11 years. 12 to 18 years. 19 to 20 years. Total. The total is the sum of the age stratifications.
Continuous Enrollment	The measurement year and the year prior to the measurement year.
Allowable Gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid/CHIP beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage during each year of continuous enrollment year.
Anchor Date	December 31 of the measurement year.
Benefits	Medical. Pharmacy during the measurement year.
Event/Diagnosis	Follow the steps below to identify the eligible population for the measure.

Step 1	Identify beneficiaries as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. • At least one ED visit (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A). • At least one acute inpatient claim/encounter (Table ASM-B) with asthma as the principal diagnosis (Table ASM-A). • At least four outpatient asthma visits (Table ASM-B) on different dates of service, with asthma as one of the listed diagnoses (Table ASM-A) and at least two asthma medication dispensing events (Table ASM-C). • At least four asthma medication dispensing events (Table ASM-C).
Step 2	A beneficiary identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Table ASM-A), in any setting, in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).
Step 3: Required Exclusions	• Beneficiaries who had at least one encounter in any setting, with any code to identify a diagnosis of emphysema, COPD, cystic fibrosis or acute respiratory failure (Table ASM-E). Look as far back as possible in the beneficary's history through December 31 of the measurement year. • Beneficiaries who have no asthma controller medications (Table ASM-D) dispensed during the measurement year.

Table ASM-A: Codes to Identify Asthma

Description	ICD-9-CM Diagnosis
Asthma	493.0, 493.1, 493.8, 493.9

Table ASM-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983
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, 0987
ED	99281-99285	045x, 0981

Table ASM-C: Asthma Medications

Description	Prescriptions
Antiasthmatic combinations	Dyphylline-guaifenesin Guaifenesin-theophylline Potassium iodide-theophylline
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol Fluticasone-salmeterol Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone Budesonide Ciclesonide Flunisolide Fluticasone CFC free Mometasone Triamcinolone
Leukotriene modifiers	Montelukast Zafirlukast Zileuton
Long-acting, inhaled beta-2 agonists	Arformoterol Salmeterol Formoterol Indacaterol
Mast cell stabilizers	Cromolyn Nedocromil
Methylxanthines	Aminophylline Dyphylline Oxtriphylline Theophylline
Short-acting, inhaled beta-2 agonists	Albuterol Levalbuterol Metaproterenol Pirbuterol

Table ASM-E: Codes to Identify Required Exclusions

Description	ICD-9-CM Diagnosis
Emphysema	492, 518.1, 518.2
COPD	491.2, 493.2, 496, 506.4
Cystic fibrosis	277.0
Acute respiratory failure	518.81

D. DATA SOURCE

D.1 – Administrative Data Specifications

Denominator

The eligible population

Numerator

Medication Compliance 50%	The number of beneficiaries who achieved a PDC of at least 50% for their asthma controller medications (Table ASM-D) during the measurement year.
Medication Compliance 75%	The number of beneficiaries who achieved a PDC of at least 75% for their asthma controller medications (Table ASM-D) during the measurement year. Follow the steps below to identify numerator compliance.
Step 1	Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication (Table ASM-D) during the measurement year.
Step 2	To determine the treatment period, calculate the number of days from the IPSD (inclusive) to the end of the measurement year.
Step 3	Count the days covered by at least one prescription for an asthma controller medication (Table ASM-D) during the treatment period. To ensure that the days supply does not exceed the treatment period, subtract any days supply that extends beyond December 31 of the measurement year.
Step 4	Calculate the beneficiary's PDC using the following equation. $\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$
Medication Compliance 50%	Sum the number of beneficiaries whose PDC is ≥50% for their treatment period.
Medication Compliance 75%	Sum the number of beneficiaries whose PDC is ≥75% for their treatment period.

Table ASM-D: Asthma Controller Medications

Description	Prescription
Antiasthmatic combinations	Dyphylline-guaifenesin Guaifenesin-theophylline Potassium iodide-theophylline
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol Fluticasone-salmeterol Mometasone-formoterol

Description	Prescription
Inhaled corticosteroids	Beclomethasone Budesonide Ciclesonide Flunisolide Fluticasone CFC free Mometasone Triamcinolone
Leukotriene modifiers	Montelukast Zafirlukast Zileuton
Mast cell stabilizers	Cromolyn Nedocromil
Methylxanthines	Aminophylline Dyphylline Oxtriphylline Theophylline

E. ADDITIONAL NOTES

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

Measure FUH: Follow-Up After Hospitalization for Mental Illness

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of discharges for children ages 6 to 20 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.

- The percentage of discharges for which children received follow-up within 30 days of discharge
- The percentage of discharges for which children received follow-up within 7 days of discharge

Guidance for Reporting:

- The eligible population for this measure includes children ages 6 to 20.
- A mental health practitioner is defined as a practitioner that 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 the practice.
- An individual who is licensed as a psychologist in his/her state of the 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 the practice.
- A registered nurse who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist or who has a master's degree in nursing with a specialization in psychiatric/mental; health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of the practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of the practice or if licensure or certification is not required by the state of the practice, who is eligible for clinical membership in the American Association of Marriage and Family Therapy.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of the

practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors.

- Follow the detailed specifications to (1) include the appropriate discharge when the patient was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the patient was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Ages	6 to 20 years old as of the date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefits	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 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 diagnosis from professional claims to identify discharges. The denominator for this measure is based on discharges, not children. Include all discharges for children who have more than one discharge on or between January 1 and December 1 of the measurement year.

