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

Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting

February 2019

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

This page left blank for double-sided copying

ACKNOWLEDGMENTS

For Proprietary Codes:

CPT® codes copyright 2018 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

SNOMED CLINICAL TERMS (SNOMED CT®) copyright 2004-2018 The International Health Terminology Standards Development Organisation. All Rights Reserved.

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the World Health Organization (WHO). ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 9th Revision, Procedure Coding System (ICD-9-PCS) is published by the World Health Organization (WHO). ICD-9-PCS is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is published by the World Health Organization (WHO). ICD-10-CM is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) is published by the World Health Organization (WHO). ICD-10-PCS is an official Health Insurance Portability and Accountability Act standard.

This material contains content from LOINC® (http://loinc.org). The LOINC table, LOINC codes, and LOINC panels and forms file are copyright © 1995-2018, Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and available at no cost under the license at http://loinc.org/terms-of-use.

The National Drug Code (NDC) Directory is published by the U.S. Food and Drug Administration and is made available under the Open Database License at http://opendatacommons.org/licenses/odbl/1.0/. Any rights on individual contents of the database are licensed under the Database Contents License at http://opendatacommons.org/licenses/dbcl/1.0/.

The American Hospital Association holds a copyright to the Uniform Bill Codes ("UB") contained in the Child Core Set measure specifications. The UB Codes in the Child Core Set specifications are included with the permission of the AHA. The UB Codes contained in the Child Core Set specifications may be used by states, health plans and other health care delivery organizations for the purpose of calculating and reporting Child Core Set measure results or using Child Core Set measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate measure results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, please contact ub04@healthforum.com.

The Code on Dental Procedures and Nomenclature is published in Current Dental Terminology (CDT), Copyright © 2018 American Dental Association (ADA). All rights reserved.

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

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications were developed by and are owned by NCQA. NCQA holds a copyright in the HEDIS measures and specifications and may rescind or alter these measures and specifications at any time. Users of the HEDIS measures and specifications shall not have the right to alter, enhance or otherwise modify the HEDIS measures and specifications, and shall not disassemble, recompile or reverse engineer the HEDIS measures and specifications. Anyone desiring to use or reproduce the materials without modification for a non-commercial purpose may do so without obtaining any approval from NCQA. All commercial uses or requests for alteration of the HEDIS measures and specifications must be approved by NCQA and are subject to a license at the discretion of NCQA.

HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided “as is” without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA also makes no representations, warranties or endorsements about the quality of any organization or clinician who uses or reports performance measures. NCQA has no liability to anyone who relies on HEDIS measures and specifications or data reflective of performance under such measures and specifications.

Calculated measure results, based on unadjusted HEDIS specifications, may not be termed "Health Plan HEDIS rates" until they are audited and designated reportable by an NCQA-Certified Auditor. Such unaudited results should be referred to as "Unaudited Health Plan HEDIS Rates." Accordingly, "Health Plan HEDIS rate" refers to and assumes a result from unadjusted HEDIS specification that has been audited by an NCQA-Certified HEDIS Auditor.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

For The Joint Commission measure in the Child Core Set:

The Specifications Manual for Joint Commission National Quality Measures [Version 2018A1, October 2018] is periodically updated by The Joint Commission. Users of the Specifications Manual for Joint Commission National Quality Measures must update their software and associated documentation based on the published manual production timelines.

For the CMS measure in the Child Core Set:

The Screening for Depression and Follow-up Plan measure was developed by Quality Insights, Inc. as a special project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services. This measure is in the public domain.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights, Inc. disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT ®) or other coding contained in the specifications. CPT® contained in the Measures specifications is copyright 2004-2017 American Medical Association. All Rights Reserved. This performance measure is not a clinical guideline and do not establish a standard of medical care, and has not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

For the Developmental Screening measure:

Copyright established November 7, 2013 to the Oregon Pediatric Improvement Partnership at Oregon Health and Science University. The copyright is 2010 - Oregon Pediatric Improvement Partnership at Oregon Health and Science University.

For the Dental Sealant measure:

© 2019 American Dental Association on behalf of the Dental Quality Alliance (DQA). All rights reserved. Use by individuals or other entities for purposes consistent with the DQA’s mission and that is not for commercial or other direct revenue generating purposes is permitted without charge.

Dental Quality Alliance Measures (Measures) and related data specifications, developed by the Dental Quality Alliance (DQA), are intended to facilitate quality improvement activities. These Measures are intended to assist stakeholders in enhancing quality of care. These performance Measures are not clinical guidelines and do not establish a standard of care. The DQA has not tested its Measures for all potential applications.

Measures are subject to review and may be revised or rescinded at any time by the DQA. The Measures may not be altered without the prior written approval of the DQA. Measures developed by the DQA, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or

This page left blank for double-sided copying.

CONTENTS

I. THE CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES (CHILD CORE SET)

Background

Section 1139A of the Social Security Act (the Act) includes broad mandates to strengthen the quality of care for and health outcomes of children in Medicaid and the Children's Health Insurance Program (CHIP). The Act calls for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish a core set of children's health care quality measures (Child Core Set) for voluntary use by state programs administered under Titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP.

More specifically, the Act requires the Secretary of Health and Human Services (HHS) to identify measures applicable to the duration of enrollment and health care coverage, preventive and health promotion services, and the treatment and management of acute and chronic conditions in children. The Act also calls for measures that could be used to assess families' experiences with health care, the availability of services, and care in the most integrated health settings. Ultimately, the goals of the Child Core Set are to provide a national estimate of the quality of health care for children served by Medicaid or CHIP and support states to drive improvements in health care quality and health outcomes using Core Set data; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

Implementation of a standardized Child Core Set is helping the Centers for Medicare & Medicaid Services (CMS) and states move toward a national system for quality measurement, reporting, and improvement. The data collected from these measures help CMS to better understand the quality of health care children receive through Medicaid and CHIP programs. The Act requires the Secretary of HHS to make publicly available the information states voluntarily report to CMS on the quality of health care furnished to children under Medicaid and CHIP.

Description of the Child Core Set

The initial core set was published in February 2011. The Act required the Secretary to publish annual changes to the Child Core Set beginning in January 2013. The following resources describe the initial core set and the annual updates.

- **Initial Core Set.** Background on the Initial Core Set can be found at http://www.cms.gov/smdl/downloads/SHO11001.pdf.
- **2013 Child Core Set Update.** Three measures (Behavioral Health Risk Assessment (for Pregnant Women); Human Papillomavirus Vaccine for Female Adolescents; Medication Management for People with Asthma) were added to the 2013 Child Core Set and one measure (Otitis Media with Effusion) was retired. Additional information on the 2013 Child Core Set can be found at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf.
- **2014 Child Core Set Update.** Three measures were retired (Appropriate Testing for Children with Pharyngitis; Annual Pediatric Hemoglobin A1C Testing; Asthma-Related Emergency Department Visits). Additional information on the 2014 Child Core Set is available in a December 2013 CMCS Informational Bulletin (http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf).

- **2015 Child Core Set Update.** Two measures were added to the 2015 Child Core Set (Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk; Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment) and one measure was retired (Percentage of Eligibles that Received Dental Treatment Services). In addition, CMS is conducting a pilot of the Child Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Additional information on the 2015 Child Core Set is available in a December 2014 CMCS Informational Bulletin (http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-30-2014.pdf).
- **2016 Child Core Set Update.** Two measures were added to the Child Core Set (Use of Multiple Concurrent Antipsychotics in Children and Adolescents; Audiological Evaluation No Later Than 3 Months of Age). Additional information on the 2016 Child Core Set is available in a December 2015 CMCS Informational Bulletin (http://medicaid.gov/federal-policy-guidance/downloads/CIB-12-11-15.pdf).
- **2017 Child Core Set Update.** Two measures were added to the Child Core Set (Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics; Contraceptive Care−Postpartum Women Ages 15-20). In addition, the standalone Human Papilloma Vaccine for Female Adolescents measure was retired as a separate measure and added to the Immunizations for Adolescents measure. Additional information on the 2017 Child Core Set is available in a December 2016 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf).
- **2018 Child Core Set Update.** Three measures were added to the Child Core Set (Screening for Depression and Follow-Up Plan: Ages 12–17; Contraceptive Care – All Women Ages 15–20; Asthma Medication Ratio: Ages 5–18). In addition, four measures were retired from the Child Core Set (Frequency of Ongoing Prenatal Care; Medication Management for People with Asthma; Behavioral Health Risk Assessment (for pregnant women); Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment). Additional information on the 2018 Child Core Set is available in a November 2017 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib111417.pdf).
- **2019 Child Core Set Update.** No measures were added to or removed from the 2019 Child Core Set. Additional information on the 2019 Child Core Set is available in a November 2018 CMCS Informational Bulletin (https://www.medicaid.gov/federal-policy-guidance/downloads/cib112018.pdf).

Table 1 lists each measure in the 2019 Child Core Set, the National Quality Forum (NQF) number (when the measure is NQF-endorsed), and the measure steward. The data collection methods include administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), electronic health records (electronic specifications), and surveys. The technical specifications in Chapter III of this manual provide additional details for each measure.

More information on the Child Core Set is available on Medicaid.gov at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

Table 1. 2019 Child Core Set

NQF#	Measure Steward[a]	Measure Name	Data Collection Method(s)
Primary Care Access and Preventive Care			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)	Administrative or EHR
0038	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	Administrative or EHR
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)	Administrative or hybrid
1407	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid
1448*	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)	Administrative or hybrid
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)	Administrative or hybrid
NA	NCQA	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)	Administrative
Maternal and Perinatal Health			
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections (CLABSI-CH)	Medical records (CDC's National Healthcare Safety Network)
0471	TJC	PC-02: Cesarean Birth (PC02-CH)	Hybrid
1360	CDC	Audiological Diagnosis No Later Than 3 Months of Age (AUD-CH)	EHR
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
1517*	NCQA	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)	Administrative
2903/2904	OPA	Contraceptive Care – All Women Ages 15–20 (CCW-CH)	Administrative
Care of Acute and Chronic Conditions			
1800	NCQA	Asthma Medication Ratio: Ages 5–18 (AMR-CH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Administrative or EHR

NQF#	Measure Steward[a]	Measure Name	Data Collection Method(s)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Administrative
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Administrative
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Administrative
Dental and Oral Health Services			
2508*	DQA (ADA)	Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk (SEAL-CH)	Administrative
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	Administrative (Form CMS-416)
Experience of Care			
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)[b]	Survey

CDC = Centers for Disease Control and Prevention; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NA = Measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; TJC = The Joint Commission.

* This measure is no longer endorsed by NQF.

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

[b] CAHPS® is a registered trademark of the AHRQ.

II. DATA COLLECTION AND REPORTING OF THE CHILD CORE SET

To support consistency in reporting the Child Core Set measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapter III and provide detailed information on how to calculate each measure. For technical assistance with calculating and reporting these measures, contact the TA mailbox at MACQualityTA@cms.hhs.gov.

Data Collection and Preparation for Reporting

- **Version of specifications.** This manual includes the most applicable version of the measure specifications available to CMS as of December 2018. For HEDIS measures, this manual follows HEDIS 2019 specifications (2018 measurement year). For non-HEDIS measures, the manual includes the most applicable version of the specifications available for reporting 2018 data.
- **Value sets.** Many of the Child Core Set measure specifications reference value sets that must be used for calculating the measures. A value set is the complete set of codes used to identify a service or condition included in a measure.
  - The HEDIS value sets are available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-hedis-value-set-directory.zip. HEDIS value set references are underlined in the specifications (e.g., BMI Percentile Value Set). Refer to Appendix A for a HEDIS Value Set Directory User Manual.
  - Value sets for the CCP-CH, CCW-CH, and PC02-CH measures are available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.
  - Value sets for electronic specifications are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC), located at https://vsac.nlm.nih.gov. Access to the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a free UMLS license at https://uts.nlm.nih.gov//license.html. When searching for value sets for a measure, states should use the measure's associated electronic specification number or NQF number. To report on the 2019 Child Core Set measures, use the version of the value sets associated with the October 2018 release. This applies to the following Child Core Set measures that have electronic specifications: ADD-CH, CDF-CH, CHL-CH, CIS-CH, and WCC-CH.
- **Data collection time frames for measures.** States should adhere to the measurement periods identified in the technical specifications for each measure. Some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a child's birthday or diagnosis. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2018 data should be reported for FFY 2019. For each measure, the measurement period used to calculate the denominator should be reported in the "Start Date" and "End Date" fields. For many measures, the denominator measurement period for FFY 2019 corresponds to calendar year 2018 (January 1, 2018–December 31, 2018). Some measures, however, also require states to review utilization or enrollment prior to this period

To identify the measure-eligible population. States should not include these review periods (sometimes referred to as "look-back" periods) in the Start and End date range. Further information regarding measurement periods is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffy-2019-child-core-set-measurement-periods.pdf.

- **Continuous enrollment.** Continuous enrollment specifies the minimum amount of time that a beneficiary must be enrolled before becoming eligible for a measure. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, a beneficiary must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap (see next bullet).
- **Allowable gap.** Some measures specify an allowable gap that can occur during continuous enrollment. For example, the W34-CH measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in enrollment of up to 45 days. Thus, a beneficiary who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year, because this beneficiary has one 38-day gap (January 1–February 7).
- **Retroactive eligibility.** This refers to the elapsed time between the actual date when Medicaid or CHIP became financially responsible for a beneficiary and the date when it received notification of the new beneficiary's eligibility. For measures with a continuous enrollment requirement, beneficiaries may be excluded if the retroactive eligibility exceeds the allowable gap.
- **Anchor date.** Some measures include an anchor date, which is the date that an individual must be enrolled and have the required benefit to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure's FFY 2019 measurement period (December 31, 2018). For other measures, the anchor date is based on a specific event, such as a birthdate or a delivery date. States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.
- **Date specificity.** A date must be specific enough to determine that an event occurred during the time frame specified in the measure. For example, in the CIS-CH measure, beneficiaries must receive three hepatitis B vaccines. Assume a beneficiary was born on February 5, 2016. Documentation in the medical record that the first hepatitis B vaccine was given "at birth" is specific enough to determine that it was given before the deadline for this measure (i.e., the child's second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2018, the immunization cannot be counted because the date is not specific enough to confirm that it occurred prior to the beneficiary's second birthday. There are instances when documentation of the year alone is adequate; for example, most optional exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable. For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the CIS-CH measure, undated documentation on an immunization chart stating "chicken pox at age 1" is specific enough to determine that it occurred prior to the child's second birthday.

- **Reporting unit.** CMS defines the reporting unit for each measure as each state's Medicaid and CHIP program. This means that states reporting any of the core measures should collect data across all of the health care delivery systems used in their state Medicaid and CHIP programs (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care [MC]). If data are collected separately across Medicaid and CHIP or across a state's various health care delivery systems, states should aggregate data from all these sources into one state-level rate before reporting the data to CMS. For more guidance about developing a state-level rate, see the bullet on "aggregating Information for state-level reporting" below.
- **Eligible population for measurement.** For all measures, the denominator includes Medicaid and CHIP beneficiaries who satisfy all specified eligibility criteria (including age, continuous enrollment, benefit, event, and anchor date enrollment requirements). The eligible Medicaid and CHIP population should include Title XIX and Title XXI populations, but not populations funded only by states (such as state-covered children that are above the Medicaid/CHIP eligibility levels).
- **Beneficiaries with partial benefits.** For each measure, states should include only the beneficiaries who are eligible to receive the services assessed in the numerator. If a beneficiary is not eligible to receive the services assessed in the measure, the beneficiary should not be included in the denominator for the measure. The technical specifications for some measures have guidance regarding which benefits an individual must be eligible for to be included, but each state should assess the specific benefit packages of the beneficiaries in their state.
- **Aggregating information for state-level reporting.** To obtain a state-level rate for a measure that is developed from the rates of multiple units of measurement (such as multiple managed care organizations [MCOs] or across MC and FFS delivery systems), the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual MCOs) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid and administrative data from different sources can be combined to develop a state/program-level rate as long as the specifications allow the use of both data sources to construct the measure. For additional guidance on developing state-level rates, refer to the TA Brief titled "Approaches to Developing State-level Rates Using Data from Multiple Sources."[1]
- **Reporting a weighted rate.** When a state develops a weighted rate combining data across multiple reporting units, the state should report the rate for the combined data in the "Rate" field. In addition, the state should check "Yes" under "Did you Combine Rates from Multiple Reporting Units (e.g., health plans, delivery systems, programs) to Create a State-Level Rate?" If the state has the numerator and denominator that were used to calculate the state-level rate, they should be entered in the Numerator and Denominator fields. If this information is not available, a state can enter "0" in the Numerator and Denominator fields, report the state-level rate in the "Rate" field, and explain the missing information in the "Additional Notes/Comments on Measure" section. If possible, the state should also provide the numerators, denominators, measure-eligible population, and rates for each health plan, delivery system, or program in this section as well as a description of the method used to calculate the state-level rate (including the approach used for weighting).

