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

Effective as of March 1, 2014, issued _____, 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

Implementation Period: The period of time starting with the first effective enrollment date, March 1, 2014, until 60 days following end of the sixth wave of passive enrollment on November 1, 2014. The implementation period is March 1, 2014 until 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.

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

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.

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 60 days following the end of the last (i.e., sixth) wave of passive enrollment
	Ongoing Period	1-1-14 through 12-31-15	From the day after the end of the implementation period through the end of the 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.htmll.

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 month, date, year, and century of the submission in CCYYMMDD format (e.g., March 30, 2014 would be 21140330).

Section IL1. Access

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

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL1. Access	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 currently enrolled members.	Total number of currently enrolled members during 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.
- No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- 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 ILII. Assessment

IL2.1 Behavioral health risk assessment and follow-up.

CONTINOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL2. Assessment	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 members.	Total number of members enrolled during the reporting period.	Field Type: Numeric
B.	Total number of 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 members identified by the plan with a positive BHRA	Of the total reported who had a BHRA, the number of new members with a positive BHRA.	Field type: Numeric Note: Is a subset of A.

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 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 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 new member must be continuously enrolled for at least 90 days between the first day of the reporting period and October 3.
- Beginning DY2, the new member must be continuously enrolled for at least 90 days between October 4 of the prior reporting period and October 3 of the current reporting period, with no gaps in enrollment.
- A newly enrolled member is a member not previously enrolled in the MMP in the six months prior to the reporting period.
- 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

Section IL III. 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 Periods**	**Due Date**
IL3. Care Coordination	Quarterly	Contract	Current 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 are documented as unwilling to complete a care plan.	Of the total reported in A, the number of members who are documented as unwilling to complete a care plan.	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 element B is less than or equal to data element A and greater than or equal to data elements C and D.
- MMPs should validate that data elements 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. A subset of all members that are eligible will be included in the sample.
- 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 contract for specific requirements pertaining to a care plan.
- Care plans that are in the process of being developed on day 90 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 Periods**	**Due Date**
IL3. Care Coordination	Quarterly	Contract	Current 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

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 B, 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. A subset of all members that are eligible will be included in the sample.
- The discussion of care goals is inclusive of the development of a member's care plan and should be 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	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 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 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 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 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. Include all events for those members who have more than one ED visit on or between the first day of the reporting period and December 17 of the reporting period.
- Beginning DY2, include all events for those members who have more than one ED visit between December 18 and December 17 of the reporting period.
- 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	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 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 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 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 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 discharges, not members. If a member has more than one discharge during the reporting period, include all discharges.
- Include all events for those members who have more than one discharge on or between the first day of the reporting period and December 17 of the reporting period.
- Beginning DY2, include all events for those members who have more than one discharge on or between December 18 and December 17 of the reporting period.
- 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**.
- 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.

NOTE TO MMAI PLANS: This measure is currently under review and pending changes to the specification

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	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 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 member must be diagnosed with a mental illness between the first day of the reporting period and December 1 of the reporting period.
- Beginning DY2, the member must be diagnosed with a mental illness between December 2 or the prior reporting period and December 1 of the current reporting period. Use the earliest diagnosis that occurred during the reporting period.
- Codes to identify members diagnosed with mental illness are provided in **Table IL-12**.
- 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.
- 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).

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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	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 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 being 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 HCBS waiver.	Of the total reported in B, the number of members classified as being in an HCBS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
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 in an HCBS waiver.	Of the total reported in A, the number of members in an HCBS waiver as of the first day of the reporting period.	Field Type: Numeric Note: Is a subset of A.
G.	Total number of members classified as being in the Community.	Of the total reported in F, 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 F.
H.	Total number of members classified as being in an HCBS waiver.	Of the total reported in F, the number of members classified as being remaining in an HCBS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of F.
I.	Total number of members classified as being in LTC.	Of the total reported in F, 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 F.
J.	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.
K.	Total number of members classified as being in the Community.	Of the total reported in J, 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 J.

Element Letter	Element Name	Definition	Allowable Values
L.	Total number of members classified as being in an HCBS waiver.	Of the total reported in J, the number of members classified as being in an HCBS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of J.
M.	Total number of members classified as being in LTC.	Of the total reported in J, 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 J.
N.	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 Sum of C, H and M.
O.	Total number of members no longer enrolled.	Of the total reported in A, the number of members no longer enrolled as of the last day of 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 C, D and E are less than or equal to data element B.
- MMPs should validate that data elements G, H and I are less than or equal to data element F.
- MMPs should validate that data elements K, L and M are less than or equal to data element J.

- MMPs should validate that data elements N and O 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 being 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 HCBS 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.
- Members in an HCBS 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 HCBS waiver as of the first day of the reporting period who were classified as being in an HCBS waiver as of the last day of the reporting period.
- Members in an HCBS 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 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 HCBS 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 being in LTC 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 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 HCBS waiver, or Nursing Facility in accordance with the rate cell definitions provided on page 43 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

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 Periods**	**Due Date**
IL4. Enrollee Protections	Quarterly	Contract	Current 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, 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 month, date, year, and century of the submission in CCYYMMDD format (e.g., March 30, 2014 would be 21140330), 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.

NOTE TO MMAI PLANS: This measure is currently under review and pending changes to the specification/potential removal

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 new care coordinators.	Total number of new care coordinators in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of new care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of new care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	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 training for supporting self-direction.
- A care coordinator includes all full-time and part-time staff.
- If a care coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least XX months, they should be included in this measure.