C. DATA SOURCE

C.1 – Administrative Data Specifications

Table FUH-A: Codes to Identify Mental Health Diagnosis

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

Mental Health Readmission or Direct Transfer

If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (Tables FUH-A1, FUH-A2) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the child was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

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

Exclude discharges followed by readmission or direct transfer to a nonacute facility for a mental health principal diagnosis (Tables FUH-A1, FUH-A2) within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-B for codes to identify nonacute care.

Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables FUH-A1 and FUH-A2. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Table FUH-A1: Codes to Identify Mental Health Diagnosis:

ICD
290, 293-302, 306-316

Source: Refer to Table MPT-A in HEDIS specifications (2013 version).

Table FUH-A2: Codes to Identify Inpatient Services:

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

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

Table FUH-B: 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

Description	HCPCS	UB Revenue	UB Type of Bill	POS
Residential substance abuse treatment facility	-	1002	-	55
Psychiatric residential treatment Center	T2048, H0017-H0019	100	-	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)	-	-	-	-

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

Non-mental Health Readmission or Direct Transfer

Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those identified above. These discharges are excluded from the measure because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Denominator

The eligible population

Numerators

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

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

Table FUH-C. Codes to Identify Visits

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

CPT	HCPCS
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner.

CPT	WITH	POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876	WITH	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53

There is no need to determine practitioner type for follow-up visits identified by the following UB revenue codes.

UB Revenue
0513, 0900-0905, 0907, 0911-0917, 0919

Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A.

UB Revenue
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983

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

D. 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 ADD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

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

Initiation Phase: Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication that had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Percentage of children 6 to 12 years old as of the IPSD with an ambulatory prescription dispensed for ADHD medication, that remained on the medication for at least 210 days and, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Guidance for Reporting:

- Children who switch between Medicaid and CHIP and whom the state cannot identify as continuously enrolled between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1 (initiation phase).
- Many of the ADHD medications are also used in the treatment of narcolepsy. In order to have a precise ADHD measure, children with narcolepsy should be removed from the denominator and both indicators.
- Include all paid, suspended, pending, reversed, and denied claims.
- A comprehensive list of medications and NDC codes can be found at: http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013FinalNDCLists.aspx

B. DEFINITIONS

Intake Period	The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.
Negative Medication History	A period of 120 days (4 months) prior to the IPSD, during which time the child had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation Phase	The 30 days following the IPSD.

C&M Phase	The 31–300 days following the IPSD (10 months).
New Episode	The child must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous Medication Treatment	The number of medication treatment days during the 10-month follow-up period must be ≥210 days (i.e., 300 treatment days – 90 gap days).
Treatment Days (Covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

C. ELIGIBLE POPULATION

Eligible Population: Rate 1 – Initiation Phase

Ages	6 years old as of March 1 of the year prior to the measurement year to 12 years old as of February 29 of the measurement year.
Continuous Enrollment	Children must be continuously enrolled in Medicaid/CHIP for 120 days (4 months) prior to the IPSD through 30 days (1 month) after the IPSD.
Allowable Gap	None.
Anchor Date	None.
Benefits	Medical and pharmacy.
Event/Diagnosis	The steps under Administrative Data Specifications: Rate 1 - Initiation Phase (Section E) to identify the eligible population for the Initiation Phase should be followed.

Eligible Population: Rate 2 – Continuation and Maintenance Phase

Ages	6 years old as of March 1 of the year prior to the measurement year to 12 old years as of February 29 of the measurement year.
Continuous Enrollment	Children must be continuously enrolled in Medicaid/CHIP for 120 days (4 months) prior to the IPSD and 300 days (9 months) after the IPSD. Children who switch between Medicaid and CHIP and whom the state cannot identify as continuously enrolled between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1.
Allowable Gap	One 45-day gap in enrollment between 31 days and 300 days after the IPSD. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor Date	None.

Benefits	Medical and pharmacy.
Event/Diagnosis	The steps under Administrative Data Specifications: Rate 2 – Continuation and Maintenance (Section E) to identify the eligible population for the Continuation and Maintenance Phase should be followed.

D. DATA SOURCE

D.1 – Administrative Data Specifications: Rate 1 - Initiation Phase

Denominator

The Rate 1 eligible population:

Step 1

Identify all children in the specified age range that were dispensed an ADHD medication during the 12-month Intake Period:

Table ADD-A: ADHD Medications

Description	Prescription
CNS stimulants	Amphetamine-dextroamphetamine Dexmethylphenidate Dextroamphetamine Lisdexamfetamine Methamphetamine Methylphenidate
Alpha-2 receptor agonists	Clonidine Guanfacine
Miscellaneous ADHD medications	Atomoxetine

Source: Refer to Table ADD-A in HEDIS specifications (2013 version).

Step 2

Test for Negative Medication History. For each child identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3

Calculate continuous enrollment. Children must be continuously enrolled for 120 days prior to the IPSD through 30 days after the IPSD.

Step 4

Exclude children that had an acute inpatient claim/encounter with a principal diagnosis, procedure or DRG code for mental health (Tables ADD-B1 and ADD-B2) or substance abuse (Tables ADD-B3 and ADD-B4) during the 300 days (10 months) after the IPSD.

Table ADD-B1: Codes to Identify Mental Health Diagnosis:

ICD-9-CM Diagnosis
290, 293-302, 306-316

Source: Refer to Table MPT-A in HEDIS specifications (2013 version).