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

- **Age criteria.** The age criteria vary by measure. If a denominator for a measure specifies an age range beyond that eligible for a state's Medicaid and CHIP programs, the state should include only the ages eligible for the program in the denominator and note any deviations from the specifications in the "Deviations from Measure Specifications" field.
- **Exclusions.** Some measure specifications contain required or optional exclusions. A beneficiary who meets required exclusion criteria should be removed from the measure denominator. Some exclusions are optional. States should note when reporting whether optional exclusions are applied.
- **Hospice exclusion.** Exclude beneficiaries who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These beneficiaries may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). States should remove these beneficiaries prior to determining a measure's eligible population and drawing the sample for hybrid measures. If a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed as a valid data error from the sample and replaced by a beneficiary from the oversample. Documentation that a beneficiary is near the end of life (e.g., comfort care, Do Not Resuscitate [DNR], Do Not Intubate [DNI]), or is in palliative care does not meet criteria for the hospice exclusion. This applies to the following measures: ADD-CH, AMB-CH, AMR-CH, APC-CH, APP-CH, AWC-CH, CAP-CH, CHL-CH, CIS-CH, FUH-CH, IMA-CH, PPC-CH, W15-CH, W34-CH, and WCC-CH.
- **Representativeness of data.** States should use the most complete data available and ensure that the rates reported are representative of the entire population enrolled in their Medicaid and CHIP programs. For a measure based on administrative data, all beneficiaries who meet the eligible population requirements for the measure should be included. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire eligible population for the measure.
- **Data collection methods.** The measures in the Child Core Set have four possible data collection methods: administrative, hybrid, survey, and medical records, including electronic health records (electronic specifications). Each measure specifies the data collection method(s) that must be used. If a measure includes a choice of methods, any of the listed methods may be used.
    - The administrative method uses transaction data (for example, claims) or other administrative data to calculate the measure. These data can be used in cases in which the data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population is included in the denominator.
    - The hybrid method uses both administrative data sources and medical record data to determine numerator compliance. Administrative data are reviewed to determine if beneficiaries in the systematic sample received the service, and medical record data are reviewed for beneficiaries who do not meet the numerator criteria through administrative data. The denominator consists of a systematic sample of beneficiaries drawn from the measure's eligible population. The hybrid method, when possible, should be used when administrative data and electronic health record (EHR) data are incomplete or may be of poor quality, or the data elements for the measure are not captured in administrative data (e.g., the PC02-CH measure). More information on the use of the hybrid method for Core Set Reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf.
    - The survey method uses data collected through a survey to calculate the measure. This data collection method applies to the CPC-CH measure in the Child Core Set.

  - The electronic specification method uses EHR data to calculate the measure. This data collection method is required for one measure in the Child Core Set: the AUD-CH measure, but is one of the data collection options for several others. A link to the electronic specifications is included in the following measure specifications: ADD-CH, CDF-CH, CHL-CH, CIS-CH, and WCC-CH.

- **Sampling.** For measures that use the hybrid method, sampling guidance is included in the technical specification if available from the measure steward. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.
  - For HEDIS measures that use the hybrid method, the sample size should be 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.
  - For the DEV-CH measure, the sample is 411 divided across three age strata, or 137 in each age group.
  - For the CAHPS survey, the sample size should be 1,650, plus an oversample based on the state's prior experience with survey response rates, to yield at least 411 completed surveys. Additional information on sampling for CAHPS is available in Appendix H.
  - States should use the "Additional Notes/Comments on Measure" section to describe the sampling approach used for each measure. Additional guidance on sampling for hybrid measures is available in the following TA brief: Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets (October 2014).[2]
- **Small numbers.** If a measure has a denominator that is less than 30 and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- **Risk adjustment.** No Child Core Set measure requires risk adjustment.
- **Inclusion of paid, suspended, pending, and denied claims.** A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided. For some measures, the Guidance for Reporting within each measure's technical specification indicates which claims (paid, suspended, pending, and denied) should be included. This applies to the following measures: ADD-CH, AMB-CH, AMR-CH, APP-CH, AWC-CH, CAP-CH, CCP-CH, CCW-CH, CHL-CH, CIS-CH, CDF-CH, CPC-CH, FUH-CH, IMA-CH, PPC-CH, SEAL-CH, W15-CH, W34-CH, and WCC-CH.
- **ICD-9/ICD-10 Conversion.** In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, measures should be calculated using ICD-10 codes for claims with a date of service or date of discharge on or after October 1, 2015. ICD-10 codes are available in the corresponding value sets (see above). ICD-9-CM and ICD-9-PCS codes are still included in measures where the lookback period plus one year has not yet passed, and in measures that require looking for a code anytime during a beneficiary's history through December 31 of the measurement year. ICD-9 codes are still relevant to the following measures: ADD-CH, AMR-CH, CAP-CH, CIS-CH, CPC-CH, IMA-CH, and PPC-CH.

[2] The TA Brief, "Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets," is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf.

Reporting and Submission

Procedures for reporting the Child Core Set measures are provided below.

- **Submission deadline.** CMS will announce the deadline for submitting and certifying final data on the Child Core Set measures for FFY 2019 in the fall of 2019. States can update data submitted after the submission deadline; however, updates made after the deadline are not guaranteed to be used in the development of reports by CMS and performance rates on https://data.medicaid.gov. States are encouraged to submit data that are as complete as possible by the submission deadline.
- **Completing fields.** Specific fields are provided for each measure. States should complete every field for each measure submitted to ensure consistent and accurate reporting and comparability across states. States are encouraged to document the methods used to calculate the measures in order to improve CMS's understanding of variations across states.
- **Including attachments.** Supporting documents related to measures can be submitted with Child Core Set data.
- **Reasons for not reporting a measure.** Although reporting the Child Core Set is voluntary, states choosing not to report a measure are required to explain their reason for not reporting the measure. This information will assist CMS in understanding why each state or why all states as a group may not be reporting on specific measures.
- **Noting deviations from the measure technical specifications.** Although states are encouraged to report measures adhering to the methods provided in the specifications, this may not always be possible. It might also be necessary to provide additional information and context about the rates reported. Examples of deviations include eligible population definitions that differ from the specifications (age ranges, codes for identifying the population, or missing population segments); differences in data sources used; differences in codes used (added, excluded, or substituted codes); differences in the version used; issues encountered in calculating the measure; and caveats not specified elsewhere.
- **Reporting by Medicaid and CHIP programs.** For each Child Core Set measure reported to CMS, states should specify the population included in the measure: Medicaid program only; CHIP program only; or Medicaid and CHIP programs combined. CMS prefers that states report Medicaid and CHIP data combined whenever possible.[3] States choosing to report a combined Medicaid and CHIP rate should coordinate internally between the two programs (and among those reporting the measures within the state) when reporting. Any populations excluded from the denominator should be noted.
- **Data auditing.** For FFY 2019, CMS will not require certification or auditing of HEDIS or other measures. However, states are encouraged to do so when possible. If there are current state mechanisms for accreditation, certification, and managed care external quality review reporting, or if the state validates its Child Core Set rates, we ask that states describe these processes in the appropriate system reporting fields.
- **Reporting electronic health record (EHR) Medicaid Incentive Program measures.** For states voluntarily reporting on a core measure that is also an EHR Medicaid incentive program measure (ADD-CH, CDF-CH, CHL-CH, CIS-CH, WCC-CH)

[3] Title XXI programs are required by CHIPRA to collect and separately sample CAHPS survey data beginning in December 2013. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf.

CMS ask that states indicate whether any information was extracted from EHRs in the appropriate system reporting fields.

Technical Assistance

To help states collect, report, and use the Child Core Set measures, CMS offers technical assistance. Please submit technical assistance requests specific to the Child Core Set to MACQualityTA@cms.hhs.gov [4]

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

[4] States with technical assistance questions about the Adult Core Set or Health Homes Core Set should also contact MACQualityTA@cms.hhs.gov.

This page left blank for double-sided copying

III. TECHNICAL SPECIFICATIONS

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

These specifications represent the most applicable version available from the measure steward as of December 2018.

MEASURE ADD-CH: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) MEDICATION

National Committee for Quality Assurance

A. DESCRIPTION

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

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

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

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- Children who switch between Medicaid and CHIP and whom the state cannot identify as continuously enrolled between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1 (initiation phase).
- Many of the ADHD medications are also used in the treatment of narcolepsy. In order to have a precise ADHD measure, children with narcolepsy should be removed from the denominator of both indicators.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- NCQA's Medication List Directory (MLD) of NDC codes for ADHD Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/measures/cms136v7.
- Refer to Appendix C for the definition of a prescribing practitioner.

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

B. DEFINITIONS

Intake period	The 12-month window starting March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year.
Negative medication history	A period of 120 days (4 months) prior to the IPSD when the beneficiary had no ADHD medications dispensed for either new or refill prescriptions.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation phase	The 30 days following the IPSD.
C&M phase	The 300 days following the IPSD (10 months).
New episode	The beneficiary must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous medication treatment	The number of medication treatment days during the 10-month follow-up period must be ≥ 210 days (i.e., 300 treatment days – 90 gap days).
Treatment days (Covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days' supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

C. ELIGIBLE POPULATION

Eligible Population: Rate 1 – Initiation Phase

Ages	Age 6 as of March 1 of the year prior to the measurement year to age 12 as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 1 – Initiation Phase (Section D) to identify the eligible population for the Initiation Phase.

Eligible Population: Rate 2 – Continuation and Maintenance Phase

Ages	Age 6 as of March 1 of the year prior to the measurement year to age 12 as of the last calendar day of February of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.
Allowable gap	One 45-day gap in continuous enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 2 – Continuation and Maintenance (Section D) to identify the eligible population for the Continuation and Maintenance Phase.

D. ADMINISTRATIVE SPECIFICATION

Rate 1 – Initiation Phase

Denominator

The Rate 1 eligible population.

Step 1

Identify all children in the specified age range who were dispensed an ADHD medication (ADHD Medications List, see link to Medication List Directory in Guidance for Reporting above) during the 12-month Intake Period.

Step 2

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

Step 3

Calculate continuous enrollment. Children must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4

Exclude children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. Any of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Numerator

An outpatient, intensive outpatient, or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set)
- An outpatient visit (BH Outpatient Value Set)
- An observation visit (Observation Value Set)
- A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set)

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

Note: Do not count visits billed with a telehealth modifier (Telehealth Modifier Value Set) or billed with a telehealth POS code (Telehealth POS Value Set).

Rate 2 – Continuation and Maintenance Phase

Denominator

The Rate 2 eligible population.

Step 1

Identify all children who meet the eligible population criteria for Rate 1 – Initiation Phase.

Step 2

Calculate continuous enrollment. Children must be continuously enrolled for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Step 3

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

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

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

Step 4

Exclude children who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSD. Any of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Numerator

Identify all children who meet the following criteria:

- Numerator compliant for Rate 1 Initiation Phase, and
- At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD

Only one of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) or a telehealth visit.

Identify follow-up visits using the code combinations below, then identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) on the claim.

Any of the following code combinations identify follow-up visits:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set)
- An outpatient visit (BH Outpatient Value Set)
- An observation visit (Observation Visit Value Set)
- A health and behavior assessment/intervention (Health and Behavior Assessment/Intervention Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)
- A telephone visit (Telephone Visits Value Set)

Exclusions (optional)

Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

E. ADDITIONAL NOTES

For children who have multiple overlapping prescriptions, count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).

There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).

MEASURE AMB-CH: AMBULATORY CARE: EMERGENCY DEPARTMENT (ED) VISITS

National Committee for Quality Assurance

A. DESCRIPTION

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

Data Collection Method: Administrative

Guidance for Reporting:

- This measure includes all ages. For reporting the Child Core Set measure, include children up to age 19 when reporting the four measure rates (less than age 1, ages 1 to 9, ages 10 to 19, and a total rate).
- Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason. If a child is enrolled retroactively, count all services for which the state paid or expects to pay.
- Consider all inpatient stays, regardless of payment status (paid, suspended, pending, denied), when confirming that an ED visit did not result in an inpatient stay. For example, if an ED visit is paid but an inpatient stay is denied, the ED visit resulted in an inpatient stay and should not be included in this measure numerator.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

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

B. DEFINITIONS

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

C. ELIGIBLE POPULATION

Age	Children up to age 19. This measure is calculated for four age groups: less than age 1, ages 1 to 9, ages 10 to 19, and a total rate.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of beneficiary months.

Step 1

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

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

Step 2

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

Numerator

Number of ED visits: Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

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

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the ED date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. Age of Beneficiary: Report age as of the date of service.

Matching Enrollment with Utilization: Run enrollment reports used for beneficiary month calculations to determine utilization rates (such as ED visits/1,000 beneficiary months) within 30 days of the claims reports and for the same time period. Include retroactive additions and terminations in these reports.

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

Exclusions (required)

The measure does not include mental health or chemical dependency services.

Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency. Any of the following meet criteria for exclusion:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set)
- Psychiatry (Psychiatry Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set)

E. CALCULATION OF THE ED VISIT RATES

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

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

Table AMB-A. ED Visits per 1,000 Beneficiary Months, by Age

Age	ED Visits	Beneficiary Months	Visits per 1,000 Beneficiary Months
< 1	.	.	.
1–9	.	.	.
10–19	.	.	.
Unknown	.	.	.
Total	.	.	.

Source: Refer to Table AMB-1 in HEDIS specifications (2019 version).

MEASURE AMR-CH: ASTHMA MEDICATION RATIO: AGES 5–18

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of beneficiaries ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- Tthe Asthma Medication Ratio measure is stratified into two age groups: ages 5 to 18 and ages 19 to 64. The Child Core Set measure applies to beneficiaries ages 5 to 18 and the Adult Core Set measure applies to beneficiaries ages 19 to 64.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- NCQA's Medication List Directory (MLD) of NDC codes for Asthma Controller Medications and Asthma Reliever Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.

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

B. DEFINITIONS

Oral medication dispensing event	One prescription of an amount lasting 30 days or less. To count the number of dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date on which the prescription is filled. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different. • Two prescriptions for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each). • Two prescriptions for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each). • Two prescriptions for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days).

Oral medication dispensing event (continued)	• Two prescriptions for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days).
Inhaler dispensing event	When identifying the eligible population, use the definition below to count inhaler dispensing events. All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a beneficiary received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled. Use the Drug ID field in the Asthma Controller Medications List and the Asthma Reliever Medications List (see link to Medication List Directory in Guidance for Reporting above) to determine if the medications are the same or different.
Injection or intravenous dispensing event	Each injection or intravenous infusion counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a beneficiary received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.
Units of medications	When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event. Use the package size and units columns in the NDC list to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicates the dispensed amount is 30 g, this indicates 3 inhaler canisters were dispensed.

