MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: ILLINOIS-SPECIFIC REPORTING REQUIREMENTS

Effective as of March 1, 2014, issued April 25, 2014

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Illinois-Specific Reporting Requirements Appendix

Introduction

The measures in this appendix are required reporting for all MMPs in the Illinois Capitated Demonstration. CMS and the state reserve the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements, which can be found at the following web address:

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology.

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®[1] and HOS. CMS and the state will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

Definitions

Calendar Year: All annual measures are reported on a calendar year basis. Calendar year 2014 (CY1) will be an abbreviated year, with data reported for the time period beginning March 1, 2014 and ending December 31, 2014. Calendar year 2015 (CY2) will represent January 1, 2015 through December 31, 2015.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: 1/1 – 3/31, 4/1 – 6/30, 7/1 – 9/30, 10/1 – 12/31. The first quarterly reporting period in CY1 will be an abbreviated quarter with data reported for the time period beginning March 1, 2014 and ending March 31, 2014. All subsequent quarterly reporting periods will align with calendar quarters. Reporting due dates for quarterly measures will occur two months after the end of the quarterly reporting period, e.g. plans would submit data on May 31 for the January 1- March 31 quarter.

[1] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).

Implementation Period: The period of time starting with the first effective enrollment date, March 1, 2014 through December 31, 2014.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Primary Care Provider (PCP): Nurse practitioners, physician assistants or physicians who are board certified or eligible for certification in one of the following specialties: family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics.

Quality Withhold Measures

CMS and each state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: (ⁱ). This document contains only Demonstration Year 1 (DY1) quality withhold measures. CMS will update the quality withhold measures for subsequent demonstration years closer to the start of Demonstration Year 2 (DY2). Additional information on the withhold methodology and benchmarks will be provided at a later time.

Code Tables

The measure specifications in this document include references to code tables that will be used to determined data elements. These code tables can be found in Appendix A starting on page IL-80.

Illinois' Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	3-1-14 through 12-31-14	From the first effective enrollment date through the end of tenth month of the demonstration.
	Ongoing Period	3-1-14 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third demonstration year.

Data Submission

All MMPs will submit data through an Excel template on a secure transmission site. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

The template is available for download at:

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

MMPs should follow the instructions below on how to properly name each data file submitted.

- Required File Format is Microsoft Excel File.
- The file name extension should be ".xls"
- File name= IL_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xls.
- Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), and (SUBMISSIONDATE) the year, month, and date of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331).

Section IL1. Access

IL1.1 Access to a member's assigned primary care provider (PCP). (ICP SAAP Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL1. Access	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members with one or more ambulatory or preventive care visits with the member's assigned PCP during the reporting period.	Of the total reported in A, the number of members with one or more ambulatory or preventive care visits with the member's assigned PCP during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members with one or more ambulatory or preventive care visits with the member's assigned PCP during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- For members assigned a PCP at a specific Federally Qualified Health Center, Rural Health Clinic or Encounter Rate Clinic, any provider assigned to that site may count as the members assigned PCP.
- Count members who changed providers during the year, if they had an ambulatory or preventive care visit with the PCP assigned to them at the time of the visit.
- Exclude residents residing in nursing facilities.
- Codes to identify preventive/ambulatory health services are provided in **Table IL-1**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section IL.II. Assessment

IL2.1 Behavioral health risk assessment and follow-up. (ICP IBHR Measure)

CONTINOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL2. Assessment	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of newly enrolled members.	Total number of newly enrolled members in the MMP who were continuously enrolled for at least 90 days during the reporting period.	Field Type: Numeric
B.	Total number of new members with a behavioral health risk assessment (BHRA) completed within 60 days of enrollment.	Of the total reported in A, the number of new members with a BHRA completed within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.
C.	Total number of new members identified by the plan with a positive BHRA.	Of the total reported in B, the number of new members with a positive BHRA.	Field type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members identified by the plan with a positive BHRA who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after the positive BHRA, including the date of discharge.	Of the total reported in C, the number of members who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after the positive BHRA, including the date of discharge.	Field type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of new members with a:

- BHRA completed within 60 days of enrollment.
- Positive BHRA who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after the positive BHRA.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The 60th day of enrollment should be based on each member's enrollment effective date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- The first reporting period, CY1, begins on March 1, 2014 and ends on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, the new member must be continuously enrolled for at least 90 days between the first day of the reporting period (March 1, 2014) and October 3, 2014.
- Beginning CY2, the new member must be continuously enrolled for at least 90 days between October 4 of the prior reporting period (e.g., October 4, 2014) and October 3 of the current reporting period (e.g., October 3, 2015), with no gaps in enrollment.
- A newly enrolled member is a member not previously enrolled in the MMP in the six months.
- A member may be included in this measure multiple times if they have multiple "new" enrollments during the reporting period, as enrollments more than six months apart would necessitate a new BHRA to be completed. Refer to the codes in **Table IL-2** to identify any of the following that meet criteria for a follow-up visit:
    1. A visit (FUH Stand Alone Visits) with a mental health practitioner;
    2. A visit (FUH Visits Group 1 **AND** FUH POS Group 1) with a mental health practitioner;
    3. A visit (FUH Visits Group 2 **AND** FUH POS Group 2) with a mental health practitioner;
    4. A visit to a behavioral healthcare facility (FUH RevCodes Group 1);
    5. A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2) with a mental health practitioner; or
    6. A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2) with a diagnosis of mental illness (**Table IL-12**).

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL2.2 Moderate and high-risk members with a comprehensive assessment completed within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL2. Assessment	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL2. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of moderate risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of moderate risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of moderate risk members who are documented as unwilling to complete a comprehensive assessment within 90 days of enrollment.	Of the total reported in A, the number of moderate risk members who are documented as unwilling to complete a comprehensive assessment within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of moderate risk members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of moderate risk members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of moderate risk members with a comprehensive assessment completed within 90 days of enrollment.	Of the total reported in A, the number of moderate risk members with a comprehensive assessment completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of high risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of high risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of high risk members who are documented as unwilling to complete a comprehensive assessment within 90 days of enrollment.	Of the total reported in E, the number of high risk members who are documented as unwilling to complete a comprehensive assessment within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
G.	Total number of high risk members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in E, the number of high risk members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
H.	Total number of high risk members with a comprehensive assessment completed within 90 days of enrollment.	Of the total reported in E, the number of high risk members with a comprehensive assessment completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- MMPs should validate that data elements F, G, and H are less than or equal to data element E.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Moderate risk members who were unable to be located to have a comprehensive assessment within 90 days of enrollment.
- Moderate risk members who refused to have a comprehensive assessment completed within 90 days of enrollment.
- Moderate risk members who had a comprehensive assessment completed within 90 days of enrollment.
- Moderate risk members who were willing to participate and who could be located who had a comprehensive assessment completed within 90 days of enrollment.
- High risk members who were unable to be located to have a comprehensive assessment within 90 days of enrollment.
- High risk members who refused to have a comprehensive assessment completed within 90 days of enrollment.
- High risk members who had a comprehensive assessment completed within 90 days of enrollment.
- High risk members who were willing to participate and who could be located who had a comprehensive assessment completed within 90 days of enrollment.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The 90th day of enrollment should be based on each member's effective date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.

- Failed attempts to contact member to complete a comprehensive assessment must be documented and CMS and the state may validate this number.
- MMPs should refer to IL's three-way contract for specific requirements pertaining to a comprehensive assessment.
- Moderate risk members are members identified as needing supportive Care Management services.
- High risk members are members identified as needing intensive Care Management services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section ILIII. Care Coordination

IL3.1 Members with care plans within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to complete a care plan within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	Total number of members with a care plan completed within 90 days of enrollment.	Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C and D are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members who were unable to be located to have a care plan completed within 90 days of enrollment.
- Members who refused to have a care plan completed within 90 days of enrollment.
- Members who had a care plan completed within 90 days of enrollment.
- Members that were willing to participate and who could be located who had an assessment completed within 90 days of enrollment.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.

- The 90th day of enrollment should be based on each member's enrollment effective date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to IL's three-way contract for specific requirements pertaining to a care plan.
- Care plans that are in the process of being developed on the 90th day of the member's enrollment should not be considered complete.
- Failed attempts to contact member to complete a care plan must be documented and CMS and the state may validate this number.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL3.2 Members with documented discussions of care goals.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Quarterly	Contract	Current Calendar Quarter: Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with a care plan developed.	Total number of members with a care plan developed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the care plan.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the care plan.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established threshold for this measure.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members who had a care plan developed in the reporting period who had at least one documented discussion of care goals in the care plan.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Care goal discussions can be completed as part of the initial development of the care plan; when care goals are discussed as part of the development of the care plan, the MMP should only include the care plan in B, when discussion of the care goal is clearly documented in the care plan.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL3.3 Ambulatory care follow-up with a provider within 14 days of emergency department (ED) visit. (ICP IAPE Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of ED visits.	Total number of ED visits that occurred during the reporting period.	Field Type: Numeric
B.	Total number of ED visits that resulted in an ambulatory care follow-up visit with a provider within 14 days following the ED visit.	Of the total reported in A, the number of ED visits that resulted in an ambulatory care follow-up visit with a provider within 14 days following the ED visit.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of ED visits that resulted in an ambulatory care follow-up visit with a provider within 14 days of the ED visit.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The denominator for this measure is based on ED visits, not members.
- The first reporting period, CY1, begins on March 1, 2014 and end on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, include all events for those members who have more than one ED visit on or between the first day of the reporting period (March 1, 2014) and December 17, 2014.
- Beginning CY2, include all events for those members who have more than one ED visit between December 18 of the prior reporting period (e.g., December 18, 2014) and December 17 of the current reporting period (e.g., December 17, 2015).
- The 14 days following December 17 are the lookout period for follow-up visits related to index events occurring on December 17.
- The member needs to be enrolled from the date of the ED discharge through 14 days after the ED discharge, with no gaps in enrollment.
- Count each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit.
- Count multiple ED visits on the same date of service as one visit.
- Codes to identify ED visits are provided in **Table IL-3**.
- Codes to determine follow-up visits are provided in **Table IL-4**.
- Exclude ED discharges in which the patient was transferred directly or readmitted within 14 days to an acute or non-acute facility. These ED discharges are excluded because the hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- Exclude ED visits with a principal diagnosis for mental illness or chemical dependency. Codes to identify exclusions are provided in **Table IL-34**.