Table ADD-B2: Codes to Identify Inpatient Services:

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

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

Substance Abuse Codes:

Table ADD-B3: Codes to Identify Chemical Dependency Diagnosis

ICD-9-CM Diagnosis
291-292, 303-304, 305.0, 305.2-305.9, 535.3, 571.1

Source: Refer to Table IAD-A in HEDIS specifications (2013 version).

Table ADD-B4: Codes to Identify Inpatient Services

ICD-9-CM Procedure	MS—DRG
94.6x WITH an inpatient facility code	894-897

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

Numerator

One face-to-face outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Use Table ADD-C to identify the follow-up visit.

Note: Do not count a visit on the IPSD as the Initiation Phase visit.

Table ADD-C: Codes to Identify Follow-Up Visits

CPT	HCPCS	UB Revenue
90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 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, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT	WITH	POS
90801, 90802, 90816-90819, 90821-90824, 90826-90829, 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, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	WITH	52, 53

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

D.2 – Administrative Data Specifications: Rate 2 – Continuation and Maintenance

Denominator

The Rate 2 eligible population:

Step 1

Identify all children that meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2

Calculate continuous enrollment. Children must be continuously enrolled from 31 days through 300 days (10 months) after the IPSD.

Step 3

Calculate the continuous medication treatment. Using the children identified in Step 2, determine if the child filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays) should be counted.

Step 4

Exclude children that had an acute inpatient claim/encounter with a principal diagnosis, procedure or DRG code for mental health (Tables ADD-B1 and ADD-B2) or substance abuse (Tables ADD-B3 and ADD-B4) during the 300 days (10 months) after the IPSD.

Numerator

Identify all children that meet the following criteria.

An Initiation Phase Visit in the first 30 days, and

At least two follow-up visits from 31–300 days after the IPSD

One of the two visits (during days 31–300) may be a telephone visit with practitioner. Refer to Table ADD-C for codes to identify follow-up visits; refer to Table ADD-D for codes to identify telephone visits.

Table ADD-D: Codes to Identify Telephone Visits

CPT
98966-98968, 99441-99443

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

Codes to identify telephone visits:

CPT Codes: 98966-98968, 99371-99373, 99441-99443

Exclusions (optional)

Children diagnosed with narcolepsy at any point in their medical history.

Table ADD-E: Code to Identify Exclusions

Description	ICD-9-CM Diagnosis
Narcolepsy	347

Source: Refer to Table ADD-E in HEDIS specifications (2013 version).

E. ADDITIONAL NOTES

For children that have multiple overlapping prescriptions, states should count the overlap days once toward the days supply (regardless of whether the overlap is for the same drug or for a different drug). 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 time frame required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).

Measure CLABSI: Pediatric Central Line-Associated Blood Stream Infections

Centers for Disease Control and Prevention

A. DESCRIPTION

The Standardized Infection Ratio (SIR) of central line-associated blood stream infections (CLABSI) in pediatric and neonatal intensive care units (ICUs). A bloodstream infection must first be determined to be a healthcare-associated infection (HAI) before it can be identified as a CLABSI. Only HAIs can be CLABSIs. An HAI is a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that was not present or incubating on admission to the acute care facility.

Once identified as an HAI, an LCBI is further identified as a CLABSI if a central line (CL) or umbilical catheter (UC) was in place at the time of infection, or removed within 48 hours prior to infection.

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted to the National Healthcare Safety Network. States will not be able to provide data for this measure in CARTS.

B. DEFINITIONS

Intensive Care Unit	A nursing care area in which at least 80 percent of the patients match definitions for critical care locations found in chapter 15, Master CDC Locations and Descriptions, of the NHSN Patient Safety Component Manual. http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf PICU and NICU descriptions can be found on pages 15-9 to 15-12.
Central Line	An intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting CLABSI and counting central-line days: Aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, common iliac veins, femoral veins and in neonates, the umbilical artery/vein. Note: Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart and be used for one of the purposes outlined above to qualify as a central line.
Infusion	The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.
Umbilical Catheter	A central vascular device inserted through the umbilical artery or vein in a neonate.

Temporary Central Line	A non-tunneled and non-implanted catheter.
Permanent Central Line	Includes tunneled catheters, including certain dialysis catheters and Implanted catheters (including ports).

C. DATA SOURCE

C.1 – Medical Record Specifications

Anchor Date

Cases of healthcare-associated infections with dates during the timeframe of selected surveillance.

Numerator

Total number of observed CLABSI among patients in PICUs and NICUs.

CLABSI Criteria:

Laboratory-confirmed bloodstream infection (LCBI):

Must meet one for the following criteria:

Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures and organism cultured from blood is not related to an infection at another site.

Criterion 2: Patient has at least one of the following signs or symptoms: fever (>38 degrees Celsius), chills, or hypotension and signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B.anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.

Criterion 3: Patient < 1 years old has at least one of the following signs or symptoms: fever (>38 degrees Celsius core) hypothermia (<36 degrees Celsius core), apnea, or bradycardia and signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.

Denominator

Total number of predicted CLABSIs, calculated by multiplying the number of central line device days for each location under surveillance for CLABSI during the period by the CLABSI rate for the same types of locations obtained from the standard population during 2006-08. Central line device- day denominator data that are collected differ according to the location of the patients being monitored.

1. Number of appropriate device days for locations under CLABSI surveillance during the period.
2. CLABSI rate per 1,000 device days for the same location types from the standard population reporting CLABSI data to NHSN from 2006-08.