C. ELIGIBLE POPULATION

Ages	Ages 5 to 18 as of December 31 of the measurement year. Report the following age stratifications and total rate: • Ages 5 to 11 • Ages 12 to 18 • Total ages 5 to 18
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical during the measurement year and the year prior to the measurement year. Pharmacy during the measurement year.
Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. • At least one ED visit (ED Value Set), with a principal diagnosis of asthma (Asthma Value Set) • At least one acute inpatient encounter (Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) • At least four outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) and at least two asthma medication dispensing events for any controller medication (Asthma Controller Medications List, see link to Medication List Directory in Guidance for Reporting above) or reliever medication (Asthma Reliever Medications List, see link to Medication List Directory in Guidance for Reporting above). Visit type need not be the same for the four visits. • Only three of the four visits may be a telehealth visit, a telephone visit or an online assessment. Identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit. Use the code combinations below to identify telephone visits and online assessments: - A telephone visit (Telephone Visits Value Set) with any diagnosis of asthma (Asthma Value Set) - An online assessment (Online Assessments Value Set) with any diagnosis of asthma (Asthma Value Set)

Event/diagnosis (continued)	• At least four asthma medication dispensing events for any controller medication (Asthma Controller Medications List, see link to Medication List Directory in Guidance for Reporting above) or reliever medication (Asthma Reliever Medications List, see link to Medication List Directory in Guidance for Reporting above) Step 2 A beneficiary identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., the measurement year or the year prior to the measurement year). Step 3: Exclusions (required) Exclude beneficiaries who met any of the following criteria: • Beneficiaries who had any diagnosis from any of the following value sets, any time during the beneficiary's history through December 31 of the measurement year: - Emphysema Value Set - Other Emphysema Value Set - COPD Value Set - Obstructive Chronic Bronchitis Value Set - Chronic Respiratory Conditions Due to Fumes/Vapors Value Set - Cystic Fibrosis Value Set - Acute Respiratory Failure Value Set • Beneficiaries who had no asthma medications (Asthma Controller Medications List; Asthma Reliever Medications List, see link to Medication List Directory in Guidance for Reporting above) dispensed during the measurement year

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries who have a medication ratio of 0.50 or greater during the measurement year. Follow the steps below to calculate the ratio.

Step 1

For each beneficiary, count the units of asthma controller medications (Asthma Controller Medications List, see link to Medication List Directory in Guidance for Reporting above) dispensed during the measurement year. Refer to the definition of Units of medications.

Step 2

For each beneficiary, count the units of asthma reliever medications (Asthma Reliever Medications List, see link to Medication List Directory in Guidance for Reporting above) dispensed during the measurement year. Refer to the definition of Units of medications.

Step 3

For each beneficiary, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4

For each beneficiary, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the .5 rule) to the nearest whole number.

Units of Controller Medications (step 1) / Units of Total Asthma Medications (step 3)

Step 5

Sum the total number of beneficiaries who have a ratio of 0.50 or greater in step 4.

MEASURE APC-CH: USE OF MULTIPLE CONCURRENT ANTIPSYCHOTICS IN CHILDREN AND ADOLESCENTS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure was developed by the National Collaborative for Innovation in Quality Measurement and has been included in HEDIS® since 2017. More information about this measure and six other measures developed for assessing safe and judicious use of antipsychotic medications in children and adolescents is available at http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra_1415-p011-1-ef_0.pdf.
- To be eligible for this measure, beneficiaries must have at least 90 days of continuous antipsychotic medication treatment during the measurement year. Continuous treatment can include different medications; however, first-time prescriptions for a beneficiary must be dispensed prior to October 3 to meet the eligibility criteria as described in Step 5 of the Denominator Specifications.
- A Guide to Calculating the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) Measure in the Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html. This resource provides a step-by-step guide to calculating the APC-CH measure and describes the sample SAS code and data elements that can be used to calculate this measure.
- Sample SAS® code (including the National Drug Code [NDC] list) is available to states upon request from the TA mailbox at MACQualityTA@cms.hhs.gov. This SAS® code can be adapted to state data systems to calculate the APC-CH measure.
- Supplemental data may not be used for this measure.
- Include all paid, suspended, and pending claims when identifying the eligible population. Do not include denied claims when identifying the eligible population or assessing the numerator for this measure.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- NCQA's Medication List Directory (MLD) of NDC codes for Antipsychotic Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.

The following coding system is used in this measure: CPT, HCPCS, NDC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year. Report three age stratifications and a total rate: • Ages 1 to 5 • Ages 6 to 11 • Ages 12 to 17 • Total ages 1 to 17
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	Beneficiaries with 90 days of continuous antipsychotic medication treatment during the measurement year. Use the steps below to determine the eligible population. Step 1 Identify beneficiaries in the specified age range who were dispensed an antipsychotic medication (Antipsychotic Medications List, see link to Medication List Directory in Guidance for Reporting above) during the measurement year. Step 2 Calculate continuous enrollment. The beneficiary must be continuously enrolled during the measurement year. Step 3 For each beneficiary, identify all antipsychotic medication dispensing events during the measurement year. Step 4 Identify start and end dates for drug events. Drug events are defined separately by drug using the Drug ID field in the Medication List Directory (MLD) of NDC codes, see link to Medication List Directory in Guidance for Reporting above. For each drug ID, sort dispensing events chronologically by dispense date. If there is more than one prescription for the same medication dispensed on the same day, use only the prescription with the longest days supply in the calculation. Starting with the first prescription in the measurement year determine if there is a second dispense date with the same Drug ID.

Event/diagnosis (continued)	• If there is no second dispensing event with the same Drug ID, the start date is the first prescription's dispense date and the end date is the start date plus the days supply minus one. For example, a January 1 prescription with a 30 days supply has an end date of January 30. • If there is a second dispensing event with the same Drug ID, determine if there are gap days (a gap of up to 32 days is allowed). Calculate the number of days between (but not including) the first prescription's dispense date and the second prescription's dispense date. If the number of days is less than or equal to the first prescription's days supply plus 32 days, the gap is less than or equal to 32 days and is allowed. The start date is the first prescription's dispense date and the end date is the second prescription's dispense date plus days supply minus one. Continue assessing all subsequent dispensing events with allowable gaps for the same Drug ID and adjust end dates as needed. - For example, a beneficiary has two dispensing events with the same Drug ID. The first is on July 1, with a 30 days supply. The second is on September 1, with a 30 days supply. The number of days between (but not including) the dispense dates is 61 (July 2–August 31). The gap is allowed because 61 is less than the first prescription's days supply plus 32 days (30 + 32 = 62). The start date is July 1 and the end date is September 30. • If there is a second dispensing event with the same Drug ID and there is a gap that exceeds the allowable gap, assign an end date for this drug event and follow the beginning of step 4 for the remaining dispensing events. A beneficiary can have multiple start and end dates per Drug ID during the measurement year. Continue assessing each dispensed prescription for each Drug ID until all dispensing events are exhausted. If a dispensing event goes beyond December 31 of the measurement year, assign the end date as December 31. Step 5 For each beneficiary, identify those with ≥ 90 consecutive treatment days. For each beneficiary, using the start and end dates from all drug events identified in step 4 (which may include events for the same or different medications and may include events with allowable gaps), determine all calendar days covered by at least one antipsychotic medication. If there were ≥ 90 consecutive calendar days, include the beneficiary in this measure.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Beneficiaries on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. Do not include denied claims.

Use the steps below to determine the numerator.

Step 1

For each beneficiary, identify Drug ID, identify all drug events identified in step 4 of the event/diagnosis criteria (used to identify the eligible population [denominator]). Exclude denied claims and recalculate start dates and end dates (using steps 1-4 of the event/diagnosis criteria used to identify the eligible population [denominator]).

Step 2

Identify concurrent antipsychotic medication treatment events as follows:

- For each beneficiary, identify the first day during the measurement year when the beneficiary was treated with two or more different antipsychotic medications (use the Drug ID to identify different drugs, see link to Medication List Directory in Guidance for Reporting above). This is the concurrent antipsychotic medication treatment event start date.
- Beginning with (and including) the start date, identify the number of consecutive days the beneficiary remains on two or more different antipsychotic medications. If the number of days is ≥ 90 days, the beneficiary is numerator compliant.
- If the number of consecutive days on multiple antipsychotic medications is < 90 days, identify the end date and identify the next day during the measurement year when the beneficiary was treated with two or more different antipsychotic medications. If the number of days between the end date and the next start date is ≤ 15 days, include the days in the concurrent antipsychotic medication treatment event (concurrent antipsychotic medication treatment events allow a gap of up to 15 days).
- If the number of days between the end date and the next start date exceeds 15 days, end the event; using the new start date, continue to assess for concurrent antipsychotic medication treatment events.
- Continue this process until the number of concurrent antipsychotic medication treatment days is ≥ 90 consecutive days (i.e., the beneficiary is numerator compliant) or until the measurement year is exhausted (i.e., no concurrent antipsychotic medication treatment events were identified during the measurement year).

MEASURE APP-CH: USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure intends to assess use of psychosocial care as a first-line treatment for conditions for which antipsychotic medications are not indicated. This measure's value set contains typical forms of psychological services, such as behavioral interventions, psychological therapies, and crisis intervention.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- NCQA's Medication List Directory (MLD) of NDC codes for Antipsychotic Medications and Antipsychotic Combination Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.

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

B. DEFINITION

Intake Period	January 1 through December 1 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 120 days (4 months) before the IPSD when the beneficiary had no antipsychotic medications dispensed for either new or refill prescriptions.

C. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year. Report three age stratifications and a total rate: • Ages 1 to 5 • Ages 6 to11 • Ages 12 to 17 • Total ages 1 to 17

Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	IPSD.
Benefit	Medical, mental health, and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify all beneficiaries in the specified age range who were dispensed an antipsychotic medication (Antipsychotic Medications List and Antipsychotic Combination Medications List, see link to Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2 Test for Negative Medication History. For each beneficiary identified in step 1, test each antipsychotic prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History. Step 3 Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD. Step 4: Exclusions (required) Exclude beneficiaries for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year meet criteria: • At least one acute inpatient encounter with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations meet criteria: - BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set) - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)

Event/diagnosis (continued)	• At least two visits in an outpatient, intensive outpatient, or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set), meet criteria: - An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) - An outpatient visit (BH Outpatient Value Set) - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) - An observation visit (Observation Value Set) - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Documentation of psychosocial care (Psychosocial Care Value Set) with or without a telehealth modifier (Telehealth Modifier Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.

MEASURE AUD-CH: AUDIOLOGICAL DIAGNOSIS NO LATER THAN 3 MONTHS OF AGE

Centers for Disease Control and Prevention

A. DESCRIPTION

Percentage of newborns who did not pass hearing screening and have an audiological diagnosis no later than 3 months of age (90 days).

Data Collection Method: EHR

Guidance for Reporting:

- This measure (NQF#1360) is one of three process measures developed by CDC's Early Hearing Detection and Intervention (EHDI) program for monitoring program performance and continuing quality improvement in the field of newborn hearing screening and follow-up services. More information about CDC's EHDI program is available at http://www.cdc.gov/ncbddd/hearingloss/ehdi-programs.html.
- State-level data from the 2016 CDC EHDI Hearing Screening and Follow-Up Survey (HSFS) are available at https://www.cdc.gov/ncbddd/hearingloss/ehdi-data2016.html.The audiological diagnosis measure data is available on the last column of the table at https://www.cdc.gov/ncbddd/hearingloss/2016-data/07-diagnosed-by-3-months.html.

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

B. ELIGIBLE POPULATION

Age	Infants who were born between January 1 and December 31 of the measurement year.
Continuous enrollment	Date of birth to 90 days of age.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of birth.
Benefit	Medical.
Event/diagnosis	Has not passed a hearing screening as indicated by "Fail / Refer."

C. ELECTRONIC HEALTH RECORD SPECIFICATION

Denominator

The number of infants born during the measurement year who have not passed ("Fail / Refer") hearing screening as indicated by the following criteria:

- LOINC# 54109-4: Newborn hearing screen – right = Refer LA10393-9 OR
- LOINC# 54108-6: Newborn hearing screen – left = Refer LA10393-9

Numerator

The number of infants born during the measurement year who have not passed ("Fail / Refer") hearing screening and whose age is less than 91 days at the time of audiological diagnosis.

To be included in the numerator, infants must meet the following criteria:

- Hearing screening results indicate “Fail / Refer” (denominator population) AND
- Have an “Audiological Diagnosis” (SNOMED-CT equals Hearing Normal 164059009, Permanent Conductive 44057004, Sensorineural 60700002, Mixed 77507001, OR Auditory Neuropathy Spectrum Disorder 443805006) AND
- Age of diagnosis is less than 91 days at the time of diagnosis.

Exclusions

Newborns who died before 91 days of age, as indicated by the following discharge status codes found in Field Locator 17 of the UB-04 (CMS-1450) claim form:

UB-04 Code	Description
20	Expired
40[a,b]	Expired at home
41[a]	Expired in a medical facility such as a hospital, skilled nursing facility, intermediate care facility, or freestanding hospice
42[a,b]	Expired – place unknown

[a] This code is for use only on hospice care claims.

[b] This code is for use only on Medicare and Tricare claims for hospice care.

MEASURE AWC-CH: ADOLESCENT WELL-CARE VISITS

National Committee for Quality Assurance

A. DESCRIPTION

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Refer to Appendix C for definitions of PCP and OB/GYN and other prenatal care practitioners.

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

At least one comprehensive well-care visit (Well-Care Value Set) with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the adolescent.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerator

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

Administrative Data

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

Medical Record Review

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

- A health history. Health history is an assessment of the beneficiary's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization), and family health history.
- A physical developmental history. Physical developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.
- A mental developmental history. Mental developmental history includes developmental milestones and assessment of whether the adolescent is developing skills to become a healthy adult.
- A physical exam.
- Health education/anticipatory guidance. Health education/anticipatory guidance is given by the health care provider to the beneficiary and/or parents or guardians in anticipation of emerging issues that a beneficiary and family may face.

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

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

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

The state may count services that occur over multiple visits, as long as all services occur in the time frame specified by this measure.

The following notations or examples of documentation do not count as numerator compliant for the Medical Record Review:

- Health History
  - Notation of allergies or medications or immunization status alone. If all three (allergies, medications, immunization status) are documented it meets criteria.
- Physical Developmental History
  - Notation of "appropriate for age" without specific mention of development
  - Notation of "well-developed/nourished/appearing"

  Note: Documentation of "Tanner Stage/Scale" meets criteria for Physical Developmental History for this measure.
- Mental Developmental History
  - Notation of "appropriately responsive for age"
  - Notation of "neurological exam"
  - Notation of "well-developed"
- Physical Exam
  - Vital signs alone
  - Visits where care is limited to OB/GYN topics (e.g., prenatal or postpartum care). The purpose of including visits with OB/GYNs is to allow that practitioner type to perform the adolescent well-care visit requirements. It is not this measure's intent to allow care limited to OB/GYN topics to be a substitute for well-care.
- Health Education/Anticipatory Guidance
  - Information regarding medications or immunizations or their side effects

E. ADDITIONAL NOTES

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

MEASURE CAP-CH: CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children and adolescents ages 12 months to age 19 who had a visit with a primary care practitioner (PCP). Four separate percentages are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Refer to Appendix C for the definition of a PCP.

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

B. ELIGIBLE POPULATION

Age	Ages 12 months to age 19 as of December 31 of the measurement year. Report four age stratifications: • Ages 12 to 24 months old as of December 31 of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 1, 2016, and December 31, 2017). • Ages 25 months to age 6 as of December 31 of the measurement year. Include all children who are at least age 2 and 31 days old but not older than age 6 during the measurement year (i.e., born on or between January 1, 2012 and November 30, 2016). • Ages 7 to 11 as of December 31 of the measurement year • Ages 12 to 19 as of December 31 of the measurement year
Continuous enrollment	For ages 12 to 24 months, ages 25 months to age 6: The measurement year. For ages 7 to 11, ages 12 to 19: The measurement year and the year prior to the measurement year.

Allowable gap	For ages 12 to 24 months, ages 25 months to age 6: No more than one gap in continuous enrollment of up to 45 days during the measurement year. For ages 7 to 11, ages 12 to 19: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the child/adolescent may not have more than a 1-month gap in coverage (i.e., a child/adolescent whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

For ages 12 to 24 months, ages 25 months to age 6: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year.

For ages 7 to 11, ages 12 to 19: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year or the year prior to the measurement year.

Count all children/adolescents who had an ambulatory or preventive care visit to any PCP.

Exclude specialist visits.

MEASURE CCP-CH: CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15–20

U.S. Office of Population Affairs

A. DESCRIPTION

Among women ages 15 to 20 who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 60 days of delivery is used to monitor the provision of contraception throughout the postpartum period. (A 60-day period is used because the American Congress of Obstetricians and Gynecologists [ACOG] recommends a postpartum visit at 6 weeks, and two additional weeks are allowed for women whose postpartum care visit is delayed.)