- Exclude discharges due to death. Codes to identify patients who have expired are provided in **Table IL-33**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL3.4 Ambulatory care follow-up with a provider within 14 days of inpatient discharge. (ICP IAPI Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of inpatient discharges.	Total number of inpatient discharges that occurred during the reporting period.	Field Type: Numeric
B.	Total number of inpatient discharges that resulted in an ambulatory care follow-up visit with a provider within 14 days following the inpatient discharge.	Of the total reported in A, the number of inpatient discharges that resulted in an ambulatory care follow-up visit with a provider within 14 days following the inpatient discharge.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of inpatient discharges that resulted in an ambulatory care follow-up visit with a provider within 14 days following the inpatient discharge.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The denominator for this measure is based on inpatient discharges, not members.
- The first reporting period, CY1, begins on March 1, 2014 and ends on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, include all events for those members who have more than one discharge on or between the first day of the reporting period (March 1, 2014) and December 17, 2014.
- Beginning CY2, include all events for those members who have more than one discharge on or between December 18 of the prior reporting period (e.g., December 18, 2014) and December 17 of the current reporting period (e.g., December 17, 2015).
- The 14 days following December 17 are the lookout period for follow-up visits related to index events occurring on December 17.
- The member needs to be enrolled from the date of the discharge through 14 days after the discharge, with no gaps in enrollment.
- Codes to determine follow-up visits are provided in **Table IL-4**.
- Codes to identify inpatient services are provided in **Table IL-57**. If the MMP does not capture MS-DRG, then use the codes provided in **Table IL-58**.
- Exclude discharges in which the patient was transferred directly or readmitted within 14 days after discharge to an acute or non-acute facility. These discharges are excluded because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- Exclude inpatient discharges with a principal diagnosis of mental health or chemical dependency. Codes to identify these exclusions are provided in **Table IL-34**.

- Exclude inpatient hospitalizations for deliveries (births). Codes to identify maternity exclusions are provided in **Table IL-35**.
- Codes to identify inpatient discharges are provided in **Table IL-5**.
- Exclude discharges due to death. Codes to identify patients who have expired are provided in **Table IL-33**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL3.5 Follow-up with a provider within 30 days after an initial behavioral health diagnosis. (ICP IFUP Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial behavioral health diagnosis.	Total number of members with an initial behavioral health diagnosis.	Field Type: Numeric
B.	Total number of members who had an outpatient visit, intensive outpatient encounter or partial hospitalization with any practitioner within 30 days after the initial diagnosis.	Of the total reported in A, the number of members who had an outpatient visit, intensive outpatient encounter or partial hospitalization with any practitioner within 30 days after the initial diagnosis during the reporting period.	Field type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members with an initial behavioral health diagnosis who had an outpatient visit, intensive outpatient encounter or partial hospitalization with any practitioner within 30 days after the initial diagnosis during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The member must be continuously enrolled for 30 days following the date of the initial behavioral health diagnosis, with no gaps in enrollment.
- The first reporting period, CY1, begins on March 1, 2014 and ends on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, the member must be diagnosed with a mental illness between the first day of the reporting period (March 1, 2014) and December 1, 2014.
- Beginning CY2, the member must be diagnosed with a mental illness between December 2 of the prior reporting period (e.g., December 2, 2014) and December 1 of the current reporting period (e.g., December 1, 2015). Use the earliest diagnosis that occurred during the reporting period.
- To be considered the initial diagnosis, the member should have negative claims/encounter history with a mental health diagnosis (principal or secondary diagnosis) for the six month period prior to the current episode.
- Codes to identify members diagnosed with mental illness are provided in **Table IL-12**.

- Refer to the codes in **Table IL-2** to identify any of the following that meet criteria for a follow-up visit:
    1. A visit (FUH Stand Alone Visits);
    2. A visit (FUH Visits Group 1 **AND** FUH POS Group 1);
    3. A visit (FUH Visits Group 2 **AND** FUH POS Group 2);
    4. A visit to a behavioral healthcare facility (FUH RevCodes Group 1); or
    5. A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2).
- Exclude members admitted to or directly transferred to a non-acute facility for a mental health principal diagnosis (Table IL-16) within the 30-day follow-up period. These members are excluded from the measure because admission or transfer may prevent an outpatient follow-up visit from taking place. Refer to the codes provided in Table IL-10 to identify non-acute care.
- Exclude members transferred directly or admitted within 30 days after the initial diagnosis to an acute or non-acute facility for a non-mental health principal diagnosis. These members are excluded from the measure because a hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL3.6 Movement of members between community, waiver, and long-term care services. (ICP IMWS Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled.	Total number of members enrolled as of the first day of the reporting period.	Field Type: Numeric
B.	Total number of members in the Community.	Of the total reported in A, the number of members in the Community as of the first day of the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members classified as remaining in the Community.	Of the total reported in B, the number of members classified as remaining in the Community as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members classified as being in an LTSS waiver.	Of the total reported in B, the number of members classified as being in an LTSS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.
E.	Total number of members classified as being in Long Term Care (LTC).	Of the total reported in B, the number of members classified as being in LTC as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.
F.	Total number of members no longer enrolled.	Of the total reported in B, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.
G.	Total number of members in an LTSS waiver.	Of the total reported in A, the number of members in an LTSS waiver as of the first day of the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of members classified as being in the Community.	Of the total reported in G, the number of members classified as being in the Community as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.
I.	Total number of members classified as remaining in an LTSS waiver.	Of the total reported in G, the number of members classified as remaining in an LTSS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.
J.	Total number of members classified as being in LTC.	Of the total reported in G, the number of members classified as being in LTC as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.
K.	Total number of members no longer enrolled.	Of the total reported in G, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.
L.	Total number of members in LTC.	Of the total reported in A, the number of members in LTC as of the first day of the reporting period.	Field Type: Numeric Note: Is a subset of A.
M.	Total number of members classified as being in the Community.	Of the total reported in L, the number of members classified as being in the Community as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.
N.	Total number of members classified as being in an LTSS waiver.	Of the total reported in L, the number of members classified as being in an LTSS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.
O.	Total number of members classified as remaining in LTC.	Of the total reported in L, the number of members classified as remaining in LTC as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.

Element Letter	Element Name	Definition	Allowable Values
P.	Total number of members no longer enrolled.	Of the total reported in L, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.
Q.	Total number of members who had no movement between services.	Of the total reported in A, the number of members who remained in the same service classification as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of A. Is the sum of C, I and O.
R.	Total number of members no longer enrolled.	Of the total reported in A, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of A. Is the sum of F, K, and P.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements C, D, E, and F are less than or equal to data element B.
- MMPs should validate that data elements H, I, J, and K are less than or equal to data element G.
- MMPs should validate that data elements M, N, O, and P are less than or equal to data element L.
- MMPs should validate that data elements B, G, L, Q, and R are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members in the Community as of the first day of the reporting period who were classified as remaining in the Community as of the last day of the reporting period.
- Members in the Community as of the first day of the reporting period who were classified as being in an LTSS waiver as of the last day of the reporting period.
- Members in the Community as of the first day of the reporting period who were classified as being in LTC as of the last day of the reporting period.
- Member in the Community as of the first day of the reporting period who were no longer enrolled in the MMP as of the last day of the reporting period.
- Members in an LTSS waiver as of the first day of the reporting period who were classified as being in the Community as of the last day of the reporting period.
- Members in an LTSS waiver as of the first day of the reporting period who were classified as remaining in an HCBS waiver as of the last day of the reporting period.
- Members in an LTSS waiver as of the first day of the reporting period who were classified as being in LTC as of the last day of the reporting period.
- Members in an LTSS waiver as of the first day of the reporting period who were no longer enrolled in the MMP as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were classified as being in the Community as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were classified as being in an LTSS waiver as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were classified as remaining in LTC as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were no longer enrolled in the MMP as of the last day of the reporting period.
- Members enrolled as of the first day of the reporting period who had no movement between services as of the last day of the reporting period.
- Members enrolled in the MMP as of the first day of the reporting period who were no longer enrolled as of the last day of the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
    - MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
    - Exclude LTC stays of 90 days or less. Report these members in the classification they were in prior to the short stay.
    - Members are classified as in the Community, an LTSS waiver, or Nursing Facility in accordance with the rate cell definitions provided on page 174 of the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an LTSS waiver.

F. Data Submission – how MMPs will submit data collected to CMS and the state.
    - MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section ILIV. Enrollee Protections

IL4.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL4. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL4. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of total critical incident and abuse reports per 1,000 members receiving LTSS.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
- Abuse refers to:

  1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
  2. Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
  3. Rape or sexual assault;
  4. Corporal punishment or striking of an individual;
  5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
  6. Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section ILV. Organizational Structure and Staffing

IL5.1 Americans with Disabilities Act (ADA) compliance.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	ADA Compliance Plan.	ADA Compliance Plan (including training activities).	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	Identification of the Compliance or Quality Officer responsible for ADA compliance.	Identification of the Compliance or Quality Officer responsible for ADA compliance.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
C.	Assessment of implementation activities.	Assessment of implementation activities.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
D.	Development of implementation of corrective action, including plans, goals, and timelines.	Development of implementation of corrective action, including plans, goals, and timelines.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established threshold for this measure.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- To be determined.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- To be determined.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- To be determined.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx
- For data submission, each data element above should be uploaded as a separate attachment.
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx".
- File name= IL_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE)_(ELEMENTNAME).docx.
- Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), (SUBMISSIONDATE) the year, month, and date of the submission in YYYYMMDD format (e.g., March 30, 2014 would be 20140330), and (ELEMENTNAME) with the element name listed below.
- For element letter "A", the (ELEMENTNAME) should be (PLAN).
- For element letter "B", the (ELEMENTNAME) should be (OFFICER).
- For element letter "C", the (ELEMENTNAME) should be (EVALUATION).
- For element letter "D", the (ELEMENTNAME) should be (DEVELOPMENT).