Definition of device days: a daily count of the number of patients with a specific device (i.e. central line) in place in a patient care location. Device days are used for denominators in CLABSI rates. Device day denominator data that are collected differ according to the location of the patients being monitored.

a. For ICUs, the number of patients with one or more central lines of any type is collected daily, at the same time each day during the month. The totals for the month are entered.

b. In NICUs, the number of patients with one or more central lines (including umbilical catheters) is stratified by birth weight in five categories since risk of BSI varies by birthweight.

The ratio is calculated as follows:

1. Identify the number of CLABSI events in each location type.

Total these numbers for an observed number of CLABSIs for the locations of interest (i.e. all pediatric and neonatal ICUs).

Obtain the number of predicted number of CLABSIs in the same location types for the standard population from 2006-08 using the 2009 National Healthcare Safety Network (NHSN) annual rate report:
(http://www.cdc.gov/nhsn/PDFs/dataStat/2009NHSNReport.PDF).

Identify the number of predicted CLABSIs for the locations of interest based on their location types and numbers of central line device days:

a. For each location type, multiply the number of central line device days experienced, by the 2006-08 standard population's CLABSI rate for that location

b. Sum the number of predicted CLABSIs from all locations of interest

Divide the total number of observed CLABSI events ("2" above) by the total "predicted" number of CLABSI events ("4.b." above).

Result = CLABSI standardized infection ratio (SIR)

(The NHSN analysis tool will perform the calculations once the patient infection data and denominator information are entered into the system.)

Tests of significance are needed to tell us whether the number of infections in a hospital is unusually high or low relative to the number of infections that would be predicted given the experience of the standard population(all NHSN hospitals reporting CLABSI data during 2006-08). A p-value provides one method for significance testing. The p-value is a probability that weighs the evidence for determining whether a facility's number of CLABSI events is unusually high or low in comparison to the standard population.

If the p-value is small (less than .05), there is sufficient evidence to suggest that the facility has seen significantly higher or lower numbers of CLABSI events than what would be predicted. If the p-value is greater than .05, then there is not enough evidence to conclude the facility has seen significantly higher or lower numbers of CLABSI events than what would be predicted.

Measure CWP: Appropriate Testing for Children with Pharyngitis

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

The percentage of children ages 2 to 18 that were diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.

Guidance for Reporting:

- If a state does not collect Logical Observation Identifiers Names and Codes (LOINC), states may use only the CPT codes to identify group A streptococcus tests conducted.
- For states reporting a child core set measure that is also an Electronic Health Record (EHR) Incentive Program measure, please indicate whether any information was extracted from electronic health records. Please report this information in the "Other Comments on Measure" field in CARTS.
- Include all paid, suspended, pending, reversed, and denied claims.

B. ELIGIBLE POPULATION

Ages	Children 2 years old as of July 1 of the year prior to the measurement year to 18 years old as of June 30 of the measurement year.
Continuous Enrollment	30 days prior to the Episode Date through 3 days after the Episode Date (inclusive).
Allowable Gap	No gaps in enrollment during the continuous enrollment period.
Anchor Date	Episode Date.
Benefits	Medical and pharmacy.
Event/Diagnosis	Outpatient or ED visit with only a diagnosis of pharyngitis and a dispensed antibiotic for that episode of care during the Intake Period. Follow the steps provided in the administrative specifications (Section E) for the denominator to identify the eligible population.

C. DEFINITIONS

Intake Period	A 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year. The Intake Period captures eligible episodes of treatment.
Episode Date	The date of service for any outpatient or ED visit (Table CWP-B) during the Intake Period with only a diagnosis of pharyngitis (Table CWP-A). Exclude claims/encounters with more than one diagnosis.

IESD	Index Episode Start Date. The earliest Episode Date during the Intake Period that meets all of the following criteria. - Linked to a dispensed antibiotic prescription on or during the three days after the Episode Date -A 30-day Negative Medication History prior to the Episode Date -The child was continuously enrolled during the 30 days prior to the Episode Date through 3 days after the Episode Date
Negative Medication History	To qualify for Negative Medication History, the following criteria must be met. - A period of 30 days prior to the Episode Date, when the child had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug - No prescriptions filled more than 30 days prior to the Episode Date that are active on the Episode Date A prescription is considered active if the "days supply" indicated on the date when the child filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

D. DATA SOURCE

D.1 – Administrative Data Specifications

Denominator

The eligible population as identified using the steps below.

Step 1

Identify all children that had an outpatient or ED visit (Table CWP-B) with only a diagnosis of pharyngitis (Table CWP-A) during the Intake Period. Exclude claims/ encounters with more than one diagnosis.

Table CWP-A: Codes to Identify Pharyngitis

Description	ICD-9-CM Diagnosis
Acute pharyngitis	462
Acute tonsillitis	463
Streptococcal sore throat	034.0

Source: Refer to Table CWP-A in HEDIS specifications (2013 version).

Table CWP-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99382-99385, 99392-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 0982, 0983
ED*	99281-99285	045x, 0981

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

*Do not include ED visits that result in an inpatient admission.

Step 2

Determine all pharyngitis Episode Dates. For each child identified in step 1, determine all outpatient or ED claims/encounters with only a diagnosis of pharyngitis.

Step 3

Determine if antibiotics (Table CWP-C) were dispensed for any of the Episode Dates. For each Episode Date with a qualifying diagnosis, determine if antibiotics were dispensed on or up to three days after. Exclude Episode Dates if the child did not receive antibiotics on or three days after the Episode Date.