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – Postpartum Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- In total, four rates will be reported for the Child Core Set measure:
  - Ages 15 to 20: Most or moderately effective contraception – 3 days
  - Ages 15 to 20: Most or moderately effective contraception – 60 days
  - Ages 15 to 20: LARC – 3 days
  - Ages 15 to 20: LARC – 60 days
- The measurement year is calendar year 2018. There is no lookback period for this measure.
- Include all paid, suspended, pending, and denied claims.
- Some women may have more than one delivery in the measurement year; this measure is designed to identify unique live births (defined as those that occur $\geq$180 days apart) rather than women who had a live birth.
- Women with a live birth occurring after October 31 are excluded from the denominator because there may not have been an opportunity to provide the woman with contraception in the postpartum period (defined as within 60 days of delivery).

- When calculating the number of days postpartum for the numerator, consider the date of delivery to be day 0. For instance, if a live birth occurred on October 28, 2018, review all claims through October 31, 2018 for the 3-day postpartum rates and review all claims through December 27, 2018 for the 60-day postpartum rates.
- The codes used to calculate this measure are available in Tables CCP-A through CCP-D at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.
- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system; contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.
- For more information on interpreting performance results on this measure, see Section E, "Additional Notes."

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

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, ring, or diaphragm.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2018.

C. ELIGIBLE POPULATION

Age	Women ages 15 to 20 as of December 31 of the measurement year who had a live birth.
Continuous enrollment	Within the measurement year, women enrolled from the date of delivery to 60 days postpartum.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	Delivery of a live birth.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population includes women ages 15 to 20 who had a live birth in the measurement year.

Women with a live birth occurring after October 31 will be excluded from the denominator because they may not have an opportunity to receive contraception in the postpartum period (defined as within 60 days of delivery). Follow the steps below to identify the eligible population:

Step 1

Identify live births and deliveries by using codes in Table CCP-A, available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Step 2

Exclude deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth, or pregnancy termination) by using the codes in Table CCP-B, available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Step 3

Exclude live births that occurred during the last 2 months of the measurement year. These deliveries should be excluded from the denominator because there may not have been an opportunity to provide the woman with contraception during the postpartum period. ACOG recommends having a postpartum visit by 6 weeks.

Numerator for Rate 1

The eligible population that was provided a most or moderately effective method of contraception.

Step 4

Define the numerator by identifying women who were provided a most (sterilization, IUD/IUS, implant) or moderately (injectables, oral pills, patch, ring, or diaphragm) effective method of contraception in the measurement year. To do this, use the codes in Table CCP-C, available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Step 5

Determine the date that the contraceptive method was provided to identify: (a) women that were provided contraception in the immediate postpartum period of 3 days after delivery; and (b) women that were provided contraception within 60 days of delivery. The second category will also include women who were provided contraception in the first 3 days postpartum.

Numerator for Rate 2

The eligible population that was provided a LARC method.

Step 4

Define the numerator by identifying women who were provided a LARC in the measurement year. To do this, use the codes in Table CCP-D, available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Step 5

Determine the date that the LARC method was provided to identify: (a) women that were provided LARC in the immediate postpartum period of 3 days after delivery; and (b) women that were provided LARC within 60 days of delivery. The second category will also include women who were provided LARC in the first 3 days postpartum.

E. ADDITIONAL NOTES

Healthy People[1] and the World Health Organization recommend an inter-pregnancy interval of at least 18 months; therefore, all postpartum women can be considered at risk of unintended pregnancy for that period of time.

The Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception that can be used in the postpartum period. If the infant is being fed only its mother's breast milk, and the woman has not experienced her first postpartum menses, then LAM provides 98 percent protection from pregnancy in the first 6 months postpartum.[2]

Despite the protection from LAM, many health care providers will want to provide contraceptive services to women at the postpartum visit because the effectiveness of breastfeeding for pregnancy prevention drops quickly when women stop exclusive breastfeeding. It may be difficult for many clients to receive contraceptive services at that time.

[1] https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives

[2] Trussell J. Contraceptive Efficacy. In Hatcher RA, Trussell J, Nelson AL, Cates W, Kowal D, Policar M. Contraceptive Technology: Twentieth Revised Edition. New York NY: Ardent Media, 2011.

MEASURE CCW-CH: CONTRACEPTIVE CARE – ALL WOMEN AGES 15-20

U.S. Office of Population Affairs

A. DESCRIPTION

Among women ages 15 to 20 at risk of unintended pregnancy, the percentage that:

1. Were provided a most effective or moderately effective method of contraception.
2. Were provided a long-acting reversible method of contraception (LARC).

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods. A state should exercise caution in using this measure for payment purposes, because performance on this measure is a function of a woman's preferences. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state, and see where there is room for improvement. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – All Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- The Contraceptive Care – All Women Ages 15–20 measure in the Child Core Set includes the most and moderately effective methods rate (NQF #2903) and the access to LARC rate (NQF #2904). Two rates will be reported for the Child Core Set measure – one for provision of most or moderately effective methods and one for provision of LARC.
- The measurement year is calendar year 2018. There is no lookback period for this measure to determine if there was a previous sterilization, LARC insertion, or other contraceptive method provided prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- A secondary data source, such as the National Survey of Family Growth (NSFG) can be used to interpret the results of this measure. For more information, see Section E, "Additional Notes" and Appendix D, "Interpreting Rates for Contraceptive Care Measures."
- The codes used to calculate this measure are available in Tables CCW-A through CCW-F at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.
- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system; contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.

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

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, ring, or diaphragm.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2018.

C. ELIGIBLE POPULATION

Age	Women ages 15 to 20 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Follow the steps below to define the denominator:

Step 1

Identify all women ages 15 to 20.

Step 2

Define the denominator by excluding women not at risk of unintended pregnancy because they:

- Were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table CCW-A.

- Had a live birth in the last 2 months of the measurement year because there may not have been an opportunity to provide them with contraception. A two-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 6 weeks, and an additional 2 weeks was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table CCW-D.
- Were still pregnant at the end of the year, as indicated by a pregnancy code (Table CCW-B) and an absence of a pregnancy outcome code indicating a non-live birth (Table CCW-C) or a live birth (Table CCW-D).

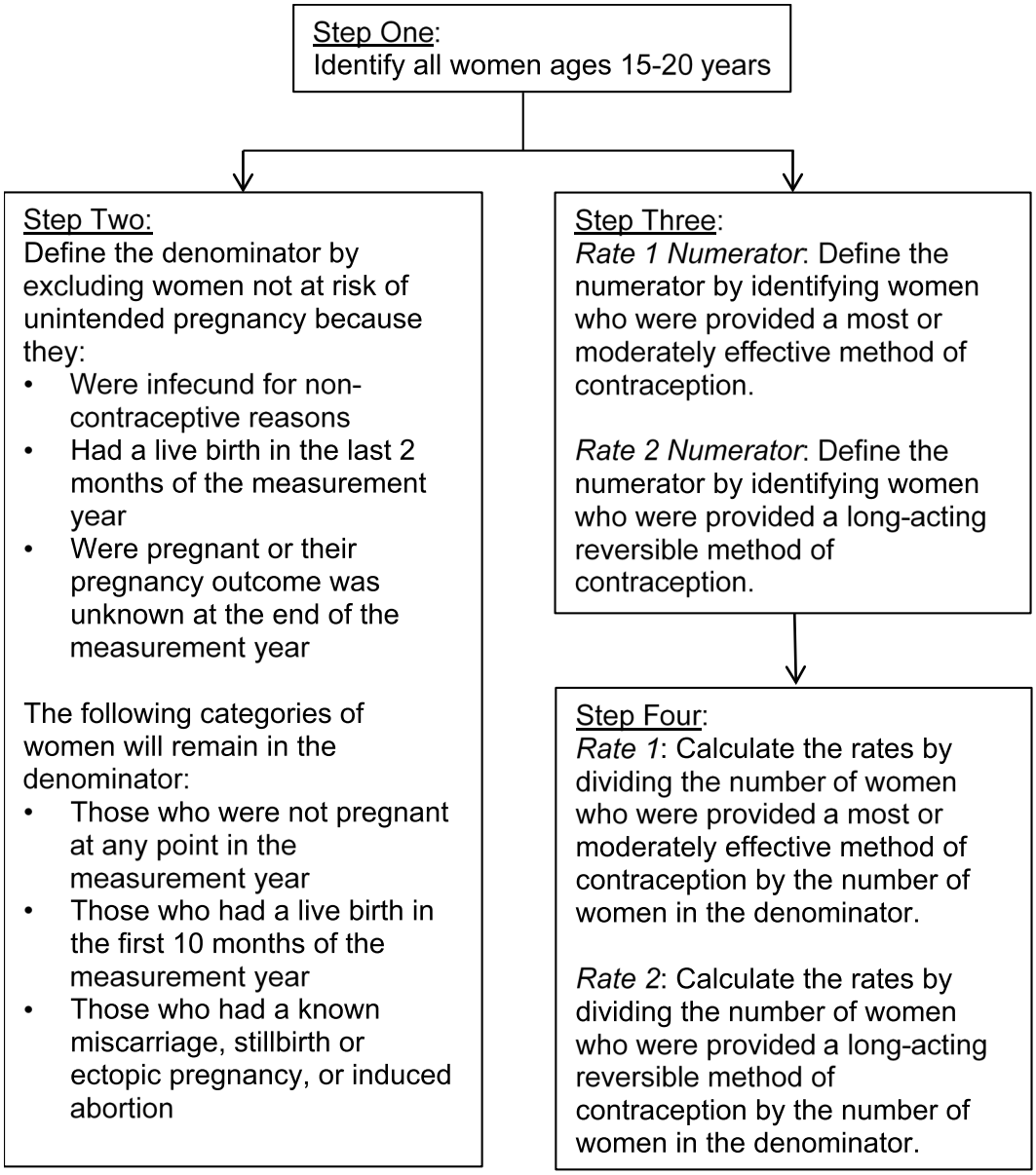
Once the exclusions are applied, the denominator includes women who were:

- Not pregnant at any point in the measurement year.
- Pregnant during the measurement year but whose pregnancy ended in the first 10 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.
- Pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

All code tables used in the calculation of the denominator are available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Figure CCW-A provides a flowchart for implementing these exclusion and inclusion categories.

Figure CCW-A. Measure Flowchart



Numerator for Rate 1

The eligible population provided a most or moderately effective method of contraception.

Step 3

Define the numerator by identifying women who were provided a most (sterilization, IUD/IUS, implant) or moderately (injectables, oral pills, patch, ring, or diaphragm) effective method of contraception in the measurement year. To do this, use the codes in Table CCW-E.

Step 4

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Numerator for Rate 2

The eligible population that was provided a LARC method.

Step 3

Define the numerator by identifying women who were provided a LARC in the measurement year. To do this, use the codes in Table CCW-F.

Step 4

Calculate the rates by dividing the number of women who were provided a LARC by the number of women in the denominator.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

E. ADDITIONAL NOTES

Stratification of the results by category of Medicaid eligibility (e.g., family planning waiver vs. other Medicaid eligibility) is recommended for interpretation. A secondary data source, such as the National Survey of Family Growth (NSFG) or the Behavioral Risk Factor Surveillance System (BRFSS) should be used to interpret provision of most and moderately effective contraceptive methods. Secondary data sources may be used to interpret the results for the general Medicaid population. However, the results for the family planning waiver recipients do not need to be adjusted with secondary data as the vast majority of clients who receive services from these programs are seeking contraceptive services and should therefore be considered at risk of unintended pregnancy.

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy (i.e., who are fecund, are not pregnant or seeking pregnancy, and have ever had sex). However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention or history of sexual activity. Further, both sterilization and LARC are long-lasting but there is no systematic record of receipt of sterilization or LARC in the year(s) preceding the measurement year. These limitations can be offset by using estimates from secondary survey data to help interpret this measure's results and to better understand the limitations of claims data.

NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men ages 15 to 44. Approximately 5,000 individuals are interviewed each year, and updated data files are released every two years. This survey can be used to identify the portion of beneficiaries that are not at risk of unintended pregnancy because they never had sex, are infecund, or are trying to get pregnant. This information can then help determine the population at risk for unintended pregnancy to provide context for measure performance. For more information about the NSFG, see http://www.cdc.gov/nchs/nsfg.htm.

BRFSS is a national telephone survey that collects that data about health-related risk factors, chronic health conditions, and use of preventive services. For more information about the BRFSS, see https://www.cdc.gov/brfss/index.html.

Refer to Appendix D, "Interpreting Rates for Contraceptive Care Measures," for examples of how to interpret performance results on this measure.

MEASURE CDF-CH: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12–17

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure is stratified into two age groups: ages 12 to 17 and age 18 and older. The Child Core Set measure applies to beneficiaries ages 12 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older.
- The denominator for this measure includes beneficiaries ages 12 to 17 with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  1. Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
  2. Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool.
- This measure can be calculated using administrative data only. Medical record review may be used to validate the state's administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report this measure.
- This measure contains both exclusions and exceptions:
  - Denominator exclusion criteria are evaluated before checking if a beneficiary meets the numerator criteria; a beneficiary who qualifies for the denominator exclusion should be removed from the denominator.
  - Denominator exception criteria are only evaluated if the beneficiary does not meet the numerator criteria; beneficiaries who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.
- For a beneficiary to meet the depression or bipolar disorder exclusion criteria, there must be an active diagnosis for one of these conditions documented prior to any encounter during the measurement period. An active diagnosis for depression/bipolar disorder in this case indicates the absence of an end date/time of the diagnosis. Patients with active antidepressant medications listed in their medical record without an active bipolar/depression diagnosis documented in their record should not be excluded from this measure.
- The original specification for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of Child Core Set reporting, there are two G codes included in the numerator to capture whether depression screening was done and if the screen was positive, whether a follow-up plan was documented.

- When multiple encounters that meet criteria for inclusion in the measure denominator take place in the measurement year, the most recent eligible encounter at which the screening took place should be used. The beneficiary should be counted in the denominator and numerator only once based on the most recent screening documented at the eligible encounter.
  - For example, if a beneficiary had a qualifying encounter in January of the measurement year and no depression screening was performed and then had a qualifying encounter in December of the same measurement year and had a depression screening, the encounter during December would be used for the measure denominator. If a beneficiary had an eligible encounter during January with a depression screening performed and an encounter during December with no screening performed, the January encounter would be used for the measure denominator.
- The date of encounter and screening must occur on the same date of service.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- Include all paid, suspended, pending, and denied claims.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/system/files/ecqm/measures/CMS2v7_1.html.

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

B. DEFINITIONS

Screening	Completion of a diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner's office that is filing the code.
Standardized tool	An assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Some depression screening tools are: • Adolescent Screening Tools (12-17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2 • Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale

Follow-up plan	Proposed outline of treatment to be conducted as a result of depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: • Additional evaluation for depression • Suicide risk assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Note: Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression are advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect. The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."

C. ELIGIBLE POPULATION

Age	Ages 12 to 17 on date of encounter.
Event/diagnosis	Outpatient visit (Table CDF-A) during the measurement year.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

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

Table CDF-A. Codes to Identify Outpatient Visits

CPT	HCPCS
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507

Numerator

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

Table CDF-B. Codes to Document Depression Screen

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

Exclusions

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

- Beneficiary has an active diagnosis of Depression or Bipolar Disorder

Use the codes in Table CDF-C, CDF-D, and CDF-E to identify exclusions.

Table CDF-C. HCPCS Code to Identify Exclusions

Code	Description
G9717	Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

Table CDF-D. ICD-10 Codes to Identify Active Diagnosis of Depression (Exclusions)

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission

ICD-10 Code	Description
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

Table CDF-E. ICD-10 Codes to Identify Diagnosed Bipolar Disorder (Exclusions)

ICD-10 Code	Description
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified

ICD-10 Code	Description
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified

Exceptions

A beneficiary that does not meet the numerator criteria and meets the following exception criteria should be excluded from the measure denominator. However, if the beneficiary meets the numerator criteria, the beneficiary would be included in the measure denominator.

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

Table CDF-F. HCPCS Code to Identify Exceptions

Code	Description
G8433	Screening for depression not completed, documented reason

MEASURE CHL-CH: CHLAMYDIA SCREENING IN WOMEN AGES 16–20

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of women ages 16 to 20 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- For HEDIS, this measure has three reportable rates—ages 16 to 20, ages 21 to 24, and a total (ages 16 to 24). The Child Core Set measure applies to beneficiaries ages 16 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 24.
- This measure includes LOINC codes. Use of the LOINC codes is optional for this measure. If LOINC codes are not available, the other code systems in the value set may be used instead.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- NCQA's Medication List Directory (MLD) of NDC codes for Contraceptive Medications and Retinoid Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/measures/cms153v6.