IL5.2 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of care coordinators who have been employed by the MMP for at least 30 days.	Total number of new care coordinators who have been employed by the MMP for at least 30 days during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators that have undergone training for supporting self-direction under the demonstration within the past 12 months.	Of the total reported in A, the number of new care coordinators that have undergone training for supporting self-direction under the demonstration within the past 12 months.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of new care coordinators that have undergone state-based training for supporting self-direction.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should refer to IL's three-way contract for specific requirements pertaining to a care coordinator.
- MMPs should refer to IL's three-way contract for specific requirements pertaining to supporting self-direction.
- A care coordinator includes all full-time and part-time staff, who have been employed by the MMP for at least 30 days.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section ILVI. Performance and Quality Improvement

IL6.1 Adherence to antipsychotic medications for individuals with schizophrenia. (ICP SAA Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with schizophrenia.	Total number of members with schizophrenia, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who achieved a proportion of days covered (PDC) of at least 80% for their antipsychotic medications.	Of the total reported in A, the number of members who achieved a PDC of at least 80% for their antipsychotic medications during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members who achieved a PDC of at least 80% for their antipsychotic medications during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- IPSD is the index prescription start date. It is the earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the reporting period.
- Treatment period is the period of time beginning on the IPSD through the last day of the reporting period.
- PDC is the proportion of days covered. It is the number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
- Oral medication dispensing event is 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.
    1. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.
- Long-acting injections dispensing event count as one dispensing event. Multiple J codes or National Drug Codes (NDC) for the same or different medication on the same day are counted as a single dispensing event.
- Follow the instructions below to determine how to calculate the number of days covered for oral medications.
    1. If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for

the numerator) using the prescription with the longest days supply.
2. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator.
3. If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator).
    - For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.

- To calculate number of days covered for long-acting injections, use the days-supply specified for the medication list in **Table IL-20**.
    1. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply.
    2. For multiple J Codes or NDCs for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Follow the steps outlined below to identify the <u>eligible population</u> (data element A).

    Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the reporting period.
        - At least one acute inpatient claim/encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:
            - **Table IL-6**, BH Stand Alone Acute Inpatient value set ***WITH*** **Table IL-13**, Schizophrenia value set.

  - **Table-7**, BH Acute Inpatient value set ***WITH*** **Table IL-8**, BH Acute Inpatient POS value set ***AND*** **Table IL-13**.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meets criteria:
  - **Table IL-6**, BH Stand Alone Outpatient/PH/IOP value set ***WITH*** **Table IL-13**, Schizophrenia value set.
  - **Table IL-7**, BH Outpatient/PH/IOP value set ***WITH*** **Table IL-8**, BH Outpatient/PH/IOP POS value set ***AND*** **Table IL-13**.
  - **Table IL-6**, ED value set ***WITH*** **Table IL-13**.
  - **Table IL-7**, BH ED value set ***WITH*** **Table IL-8**, BH ED POS value set ***AND*** **Table IL-13**.
  - **Table IL-6**, BH Stand Alone Nonacute Inpatient value set ***WITH*** **Table IL-13**.
  - **Table IL-7**, BH Nonacute Inpatient value set ***WITH*** **Table IL-8**, BH Nonacute Inpatient POS value set ***AND*** **Table IL-13**.

Step 2: Identify required exclusions.
- Exclude members with a diagnosis of dementia (**Table IL-15**) during the reporting period.
- Exclude members who did not have at least two antipsychotic medication (**Table IL-20**) dispensing events during the reporting period.

- Follow the steps outlined below to identify <u>numerator compliance</u> (data element B).

Step 1: Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (**Table IL-20** in conjunction with **Table IL-21**) during the reporting period.

Step 2: Determine the treatment period. Calculate the number of days from the IPSD (inclusive) to the end of the reporting period.

Step 3: Count the days covered by at least one antipsychotic medication (**Table IL-20** in conjunction with **Table IL-21**) 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 reporting period.

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

$$\frac{\textbf{Total days covered by an antipsychotic medication in the treatment period (Step 3)}}{\textbf{Total days in treatment period (Step 2)}}$$

Step 5: Sum the number of members whose PDC is ≥80% for their treatment period.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL6.2 Cervical cancer screening. (ICP CCS Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of female members 24-64 years old.	Total number of female members 24-64 years old, who were continuously enrolled during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of female members sampled that met inclusion criteria.	Of the total reported in A, the number of female members sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of female members who were appropriately screened for cervical cancer.	Of the total reported in B, the number of female members who were appropriately screened for cervical cancer during the reporting period.	Field Type: Numeric Note: Is a subset of B.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A and greater than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of female members 24-64 years old who were appropriately screened for cervical cancer during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all female members ages 24-64 regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria this measure will be reported beginning CY2.

Administrative Specifications

- The MMP should refer to the HEDIS® Value Sets listed in steps 1 and 2 to identify numerator positive hits when using administrative data.
  - **Step 1**: Identify women 24-64 years of age as of December 31 of the reporting period who had a cervical cytology (**Table IL-24**) during the reporting period or the two years prior to the reporting period.
  - **Step 2**: From the women who did not meet step 1 criteria, identify women 35-64 years of age as of December 31 of the reporting period who had cervical cytology (**Table IL-24**) and a human papillomavirus (HPV) test (**Table IL-25**) with service dates four or less days apart during the reporting period or the four years prior to the reporting period.
  - **Step 3**: Sum the events from steps 1 and 2 to obtain the rate.
- Exclude hysterectomy (Table IL-36) with no residual cervix any time during the member's history through December 31 of the reporting period.

Hybrid Specifications

- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.
- Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- The MMP should refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- When reviewing a members medical record, the following steps should be used to identify numerator compliance.
  - **Step 1**: Identify the number of women who are 24–64 years of age as of December 31 of the reporting period who had cervical cytology during the reporting period, or the two years prior to the reporting period. Documentation in the medical record must include both of the following:
    - A note indicating the date when the cervical cytology was performed.
    - The result or finding.
  - Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Step 2: From the women who did <u>not</u> meet step 1 criteria, identify the number of women who are 35–64 years of age as of December 31 of the reporting period who had cervical cytology and an HPV test on the same date of service during the reporting period or the four years prior to the reporting period. Documentation in the medical record must include both of the following:
  - A note indicating the date when the cervical cytology and the HPV test were performed.
  - The result or finding.
- Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
- In administrative data, there is flexibility in the date of service to allow for a potential lag in claims.
- In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.
- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

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

- Exclude the following (these are optional exclusions):
  1. Hysterectomy with no residual cervix (**Table IL-36**) any time during the member's history through December 31 of the reporting period. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.
  2. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL6.3 Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with schizophrenia or bipolar disorder.	Total number of members with schizophrenia or bipolar disorder, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who had a glucose test or an HbA1c test.	Of the total reported in A, the number of members who had a glucose test or HbA1c test during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members with schizophrenia or bipolar disorder who had a glucose test or HbA1c test during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Follow the steps outlined below to identify the <u>eligible population</u> (data element A).
    1. **Step 1**: Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the reporting period:
        - At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
            - **Table IL-6**, BH Stand Alone Acute Inpatient value set ***WITH*** **Table IL-13**, Schizophrenia value set.
            - **Table IL-6**, BH Stand Alone Acute Inpatient value set ***WITH*** **Table IL-14**, Bipolar Disorder value set.
            - **Table IL-7**, BH Acute Inpatient value set ***WITH*** **Table IL-8**, BH Acute Inpatient POS value set ***AND*** **Table IL-13.**

  - **Table IL-7**, BH Acute Inpatient value set ***WITH*** **Table IL-8**, BH Acute Inpatient POS value set ***AND*** **Table IL-14.**

- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia.
  - **Table IL-6**, BH Stand Alone Outpatient/PH/IOP value set ***WITH*** **Table IL-13**.
  - **Table IL-7**, BH Outpatient/PH/IOP value set ***WITH*** **Table IL-8**, BH Outpatient/PH/IOP POS value set ***AND*** **Table IL-13**.
  - **Table IL-6**, ED value set ***WITH*** **Table IL-13**.
  - **Table IL-7**, BH ED value set ***WITH*** **Table IL-8**, BH ED POS value set ***AND*** **Table IL-13**.
  - **Table IL-6**, BH Stand Alone Nonacute Inpatient value set ***WITH*** **Table IL-13**.
  - **Table IL-7**, BH Nonacute inpatient value set ***WITH*** **Table IL-8**, BH Nonacute Inpatient POS value set ***AND*** **Table IL-13**.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder.
  - **Table IL-6**, BH Stand Alone Outpatient/PH/IOP value set ***WITH*** **Table IL-14**.
  - **Table IL-7**, BH Outpatient/PH/IOP value set ***WITH*** **Table IL-8**, BH Outpatient/PH/IOP POS value set ***AND*** **Table IL-14**.
  - **Table IL-6**, ED value set ***WITH*** **Table IL-14**.
  - **Table IL-7**, BH ED value set ***WITH*** **Table IL-8**, BH ED POS value set ***AND*** **Table IL-14**.
  - **Table IL-6**, BH Stand Alone Nonacute Inpatient value set ***WITH*** **Table IL-14**.
  - **Table IL-7**, BH Nonacute inpatient value set ***WITH*** **Table IL-8**, BH Nonacute Inpatient POS value set ***AND*** **Table IL-14**.