Table CWP-C: Antibiotic Medications

Description	Prescription
Aminopenicillins	Amoxicillin Ampicillin
Beta-lactamase inhibitors	amoxicillin-clavulanate
First generation cephalosporins	cefadroxil cefazolin cephalexin
Folate antagonist	Trimethoprim
Lincomycin derivatives	Clindamycin
Macrolides	azithromycin clarithromycin erythromycin erythromycin ethylsuccinate erythromycin lactobionate erythromycin stearate
Miscellaneous antibiotics	erythromycin-sulfisoxazole
Natural penicillins	penicillin G potassium penicillin G sodium penicillin V potassium
Penicillinase-resistant penicillins	Dicloxacillin

Description	Prescription
Quinolones	ciprofloxacin gatifloxacin levofloxacin lomefloxacin moxifloxacin ofloxacin sparfloxacin
Second generation cephalosporins	cefaclor cefprozil cefuroxime loracarbef
Sulfonamides	sulfamethoxazole-trimethoprim sulfisoxazole
Tetracyclines	doxycycline minocycline tetracycline
Third generation cephalosporins	cefdinir cefixime cefpodoxime ceftibuten cefditoren ceftriaxone

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

Note: A comprehensive list of medications and NDC codes can be found at http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2013/HEDIS2013NDCLicense.aspx.

Step 4

Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table CWP-C) was filled 30 days prior to the Episode Date or where a prescription filled more than 30 days prior to the Episode Date was active on the Episode Date.

Step 5

Calculate continuous enrollment. The child must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6

Select the IESD. This measure examines the earliest eligible episode per child.

Numerator

A group A streptococcus test (Table CWP-D) in the seven-day period from three days prior to the IESD through three days after the IESD.

Table CWP-D: Codes to Identify Group A Streptococcus Tests

CPT	LOINC
87070, 87071, 87081, 87430, 87650-87652, 87880	626-2, 5036-9, 6556-5, 6557-3, 6558-1, 6559-9, 11268-0, 17656-0, 18481-2, 31971-5, 49610-9, 60489-2, 68954-7

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

Measure ASMER: Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits

Alabama Medicaid

A. DESCRIPTION

Percentage of children ages 2 to 20 diagnosed with asthma during the measurement year with one or more asthma-related emergency room (ER) visits.

Guidance for Reporting:

- This measure does not require that a child be continuously enrolled to be eligible for the measure. The eligible population is defined by age and diagnosis of asthma.
- For purposes of reporting on the initial core set, the measurement period is the calendar year. Children should be ages 2 to 20 as of December 31st.
- Only include claims once the child is 2 years old. If a child becomes 2 years old during the reporting period, only include claims after the child's second birthday.
- If any of the exclusion diagnoses occur in any setting during the measurement period, exclude the patient from the denominator.
- The December 2011 version of the specification removed the use of at least two short-acting beta adrenergic agents as a method for identifying asthmatics. States should indicate the version of the specifications used for this measure when reporting into CARTS.

B. ELIGIBLE POPULATION

Age	Children ages 2 to 20 during the measurement period
Measurement Period	12 consecutive months
Event/Diagnosis	Diagnosis of asthma during the measurement period

C. DATA SOURCE

C.1 – Administrative Data Specifications

Denominator

Denominator is all patients ages 2 to 20, diagnosed with asthma during the measurement period. Denominator will include recipients with any claims with ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92 as primary and secondary diagnoses with the dates of service "Begin Date through End Date" equal to any consecutive 12 month period with paid dates from "Begin Date through End Date which includes 3 month tail."

Exclusions

ICD-9-CM codes 493.20, 493.21 and 493.22

Numerator

Emergency Department Visits

Numerator is patients with asthma who have an emergency room visit during the measurement period (as identified by procedure codes 99281-99285 AND asthma diagnosis code ICD-9-CM codes 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.81, 493.82, 493.90, 493.91, and 493.92 as the primary diagnosis on the emergency room claim during the measurement period).

Measure AMB: Ambulatory Care - Emergency Department Visits

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

Rate of emergency department (ED) visits per 1,000 enrollee months among children up to age 19.

Guidance for Reporting:

- The entire measure specification was updated based on input from the measure steward. The revised measure specification clarifies the age and continuous enrollment criteria for the eligible population and how to calculate the numerator (number of ED visits), denominator (number of enrollee months), and the ED visit rate per 1,000 enrollee months.
- The eligible population (denominator) for this measure includes children up to age 19. States should include the age range eligible for the state's Medicaid/CHIP program when calculating rates for the three age groups. The age groups for this measure correspond to those included in the HEDIS emergency department utilization measure.
- Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason. If a child is enrolled retroactively, count all services for which the state paid or expects to pay.

B. ELIGIBLE POPULATION

Age	Children up to age 19 enrolled in Medicaid or CHIP. This measure is calculated for three age groups: less than 1, 1 to 9, and 10 to 19.
Continuous Enrollment	None.

C. DEFINITIONS

Member Months	Enrollee months are a beneficiary's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each beneficiary is enrolled in the program during the measurement year.

D. DATA SOURCE

D.1 – Administrative Data Specifications

Denominator

Number of enrollee months

Step 1: Determine enrollee months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The day selected must be consistent from person to person, month to

month, and year to year. For example, if the state tallies enrollment on the 15th of the month and a child is enrolled in the Medicaid or CHIP program on January 15, the child contributes one enrollee month in January.

Retroactive enrollment. The state may include in these enrollee months, any months in which children were enrolled retrospectively and for which the state is responsible for providing benefit coverage.