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

B. ELIGIBLE POPULATION

Age	Women ages 16 to 20 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/diagnosis	Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The state must use both methods to identify the eligible population; however, a beneficiary only needs to be identified in one method to be eligible for this measure. Claim/encounter data. Beneficiaries who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria: • Pregnancy Value Set • Sexual Activity Value Set • Pregnancy Tests Value Set Pharmacy data. Beneficiaries who were dispensed prescription contraceptives during the measurement year (Contraceptive Medications List, see link to Medication List Directory in Guidance for Reporting above).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Exclusions (optional)

Exclude women who qualified for the denominator based on a pregnancy test (Pregnancy Tests Value Set) alone and who meet either of the following:

- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and a prescription for isotretinoin (Retinoid Medications List, see link to Medication List Directory in Guidance for Reporting above) on the date of the pregnancy test or within 6 days after the pregnancy test
- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or within 6 days after the pregnancy test

MEASURE CIS-CH: CHILDHOOD IMMUNIZATION STATUS

National Committee for Quality Assurance

A. DESCRIPTION

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

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- States should report a separate rate for each vaccine, as well as 9 combination rates.
- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all children who turned age 2 during the reporting year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, any immunizations missing from claims or registry data must be sought from medical records.
- For states reporting a Child Core Set measure that is also an Electronic Health Record (EHR) Medicaid Incentive Program measure, indicate whether any information was extracted from electronic health records. Please report this information in the “Other Comments on Measure” field.
- The 14-Day Rule specifies that the vaccinations (with the exception of MMR) must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. This rule does not apply to the MMR vaccine. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/measures/cms117v6.

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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

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

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

- Evidence of the antigen or combination vaccine

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

DTaP

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

IPV

At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

MMR

Any of the following meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set) on or between the child's first and second birthdays
- At least one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) on the same date of service or on different dates of service. Only count vaccinations that are administered on or between the child's first and second birthdays (e.g., "Vaccine Administered" value sets). History of illness (Mumps Value Set) can occur on or before the child's second birthday.
- At least one measles vaccination or history of the illness (Measles Vaccine Administered Value Set; Measles Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) and at least one rubella vaccination or history of the illness (Rubella Vaccine Administered Value Set; Rubella Value Set) on the same date of service or on different dates of service. Only count vaccinations that are administered on or between the child's first and second birthdays (e.g., "Vaccine Administered" value sets). History of illness (Measles Value Set, Mumps Value Set, Rubella Value Set) can occur on or before the child's second birthday.

Note: The “14-day rule” does not apply to MMR.

HiB

At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis B

Any of the following on or before the child’s second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service
    - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the child's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis illness (Hepatitis B Value Set)

VZV

Either of the following meets criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service on or between the child's first and second birthdays
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday

Pneumococcal Conjugate

At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis A

Either of the following meets criteria:

- At least one hepatitis A vaccination (Hepatitis A Vaccine Administered Value Set), with a date of service on or between the child's first and second birthdays
- History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday

Rotavirus

Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth:

- At least two doses of the two-dose rotavirus vaccine (Rotavirus Vaccine (2 Dose Schedule) Administered Value Set) on different dates of service
- At least three doses of the three-dose rotavirus vaccine (Rotavirus Vaccine (3 Dose Schedule) Administered Value Set) on different dates of service
- At least one dose of the two-dose rotavirus vaccine (Rotavirus Vaccine (2 Dose Schedule) Administered Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus Vaccine (3 Dose Schedule) Administered Value Set), all on different dates of service

Influenza

At least two influenza vaccinations (Influenza Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.

Combination rates

Calculate the following rates for Combination 2–Combination 10.

Combination Vaccinations for Childhood Immunization Status

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

Exclusions (optional)

Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Any of the following on or before the child's second birthday meet optional exclusion criteria:

Any vaccine:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set)

DTaP:

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set)

MMR, VZV, and Influenza:

- Immunodeficiency (Disorders of the Immune System Value Set)
- HIV (HIV Value Set; HIV Type 2 Value Set)
- Lymphoreticular cancer, multiple myeloma, or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set)
- Anaphylactic reaction to neomycin

Rotavirus:

- Severe combined immunodeficiency (Severe Combined Immunodeficiency Value Set)
- History of intussusception (Intussusception Value Set)

IPV:

- Anaphylactic reaction to streptomycin, polymyxin B or neomycin

Hepatitis B:

- Anaphylactic reaction to common baker's yeast

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

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

- Evidence of the antigen or combination vaccine
- Documented history of the illness

- A seropositive test result

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

- Evidence of the antigen or combination vaccine

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

Administrative Data

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

Medical Record Review

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

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

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

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

Immunizations documented using a generic header (e.g., polio vaccine or "IPV/OPV") can be counted as evidence of IPV. Immunizations documented using a generic header or "DTap/DTP/DT" can be counted as evidence of DTaP. The burden on organizations to substantiate the specific antigen is excessive compared to a risk associated with data integrity.

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

Exclusion (optional)

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

E. ADDITIONAL NOTES

This measure follows the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations.

MEASURE CLABSI-CH: PEDIATRIC CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

Centers for Disease Control and Prevention

A. DESCRIPTION

The Standardized Infection Ratio (SIR) of central line-associated bloodstream infections (CLABSI) in pediatric and neonatal intensive care units (ICUs). A bloodstream infection must first be determined to be a healthcare-associated infection (HAI) before it can be identified as a CLABSI. Only HAIs can be CLABSIs.

A bloodstream infection is considered an HAI if the date of event for a National Healthcare Surveillance Network (NHSN) defined laboratory-confirmed bloodstream infection (LCBI) is on or after day 3 of hospitalization, with day 1 being the date of admission to an inpatient location. A bloodstream infection is Present on Admission (POA) if the date of event of the NHSN defined LCBI was anytime during the two calendar days before the day of admission, the first day of admission, or the day after admission to an inpatient location. Symptoms must be documented in the chart by a health care professional during the POA time frame. POAs are not considered HAIs and are not reported to NHSN.

Once identified as an HAI, an LCBI is further identified as a CLABSI if a central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event (DOE), with day of device placement being Day 1, and was in place on the DOE or the day before. If a CL or a UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), and that is the patient's only central line, day of first access in inpatient location is considered Day 1. The DOE is defined as the date that the first element used to meet the LCBI criteria occurred during the Infection Window Period (IWP). Access is defined as line placement or use of the line for infusion, withdrawal through the line, or hemodynamic monitoring. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued (removed from the body) or the day after patient discharge. Note that de-access of a port does not result in the patient's removal from CLABSI surveillance.

The IWP is defined as the 7 days during which all site-specific infection criteria must be met. It includes the collection date of the first positive diagnostic test that is used as an element to meet the site-specific infection criterion was obtained, the 3 calendar days before, and the 3 calendar days after. For purposes of defining the IWP for CLABSI, the positive blood culture is the diagnostic test, and in the case of LCBI criterion 2, the first positive blood culture of the matched pair of common commensals is used to set the IWP.

The date of event for an LCBI sets a 14-day Repeat Infection Timeframe (RIT) during which no additional BSIs will be counted or reported. The RIT includes the date of event for the LCBI and the next 13 calendar days.

Data Collection Method: Medical records (CDC's National Healthcare Safety Network)

Guidance for Reporting:

- CMS will report this measure for states based on data submitted to the National Healthcare Safety Network. States will not be asked for, and will not be able to provide, data for this measure to CMS.
- Refer to Appendix E for guidance on identifying Secondary Bloodstream Infections.

B. DEFINITIONS

Intensive care unit	A nursing care area in which at least 80 percent of the patients match definitions for critical care locations found in chapter 15, Master CDC Locations and Descriptions, of the NHSN Patient Safety Component Manual, available at https://www.cdc.gov/nhsn/pdfs/validation/2018/pcsmanual_2018-508.pdf. PICU and NICU descriptions can be found on pages 15-11 to 15-15.
CDC location	A CDC-defined designation given to a patient care area housing patients who have similar disease conditions or who are receiving care for similar medical or surgical specialties. Each facility location that is monitored is "mapped" to one CDC Location. The specific CDC Location code is determined by the type of patients cared for in that area according to the 80% Rule. That is, if 80% of patients are of a certain type (e.g., pediatric patients with orthopedic problems) then that area is designated as that type of location (in this case, an Inpatient Pediatric Orthopedic Ward). The admission/transfer diagnosis should be used when determining the appropriate location mapping. The admission diagnosis is considered the most accurate depiction of the patient's illness and reason for being admitted to a particular unit. For detailed instructions on how to map locations, see "Instructions for Mapping Patient Care Locations in NHSN" in the Locations and Descriptions chapter, available at https://www.cdc.gov/nhsn/pdfs/validation/2018/pcsmanual_2018-508.pdf.
Central line	An intravascular catheter that terminates at, or close to the heart, or in one of the great vessels, which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting CLABSI and counting central-line days: Aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, common iliac veins, femoral veins and in neonates, the umbilical artery/vein. Notes: • Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart and be used for one of the purposes outlined above to qualify as a central line. • At times an intravascular line may migrate from its original great vessel location. Subsequent to the original confirmation, NHSN does not require ongoing confirmation that a line resides in a great vessel. Therefore, once a line is identified to be a central line for NHSN purposes, it is considered a central line until discontinuation (removal from the body), regardless of migration, and associated central line days are included in any CLABSI surveillance being performed in that location.

Central line (continued)	• An introducer is considered an intravascular catheter, and depending on the location of its tip and use, may be a central line. • Pacemaker wires and other non-lumened devices inserted into central blood vessels or the heart are not considered central lines, because fluids are not infused, pushed, nor withdrawn through such devices. • The following devices are not considered central lines: - Arterial catheters - Arteriovenous fistula - Arteriovenous graft - Extracorporeal membrane oxygenation (ECMO) - Intra-aortic balloon pump (IABP) devices. - Hemodialysis reliable outflow (HeRO) dialysis catheters - Peripheral IV or midline - Non-accessed central line - Ventricular Assist Device (VAD) • Infusion: The introduction of a solution through a catheter into a blood vessel.
Infusion	The introduction of a solution through the lumen of a catheter into a blood vessel. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.
Umbilical catheter	A central vascular device inserted through the umbilical artery or vein in a neonate.
Temporary central line	A non-tunneled and non-implanted catheter.
Permanent central line	Includes tunneled catheters, including certain dialysis catheters and Implanted catheters (including ports).

C. MEDICAL RECORD SPECIFICATION

Anchor Date

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

Denominator

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

For ICUs, the number of patients with one or more central lines of any type is collected daily, at the same time each day during the month. The totals for the month are entered. Alternatively, for non-oncology ICUs with 75 or more central line days per month in the previous year, the number of patients with one or more central lines of any type may be collected, using the sampling method, once per week (on a designated weekday).

In NICUs, the number of patients with one or more central lines (including umbilical catheters) stratified by birth weight in five categories is collected daily, at the same time each day during the month. The totals for the month are entered.

Numerator

Total number of observed CLABSI that are LCBI 1, 2, or 3 (excluding Mucosal Barrier Injury-LCBI [MBI-LCBI] 1, 2, and 3) among patients in PICUs, NICUs, and pediatric ward locations. See Appendix E for guidance on determining if the bloodstream infection is "related to an infection at another site," and therefore secondary and not an LCBI.

Laboratory-confirmed bloodstream infection (LCBI) must meet one of the following criteria:

- LCBI Criterion 1: Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for the purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing [ASC/AST]) and organism cultured from blood is not related to an infection at another site (Appendix E).
- LCBI Criterion 2: Patient has at least one of the following signs or symptoms: fever (> 38.0 degrees Celsius), chills, or hypotension and organism(s) identified from blood is not related to an infection at another site (Appendix E) and the same common commensal (including, but not limited to, diphtheroids [Corynebacterium spp. not C. diphtheria], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp. Micrococcus spp, and Rhodococcus spp. For a full list of Common Commensals see the Common Commensal tab of the 2018 NHSN Organisms List, available under '2018 Resources' at https://www.cdc.gov/nhsn/validation/index.html) is identified from two or more blood specimens drawn on separate occasions by a culture or non-culture based method which is performed for the purposes of clinical diagnosis or treatment (e.g. not ASC/AST) Criterion elements must occur within the IWP, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after (See complete list of common commensals by selecting the common commensal tab at the bottom of the 2018 NHSN Organisms List, available under '2018 Resources' at https://www.cdc.gov/nhsn/validation/index.html).

Note: the matching common commensals represent a single element; therefore, the collection date of the first common commensal can be the date of the element used to determine the DOE if no eligible symptoms occur in the IWP before the first positive blood specimen.

- LCBI Criterion 3: Patient ≤ 1 years old has at least one of the following signs or symptoms: fever (> 38.0 degrees Celsius) hypothermia (< 36.0 degrees Celsius), apnea, or bradycardia and organism(s) identified from blood is not related to an infection at another site (Appendix E) and the same common commensal (including, but not limited to, diphtheroids [Corynebacterium spp. not C. diphtheria], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp. Micrococcus spp, and Rhodococcus spp. For a full list of Common Commensals see the Common Commensal tab of the NHSN Organisms List, available under '2018 Resources' at https://www.cdc.gov/nhsn/validation/index.html) is identified from two or more blood specimens drawn on separate occasions by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar

days after. (See 2018 resources for a complete list of common commensals by selecting the common commensal tab at the bottom of the Excel worksheet 2018 NHSN Organisms List at https://www.cdc.gov/nhsn/validation/index.html).

Note: The matching common commensals represent a single element; therefore, the collection date of the first common commensal is the date of the element used to determine the DOE if no eligible symptoms occur in the IWP before the first positive blood specimen.

Mucosal Barrier Injury-LCBI [MBI-LCBI] must meet the following criteria:

Note: For MBI-LCBIs, ANC/WBC levels should not be used to set the IWP or to identify the date of event. MBI-LCBIs are subsets of LCBIs and therefore the date of the LCBI would be the date of the MBI-LCBI event.

- MBI-LCBI Criterion 1: Patient of any age meets criterion 1 for LCBI with at least one blood specimen identified by a culture or non-culture based microbiologic testing method. A full list of MBI-LCBI organism is available in the organism tag on the NHSN Organisms List, available under '2018 Resources' at https://www.cdc.gov/nhsn/validation/index.html. Patient also meets at least one of the following:
  1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:
     a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
     b. ≥1 liter diarrhea in a 24-hour period (or ≥ 20 mL/kg in a 24-hour period for patients < 18 years of age) with onset on or within 7 calendar days before the date the positive blood culture was collected.
  2. Is neutropenic, defined as at least 2 separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) < 500 cells/mm^3 within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before and the 3 calendar days after.
- MBI-LCBI Criterion 2: Patient of any age meets criterion 2 for LCBI with at least one blood specimen identified by a culture or non-culture-based microbiologic testing method, with only viridans group streptococci and no other organisms and patient meets at least one of the following:
  1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:
     a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
     b. ≥ 1 liter diarrhea in a 24-hour period (or ≥ 20 mL/kg in a 24-hour period for patients < 18 years of age) with onset on or within 7 calendar days before the date the first positive blood culture was collected.
  2. Is neutropenic, defined as at least 2 separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) < 500 cells/mm^3 within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before and the 3 calendar days after.
- MBI-LCBI Criterion 3: Patient ≤ 1 year of age meets criterion 3 for LCBI when the blood specimens are growing only viridans group streptococci with no other organisms isolated* and patient meets at least one of the following:

1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood specimen:
    a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
    b. ≥ 20 mL/kg diarrhea in a 24-hour period with onset on or within 7 calendar days before the date the first positive blood culture is collected.
2. Is neutropenic, defined as at least 2 separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) < 500 cells/mm^3 on or within a seven-day time period which includes the date the positive blood specimen was collected (Day 1), the 3 calendar days before and the 3 calendar days after.