2**. Step 2**: Exclude members who met any of the following criteria:
   - Members with diabetes. The MMP must use both claim/encounter data and pharmacy data to identify members with diabetes, but a member only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the current reporting period or the prior reporting period.
     - *Claim/encounter data*. Members who met any of the following criteria during the reporting period or the prior reporting period:
       i. At least two outpatient visits (**Table IL-9**, Outpatient value set), observation visits (**Table IL-9**, Observation value set), or nonacute inpatient encounters (**Table IL-9**, Nonacute Inpatient value set), on different dates of service, with a diagnosis of diabetes (**Table IL-17**).
          1. The visit type does not have to be the same for the two visits.
       ii. At least one acute inpatient encounter (**Table IL-9**, Acute Inpatient value set), with a diagnosis of diabetes (**Table IL-17**).
       iii. At least one ED visit (**Table IL-9**, ED value set) with a diagnosis of diabetes (**Table IL-17**).
     - *Pharmacy data*. Members who were dispensed insulin or oral hypoglycemic/antihyperglycemics (**Table IL-19**) during the reporting period or the prior reporting period on an ambulatory basis.
   - Members who had no antipsychotic medications dispensed during the reporting period. The MMP must use both claim/encounter data and pharmacy data to identify dispensing events, but an event only needs to be identified by one method to be excluded from the measure.
     - *Claim/encounter data*. An antipsychotic medication (**Table IL-20**).
     - *Pharmacy data*. Dispensed an antipsychotic medication (**Table IL-20**) on an ambulatory basis.

- Refer to codes provided in **Table IL-26** to identify glucose tests.
- Refer to codes provided in **Table IL-27** to identify HbA1c tests.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL6.4 Comprehensive diabetes care (administrative method). (ICP SCDC Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members age 18-75 who have a diagnosis of diabetes.	Total number of members age 18-75 who were continuously enrolled in the MMP during the current reporting period, who had a diagnosis of diabetes during the current reporting period or the prior reporting period, and who were enrolled on December 31 of the current reporting period.	Field Type: Numeric
B.	Total number of days the member was enrolled.	Of the total reported in A, the number of days the member was enrolled during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of days supply for all statin prescriptions filled.	Of the total reported in B, the number of days supply for all statin prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of days supply for all ACE/ARB prescriptions filled.	Of the total reported in B, the number of days supply for all ACE/ARB prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of B.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements C and D are less than or equal to data element B.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of :

- Days members age 18-75[2] diagnosed with diabetes were enrolled during the reporting period.
- Days supply for all statin prescriptions filled during the reporting period.
- Days supply for all ACE/ARB prescriptions filled during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.

[2] The Illinois Demonstration population includes individuals 21 years of age and older; therefore, all members will be 18 years and older.

- This measure must be calculated using the administrative methodology.
- This measure uses the total number of days, rather than number of eligible members, to identify the denominator.
- Members must have been continuously enrolled during the reporting period.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Codes to identify members with diabetes are listed in **Table IL-17**.
- There are two ways to identify members with diabetes:
    1. Pharmacy data, OR
    2. Claims/encounter data

  The MMP must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified has having diabetes during the current reporting period or the prior reporting period.
- To identify members with diabetes using pharmacy data, refer to the prescriptions provided in **Table IL-19** to identify members who were dispensed insulin or hypoglycemics/antihyperglycemics during the current reporting period or the prior reporting period.
- To identify members with diabetes using claim/encounter data, include all members who met any of the following criteria during the current reporting period or the prior reporting period (count services that occur over both years):
    1. At least two outpatient visits (**Table IL-9**, Outpatient value set), observation visits (**Table IL-9**, Observation value set), or nonacute inpatient encounters (**Table IL-9**, Nonacute Inpatient value set), on different dates of service, with a diagnosis of diabetes (**Table IL-17**).
        - The visit type does not have to be the same for the two visits.
    2. At least one acute inpatient encounter (**Table IL-9**, Acute Inpatient value set) with a diagnosis of diabetes (**Table IL-17**).
    3. At least one ED visit (**Table IL-9**, ED value set) with a diagnosis of diabetes (**Table IL-17**).
- Refer to pharmacy codes provided in **Table IL-22** to identify all statin prescriptions.

- Refer to pharmacy codes provided in **Table IL-23** to identify all ACE/ARB prescriptions.
- Exclude members with a contraindication for Statin Therapy identified in **Table IL-37**.
- Exclude members with a contraindication for ACE inhibitors and ARB identified in **Table IL-38**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL6.5 Medication monitoring for patients with psychotic disorders. (ICP IMMP Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members diagnosed with a psychotic disorder.	Total number of members who were continuously enrolled in the MMP during the current reporting period, who were diagnosed with a psychotic disorder during the prior reporting period, and who were enrolled on December 31 of the current reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who received at least 150 days supply of medication.	Of the total reported in A, the number of members who received at least 150 days supply of medication during the current reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who received at least 335 days supply of medication.	Of the total reported in A, the number of members who received at least 335 days supply of medication during the current reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members diagnosed with a psychotic disorder during the prior reporting period who:

- Received at least 150 days supply of medication during the current reporting period (6-month adherence rate).
- Received at least 335 days supply of medication during the current reporting period (12-month adherence rate).

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment

(i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Refer to the codes in **Table IL-42** to identify members diagnosed with a psychotic disorder in the prior reporting period.
- To calculate the number of days covered for oral medications, identify all prescriptions filled during the year and count the days supplied. Two or more prescriptions on the same date of service count as one prescription.
- To calculate number of days covered for long-acting injections, use the days supply specified for the medication in **Table IL-21**. For multiple J codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply. For multiple J codes or NDCs with the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.
- For prescriptions filled at the end of the prior reporting period, days covered are the actual number of calendar days covered with prescriptions within the current reporting period (e.g., a prescription of 90 days' supply dispensed on December 1 of the current reporting period counts as 30 days covered, and a 90 days' supply dispensed on December 1 of the prior reporting period count as 60 days covered).
- To identify a six-month course of treatment, data element B, refer to the medications listed in **Table IL-43**.
- To identify a twelve-month course of treatment, data element C, refer to the medications listed in **Table IL-43**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL6.6 Annual monitoring for patients on persistent medications. (ICP MPM Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who received at least 180 treatment days of ACE inhibitors or ARBs.	Total number of members who were continuously enrolled in the MMP during the reporting period, who received at least 180 treatment days of ACE inhibitors or ARBs during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test.	Of the total reported in A, the number of members who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members who received at least 180 treatment days of digoxin.	Total number of members who were continuously enrolled in the MMP during the reporting period, who received at least 180 treatment days of digoxin during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
D.	Total number of members who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test.	Of the total reported in C, the number of members who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during the reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members who received at least 180 treatment days of a diuretic.	Total number of members who were continuously enrolled in the MMP during the reporting period, who received at least 180 treatment days of a diuretic during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
F.	Total number of members who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test.	Of the total reported in E, the number of members who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during the reporting period.	Field Type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of members who received at least 180 treatment days for an anticonvulsant.	Total number of members were continuously enrolled in the MMP during the reporting period, who received at least 180 treatment days for an anticonvulsant during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
H.	Total number of members who received at least one serum concentration level monitoring test for the prescribed drug.	Of the total reported in G, the number of members who received at least one serum concentration level monitoring test for the prescribed drug. during the reporting period.	Field Type: Numeric Note: Is a subset of G.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- MMPs should validate that data element F is less than or equal to data element E.
- MMPs should validate that data element H is less than or equal to data element G.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who received at least 180 treatment days of:

- ACE inhibitors or ARBs during the reporting period who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during the reporting period.
- Digoxin during the reporting period who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during the reporting period.
- Diuretic during the reporting period who received at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during the reporting period.
- An anticonvulsant during the reporting who received at least one serum concentration level monitoring test for the prescribed drug during the reporting period.
- Ambulatory medication therapy for a select therapeutic agent during the reporting period and at least one therapeutic monitoring event for the therapeutic agent in the reporting period (i.e., the sum of B, D, F, and H divided by the sum of A, C, E, and G).

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Treatment days are the actual number of calendar days covered with prescriptions within the reporting period (i.e., a prescription of 90 days' supply dispensed on December 1 of the reporting period counts as 30 treatment days). Sum the days' supply for all medications and subtract any days supply that extends beyond December of the reporting period.
    1. Medications dispensed in the year prior to the reporting period must be counted toward the 180 treatment days.
- Exclude members from each eligible population rate who had an inpatient (acute or non-acute) claim/encounter during the reporting period.
- Refer to the codes in **Table IL-23** to identify ACE inhibitors and ARBs.

- For data element A, a member may switch therapy with any medication listed in Table IL-23 during the reporting period and have the days' supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator requirements).
- For members who received at least serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test during the reporting period, any of the following listed in **Table IL-44** meet criteria:
    1. A lab panel test (Lab Panel value set)
    2. A serum potassium test (Serum Potassium value set) ***and*** a serum creatinine test (Serum Creatinine value set)
    3. A serum potassium test(Serum Potassium value set) ***and*** a blood urea nitrogen test (Blood Urea Nitrogen value set)
- For data elements B and D, the tests do not have to occur on the same service date, only within the reporting period.
- Refer to the codes in **Table IL-45** to identify members on digoxin.
- Refer to the codes in **Table IL-46** to identify members on a diuretic.
- For data element E, a members may switch therapy with and medication listed in Table IL-46 during the reporting period and have the days' supply for those medications count toward the total 180 treatment days.
- Refer to the codes in **Table IL-47** to identify members on anticonvulsants.
- For data element G, members who are on multiple anticonvulsant drugs count toward multiple times if they meet the persistent medications criteria for each drug taken during the reporting period (i.e., a member who received at least 180 days of phenytoin and 180 days of valproic acid is counted twice in the denominator rate for data element G, once for each drug).
- For members who received at least one serum concentration level monitoring test for the prescribed drug during the reporting period, any of the following listed in **Table IL-48** meet criteria:
    1. Members prescribed phenobarbital must have at least one drug serum concentration for phenobarbital (Phenobarbital Level value set)
    2. Members prescribed carbamazepine must have at least one drug serum concentration for carbamazepine (Carbamazepine Level value set)
    3. Members prescribed phenytoin must have at least one drug serum concentration for phenytoin (Phenytoin Level value set)
    4. Members prescribed valproic acid or divalproex sodium must have at least one drug serum concentration for valproic acid (Valproic Acid Level value set)

- If a member received only one type of anticonvulsant, the drug serum concentration level test must be for the specific drug taken as a persistent medication (i.e., a member on phenytoin received a drug serum test of phenytoin).
- If a member persistently received multiple types of anticonvulsants, each anticonvulsant medication and drug monitoring test combination is counted as a unique event (i.e., a member on both phenytoin and valproic acid with at least 180 treatment days for each drug in the reporting period must separately show evidence of receiving drug serum concentration tests for each drug to be considered numerator-compliant for each drug).