Step 2: Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if a state tallies enrollment on the 15th of each month and a child turns 10 on April 3 and is enrolled for the entire year, then he or she contributes three enrollee months (January, February, and March) to the 1-9 age category and nine member months to the 10-19 age category.

Numerator

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

Table AMB-B: Codes to Identify ED Visits

CPT	UB Revenue
99281-99285	045x, 0981

OR

CPT	WITH	POS
10040-69979	WITH	23

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

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

Matching enrollment with utilization: Run enrollment reports used for enrollee month calculations to determine utilization rates within 30 days of the claims reports and for the same time period. These reports should include retroactive additions and terminations.

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

E. EXCLUSIONS (REQUIRED)

The measure does not include mental health or chemical dependency services. Exclude (from all categories) claims and encounters that contain any code in Table AMB-C.

Table AMB-C: Codes to Identify Exclusions

Code	Mental Health Exclusion (Exclude if individual has any one of the CPT, principal ICD-9 diagnosis, or ICD-9 procedure codes listed below)	Chemical Dependency Exclusion (Exclude if individual has one of the principal ICD-9 diagnosis AND one of the secondary ICD-9 diagnosis codes listed below)
CPT	90801-90899	-
Principal ICD-9-CM Diagnosis	290-316	960-979
ICD-9-CM Procedure	94.26, 94.27, 94.6	-
Secodary ICD-9-CM Diagnosis	-	291-292, 303-305

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

F. CALCULATION OF THE ED VISIT RATES

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

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

Table AMB-1: ED Visits per 1,000 Enrollee Months, by Age

Age	ED Visits	Enrollee Months	Visits per 1,000 Enrollee Months
<1	.	.	.
1-9	.	.	.
10-19	.	.	.
Unknown	.	.	.
Total	.	.	.

Source: Refer to Table AMB-1 in HEDIS specifications (2013 version).

Measure CPC: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H (Child Version Including Medicaid and with Children with Chronic Conditions Supplemental Items)

National Committee for Quality Assurance/HEDIS

A. DESCRIPTION

Guidance for Reporting:

- For purposes of reporting for the child core set, CAHPS Health Plan Survey 5.0H, Child Version should be used. The inclusion of Children with Chronic Conditions (CCC) supplemental items is encouraged, but not required by CMS. Appendix A contains the CAHPS 5.0H instrument with CCC supplemental items and Appendix B contains the CAHPS 5.0H instrument without the CCC supplemental items.
- 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 survey vendors is available at: http://www.ncqa.org/Portals/0/HEDISQM/Programs/SVC/2013%20HEDIS_CAHPS_Vendor_Web_List_12.20.12.pdf.
- Any deviations in the questionnaire, data collection or survey administration, sampling, or data analysis should be reported in the CARTS field labeled "Additional Notes/Comments on Measure."
- CHIPRA requirement for CAHPS: CHIPRA section 402 requires Title XXI programs to submit to CMS "data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality of care and consumer satisfaction measures included in the CAHPS survey." CHIPRA requires Title XXI programs to conduct specific sampling and data collection. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSFactSheet.pdf.
- A technical assistance brief on collecting and reporting the CAHPS 5.0H survey is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/CAHPSBrief.pdf.

A.1 – CAHPS Health Plan Survey 5.0H, Child Version

This measure provides information on parents' experiences with their child's health care. Results summarize child experiences through ratings, composites, and individual question summary rates.

Four global rating questions reflect overall satisfaction: (1) Rating of All Health Care; (2) Rating of Personal Doctor; (3) Rating of Specialist Seen Most Often; (4) Rating of Health Plan.

Five composite scores summarize responses in key areas: (1) Customer Service; (2) Getting Care Quickly; (3) Getting Needed Care; (4) How Well Doctors Communicate; (5) Shared Decision Making.

A.2 – Children With Chronic Conditions (CCC)

This measure provides information on parents' experience with their child's health care for the population of children with chronic conditions.

Results include the same ratings, composites, and individual question summary rates as those reported for the CAHPS Health Plan Survey 5.0H, Child Version. In addition, three CCC composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions: (1) Access to Specialized Services; (2) Family Centered Care: Personal Doctor Who Knows Child; (3) Coordination of Care for CCC.

Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts: (1) Access to Prescription Medicines; (2) Family Centered Care: Getting Needed Information.

B. IMPLEMENTING THE CAHPS SURVEY

Data Collection	Description
Administration	Survey must be conducted by a third party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol.
Collection mode	Mail only, or mixed (mail and telephone) mode protocols are recommended. Internet enhancement is accepted.
Sample size	The sample needs to be large enough to yield 411 completed surveys per reporting unit (e.g., health plan, PCCM program, or state), a cost-effective method shown to produce statistically valid survey comparisons.

C. COMPLETION CRITERIA

Survey vendors assign a disposition code of Complete and Valid Survey when the respondent appropriately answers one or more survey questions and none of the responses indicate the beneficiary does not meet the eligible population criteria.

Appendix A
CAHPS Health Plan Survey 5.0H
Child Questionnaire
(With CCC Measure)

CAHPS® 5.0H, Child Questionnaire (With CCC Measure)

SURVEY INSTRUCTIONS

Note: The questionnaire is worded for the Medicaid product line. If administering to a commercial product line, replace "6" with "12" in all references to "last 6 months."

- 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}.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. Our records show that your child is now in {INSERT HEALTH PLAN NAME}. Is that right?