Note: MBI-LCBI is a subset of LCBI criterion, and may be considered only after LCBI criteria is met. Once a LCBI Date of Event is set, it is not changed, even when MBI-LCBI criteria is met. For MBI-LCBIs, ANC/WBC levels should not be used to set the IWP or to identify the date of event. MBI-LCBIs are subsets of LCBIs and therefore the LCBI DOE would also be the MBI-LCBI DOE.

Standardized Infection Ratio (SIR) Calculation

The SIR is calculated as follows:

1. Identify number of observed healthcare-associated CLABSIs for a given time period by adding the total number of observed CLABSIs across the facility. CLABSIs attributed to neonatal ICUs are stratified by birth weight category. CLABSI events reported to NHSN as mucosal barrier injury (MBI-LCBI) are excluded from the numerator of the CLABSI SIR.
2. Calculate the number of predicted healthcare-associated CLABSIs for each CDC location. The number of predicted events is calculated using probabilities estimated from negative binomial models constructed from 2015 NHSN data, which represents a standard population. In cases when the number of predicted events is less than 1, the SIR will not be calculated in NHSN. The number of predicted CLABSIs calculated under the 2015 baseline is risk adjusted based on factors found to be statistically significant, as described in the CDC's NHSN Guide to the SIR, available at https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf.[1]
3. If the number of predicted events is greater than or equal to one, divide the number of observed healthcare-associated CLABSIs (1 above) by the number of predicted healthcare-associated CLABSIs (2 above) to obtain the SIR.
4. Perform a Poisson test to compare the SIR obtained in 4 above to the nominal value of 1. The resulting p-value and 95% confidence interval will be calculated, which can be used to assess significance of the SIR.

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

- If the SIR > 1, then more HAIs were observed than predicted, based on the 2015 national aggregate data.
- If the SIR < 1, then fewer HAIs were observed than predicted, based on the 2015 national aggregate data.
- Is the SIR= 1, then the same number of HAIs were observed as predicted, based on the 2015 national aggregate data.

[1] Additional information on the 2015 rebaseline is available at https://www.cdc.gov/nhsn/pdfs/rebaseline/faq-general-rebaseline.pdf.

- Remember, the SIR is only calculated when the number of predicted infections is at least 1. When the predicted number of infection is less than 1, facilities have a few options for reviewing and interpreting HAI data in NHSN:
  - A longer time period can be included in the SIR calculation in order to reach the threshold of 1 predicted infection.
  - Infection rates can be used to track internal HAI incidence over time.
  - Run the TAP Reports to review the CAD (cumulative attributable difference, which is the difference between the # observed and # predicted).
  - Additional information about the SIR is available at https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf.

P-value

- In the context of the SIR, the p-value is a statistical measure that tells us whether the number of observed infections is statistically significantly different than the number of predicted infections (i.e., whether the SIR is significantly different from 1). NHSN calculates p-values using a mid-P exact test.
- If the p-value ≤ 0.05, we can conclude that the number of observed infections is statistically significantly different than the number predicted.
- If the p-value > 0.05, we conclude that the number of observed infections is not statistically significantly different than the number predicted.

95% Confidence Interval

- The 95% confidence interval is a statistical range of values for which we have a high degree of confidence that the true SIR lies within that range.
- If the confidence interval does not include 1, then the SIR is significantly different than 1 (i.e., the number of observed events is significantly different than the number predicted).
  - Example: 95% confidence interval= (0.85, 0.92)
- If the confidence interval includes the value of 1, then the SIR is not significantly different than 1 (i.e., the number of observed events is not significantly different than the number predicted).
  - Example: 95% confidence interval= (0.85, 1.24)

If the SIR is 0.000 (i.e., the infection count is 0 and the number of predicted infections is ≥ 1), the lower bound of the 95% confidence interval will not be calculated.

MEASURE CPC-CH: CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) HEALTH PLAN SURVEY 5.0H – CHILD VERSION INCLUDING MEDICAID AND CHILDREN WITH CHRONIC CONDITIONS SUPPLEMENTAL ITEMS

National Committee for Quality Assurance

A. DESCRIPTION

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

This measure provides information on parents' experiences with their child's health care and gives a general indication of how well the health care meets their expectations. Results summarize children's experiences through ratings, composites, and individual question summary rates.

Four global rating questions reflect overall satisfaction:

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

Five composite scores summarize responses in key areas:

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

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

- Health Promotion and Education
- Coordination of Care

A.2 – Children with Chronic Conditions (CCC)

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

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

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

Data Collection Method: Survey

Guidance for Reporting:

- For the purpose of Child Core Set reporting, CAHPS Health Plan Survey 5.0H – Child Version should be used. The inclusion of Children with Chronic Conditions (CCC) supplemental items is encouraged, but not required by CMS. Appendix F contains the CAHPS 5.0H instrument with CCC supplemental items and Appendix G contains the CAHPS 5.0H instrument without the CCC supplemental items. Appendix H contains additional guidance on conducting the CAHPS 5.0H Child Survey, including the sampling protocol.
- When reporting this measure, states should document (1) how this measure was reported (e.g., whether raw data was submitted to AHRQ's CAHPS Database), (2) which measurement specification (e.g., HEDIS) and data source (i.e., survey version, supplemental item sets, and administrative protocol) were used, and (3) the population included in the denominator (e.g., Medicaid, CHIP). Finally, states should upload a summary of their CAHPS results as an attachment.
- The survey should be conducted by a third-party vendor certified by NCQA according to the HEDIS protocol. A current listing of NCQA-certified HEDIS survey vendors is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-0h-survey-certification/vendor-directory/.
- Any deviations in the questionnaire, data collection or survey administration, sampling, or data analysis should be reported in the "Additional Notes/Comments on Measure" section.
- CHIPRA requirement for CAHPS: CHIPRA section 402 requires Title XXI programs to submit to CMS "data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality of care and consumer satisfaction measures included in the CAHPS survey." CHIPRA requires Title XXI programs to conduct specific sampling and data collection. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf.
- A technical assistance brief on collecting and reporting the CAHPS 5.0H survey is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsbrief.pdf.

B. ELIGIBLE POPULATION

Age	Age 17 and younger as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

C. IMPLEMENTING THE CAHPS SURVEY

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

D. COMPLETION CRITERIA

Survey vendors assign a disposition code of Complete and Eligible Survey when responses indicate that the beneficiary meets the eligible population criteria and three of the five questions listed in the table below are answered appropriately.

Survey Type	**Questions for Complete and Eligible Survey**				
Children With Chronic Conditions Supplemental Items	Q3	Q30	Q45	Q49	Q54
Children Without Chronic Conditions Supplemental Items	Q3	Q15	Q27	Q31	Q36

MEASURE DEV-CH: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE

Oregon Health and Sciences University

A. DESCRIPTION

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C). The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts. For example, a state could do a chart review on a sample of records where the CPT code was used to determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening. To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes/Comments on Measure" section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).
- Only those tools cited in the specifications for this measure meet the criteria for the numerator. During the development of this measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays. States should use the "Deviations from Measure Specifications" field to document any deviations from the specifications for this measure.

The following coding system is used in this measure: CPT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

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

Numerators

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

Numerator 1

Children in Denominator 1 who had a claim with CPT code 96110 before or on their first birthday.

Numerator 2

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

Numerator 3

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

Numerator 4

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

Claims data

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

Important note about appropriate use of claims data

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

Claims NOT included in this measure

It is important to note that modified 96110 claims (for example, where modifiers are added to claims indicating standardized screening for a specific domain of development such as social emotional screening via the ASQ-SE, autism screening) should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral, and social delays.

Exclusions

None.

D. MEDICAL RECORD SPECIFICATION

Denominator

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

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

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

Numerator 2

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

Numerator 3

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

Numerator 4

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

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

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

Tools must meet the following criteria:

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

The following tools are cited by Bright Futures (and the American Academy of Pediatrics statement on developmental screening) and meet the above criteria:

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

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

Tools listed above: The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that have met the above criteria. Bright Futures cites the 2006 statement on Developmental Screening by the American Academy of Pediatrics. New and updated recommendations are anticipated and may include additional tools that meet these criteria. In addition, new tools meeting these criteria may be developed and may be included in future versions of Bright Futures.

Exclusions

None.

E. CALCULATION ALGORITHM

Step 1

Determine the denominators.

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

Step 2

Determine the numerators.

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

Administrative Data: Children for whom a claim of 96110 was submitted for services in the 12 months preceding or on their birthday.

Medical Record Review: Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding or on their birthday. Documentation must include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.

Step 3

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

Step 4

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

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

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

F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

A sample of 411 will provide sufficient statistical power for states reporting a statewide developmental screening rate for children ages 1 to 3. With the smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 may be insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

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

MEASURE FUH-CH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGES 6–17

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has four reportable rates—ages 6 to 17, ages 18 to 64, age 65 and older, and Total (age 6 and older). The Child Core Set measure applies to beneficiaries ages 6 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older.
- Follow the detailed specifications to (1) include the appropriate discharge when the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than (or equal to) the 7-day follow-up rate.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or be found on the same date of service.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or same date of service).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Refer to Appendix C for the definition of a mental health practitioner.

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

B. ELIGIBLE POPULATION

Age	Ages 6 to 17 as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay to determine whether it falls on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stays to determine whether they fall after December 1 of the measurement year. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge. If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30 Day Follow-up: A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.

7 Day Follow-up: A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge.

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

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a mental health practitioner
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a mental health practitioner
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)

- An observation visit (Observation Value Set) with a mental health practitioner
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)

D. ADDITIONAL NOTES

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

MEASURE IMA-CH: IMMUNIZATIONS FOR ADOLESCENTS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. This measure calculates a rate for each vaccine and two combination rates.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- When no sampling is involved, states may use claims or registry data together or alone to obtain immunization records for the entire eligible population (all adolescents who turned age 13 during the reporting year) and report using the administrative specification.
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, seek any immunizations missing from claims or registry data from medical records.
- This measure adheres to the HEDIS 14-Day Rule. The 14-Day Rule specifies that vaccinations must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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

Meningococcal serogroups A, C, W, Y: At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Vaccine Administered Value Set), with a date of service on or between the adolescent's 11th and 13th birthdays.

Tdap: At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine (Tdap Vaccine Administered Value Set), with a date of service on or between the adolescent's 10th and 13th birthdays.

HPV:

- At least two HPV vaccines (HPV Vaccine Administered Value Set), with different dates of service on or between the adolescent's 9th and 13th birthdays.
    - There must be at least 146 days between the first and second dose of the HPV vaccine. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25

  OR

- At least three HPV vaccines (HPV Vaccine Administered Value Set), with a different dates of service on or between the adolescent's 9th and 13th birthdays

Combination 1 (Meningococcal, Tdap): Adolescents who are numerator compliant for both the meningococcal and Tdap indicators.

Combination 2 (Meningococcal, Tdap, HPV): Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Exclusions (optional)

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

Any of the following meet optional exclusion criteria:

Any vaccine:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the adolescent's 13th birthday
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011

Tdap:

- Encephalopathy (Encephalopathy Due to Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set) anytime on or before the adolescent's 13th birthday.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

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

Administrative Data

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

Medical Record Review

For immunization information obtained from the medical record, count adolescents where there is evidence that the antigen was rendered from either of the following:

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

For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

For meningococcal, do not count meningococcal recombinant (serogroup B) (MenB) vaccines. Immunizations documented under a generic header of “meningococcal” and generic documentation that the “meningococcal vaccine” was administered meet criteria.

Immunizations documented using a generic header or “Tdap/Td” can be counted as evidence of Tdap. The burden on states to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

Exclusions (optional)

Refer to Administrative Specification for exclusion criteria. The exclusion must have occurred on or before the adolescent's 13th birthday.

E. ADDITIONAL NOTES

To align with Advisory Committee on Immunization Practices (ACIP) recommendations, only the quadrivalent meningococcal conjugate vaccine (serogroups A, C, W and Y) is included in this measure.

To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days (5 months), with a 4-day grace period (146 days).

MEASURE LBW-CH: LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS

Centers for Disease Control and Prevention

(National Center for Health Statistics)

A. DESCRIPTION

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

Note: A lower rate indicates better performance.

Data Collection Method: State Vital Records

Guidance for Reporting:

- The denominator should include the number of Medicaid and CHIP resident live births in the state for the measurement period regardless of the length of enrollment for women with these births.
- The measurement period for this measure is the calendar year before the Child Core Set reporting year. For example, calendar year 2018 data should be used for the FFY 2019 reporting year.
- Eligibility for this measure is based on deliveries that were covered by Medicaid or CHIP. For the purpose of Child Core Set reporting, states should identify Medicaid/CHIP beneficiaries based on (1) the primary source of payment for delivery designated on the vital record, or (2) the linkage of vital records and Medicaid/CHIP eligibility data. States that link the vital records to Medicaid/CHIP eligibility data may use either the mother's or infant's record (or a linkage of the two records) to determine eligibility for the denominator. States should document the methodology in the "Additional Notes/Comments on Measure" section.

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

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

Numerator

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

Units

Report as a percentage.

MEASURE PC02-CH: PC-02: CESAREAN BIRTH

The Joint Commission

A. DESCRIPTION

Percentage of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth (C-section).

Note: A lower rate indicates better performance.

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure applies to women who meet the measure eligibility criteria.
- Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.
- This measure requires administrative data and medical record review to determine required data elements for the numerator and denominator. Appendix I provides additional information on data elements for this measure.
- Medical record review or use of vital records is required to determine both the numerator and denominator for this measure. The Hybrid Specification section includes a link to The Joint Commission sampling guidelines that can ease the burden of the medical record review process.
- Risk adjustment is not specified for reporting this measure at the state level.
- To determine gestational age it is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix I.
- Tables PC02-A, PC02-B, PC02-C, and PC02-D are available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

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

B. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population of nulliparous patients who delivered a live term singleton newborn in vertex presentation. See specifications related to Medical Record Review below.

The following table provides guidance for the minimum recommended sample size for Medical Record Review.

Eligible Population	Minimum Recommended Sample Size
≥ 1,551	311
391 – 1,550	20% of the Eligible Population (78 – 310)
78 – 390	78
30 – 77	No sampling; 100% of Eligible Population required
< 30	Denominator too small to report

Source: Adapted from The Joint Commission, "Quarterly Sampling Examples," available at https://manual.jointcommission.org/releases/TJC2018A1/SamplingChapterTJC.html.

Regardless of the selected sample size, The Joint Commission recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for this measure. For additional information on sampling, refer to The Joint Commission's "Population and Sampling Specifications" guidelines located at https://manual.jointcommission.org/releases/TJC2018A1/SamplingChapterTJC.html.

Include populations with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for delivery as defined in Table PC02-A available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Include nulliparous patients with ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for outcome of delivery as defined in Table PC02-B and with a delivery of a newborn with 37 weeks or more of gestation completed. Table PC02-B is available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Medical Record Review

Medical record review is required to collect the following denominator data elements: gestational age and number of previous live births. See Appendix I for additional guidance on collecting these data elements.

To determine gestational age and number of previous live births, it is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix I.

Numerator

Patients with cesarean births. Include patients with ICD-10-PCS Principal Procedure Code or ICD-10-PCS Other Procedure Codes for Cesarean birth as defined in Table PC02-C, available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip.

Exclusions

- ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Table PC02-D available at https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-child-non-hedis-value-set-directory.zip), or

- Less than age 8, or
- Greater than or equal to age 65, or
- Length of stay >120 days, or
- Gestational age < 37 weeks or unable to determine

Medical record review is required to collect the following exclusion data elements: admission date, birthdate, and discharge date. See Appendix I for additional guidance on collecting these data elements.

MEASURE PDENT-CH: PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.

Data Collection Method: Administrative (Form CMS-416)

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted as part of the EPSDT report (Form CMS-416). States are not asked, and will not be able to provide data for this measure.
- The denominator for this measure includes only individuals enrolled in a Medicaid program or a CHIP Medicaid expansion program for at least 90 continuous days during the federal fiscal year and eligible for EPSDT services.
- States with a separate CHIP program should report dental data in Section III.G of the CHIP Annual Report Template System (CARTS) report.
- Instructions for the CMS-416, including for the dental lines of the report, are available at https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf. The instructions for each dental line specify the provider type(s) relevant to that line. It is important to report only services delivered by the type(s) of providers specified for that line. Line 12b collects information on dental services (not oral health services), and this distinction relates to the type of provider who delivered the service (see Section B. Definitions).
- Report dental services provided to eligible children in all places of service, such as dental offices, federally qualified health centers, and schools.
- Include all paid, unpaid, and denied claims.