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL6.7 Use of high-risk medications in the elderly. (ICP SDAE Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members age 60 – 65.	Total number of members age 60 – 65, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members age 60 – 65 who received at least one high-risk medication.	Of the total reported in A, the number of members age 60 – 65 who received at least one high-risk medication during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members age 60 – 65 who received at least two different high-risk medications.	Of the total reported in A, the number of members age 60 – 65 who received at least two different high-risk medications during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members age 66 and older.	Total number of members age 66 and older, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
E.	Total number of members age 66 and older who received at least one high-risk medication.	Of the total reported in D, the number of members age 66 and older who received at least one high-risk medication during the reporting period.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of members age 66 and older who received at least two different high-risk medications.	Of the total reported in D, the number of members age 66 and older who received at least two different high-risk medications during the reporting period.	Field Type: Numeric Note: Is a subset of D.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C are less than or equal to data element A.
- MMPs should validate that data elements E and F are less than or equal to data element D.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members age 60 – 65 who received at least one high-risk medication during the reporting period.
- Members age 60 – 65 who received at least two different high-risk medications during the reporting period.
- Members age 66 and older who received at least one high-risk medication during the reporting period.
- Members age 66 and older who received at least two different high-risk medications during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- A high-risk medication is defined as any of the following:
    1. A dispensed prescription for a medication listed in **Table IL-49**, or
        - For medications in **Table IL-49**, identify different drugs using the Drug ID field located in the NDC list on NCQA's Web site (www.ncqa.org).
    2. Dispensed prescriptions that meet days supply criteria within a medication class listed in **Table IL-50**, or
    3. A dispensed prescription that meets average daily dose criteria in **Table IL-51**
- To calculate days supply:

1. Calculate the days supply during the reporting period for medication classes in **Table IL-49**. The intent is to sum the days supply for all medications within a medication class.
    - For example, a 30-days supply prescription for Zolpidem and a 30-days supply prescription for Zaleplon is equal to 60-days supply of a high-risk medication class.
2. Sum the days supply and subtract any days supply that extends beyond December 31 of the reporting period.
    - For example, a prescription of 90 days supply dispensed on December 1 of the reporting period counts as 30 days supply
3. For calculating data elements C and F, if the total days supply in a medication class is greater than or equal to 182 days, count as two high-risk medications. Assess each medication class separately.

- Medications dispensed in the year prior to the current reporting period with days supply that extend into the current reporting period must be counted toward the total days supply.
- To calculate daily dose:
    1. Calculate the average daily dose for medications listed in **Table IL-51.** Multiply the quantity of pills dispensed by the dose of each pill and divide by days supply.
        - For example, a prescription for digoxin containing 15 pills, .250mg each pill, 30 days supply has an average daily dose of 0.125mg.
- For calculating data elements C and F, if a member has two prescriptions that meet the average daily dose criteria, count as two high-risk medications, even if the two prescriptions are for the same medication.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section ILVII. Utilization

IL7.1 Coronary artery disease (CAD). (ICP ICAD Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with coronary artery disease (CAD).	Total number of members with CAD, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who had their cholesterol tested at least once.	Of the total reported in A, the number of members who had their cholesterol tested at least once during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of days members with CAD were enrolled.	Of the total reported in A, the number of days members with CAD were enrolled during the reporting period.	Field Type: Numeric
D.	Total number of days supply for all statin prescriptions filled.	Of the total reported in C, the number of days supply for all statin prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of C.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of days supply for all ACE/ARB prescriptions filled.	Of the total reported in C, the number of days supply for all ACE/ARB prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks - validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data elements D and E are less than or equal to data element C.
- All data elements should be positive values.

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members with CAD who had their cholesterol tested at least once during the reporting period.
- Days supply for all statin prescriptions filled during the reporting period.
- Days supply for all ACE/ARB prescriptions filled during the reporting period.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Refer to the codes provided in **Table IL-18** to determine a diagnosis (primary or secondary) of CAD in any setting during the current reporting period or the year prior to the reporting period.
- Refer to the codes provided in **Table IL-28** to identify cholesterol testing.
- Refer to the pharmacy codes provided in **Table IL-22** to identify total days supply for all statin prescriptions filled (data element D).
- Refer to the pharmacy codes provided in **Table IL-23** to identify total days supply for all ACE/ARB prescriptions filled (data element E).
- For Statin and ACE/ARB numerators only, exclude the following:
    i. Members with a contraindication for Statin (**Table IL-37**); and
    ii. Members with a contraindication for ACE Inhibitors and ARB (**Table IL-38**).

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL7.2 Congestive Heart Failure (CHF) Admission Rate (PQI08).

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 18 – 64.	Total number of member months for members age 18 – 64 during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	The number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 18 – 64.	Of the total reported in A, the number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 18 – 64 during the reporting period.	Field Type: Numeric
C.	Total number of member months for members age 65 and older.	Total number of member months for members age 65 and older during the reporting period.	Field Type: Numeric
D.	The number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 65 and older.	Of the total reported in C, the number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 65 and older during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Discharges for members age 18 – 64 with a primary diagnosis of CHF per 1,000 member months.

- Discharges for members age 65 and older with a primary diagnosis of CHF per 1,000 member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.[3]
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 30th of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the MMP on January 30, Ms. X contributes one member month in January.
- For data elements A and C, use the members' age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an MMP tallies members on the 30th of each month and Ms. X turns 65 on April 3 and is enrolled for the entire year, then she contributes three member months (January, February, March) to the 18 – 64 age group category and nine months to the 65 and older age group category.
- For data elements B and D, age is based on the date of admission.
- Refer to the codes in **Table IL-52** to identify ICD-9-CM diagnosis codes for heart failure.
- Exclude claims and encounters that contain any of the following:
    i. Transfer from a hospital (different facility) (**Table IL-53**).
    ii. Transfer from a skilling nursing facility (SNF) or intermediate care facility (ICF) (**Table IL-53**).
    iii. Transfer from another health care facility (**Table IL-53**).
    iv. With missing gender, age, quarter, year, principal diagnosis, or county data
    v. MDC 14 (pregnancy, childbirth, and puerperium)
        1. Discharges with a principal diagnosis of heart failure are precluded from an assignment of MDC 14 by grouper software. Thus, obstetric discharges should not be considered in the PQI rate, though the specifications do not explicitly exclude obstetric cases.
    vi. With any listed ICD-9-CM procedure codes for cardiac procedure (**Table IL-54**).

[3] The Illinois Demonstration population includes individuals 21 years of age and older; therefore, all members will be 18 years and older.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL7.1 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members that were continuously enrolled for six months during the reporting period.	Field Type: Numeric
B.	Total number of eligible members receiving HCBS.	Of the total reported in A, the number of eligible members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of eligible members receiving nursing facility services.	Of the total reported in A, the number of eligible members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of eligible members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of eligible members receiving both HCBS and nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will obtain enrollment data from CMS' Web site and will evaluate the following:
    - The percentage of eligible members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.
    - The percentage of eligible members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.
    - The percentage of eligible members receiving both HCBS and nursing facility services during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
   - MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
   - Members receiving HCBS should only be counted for data element B (unduplicated). Members receiving nursing facility services should only be counted for data element C (unduplicated). Members receiving both HCBS and nursing facility services should only be counted for data element D (unduplicated). Data elements B, C and D are mutually exclusive.
   - Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
   - HCBS refers to Home and Community Based Services.
   - Members are classified as in an HCBS waiver or nursing facility in accordance with the rate cell definitions provided on page 174 of the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an HCBS waiver.

F. Data Submission – how MMPs will submit data collected to CMS and the state.
   - MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspxm

IL7.4 Average length of receipt in HCBS.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving HCBS.	Total number of members receiving HCBS during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of days members were enrolled in HCBS.	Of the total reported in A, the number of days members were enrolled in HCBS during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of days members were enrolled in HCBS during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPS should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- HCBS refers to Home and Community Based Services.
- Members are classified as in an HCBS waiver or nursing facility in accordance with the rate cell definitions provided on page 174 of the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an HCBS waiver.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL7.5 Long Term Care (LTC) urinary tract infection admission rate and bacterial pneumonia admission rate. (ICP IUTI and IBPR Measures)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of long term care (LTC) members.	The total number of LTC members enrolled in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of LTC member months.	Of the total reported in A, the number of LTC member months during the reporting period.	Field Type: Numeric
C.	Total number of urinary tract infection inpatient admissions for LTC members.	Of the total reported in B, the number of urinary tract infection inpatient admissions for LTC members during the reporting period.	Field Type: Numeric
D.	Total number of LTC of bacterial pneumonia inpatient admissions for LTC members.	Of the total reported in B, the number of bacterial pneumonia inpatient admissions for LTC members during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the number of:

- Inpatient admissions by LTC members for urinary tract infections per 1,000 LTC member months.
- Inpatient admissions by LTC members for bacterial pneumonia per 1,000 LTC member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPS should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Member must be enrolled in LTC at least 30 days prior to the inpatient hospital admission, with no gaps in enrollment.
- Refer to codes provided in **Table IL-29** to identify inpatient admissions for urinary tract infections as a principal diagnosis.
- For reporting urinary tract infection admissions, MMP should exclude transfers from another hospital and claims and encounters that contain any of the codes provided in **Table IL-39**.
- Refer to the codes provided in **Table IL-30** to identify inpatient admissions for bacterial pneumonia as a principal diagnosis.
- For reporting bacterial pneumonia admissions, MMP should exclude transfers from another hospital and claims and encounters that contain any of the codes provided in **Table IL-40**.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.
- LTC refers to members receiving Long Term Care services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL7.6 Long Term Care (LTC) prevalence of hospital acquired pressure ulcers. (ICP IPPU and IIMR Measures)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members residing in long term care (LTC) facilities.	The total number of members residing in LTC facilities during the reporting period.	Field Type: Numeric
B.	Total number of LTC member months.	Of the total reported in A, the number of LTC member months during the reporting period.	Field Type: Numeric
C.	Total number of inpatient hospital stays during the reporting period with a secondary diagnosis of stage II or greater pressure ulcers, identified as a hospital acquired condition.	Of the total reported in B, the number of inpatient hospital stays during the reporting period with a secondary diagnosis of stage II or greater pressure ulcers, identified as a hospital acquired condition.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of inpatient stays with a secondary diagnosis of stage II or greater pressure ulcers, identified as a hospital acquired condition per 1,000 LTC member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Member must be enrolled in LTC at least 30 days prior to the inpatient hospital admission through hospital discharge, with no gaps in enrollment.
- The denominator for this measure is based on inpatient stays, not members.
- If a member has more than one qualifying inpatient stay, include all stays during the reporting period.
- Refer to codes provided in **Table IL-31** to identify stage II or greater hospital acquired pressure ulcers.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.
- LTC refers to members receiving Long Term Care services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

IL7.7 Inpatient hospital and mental hospital 30-day readmission rate.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of live non-mental health inpatient hospital discharges.	Total number of live non-mental health inpatient hospital discharges during the reporting period.	Field Type: Numeric
B.	Total number of non-mental health inpatient hospital readmissions during the reporting period for the same discharge diagnosis within 30 days of the hospital discharge date.	Of the total reported in A, the number of non-mental health inpatient hospital readmissions during the reporting period for the same discharge diagnosis within 30 days of the hospital discharge date.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of live mental health inpatient hospital discharges.	Total number of live mental health inpatient hospital discharges during the reporting period.	Field Type: Numeric
D.	Total number of mental health inpatient hospital readmissions during the reporting period for the same mental health discharge diagnosis within 30 days of the hospital discharge date.	Of the total reported in C, the number of mental health inpatient hospital readmissions during the reporting period for the same mental health discharge diagnosis within 30 days of the hospital discharge date.	Field Type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- 30-day inpatient hospital readmissions for non-mental health inpatient stays.
- 30-day inpatient hospital readmissions for mental health inpatient stays.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- The inpatient diagnosis for the readmission must be the same as the discharge diagnosis from the initial hospitalization, at the 3 digit classification level for the ICD-9 code (e.g., 428 rather than 428.01).
- The member must be continuously enrolled from the date of discharge through 30 days after discharge, with no gaps in enrollment.
- The denominator for this measure is based on discharges, not members.
- The first reporting period, CY1, begins on March 1, 2014 and ends on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, include all events (that meet measure criteria) for those members who have more than one discharge on or between the first day of the reporting period (March 1, 2014) and December 1, 2014.
- Beginning CY2, include all events (that meet measure criteria) for those members who have more than one discharge on or between December 2 of the prior reporting period (e.g., December 2, 2014) and December 1 of the current reporting period (e.g., December 1, 2015).
- Codes to identify discharges from an inpatient setting are provided in **Table IL-5**.
- For reporting data elements A and B, exclude inpatient discharges with a principal mental health diagnosis, defined in **Table IL-16**.
- For reporting data elements A and B, exclude discharges for pregnancies and deliveries, defined in **Table IL-32**.
- For reporting data elements A-D, exclude discharges due to death, defined in **Table IL-35**.

- Exclude transfers to an acute facility following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.
- Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the reporting period.
- Exclude direct transfer to a non-acute facility within the 30 day follow-up period. Codes to identify non-acute care are provided in **Table IL-10**.
- For reporting data element C, include inpatient care at either a hospital or treatment facility with mental health as the principal diagnosis. Use one of the following criteria to identify mental health inpatient services:
    i. An inpatient facility code (**Table IL-5**) in conjunction with a principal mental health diagnosis (**Table IL-16**), ***or***
    ii. MS-DRGs (**Table IL-11**)

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Appendix A. Illinois Measure Tables

Table IL-1: Codes to Identify Preventive/Ambulatory Health Services				
Value Set	**Description**	**CPT**	**ICD-9-CM Diagnosis**	**UB Revenue**
Ambulatory Visits	Office or other outpatient services	99201-99205, 99211-99215, 99241-99245		051x, 0520-0523, 0526-0529, 0982, 0983
	Home services	99341-99345, 99347-99350		
	General medical examination		V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	
	Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429		
Other Ambulatory Visits	Domiciliary, rest home or custodial care services	99324-99328, 99334-99337		

Table IL-2: Codes to Identify Visits				
Value Set	**CPT**	**HCPCS**	**UB Revenue**	**POS**
FUH Stand Alone Visits	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		
FUH Visits Group 1	90791-90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876			
FUH POS Group 1				03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
FUH Visits Group 2	99221-99223, 99231-99233, 99238, 99239, 99251-99255			
FUH POS Group 2				52, 53
FUH RevCodes Group 1			0513, 0900-0905, 0907, 0911-0917, 0919	
FUH RevCodes Group 2			0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983	

Table IL-3: Codes to Identify ED Visits		
Value Set	**CPT**	**UB Revenue**
ED	99281-99285	045x, 0981

OR

Value Set	CPT	POS
ED Procedure Code	10040-69979	
ED POS		23

Table IL-4: Codes to Identify Ambulatory Health Services					
Value Set	**Description**	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
Ambulatory Visits	Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
	Home services	99341-99345, 99347-99350			
	Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0402, G0438, G0439		
	General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	
Other Ambulatory Visits	Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
	Ophthalmology and optometry	92002, 92004, 92012, 92014			
	Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			

Table IL-5: Codes to Identify Inpatient Discharges		
Principal ICD-9-CM Diagnosis		**MS-DRG**
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264265, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 570-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

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

Table IL-6: Codes to Identify Behavioral Health Stand Alone Value Sets			
Value Set	**CPT**	**HCPCS**	**UB Revenue**
BH Stand Alone Acute Inpatient			010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987
BH Stand Alone Outpatient/PH/IOP	90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99510	G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485	0510, 0513, 0516, 0517, 0519-0523, 0526-0529, 0900, 0901, 0902-0905, 0907, 0911-0917, 0919, 0982, 0983
ED	99281-99285		045x, 0981
BH Stand Alone Nonacute Inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	H0017-H0019, T2048	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x, 1000, 1001, 1003-1005

Table IL-7: Codes to Identify Behavioral Health CPT Value Sets	
Value Set	**CPT**
BH Acute Inpatient	90791-90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
BH Outpatient/PH/IOP	90791-90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
BH ED	90791-90792, 90801, 90802, 90832-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291
BH Nonacute Inpatient	90791-90792, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90832-90840, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99291

Table IL-8: Codes to Identify Behavioral Health POS Value Sets	
Value Set	**POS**
BH Acute Inpatient POS	21, 51
BH Outpatient/PH/IOP POS	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
BH ED POS	23
BH Nonacute Inpatient POS	31, 32, 56

Table IL-9: Codes to Identify Visits			
Value Set	**CPT**	**HCPCS**	**UB Revenue**
Outpatient	92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0402, G0438, G0439	051x, 0520-0523, 0526-0529, 0982, 0983
Observation	99217-99220		
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, 0987
ED	99281-99285		045x, 0981

Table IL-10: Codes to Identify Non-acute Care				
Description	**HCPCS**	**UB Revenue**	**UB Type of Bill**	**POS**
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61

Table IL-11: Codes to Identify Mental Health Inpatient Services
MS-DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

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

Table IL-12: Codes to Identify Mental Illness
ICD-9-CM Diagnosis
295–299, 300.3, 300.4, 301, 308, 309, 311–314

Table IL-13: Codes to Identify Members with Schizophrenia
ICD-9-CM Diagnosis
295

Table IL-14: Codes to Identify Members with Bipolar Disorder
ICD-9-CM Diagnosis
296.0, 296.1, 296.4, 296.5, 296.6, 296.7

Table IL-15: Codes to Identify Members Diagnosed with Dementia
ICD-9-CM Diagnosis
290, 291.2, 292.82, 294.0-294.2, 331.0, 331.1, 331.82

Table IL-16: Codes to Identify Mental Health Diagnosis
ICD-9-CM Diagnosis
290, 293-302, 306-316

Table IL-17: Codes to Identify Diabetes
ICD-9-CM Diagnosis
250, 357.2, 362.0, 366.41, 648.0

Table IL-18: Codes to Identify CAD		
ICD-9-CM Diagnosis	**CPT-4**	**ICD-9 Procedures**
410.xx – 413.xx, 414.01, 414.8x, 414.9x	33510-33514, 33516-33519, 33521-33523, 33530, 33533-33536, 33572, 92980-92982, 92984, 92995, 92996, 92975, 92977, 92973	00.66, 36.0x – 36.3x, 36.9x

Table IL-19: Prescriptions to Identify Members with Diabetes		
Description	**Prescription**	
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol
Amylin analogs	• Pramlinitide	

Table IL-19: Prescriptions to Identify Members with Diabetes				
Description	**Prescription**			
Antidiabetic combinations	• Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-rosiglitazone • Metformin-saxagliptin	• Metformin-sitagliptin • Saxagliptin • Sitagliptin-simvastatin	
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine • Insulin inhalation		• Insulin isophane beef-pork • Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human	
Meglitinides	• Nateglinide	• Repaglinide		
Miscellaneous antidiabetic agents	• Exenatide • Linagliptin • Liraglutide	• Metformin-repaglinide • Sitagliptin		
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin			
Sulfonylureas	• Acetohexamide • Chlorpropamide	• Glimepiride • Glipizide	• Glyburide • Tolazamide	• Tolbutamide
Thiazolidinediones	• Pioglitazone	• Rosiglitazone		