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

   [2] ☐ No

2. What is the name of your child's health plan? (please print)

   _____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do not include care your child got when he or she stayed overnight in a hospital. Do not include the times your child went for dental care visits.

3. In the last 6 months, did your child 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 your child needed care right away, how often did your child get care as soon as he or she 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 for your child at a doctor's office or clinic?

   [1] ☐ Yes

   [2] ☐ No →If No, Go to Question 7

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

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

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

   0☐ None → If None, Go to Question 16

   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 your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?

   1☐ Yes

   2☐ No

9. In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

10. In the last 6 months, did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?

    1☐ Yes

    2☐ No →If No, Go to Question 14

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

    1☐ Not at all

    2☐ A little

    3☐ Some

    4☐ A lot

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

    1☐ Not at all

    2☐ A little

    3☐ Some

    4☐ A lot

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

    1☐ Yes

    2☐ No

14. 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 child's 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 healthcare possible

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

16. Is your child now enrolled in any kind of school or daycare?

    1☐ Yes

    2☐ No→ If No, Go to Question 19

17. In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?

    1☐ Yes

    2☐ No →If No, Go to Question 19

18. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?

    1☐ Yes

    2☐ No

SPECIALIZED SERVICES

19. Special medical equipment or devices include a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment. In the last 6 months, did you get or try to get any special medical equipment or devices for your child?

    1☐ Yes

    2☐ No→ If No, Go to Question 22

20. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

21. Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?

    1☐ Yes

    2☐ No

22. In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?

    1☐ Yes

    2☐ No→ If No, Go to Question 25

23. In the last 6 months, how often was it easy to get this therapy for your child?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

24. Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?

    1☐ Yes

    2☐ No

25. In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?

    1☐ Yes

    2☐ No → If No, Go to Question 28

26. In the last 6 months, how often was it easy to get this treatment or counseling for your child?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

27. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?

    1☐ Yes

    2☐ No

28. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?

    1☐ Yes

    2☐ No → If No, Go to Question 30

29. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

    1☐ Yes

    2☐ No

YOUR CHILD'S PERSONAL DOCTOR

30. A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

    1☐ Yes

    2☐ No → If No, Go to Question 45

31. In the last 6 months, how many times did your child visit his or her personal doctor for care?

    0☐ None → If None, Go to Question 41

    1☐ 1 time

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 to 9

    6☐ 10 or more times

32. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

33. In the last 6 months, how often did your child's personal doctor listen carefully to you?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

35. Is your child able to talk with doctors about his or her health care?

    1☐ Yes

    2☐ No →If No, Go to Question 37

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

37. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

38. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

    1☐ Yes

    2☐ No

39. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?

    1☐ Yes

    2☐ No → If No, Go to Question 41

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

41. 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 child's 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

42. Does your child have any medical, behavioral, or other health conditions that have lasted for more than 3 months?

    1☐ Yes

    2☐ No → If No, Go to Question 45

43. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

    1☐ Yes

    2☐ No

44. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

    1☐ Yes

    2☐ No

GETTING HEALTH CARE FROM SPECIALISTS

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

45. 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 for your child to see a specialist?

    1☐ Yes

    2☐ No → If No, Go to Question 49

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

47. How many specialists has your child seen in the last 6 months?

    0☐ None → If None, Go to Question 49

    1☐ 1 time

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 or more specialists

48. We want to know your rating of the specialist your child 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 CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

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

    1☐ Yes

    2☐ No → If No, Go to Question 52

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

52. In the last 6 months, did your child's health plan give you any forms to fill out?

    1☐ Yes

    2☐ No →If No, Go to Question 54

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

54. 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 child's 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

PRESCRIPTION MEDICINES

55. In the last 6 months, did you get or refill any prescription medicines for your child?

    1☐ Yes

    2☐ No → If No, Go to Question 58

56. In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

57. Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

    1☐ Yes

    2☐ No

ABOUT YOUR CHILD AND YOU

58. In general, how would you rate your child's overall health?

    1☐ Excellent

    2☐ Very Good

    3☐ Good

    4☐ Fair

    5☐ Poor

59. In general, how would you rate your child's overall mental or emotional health?

    1☐ Excellent

    2☐ Very Good

    3☐ Good

    4☐ Fair

    5☐ Poor

60. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?

    1☐ Yes

    2☐ No → If No, Go to Question 63

61. Is this because of any medical, behavioral, or other health condition?

    1☐ Yes

    2☐ No →If No, Go to Question 63

62. Is this a condition that has lasted or is expected to last for at least 12 months?

    1☐ Yes

    2☐ No

63. Does your child need or use more medical care, more mental health services, or more educational services than is usual for most children of the same age?

    1☐ Yes

    2☐ No → If No, Go to Question 66

64. Is this because of any medical, behavioral, or other health condition?

    1☐ Yes

    2☐ No → If No, Go to Question 66

65. Is this a condition that has lasted or is expected to last for at least 12 months?

    1☐ Yes

    2☐ No

66. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

    1☐ Yes

    2☐ No → If No, Go to Question 69

67. Is this because of any medical, behavioral, or other health condition?

    1☐ Yes

    2☐ No →If No, Go to Question 69

68. Is this a condition that has lasted or is expected to last for at least 12 months?

    1☐ Yes

    2☐ No

69. Does your child need or get special therapy such as physical, occupational, or speech therapy?

    1☐ Yes

    2☐ No → If No, Go to Question 72

70. Is this because of any medical, behavioral, or other health condition?

    1☐ Yes

    2☐ No → If No, Go to Question 72

71. Is this a condition that has lasted or is expected to last for at least 12 months?

    1☐ Yes

    2☐ No

72. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?