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

B. DEFINITIONS

Unduplicated	An individual may only be counted once.
Dental services	Services provided by or under the supervision of a dentist. Supervision is a spectrum and includes, for example, direct, indirect, general, collaborative or public health supervision as provided in the state's dental practice act. The most common examples of this are dentists themselves, and dental hygienists who are working under the supervision of dentists.
Oral health services	Services provided by any qualified health care practitioner or by a dental professional who is neither a dentist nor providing services under the supervision of a dentist. The most common examples of this are primary care medical providers and dental hygienists or dental therapists who are not working under the supervision of a dentist.

C. ELIGIBLE POPULATION

Age	Individuals ages 1 to 20.
Continuous enrollment	Eligible for EPSDT services for at least 90 continuous days during the federal fiscal year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

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

Numerator

The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

The numerator should be inclusive of services reimbursed directly by the state under fee-for-service, managed care, prospective payment, or any other payment arrangements, or through any other health or dental plans that contract with the state to provide services to Medicaid or CHIP Medicaid expansion beneficiaries, based on an unduplicated paid, unpaid, or denied claim.

Exclusions

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

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

MEASURE PPC-CH: PRENATAL AND POSTPARTUM CARE: TIMELINESS OF PRENATAL CARE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment in Medicaid/CHIP.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- For HEDIS, this measure includes a Timeliness of Prenatal Care rate and a Postpartum Care rate. The Child Core Set includes the Timeliness of Prenatal Care rate and the Adult Core Set includes the Postpartum Care rate.
- If the Hybrid Method is used, a combination of administrative data and medical record review may not be used to identify prenatal care visits for an individual in the denominator. For example, for one woman, two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) may not be counted, even if each visit shows a different date of service.
- States may use vital records as an alternative data source for this measure if they have confidence in the completeness and accuracy of these data. States can use Medicaid/CHIP administrative data to determine the measure-eligible population (including the requirement of continuous eligibility from 43 days before delivery through 56 days after delivery) and then link the Medicaid/CHIP records to vital records data to identify the information needed to calculate the numerator, including gestational age at delivery, the number of prenatal care visits, and the timing of these visits in relation to the gestational age. States using vital records should document this data source in the "Additional Notes/Comments on Measure" section. States should also provide information about the proportion of measure-eligible beneficiaries who were identified in Medicaid/CHIP administrative data but for whom a birth certificate could not be found in vital records data.
- This measure includes LOINC codes. Use of the LOINC codes is optional for this measure. If LOINC codes are not available, the other code systems in the value set may be used instead.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Refer to Appendix C for definitions of a PCP and OB/GYN practitioner and other prenatal care practitioners.

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

B. ELIGIBLE POPULATION

Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting. Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year count twice. Women who had multiple live births during one pregnancy count once. Follow the steps below to identify the eligible population, which is the denominator for the rate. Step 1 Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Step 2 Exclude non-live births (Non-live Births Value Set). Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 56 days after delivery, with no gaps.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Timeliness of Prenatal Care

A prenatal visit in the first trimester, on the enrollment start date, or within 42 days of enrollment, depending on the date of enrollment in Medicaid/CHIP and the gaps in enrollment during the pregnancy.

Include only visits that occur while the woman was enrolled.

Follow the steps below to identify the numerator.

Step 1

Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to step 2.

For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3.

Step 2

Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester.

For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.

Step 3

Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).

For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4.

For women whose last enrollment started less than 219 days before delivery, proceed to step 5.

Step 4

Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester and find a visit between the last enrollment start date and 176 days before delivery.

Step 5

Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester and find a visit on the enrollment start date or within 42 days after enrollment.

Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester

Decision Rule 1

Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria:

- A bundled service (Prenatal Bundled Services Value Set) where the state can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated)
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set)

Decision Rule 2

A prenatal visit (Prenatal Visits Value Set) with an OB/GYN or other prenatal care practitioner and at least one of the following, all during the first trimester (on the same date of service as the prenatal visit or on different dates of service):

- An obstetric panel (Obstetric Panel Value Set)

- An ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set)
- A pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) for the prenatal visit (codes must be from the same visit)
- All of the following on the same date of the service or on different dates of service:
  - Toxoplasma (Toxoplasma Antibody Value Set)
  - Rubella (Rubella Antibody Value Set)
  - Cytomegalovirus (Cytomegalovirus Antibody Value Set)
  - Herpes simplex (Herpes Simplex Antibody Value Set)
- A rubella antibody test (Rubella Antibody Value Set) and an ABO test (ABO Value Set) on the same date of service or on different dates of service
- A rubella antibody test (Rubella Antibody Value Set) and an Rh test (Rh Value Set) on the same date of service or on different dates of service
- A rubella antibody test (Rubella Antibody Value Set) and an ABO/Rh test (ABO and Rh Value Set) on the same date of service or on different dates of service

Decision Rule 3

A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) (codes must be on the same visit) where the practitioner type is a PCP and at least one of the following, all during the first trimester (on the same date of service as the prenatal visit or on different dates of service).

- An obstetric panel (Obstetric Panel Value Set)
- An ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set)
- All of the following on the same date of service or on different dates of service:
  - Toxoplasma (Toxoplasma Antibody Value Set)
  - Rubella (Rubella Antibody Value Set)
  - Cytomegalovirus (Cytomegalovirus Antibody Value Set)
  - Herpes simplex (Herpes Simplex Antibody Value Set)
- A rubella antibody test (Rubella Antibody Value Set) and an ABO test (ABO Value Set) on the same date of service or on different dates of service
- A rubella antibody test (Rubella Antibody Value Set) and an Rh test (Rh Value Set) on the same date of service or on different dates of service
- A rubella antibody test (Rubella Antibody Value Set) and an ABO/Rh test (ABO and Rh Value Set) on the same date of service or on different dates of service

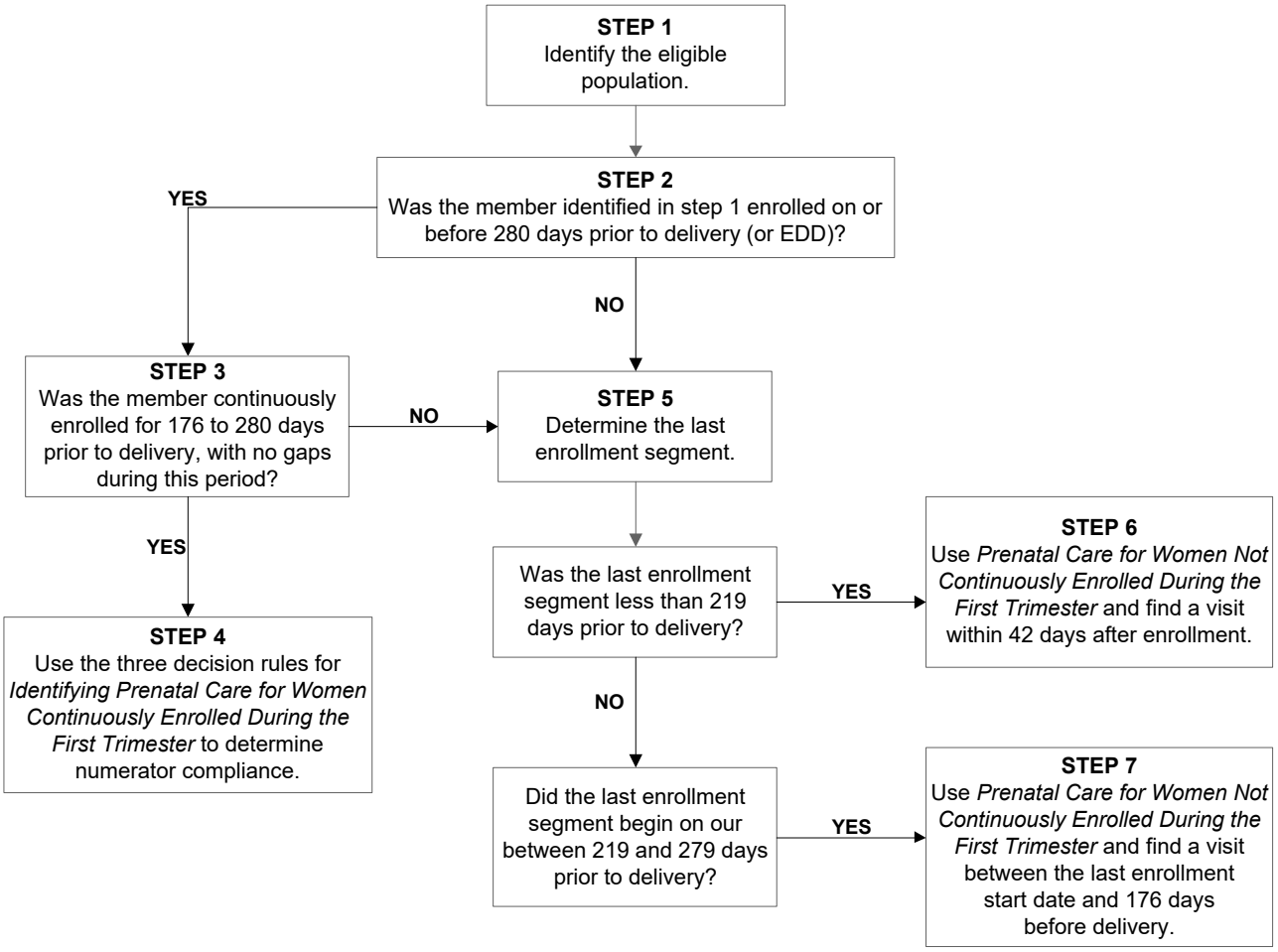
Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester

Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:

- A bundled service (Prenatal Bundled Services Value Set) where the state can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated)
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set)

- A prenatal visit (Prenatal Visits Value Set) and an ultrasound of the pregnant uterus (Prenatal Ultrasound Value Set) on the same date of service or on different dates of service
- A prenatal visit (Prenatal Visits Value Set) with a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set)

The following flow chart depicts how to identify prenatal care for (1) women continuously enrolled during the first trimester and (2) women not continuously enrolled during the first trimester.



D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerator

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

Administrative Data

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

Medical Record Review

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

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used)
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or
  - TORCH antibody panel alone, or
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
  - Ultrasound of a pregnant uterus
- Documentation of LMP, EDD, or gestational age in conjunction with either of the following:
  - Prenatal risk assessment and counseling/education
  - Complete obstetrical history

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

E. ADDITIONAL NOTES

For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the state has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.

Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.

- For women whose last enrollment segment started on or between 219 and 279 days before delivery, the state has sufficient opportunity to provide prenatal care by the end of the first trimester.
- For women whose last enrollment segment started less than 219 days before delivery, the state has sufficient opportunity to provide prenatal care within 42 days after enrollment.

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

The state must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple estimated dates of delivery (EDD) are documented, the state must define a method to determine which EDD to use, and use that date consistently. If the state elects to use EDD, and the EDD is not on or between November 6 of the year prior to the measurement year and November 5 of the measurement year, the woman is excluded as a valid data error and replaced by the next woman of the oversample. The LMP may not be used to determine the first trimester.

The state may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate.

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

The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.

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

MEASURE SEAL-CH: DENTAL SEALANTS FOR 6–9 YEAR-OLD CHILDREN AT ELEVATED CARIES RISK

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled children ages 6 to 9 at elevated risk of dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth within the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- There are five primary differences between the SEAL Child Core Set measure and the dental sealant measure included in the Form CMS-416: (1) the SEAL measure is reported for children ages 6 to 9, only, while the Form CMS-416 measure is reported for children ages 6 to 9 and ages 10 to 14; (2) the SEAL measure denominator includes children at elevated risk of dental caries (i.e., “moderate” or “high” risk), while the Form CMS-416 measure does not require assessment of risk for dental caries; (3) the SEAL measure has a continuous enrollment criterion of 180 days, while the Form CMS-416 measure has a continuous enrollment criterion of 90 days; (4) the SEAL measure counts sealants on first permanent molars only, while the Form CMS-416 measure counts sealants on all permanent molars; and (5) the measurement period for the Child Core Set measure is the calendar year, while the Form CMS-416 measure is calculated for the federal fiscal year.
- Elevated risk can be assessed using one of two methods (1) identify beneficiaries with ‘moderate’ or ‘high’ risk during the measurement year using CDT codes D0602 or D0603 or (2) identify beneficiaries with at least one CDT service code from Table SEAL-A. States may use a three-year lookback period for these codes if data are available or else may use one year of data for the measurement year.
- Children enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for this measure.
- A technical assistance brief on calculating the dental sealant measure is available at https://www.medicaid.gov/medicaid/benefits/downloads/sealant-measure-brief.pdf.
- Sample SAS® Code for programming the dental sealant measure and an accompanying Guide to Data Elements are available on request through the TA mailbox at MACQualityTA@cms.hhs.gov.
- Include all paid, suspended, pending, and denied claims.

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

B. ELIGIBLE POPULATION

Age	Children ages 6 to 9 at the last day of the measurement year.
Continuous enrollment	Child must be continuously enrolled for at least 180 days.
Allowable gap	None.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	At “elevated” risk for dental caries (i.e., “moderate” or “high” risk).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The unduplicated number of eligible children ages 6 to 9 at “elevated” risk for dental caries (i.e., “moderate” or “high” risk).

“Elevated” risk is determined as follows:

- The beneficiary has a visit with a CDT code = (D0602 or D0603) in the measurement year, OR
- The beneficiary has a CDT Code among those in Table SEAL-A in the measurement year, OR
- The beneficiary has a CDT Code among those in Table SEAL-A in any of the three years prior to the measurement year. (Note: the beneficiary does not need to be enrolled in Medicaid/CHIP in any of the prior three years for the denominator enrollment criteria; this is a “look back” for beneficiaries who do have claims experience in any of the prior three years.)

Table SEAL-A. CDT Codes to Identify “Elevated Risk”

D2140	D2394	D2630	D2720	D2791	D3110
D2150	D2410	D2642	D2721	D2792	D3120
D2160	D2420	D2643	D2722	D2794	D3220
D2161	D2430	D2644	D2740	D2799	D3221
D2330	D2510	D2650	D2750	D2930	D3222
D2331	D2520	D2651	D2751	D2931	D3230
D2332	D2530	D2652	D2752	D2932	D3240
D2335	D2542	D2662	D2780	D2933	D3310
D2390	D2543	D2663	D2781	D2934	D3320
D2391	D2544	D2664	D2782	D2940	D3330
D2392	D2610	D2710	D2783	D2941	D1354
D2393	D2620	D2712	D2790	D2950	

Numerator

The unduplicated number of eligible children ages 6 to 9 at "elevated" risk for dental caries (i.e., "moderate" or "high" risk) who received a sealant on a permanent first molar tooth as a dental service.

Step 1

Check if beneficiary received a sealant as a dental service.

- If [CDT CODE] = D1351 AND
- If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table SEAL-B below, then proceed to the next step.[1]
- If both of these criteria are not met, then the service is not counted as a "dental service." The beneficiary is counted in the denominator but is not counted in the numerator.

Note: In this step, all claims with missing or invalid CDT Code, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table SEAL-B will not be counted in the numerator.

Step 2

For those who received a sealant as a dental service (determined in Step 1), check if the sealant was placed on a permanent first molar.

- If [TOOTH-NUMBER] = 3, 14, 19 or 30, then count in numerator.
- If not, then service was not provided for the permanent first molar. The beneficiary is counted in the denominator but is not counted in the numerator.

Table SEAL-B. NUCC maintained Provider Taxonomy Codes classified as "Dental Service"*

122300000X	1223P0106X	1223X0008X	125Q00000X
1223D0001X	1223P0221X	1223X0400X	261QF0400X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

* Services provided by County Health Department dental clinics may also be included as "dental" services.

+ Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services. Services provided by independently practicing dental hygienists should be classified as "oral health" services and are not applicable for this measure.

[1] Identifying "dental" services: Programs and plans that do not use standard NUCC maintained provider taxonomy codes should use valid mapping to identify providers whose services will be categorized as "dental" services. In the case of stand-alone dental plans that reimburse ONLY for services rendered by or under the supervision of the dentist, states should consider all claims as "dental" services.