Table IL-20: Codes to Identify Antipsychotic Medications			
Description	**Prescription**		**Covered Days**
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurisadone • Molindone	• Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone	
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine • Perphenazine-amitriptyline	• Prochlorperazine • Thioridazine • Trifluoperazine	
Psychotherapeutic combinations	• Fluoxetine-olanzapine		
Thioxanthenes	• Thiothixene		
Long-acting injections	• Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate	28 days supply
	• Risperidone		14 days supply

Table IL-21: Codes to Identify Long-Acting Injection Days Supply	
Value Set	**HCPCS**
Long-Acting Injections 14 Days Supply	J2794
Long-Acting Injections 28 Days Supply	J1631, J2358, J2426, J2680

Table IL-22: Codes to Identify Statins and Cholesterol Lowering Medications				
STCC	**Description**	**Prescription**		
D7L	Bile salt sequestrants	• Cholestyramine • Colesevelam	• Colestipol	
M4D, M4E, M4L, M4M	Lipotropics	• Fenofibrate • Gemfibrozil • Lovastatin • Niacin • Niacin/Lovastatin	• Omega-3 Acid Ethyl Esters • Pravastatin Sodium • Simvastatin • Aspirin/Calcium Carb/Mag/Pravastatin • Ezetimibe/Simvastatin	• Atrovastatin Calcium • Ezetimibe • Fluvastatin • Rosuvastatin
M4I	Antihyperlip (HMGCOA) & Calcium channel blocker CMB	• Amlodipine / Atorvastatin		

Table IL-23: Prescriptions to Identify Members on ACE Inhibitors/ARBs					
Description	**Prescription**				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Aliskiren-valsartan • Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-telmisartan	• Amlodipine-valsartan • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan	• Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Trandolapril-verapamil	

Table IL-24: Codes to Identify Cervical Cytology			
CPT	**HCPCS**	**UB Revenue**	**LOINC**
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	0923	10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

Table IL-25: Codes to Identify HPV Test	
CPT	**LOINC**
87620-87622	21440-3, 30167-1, 38372-9, 49896-4, 59420-0

Table IL-26: Codes to Identify Glucose Tests	
LOINC	**CPT**
10450-5, 14753-8, 14754-6, 14756-1, 14757-9, 14759-5, 14764-5, 14765-2, 14771-0, 1492-8, 1494-4, 1496-9, 1499-3, 14995-5, 1501-6, 1504-0, 1507-3, 1514-9, 1518-0, 1530-5, 1533-9, 1554-5, 1557-8, 1558-6, 17865-7, 20436-2, 20437-0, 20438-8, 25666-9, 26554-6, 30251-3, 30265-3, 30267-9, 32320-4, 40285-9, 40286-7, 41024-1, 49134-0, 51597-3, 55351-1, 55381-8, 6749-6, 9375-7	80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951

Table IL-27: Codes to Identify HbA1c Tests	
LOINC	**CPT**
71875-9, 4548-4, 4549-2, 17856-6, 59261-8, 62388-4	83036, 83037, 3044F, 3045F, 3046F

Table IL-28: Codes to Identify Cholesterol Testing (LDL-C Screening)		
CPT	**CPT Category II**	**LOINC**
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F	2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4, 55440-2, 69419-0

Table IL-29: Codes to Identify Inpatient Urinary Tract Infections		
Principal ICD-9-CM Diagnosis		
590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 590.9, 595.0, 595.9, 599.0		
WITH		
UB Type of Bill	***OR***	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Table IL-30: Codes to Identify Inpatient Bacterial Pneumonia		
Principal ICD-9-CM Diagnosis		
481, 482.2, 482.30-482.32, 482.39, 482.41, 482.42, 482.9, 483.0, 483.1, 483.8, 485, 486		
WITH		
UB Type of Bill	***OR***	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Table IL-31: Codes to Identify Hospital Acquired Pressure Ulcers, Stage II or Greater
UB Type of Bill
11x, 12x

WITH

Secondary ICD-9-CM Diagnosis		Present on Admission (POA)
707.22 – 707.24	***And***	N – No (not present at the time of inpatient admission) U – Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)

Table IL-32: Codes to Identify Pregnancies and Deliveries	
ICD-9-CM Diagnosis	**MS-DRG**
630-679	370-375

Table IL-33: Codes to Identify Patients who Expired
Discharge Status Code
20

Table IL-34: Codes to Identify Mental Illness or Chemical Dependency Exclusions		
Principal ICD-9-CM Diagnosis	***WITH***	**Secondary ICD-9-CM Diagnosis**
960-979		291-292, 303-305

Table IL-35: Codes to Identify Maternity Exclusions			
Value Set	**Principal ICD-9-CM Diagnosis**	**UB Revenue**	**UB Type of Bill**
Maternity Diagnosis	630-679, V24.0		
Maternity		0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x

AND

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

Table IL-36: Codes to Identify Exclusions due to Hysterectomy		
CPT	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure**
51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	618.5, V67.01, V76.47, V88.01, V88.03, 752.43	68.4-68.8

Table IL-37: Codes to Identify Contraindications for Statin Therapy	
• (V22) Pregnancy • (V24.1) Lactation	• (995.27) Hypersensitivity or allergy to previous Statin therapy • (571.4, 571.49, 070) Active liver disease or unexplained persistent elevations of hepatic transaminases

Table IL-38: Codes to Identify Contraindications for ACE/ARB	
• (V22) Pregnancy • (V24.1) Lactation • (440.1) Renal artery stenosis	• (425.1) Hypertrophic cardiomyopathy • (995.27) Hypersensitivity or allergy to previous ACE or ARB treatment • (995.1) Angioedema due to previous treatment with ACE inhibitors • (277.6) Hereditary angioedema

Table IL-39: Codes to Identify Exclusions for Urinary Tract Infection Admissions		
Exclusions	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure Codes**
Kidney/Urinary Tract Disorder	590.00, 590.01, 593.70-593.73, 753.0, 753.10 – 753.17, 753.19 – 753.23, 753.29, 753.3 – 753.6, 753.8, 753.9	
Immunocompromised States	042, 136.3, 199.2, 238.73, 238.76-238.79, 260-262, 279.00-279.06, 279.09-279.13, 279.19, 279.2-279.4, 279.41, 279.49-279.53, 279.8, 279.9, 284.09, 284.1, 288.0, 288.00 – 288.03, 288.09, 288.2, 288.4, 288.50, 288.51, 288.59, 289.53, 289.83, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 579.3, 585, 585.5, 585.6, 996.8, 996.80-996.87, 996.89, V42.0, V42.1, V42.6 – V42.8, V42.81-V42.84, V42.89, V45.1, V45.11, V56.0, V56.1, V56.2	00.18, 33.5, 33.6, 37.5, 41.00-41.09, 50.51, 50.59, 52.80-52.83, 52.85, 52.86, 55.69

Table IL-40: Codes to Identify Exclusions for Bacterial Pneumonia Admissions		
Exclusions	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure Codes**
Sickle Cell or HB-S Disease	282.41, 282.42, 282.60-282.64, 282.68, 282.69	
Immunocompromised States	042, 136.3, 199.2, 238.73, 238.76-238.79, 260-262, 279.00-279.06, 279.09-279.13, 279.19, 279.2-279.4, 279.41, 279.49-279.53, 279.8, 279.9, 284.09, 284.1, 288.0, 288.00 – 288.03, 288.09, 288.2, 288.4, 288.50, 288.51, 288.59, 289.53, 289.83, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 579.3, 585, 585.5, 585.6, 996.8, 996.80-996.87, 996.89, V42.0, V42.1, V42.6 – V42.8, V42.81-V42.84, V42.89, V45.1, V45.11, V56.0, V56.1, V56.2	00.18, 33.5, 33.50-33.52, 33.6, 37.5, 41.00-41.09, 50.51, 50.59, 52.80-52.83, 52.85, 52.86, 55.69

Table IL-41: Codes to Identify Diabetes Exclusions	
Value Set	**ICD-9-CM Diagnosis**
Polycystic ovaries	256.4
Gestational or steroid induced diabetes	249, 251.8, 648.8, 962.0

Table IL-42: Code to Identify Members with Psychotic Disorders		
Schizophrenic Disorders	**ICD-9-CM Diagnosis**	**Applicable 5th Digit Usage**
Disorganized type schizophrenia	295.1	2 – chronic 3 – subchronic with acute exacerbation 4 – chronic with acute exacerbation 5 – in remission
Catatonic type schizophrenia	295.2	
Paranoid type schizophrenia	295.3	
Schizoaffective disorder	295.7	
Episodic Mood Disorders	**ICD-9-CM Diagnosis**	**Applicable 5th Digit Usage**
Manic disporder, recurrent episode	296.1	2 – moderate 4 – severe, specified as with psychotic behavior 5 – in partial or unspecified remission
Major depressive disorder, recurrent episode	296.3	
Bipolar I disorder, most recent episode manic	296.4	
Bipolar I disorder, most recent episode depressed	296.5	
Bipolar I disorder, most recent episode (or current) mixed	296.6	
Bipolar I disorder, most recent episode unspecified	296.7	
Other Nonorganic Disorders	**ICD-9-CM Diagnosis**	**Applicable 5th Digit Usage**
Depressive type psychosis	298.0	No applicable 5th digit
Excitative type psychosis	298.1	No applicable 5th digit