    1☐ Yes

    2☐ No → If No, Go to Question 74

73. Has this problem lasted or is it expected to last for at least 12 months?

    1☐ Yes

    2☐ No

74. What is your child's age?

    00☐ Less than 1 year old

    _____ YEARS OLD (write in)

75. Is your child male or female?

    1☐ Male

    2☐ Female

76. Is your child of Hispanic or Latino origin or descent?

    1☐ Yes, Hispanic or Latino

    2☐ No, not Hispanic or Latino

77. What is your child's 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

78. What is your age?

    0☐ Under 18

    1☐ 18 to 24

    2☐ 25 to 34

    3☐ 35 to 44

    4☐ 45 to 54

    5☐ 55 to 64

    6☐ 65 to 74

    7☐ 75 or older

79. Are you male or female?

    1☐ Male

    2☐ Female

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

    1☐ 8thgrade 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

81. How are you related to the child?

    1☐ Mother or father

    2☐ Grandparent

    3☐ Aunt or uncle

    4☐ Older brother or sister

    5☐ Other relative

    6☐ Legal guardian

    7☐ Someone else

82. Did someone help you complete this survey?

    1☐ Yes → If yes, go to question 83

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

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

    a☐ Read the question to me

    b☐ Wrote down the answer 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.

Appendix B
CAHPS Health Plan Survey 5.0H
Child Questionnaire

CAHPS® 5.0H, Child Questionnaire (Without CCC Measure)

SURVEY INSTRUCTIONS

Note: The questionnaire is worded for the Medicaid product line. If administering to a commercial product line, replace "6" with "12" in all references of "last 6 months."

- 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}.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. Our records show that your child is now in {INSERT HEALTH PLAN NAME}. Is that right?

   [1] ☐ Yes →If yes, go to question 3

   [2] ☐ No

2. What is the name of your child's health plan? (please print)

   _____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do not include care your child got when he or she stayed overnight in a hospital. Do not include the times your child went for dental care visits.

3. In the last 6 months, did your child 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 your child needed care right away, how often did your child get care as soon as he or she 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 for your child at a doctor's office or clinic?

   [1] ☐ Yes

   [2] ☐ No →If No, Go to Question 7

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

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

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

   0☐ None → If None, Go to Question 13

   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 your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?

   1☐ Yes

   2☐ No

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

   1☐ Yes

   2☐ No → If No, Go to Question 13

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

    1☐ Not at all

    2☐ A little

    3☐ Some

    4☐ A lot

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

    1☐ Not at all

    2☐ A little

    3☐ Some

    4☐ A lot

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

    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 child's 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 your child needed?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

YOUR CHILD'S PERSONAL DOCTOR

15. A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

    1☐ Yes

    2☐ No → If No, Go to Question 27

16. In the last 6 months, how many times did your child visit his or her personal doctor for care?

    0☐ None → If None, Go to Question 13

    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 child's personal doctor explain things about your child's health 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 child's personal doctor listen carefully to you?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

20. Is your child able to talk with doctors about his or her health care?

    1☐ Yes

    2☐ No →If No, Go to Question 22

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

22. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

23. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

    1☐ Yes

    2☐ No

24. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?

    1☐ Yes

    2☐ No → If No, Go to Question 26

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

26. 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 child's 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 your child got when he or she stayed overnight in a hospital.

27. 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 for your child to see a specialist?

    1☐ Yes

    2☐ No →If No, Go to Question 31

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

29. How many specialists has your child seen in the last 6 months?

    0☐ None → If None, Go to Question 31

    1☐ 1 specialist

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 or more specialists

30. We want to know your rating of the specialist your child 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 CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

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

    1☐ Yes

    2☐ No →If No, Go to Question 34

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

34. In the last 6 months, did your child's health plan give you any forms to fill out?

    1☐ Yes

    2☐ No →If No, Go to Question 36

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

36. 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 child's health plan?

    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

ABOUT YOUR CHILD AND YOU

37. In general, how would you rate your child's overall health?

    1☐ Excellent

    2☐ Very Good

    3☐ Good

    4☐ Fair

    5☐ Poor

38. In general, how would you rate your child's overall mental or emotional health?

    1☐ Excellent

    2☐ Very Good

    3☐ Good

    4☐ Fair

    5☐ Poor

39. What is your child's age?

    00☐ Less than 1 year old

    _____ YEARS OLD (write in)

40. Is your child male or female?

    1☐ Male

    2☐ Female

41. Is your child of Hispanic or Latino origin or descent?

    1☐ Yes, Hispanic or Latino

    2☐ No, not Hispanic or Latino

42. What is your child's 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

43. What is your age?

    0☐ Under 18

    1☐ 18 to 24

    2☐ 25 to 34

    3☐ 35 to 44

    4☐ 45 to 54

    5☐ 55 to 64

    6☐ 65 to 74

    7☐ 75 or older

44. Are you male or female?

    1☐ Male

    2☐ Female

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

    1☐ 8thgrade 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

46. How are you related to the child?

    1☐ Mother or father

    2☐ Grandparent

    3☐ Aunt or uncle

    4☐ Older brother or sister

    5☐ Other relative

    6☐ Legal guardian

    7☐ Someone else

47. Did someone help you complete this survey?

    1☐ Yes → If yes, go to question 48

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

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

    a☐ Read the question to me

    b☐ Wrote down the answer 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.