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.

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 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 schizophrenia.	Total number of members with schizophrenia during 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-21**.
  1. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply.
  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.
- No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Follow the steps outlined below to identify the eligible population (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.
    - **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.
  - At least one dispensing event must occur between the first day of the reporting period and September 30 of the reporting period.
  - Beginning DY2, at least one dispensing event must occur between January 1 and September 30 of 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 measurement year.

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

Total days covered by an antipsychotic medication in the treatment period (Step 3)

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.

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 female members 24-64 years old.	Total number of female members 24-64 years old enrolled during 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.
- The member must be continuously enrolled for the entire reporting period, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

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 30-64 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 and who were 30 years or older on the date of both tests.

Step 3: Sum the events from steps 1 and 2 to obtain the rate.

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.
- 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 30–64 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 and who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:
  - A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
  - The 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	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 schizophrenia or bipolar disorder.	Total number of members with schizophrenia or bipolar disorder enrolled in the MMP during 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.
- The member must be continuously enrolled for the entire reporting period, with no more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Follow the steps outlined below to identify the eligible population (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**, Schizophrenia value set.
            - **Table IL-7**, BH Acute Inpatient value set ***WITH*** **Table IL-8**, BH Acute Inpatient POS value set ***AND*** **Table IL-14**, Bipolar Disorder value set.
        - At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia.
            - **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).

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 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 who have a diagnosis of diabetes.	Total number of members enrolled who have a diagnosis of diabetes during the current reporting period or the prior 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
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 element B is less than or equal to data element A.
- 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 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.
- 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.
- No more than one gap in enrollment of up to 45 days during the reporting period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- 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 Comprehensive Diabetes Care – LDL-C Screening

- Specifications forthcoming

IL6.6 Medication Monitoring for Patients with Psychotic Disorders

- Specifications forthcoming

IL6.7 Annual Monitoring for Patients on Persistent Medications

- Specifications forthcoming

IL6.8 Use of High-Risk Medications in the Elderly

- State modified specifications forthcoming

Section ILVII. Utilization

IL7.1 Coronary artery disease (CAD).

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	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 members with coronary artery disease (CAD).	Total number of members with CAD during 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 the member was enrolled.	Total number of days the member was 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 who had their cholesterol tested at least once during the reporting period.
- Days supply for all state 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.
- No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

- 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:
    1. Members with a contraindication for Statin (**Table IL-37**); and
    2. 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 Heart Failure Admission Rate (PQI08).

- Specifications forthcoming

IL7.3 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 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 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 members receiving nursing facility services.	Total number of members receiving nursing facility services 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 obtain enrollment data from CMS' Web site and will evaluate the following:
    1. The percentage of members receiving HCBS.
    2. The percentage of members receiving nursing facility services.

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 A (unduplicated).
- Members receiving nursing facility services should only be counted for data element B (unduplicated).
- HCBS refers to Home and Community Based 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

IL7.4 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 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 HCBS.	Total number of members receiving HCBS during the reporting period.	Field Type: Numeric
B.	Total number of days members received HCBS.	Of the total reported in A, the number of days members received 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 received HCBS.

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.

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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	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 LTC members.	The total number of LTC members 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 A, the number of urinary tract infection inpatient admissions for LTC members during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of LTC of bacterial pneumonia inpatient admissions for LTC members.	Of the total reported in A, the number of bacterial pneumonia inpatient admissions for LTC members 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.

- 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	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 members residing in 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 Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
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 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.

- 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 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 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.

Element Letter	Element Name	Definition	Allowable Values
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 denominator for this measure is based on discharges, not members.
- The member must be continuously enrolled from the date of discharge through 30 days after discharge, with no gaps in enrollment.
- 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 and December 1 of the reporting period.
- Beginning DY2, include all events (that meet measure criteria) for those members who have more than one discharge on or between December 2 of the prior year and December 1 of the reporting period.
- 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-33**.
- 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:
    1. An inpatient facility code (**Table IL-5**) in conjunction with a principal mental health diagnosis (**Table IL-16**), ***or***
    2. 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

IL7.8 Ambulatory Care. Outpatient visits per 1,000 member months.

- Specifications forthcoming

IL Measure Tables:

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

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	10040-69979	045x, 0981

OR

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

Table IL-4: Codes to Identify Ambulatory Health Services				
Description	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

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

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	
Value Set	**ICD-9-CM Diagnosis**
Mental Illness	295–299, 300.3, 300.4, 301, 308, 309, 311–314

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

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

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

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

Table IL-17: Codes to Identify Diabetes	
Value Set	**ICD-9-CM Diagnosis**
Diabetes	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		
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	

Table IL-19: Prescriptions to Identify Members with Diabetes				
Description	**Prescription**			
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**	
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 • Risperidone

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

Value Set	CPT	HCPCS	UB Revenue	LOINC
Cervical Cytology	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

Value Set	CPT	LOINC
HPV Tests	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)			
Value Set	**CPT**	**CPT Category II**	**LOINC**
LDL-C Tests	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	***And***	**Present on Admission (POA)**
707.22 – 707.24		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				
Description	**Principal ICD-9-CM Diagnosis**	**UB Revenue**	**UB Type of Bill**	**MS-DRG**
Maternity	640-676, 678, 679, V24.0, V27.x, V30-V37, V39	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	765-770, 774-782

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