Table IL-43: Medications to Treat Psychotic Disorders		
Description	**Prescription**	**Covered Days**
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone • Pimozide • Quetiapine • Risperidone • Ziprasidone	
Phenothiazine Antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine • Thioridazine • Trifluoperazine	
Psychotherapeutic combinations	• Fluoxetine-olanzapine • Perphenazine-Amitriptyline	
Thioxanthenes	• Thiothixene	
Long-acting injections	• Aripiprazole • Haloperidol–Decanoate • Olanzapine pamoate • Paliperidone palmitate	28 day supply (4 week)
	• Fluphenazine–Decanoate	21 day supply (3 week)
	• Risperidone	14 day supply (2 week)
Mood Stabilizers	• Lithium carbonate • Lithium citrate	
Anticonvulsants	• Carbamazepine • Lamotrigine • Oxcarbazepine • Topiramate • Valproic acid • Divalproex sodium • Sodium valproate	

Table IL-44: Therapeutic Monitoring Tests for ACE/ARBs		
Value Set	**CPT**	**LOINC**
Lab panel	80047, 80048, 80050, 80053, 80069	
Serum potassium (K+)	80051, 84132	2824-1, 2823-3, 6298-4, 12812-4, 12813-2, 22760-3, 29349-8, 32713-0, 39789-3, 39790-1, 41656-0, 51618-7
Serum creatinine (Scar)	82565, 82575	2160-0, 2163-4, 2164-2, 11041-1, 11042-9, 12195-4, 13441-1, 13442-9, 13443-7, 13446-0, 13447-8, 13449-4, 13450-2, 14682-9, 16188-5, 16189-3, 21232-4, 26752-6, 31045-8, 33558-8, 35203-9, 35591-7, 35592-5, 35593-3, 35594-1, 38483-4, 39955-0, 39956-8, 39957-6, 39958-4, 39959-2, 39960-0, 39961-8, 39962-6, 39963-4, 39964-2, 39965-9, 39966-7, 39967-5, 39968-3, 39969-1, 39970-9, 39971-7, 39972-5, 39973-3, 39974-1, 39975-8, 39976-6, 40112-5, 40113-3, 40114-1, 40115-8, 40116-6, 40117-4, 40118-2, 40119-0, 40120-8, 40121-6, 40122-4, 40123-2, 40124-0, 40125-7, 40126-5, 40127-3, 40128-1, 40248-7, 40249-5, 40250-3, 40251-1, 40252-9, 40253-7, 40254-5, 40255-2, 40256-0, 40257-8, 40258-6, 40264-4, 40265-1, 40266-9, 40267-7, 40268-5, 40269-3, 40270-1, 40271-9, 40272-7, 40273-5, 44784-7, 50380-5, 50381-3, 51619-5, 51620-3, 59826-8, 59834-2, 62425-3
Blood urea nitrogen (BUN)	84520, 84525	3094-0, 6299-2, 11064-3, 11065-0, 12964-3, 12965-0, 12966-8, 14937-7, 44734-2, 49071-4, 59570-2

Table IL-45: Drugs to Identify Members on Digoxin	
Description	**Prescription**
Inotropic agents	Digoxin

Table IL-46: Drugs to Identify Members on Diuretics			
Description	**Prescription**		
Antihypertensive combinations	• Aliskiren-hydrochlorothiazide • Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide	• Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan	
Loop diuretics	• Bumetanide • Ethacrynic acid	• Furosemide • Torsemide	
Potassium-sparing diuretics	• Amiloride • Eplerenone	• Spironolactone • Triamterene	
Thiazide diuretics	• Chlorothiazide • Chlorthalidone	• Hydrochlorothiazide • Indapamide	• Methyclothiazide • Metolazone

Table IL-47: Drugs to Identify Members on Anticonvulsants	
Description	**Drugs**
Barbiturate anticonvulsants	• Phenobarbital
Dibenzazepine anticonvulsants	• Carbamazepine
Hydantoin anticonvulsants	• Phenytoin
Miscellaneous anticonvulsants	• Divalproex sodium • Valproic acid

Table IL-48: Serum Concentration Level Monitoring Test for Anticonvulsants		
Value Set	**CPT**	**LOINC**
Phenobarbital Level	80184	3948-7, 3951-1, 10547-8, 14874-2, 34365-7, 60468-6
Phenytoin Level	80185, 80186	3968-5, 3969-3, 14877-5, 32109-1, 40460-8, 65361-8
Valproic Acid Level	80164	4086-5, 4087-3, 4088-1, 14946-8, 18489-5, 21590-5, 32119-0, 32283-4, 73677-7
Carbamazepine Level	80156, 80157	3432-2, 3433-0, 9415-1, 14056-6, 14639-9, 18270-9, 29147-6, 29148-4, 32058-0, 32852-6, 47097-1

Table IL-49: High-Risk Medications		
Description	**Prescription**	
Anticholinergics (excludes TCAs), First-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine • Cyproheptadine • Dexbrompheniramine	• Dexchlorpheniramine • Diphenhydramine (oral) • Doxylamine • Hydroxyzine • Promethazine • Triprolidine
Anticholinergics (excludes TCAs), anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl
Antithrombotics	• Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)	• Ticlopidine
Cardiovascular, alpha agonists, central	• Guanabenz • Guanfacine	• Methyldopa
Cardiovascular, other	• Disopyramide	• Nifedipine, immediate release
Central nervous system, tertiary TCAs	• Amitriptyline • Clomipramine	• Imipramine • Trimipramine
Central nervous system, barbiturates	• Amobarbital • Butabarbital • Butalbital • Mephobarbital	• Pentobarbital • Phenobarbital • Secobarbital
Central nervous system, vasodilators	• Ergot mesylates	• Isoxsuprine
Central nervous system, other	• Chloral Hydrate • Meprobamate	• Thioridazine
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen	• Estradiol • Estropipate
Endocrine system, sulfonylureas, long-duration	• Chlorpropamide	• Glyburide
Endocrine system, other	• Desiccated thyroid	• Megestrol
Gastrointestinal system, other	• Trimethobenzamide	
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone • Cyclobenzaprine	• Metaxalone • Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin • Ketorolac, includes parenteral	• Meperidine • Pentazocine

Table IL-50: High-Risk Medications with Days Supply Criteria			
Description	**Prescription**		**Days Supply**
Anti-Infectives, Other	• Nitrofurantoin • Nitrofurantoin macrocrystals	• Nitrofurantoin macrocrystals-monohydrate	>90 days
Nonbenzodiazepine hypnotics	• Eszopiclone • Zolpidem	• Zaleplon	>90 days

Table IL-51: High-Risk Medications with Average Daily Dose Criteria		
Description	**Prescription**	**Average Daily Dose**
Alpha agonists, central	• Reserpine	>0.1 mg/day
Cardiovascular, Other	• Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	• Doxepin	>6 mg/day

Table IL-52: Codes to Identify Heart Failure	
Description	**ICD-9-CM Diagnosis**
Heart Failure	For discharges on or after October 1, 2002 398.91, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
	For discharges prior to October 1, 2002 402.01, 402.11, 402.91,404.01, 404.03, 404.11, 404.13, 404.91, 404.93

Table IL-53: Codes to Identify Transfers
Point of Origin UB-04 Codes
4 - Transfer from a hospital 5 - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 - Transfer from another health care facility
SID ASOURCE Codes
2 - Another hospital 3 - Another facility, including long-term care

Table IL-54: Codes to Identify Cardiac Procedures
ICD-9-CM Procedure
0050, 0051, 0052, 0053, 0054, 0056, 0057, 0066, 1751, 1752, 1755, 3500, 3501, 3502, 3503, 3504, 3510, 3511, 3512, 3513, 3514, 3520, 3521, 3522, 3523, 3524, 3525, 3526, 3527, 3528, 3531, 3532, 3533, 3534, 3535, 3539, 3541, 3542, 3550, 3551, 3552, 3553, 3554, 3555, 3560, 3561, 3562, 3563, 3570, 3571, 3572, 3573, 3581, 3582, 3583, 3584, 3591, 3592, 3593, 3594, 3595, 3596, , 3598, 3599, 3601, 3602, 3603, 3604, 3605, 3606, 3607, 3609, 3610, 3611, 3612, 3613, 3614, 3615, 3616, 3617, 3619, 362, 363, 3631, 3632, 3633, 3634, 3639, 3691, 3699, 3731, 3732, 3733, 3734, 3735, 3736, , 3741, 375 (NOT VALID AFTER OCT 03), 3751, 3752, 3753, 3754, 3755, 3760, 3761, 3762, 3763, 3764, 3765, 3766, 3770, 3771, 3772, 3773, 3774, 3775, 3776, 3777, 3778, 3779, 3780, 3781, 3782, 3783, 3785, 3786, 3787, 3789, 3794, 3795, 3796, 3797, 3798

Table IL-55: Codes to Identify Ambulatory Outpatient Visits

Value Set	CPT	UB Revenue
Ambulatory Outpatient Visits	99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 92002, 92004, 92012, 92014, 99461	051x, 0520-0523, 0526-0529, 0982, 0983, 0524, 0525

Table IL-56: Codes to Identify Ambulatory Exclusions

Value Set	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure
Mental and Behavioral Disorders		290-316	
Psychiatry	90785, 90791, 90792, 90801-90899		
Electroconvulsive Therapy			94.26, 94.27
AOD Rehab and Detox			94.6, 94.61-94.69

Table IL-57: Codes to Identify Inpatient Services

Value Set	MS-DRG
Maternity MS-DRG	765-770, 774-782
Surgery MS-DRG	001-008, 010-013, 014, 016-017, 020-042, 113-117, 129-139, 163-168, 215-265, 326-358, 405-425, 453-517, 570-585, 614-630, 652-675, 707-718, 734-750, 799-804, 820-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-989
Medicine MS-DRG	052-103, 121-125, 146-159, 175-208, 280-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-700, 722-730, 754-761, 808-816, 834-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977
Newborns/Neonates MS-DRG	789-795

Table IL-58: Codes to Identify Inpatient Services

Principal ICD-9-CM Diagnosis
001-289, 317-999, V01-V29, V40-V90

WITH

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