D. ADDITIONAL NOTES

More information on the rationale for and implementation of this measure is provided in the DQA Measures User Guide, available at https://www.ada.org/~/media/ADA/DQA/2019DQAPediatricMeasuresUserGuide.pdf?la=en.

Reliability of this measure score depends on the quality of the data used to calculate this measure. The percentages of missing and invalid data for these data elements must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, records with missing or invalid TOOTH-NUMBER CODE may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low quality data set will result in a low measure score and will not be reliable.

Measure Limitations Due to Limitations of Administrative Data

This measure will not delineate those whose teeth have not erupted, those who have already received sealants in prior years, and those with decayed/filled teeth not candidates for sealants. However, this measure is designed to identify the prevalence of sealant placement on a permanent first molar tooth during the reporting year for children ages 6 to 9 at elevated risk for caries; this measure is not designed to provide the absolute percentage of children who have ever had a sealant on a permanent first molar. As such, this prevalence-based measure is intended to be used for monitoring trends in sealant placement over time, variations in sealant placement between reporting entities, and disparities in sealant placement.

Some codes (i.e., a few endodontic codes) included to identify children at elevated risk may also be reported for instances such as trauma and may contribute to slight overestimation of children at “elevated risk.”

Since “elevated risk” determination requires an evaluation (to record CDT risk code) or a treatment visit (to record a treatment code), children who are enrolled but do not have a visit in the reporting year or a treatment visit in any of the prior three years will not have sufficient information to be included in this measure. While this is a limitation, the intent of this process of care measure is to seek to understand whether children who can be positively identified as being at elevated risk receive the recommended preventive services.

MEASURE W15-CH: WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

National Committee for Quality Assurance

A. DESCRIPTION

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

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Children should be listed in the numerator for their highest number of visits only. Thus if a child has 5 visits, include the child only in the 5-visit numerator. The sum of all rates should equal 100 percent.
- This measure adheres to the HEDIS 14-Day Rule. The 14-Day Rule specifies that vaccinations must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Refer to Appendix C for the definition of a PCP.

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

B. ELIGIBLE POPULATION

Age	Children who turn 15 months old during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.
Continuous enrollment	Ages 31 days to 15 months. Calculate age 31 days by adding 31 days to the child's date of birth.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Day the child turns age 15 months.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Seven separate numerators are calculated, corresponding to the number of children who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits (Well-Care Value Set), with a PCP on different dates of service, on or before the child's 15-month birthday.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

Seven separate numerators are calculated, corresponding to the number of children who received 0, 1, 2, 3, 4, 5, 6 or more complete well-child visits with a PCP, on different dates of service, on or before the child's 15-month birthday.

The well-child visit must occur with a PCP.

Administrative Data

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

Medical Record Review

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

- A health history. Health history is an assessment of the child's history of diseases or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery or hospitalization (or lack of surgery or hospitalization) and family health history.
- A physical developmental history. Physical development history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- A mental developmental history. Mental development history assesses specific age-appropriate mental developmental milestones, which are behaviors seen in children as they grow and develop.
- A physical exam.
- Health education/anticipatory guidance. Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that a child and family may face.

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

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

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

The following notations or examples of documentation do not count as numerator compliant for the Medical Record Review:

- Health History
  - Notation of allergies or medications or immunization status alone. If all three (allergies, medications, immunization status) are documented it meets criteria.
- Physical Developmental History
  - Notation of Tanner Stage/Scale
  - Notation of "appropriate for age" without specific mention of development
  - Notation of "well-developed/nourished/appearing"
- Mental Development History
  - Notation of "appropriately responsive for age"
  - Notation of "neurological exam"
  - Notation of "well-developed"
- Physical Exam
  - Vital signs alone
- Health Education/Anticipatory Guidance
  - Information regarding medications or immunizations or their side effects

E. ADDITIONAL NOTES

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

MEASURE W34-CH: WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE

National Committee for Quality Assurance

A. DESCRIPTION

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

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- Refer to Appendix C for the definition of a PCP.

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

B. ELIGIBLE POPULATION

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

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

At least one well-child visit (Well-Care Value Set) with a PCP during the measurement year.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerator

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

Administrative Data

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

Medical Record Review

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

- A health history. Health history is an assessment of the child's history of disease or illness. Health history can include, but is not limited to, past illness (or lack of illness), surgery, hospitalization (or lack of surgery or hospitalization) and family health history.
- A physical developmental history. Physical developmental history assesses specific age-appropriate physical developmental milestones, which are physical skills seen in children as they grow and develop.
- A mental developmental history. Mental developmental history assesses specific age-appropriate mental development milestones, which are behaviors seen in children as they grow and develop.
- A physical exam.
- Health education/anticipatory guidance. Health education/anticipatory guidance is given by the health care provider to parents or guardians in anticipation of emerging issues that child and family may face.

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

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

Visits to school-based clinics with practitioners whom the state would consider PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by this measure. The PCP does not have to be assigned to the child.

The state may count services that occur over multiple visits, as long as all services occur in the time frame specified by this measure.

The following notations or examples of documentation do not count as numerator compliant for the Medical Record Review:

- Health History
  - Notation of allergies or medications or immunization status alone. If all three (allergies, medications, immunization status) are documented it meets criteria.
- Physical Developmental History
  - Notation of Tanner Stage/Scale
  - Notation of "appropriate for age" without specific mention of development
  - Notation of "well-developed/nourished/appearing"
- Mental Developmental History
  - Notation of "appropriately responsive for age"
  - Notation of "neurological exam"
  - Notation of "well-developed"
- Physical Exam
  - Vital signs alone
- Health Education/Anticipatory Guidance
  - Information regarding medications or their side effects

E. ADDITIONAL NOTES

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

MEASURE WCC-CH: WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS – BODY MASS INDEX ASSESSMENT FOR CHILDREN/ADOLESCENTS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and who had evidence of body mass index (BMI) percentile documentation during the measurement year.

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

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- Only the BMI percentile component is included in the Child Core Set measure; the physical activity/nutrition counseling measure components are not included in this measure.
- The eligible population (denominator) for this measure includes children ages 3 to 17 who have an outpatient visit and meet the continuous enrollment criteria.
- A BMI percentile is included in the numerator count if the specified documentation is present, regardless of the primary intent of the visit. A BMI without a percentile is not acceptable for inclusion in the numerator count.
- For states reporting a Child Core Set measure that is also an Electronic Health Record (EHR) Medicaid Incentive Program measure, please indicate whether any information was extracted from electronic health records. Please report this information in the "Additional Notes/Comments on Measure" section.
- The height, weight, and BMI must be from the same data source.
- The height and weight measurement should be taken during the measurement year.
- If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/measures/cms155v6.
- Refer to Appendix C for definitions of a PCP and OB/GYN practitioner.

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

B. DEFINITION

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

C. ELIGIBLE POPULATION

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

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

BMI percentile (BMI Percentile Value Set) during the measurement year.

Exclusions (optional)

Female beneficiaries who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population for the Total age band (ages 3 to 17). The Total sample is stratified by age to report rates for the two age groups: ages 3 to 11 and ages 12 to 17. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerator

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

Administrative Data

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

Medical Record Review

Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

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

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

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

Exclusions (optional)

Female beneficiaries who have a diagnosis of pregnancy during the measurement year. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy during the measurement year.

F. ADDITIONAL NOTES

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

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

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

This page left blank for double-sided copying

Appendix A
Child Core Set HEDIS® Value Set Directory User Manual

This page left blank for double-sided copying.

A. WHAT IS THE VALUE SET DIRECTORY?

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

B. STRUCTURE OF THE VALUE SET DIRECTORY

The VSD (Excel workbook) contains the following spreadsheets:

- Copyright & Licensing
- Child Measures to Value Sets
- Child Value Sets to Codes
- Summary of Changes – Codes
- Summary of Changes – Value Sets

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

C. WHAT'S NEW IN THE VALUE SET DIRECTORY?

ICD-9-CM and ICD-9-PCS codes were removed from value sets if the look-back period plus one additional year has passed and in measures that require looking for a code anytime during a beneficiary's history through December 31 of the measurement year, consistent with our policy for removing obsolete codes from value sets. The affected value sets can be identified in the Summary of Changes – Codes spreadsheet by filtering the "Code" column on the term "ALL."

Modifier codes are labeled "Modifier" (previously labeled "CPT Modifier").

D. CHILD MEASURES TO VALUE SETS

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

Table A.1. Child Measures to Value Sets

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

Use the Child Measures to Value Sets spreadsheet to identify all value sets used for a particular measure or to identify all measures that use a specific value set. For example, setting the Measure ID filter to “WCC-CH” demonstrates that the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents measure uses the following value sets:

Measure ID	Measure Name	Value Set Name	Value Set OID
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	BMI Percentile	2.16.840.1.113883.3.464.1004.1038
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	Hospice	2.16.840.1.113883.3.464.1004.1418
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	Outpatient	2.16.840.1.113883.3.464.1004.1202
WCC-CH	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	Pregnancy	2.16.840.1.113883.3.464.1004.1219

Setting the Value Set Name filter to “Well-Care” identifies the three measures that use the value set:

Measure ID	Measure Name	Value Set Name	Value Set OID
AWC-CH	Adolescent Well-Care Visits	Well-Care	2.16.840.1.113883.3.464.1004.1262
W15-CH	Well-Child Visits in the First 15 Months of Life	Well-Care	2.16.840.1.113883.3.464.1004.1262
W34-CH	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Well-Care	2.16.840.1.113883.3.464.1004.1262

E. CHILD VALUE SETS TO CODES

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

Table A.2. Child Value Sets to Codes

Element Name	Element Description
Value Set Name	The value set name.
Value Set OID	Unique identifier for the value set.
Value Set Version	The version date for the value set directory (2018-10-01 or 2018-09-15 for federal fiscal year 2019 reporting).
Code	The code.
Definition	The code definition. Note: The definition is not included for Uniform Bill,[1] CPT,[2] or the American Dental Association's Code on Dental Procedures and Nomenclature (CDT) codes due to licensing restrictions.
Code System	The code system for the code. Code systems are labeled as: CPT Current Procedural Terminology CPT-CAT-II Current Procedural Terminology Category II Codes CVX Vaccines Administered HCPCS Healthcare Common Procedure Coding System Level II ICD10CM International Classification of Diseases, 10th Revision, Clinical Modification (Diagnosis codes) ICD10PCS International Classification of Diseases, 10th Revision, Procedure Coding System (Procedure codes) ICD9CM International Classification of Diseases, 9th Revision, Clinical Modification (Diagnosis codes) ICD9PCS International Classification of Diseases, 9th Revision, Clinical Modification (Procedure codes) LOINC[3] Logical Observation Identifiers Names and Codes Modifier Current Procedural Terminology and HCPCS Modifier Codes POS CMS Place of Service UBREV Uniform Bill (Revenue codes) UBTOB Uniform Bill (Type of Bill codes)
Code System OID	Unique identifier for the code system.
Code System Version	Code system version tracking number.

[1] The American Hospital Association (AHA) holds a copyright to the Uniform Bill Codes ("UB") contained in the Child Core Set measure specifications. The UB Codes in the Child Core Set specifications are included with the permission of the AHA. The UB Codes contained in the Child Core Set specifications may be used by states, health plans, and other health care delivery organizations for the purpose of calculating and reporting Child Core Set measure results or using Child Core Set measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Anyone desiring to use the UB Codes in a commercial product to generate measure results, or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, please contact ub04@healthforum.com.

[2] Current Procedural Terminology (CPT) codes copyright 2018 American Medical Association (AMA). All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

[3] Some measure specifications contain coding from Logical Observation Identifiers Names and Codes (LOINC®) Committee (http://loinc.org). The LOINC table, LOINC codes, LOINC panels and form file, LOINC linguistic variants file, LOINC/RSNA Radiology Playbook, and LOINC/IEEE Medical Device Code Mapping Table are copyright 1995-2018, Regenstrief Institute, Inc. and the LOINC Committee is available at no cost under the license at http://loinc.org/terms-of-use.

Use the Child Value Sets to Codes spreadsheet to identify all codes in a value set or to identify all value sets that use a particular code. For example, setting the Value Set Name filter to "Vaccine Causing Adverse Effect," which is referenced in the Childhood Immunization Status measure (Measure CIS-CH) demonstrates that the following codes are included in the value set:

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.464.1004.1259	2018-10-01	T50.A15A	[T50.A15A] Adverse effect of pertussis vaccine, including combinations with a pertussis component, initial encounter	ICD10CM	2.16.840.1.113883.6.90	2019.1.18AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.464.1004.1259	2018-10-01	T50.A15D	[T50.A15D] Adverse effect of pertussis vaccine, including combinations with a pertussis component, subsequent encounter	ICD10CM	2.16.840.1.113883.6.90	2019.1.18AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.464.1004.1259	2018-10-01	T50.A15S	[T50.A15S] Adverse effect of pertussis vaccine, including combinations with a pertussis component, sequela	ICD10CM	2.16.840.1.113883.6.90	2019.1.18AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.464.1004.1259	2018-10-01	E948.4	Tetanus vaccine causing adverse effects in therapeutic use	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.464.1004.1259	2018-10-01	E948.5	Diphtheria vaccine causing adverse effects in therapeutic use	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.464.1004.1259	2018-10-01	E948.6	Pertussis vaccine, including combinations with a pertussis component, causing adverse effects in therapeutic use	ICD9CM	2.16.840.1.113883.6.103	2014.1.13AA

Setting the Code filter to “O09.00” demonstrates that the code is included in the following value sets:

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Pregnancy	2.16.840.1.113883.3.464.1004.1219	2018-10-01	O09.00	[O09.00] Supervision of pregnancy with history of infertility, unspecified trimester	ICD10CM	2.16.840.1.113883.6.90	2019.1.18AA
Pregnancy Diagnosis	2.16.840.1.113883.3.464.1004.1220	2018-10-01	O09.00	[O09.00] Supervision of pregnancy with history of infertility, unspecified trimester	ICD10CM	2.16.840.1.113883.6.90	2019.1.18AA

F. SUMMARY OF CHANGES – CODES

The Summary of Changes – Codes spreadsheet lists code changes in FFY 2019 by value set and includes the elements in Table A.3.

Table A.3. Summary of Changes – Codes

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

Use the Summary of Changes – Codes spreadsheet to identify codes added to or deleted from a value set. For example, setting the Value Set Name filter to “BH Outpatient" and "Cytomegalovirus Antibody" demonstrates added and deleted codes:

Value Set	Change	Code System	Code
BH Outpatient	Added	CPT	99483
Cytomegalovirus Antibody	Deleted	LOINC	47363-7
Cytomegalovirus Antibody	Deleted	LOINC	47430-4

Codes for value sets that are new to the Child Core Set and value sets that are new to a specific measures are not listed individually in the Summary of Changes – Codes spreadsheet.

Codes for value sets that have been deleted from the Child Core Set or from a specific measure are not listed individually (as Deleted) in the Summary of Changes – Codes spreadsheet.

If all codes from a code system (e.g., ICD-9) have been deleted from a value set, then the Code column will indicate “All.”

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

G. SUMMARY OF CHANGES – VALUE SETS

The Summary of Changes – Value Sets spreadsheet lists changes in FFY 2018 by value sets and includes the elements in Table A.4.

Use the Summary of Changes - Value Sets spreadsheet to identify revised, added, or deleted value sets

Table A.4. Summary of Changes – Value Sets

Element Name	Element Description
Value Set Name	The name of the affected value set.
Change	The change (Added; Deleted; Revised).
Description	Describes the affected measures or, for renamed value sets, the new value set name.
Revised	October changes are identified by a revised date of 2018-10-01.

For example, the following shows an excerpt for the ADD-CH measure:

Value Set Name	Change	Description	Revised
ADD-CH POS Group 1	Deleted	Deleted from: ADD-CH	
ADD-CH POS Group 2	Deleted	Deleted from: ADD-CH	
ADD-CH Stand Alone Visits	Deleted	Deleted from: ADD-CH	
ADD-CH Visits Group 1	Deleted	Deleted from: ADD-CH	
ADD-CH Visits Group 2	Deleted	Deleted from: ADD-CH	
BH Outpatient	Added	Added to: ADD-CH	
Community Mental Health Center POS	Added	Added to: ADD-CH	
Health and Behavior Assessment/Intervention	Added	Added to: ADD-CH	
Observation	Added	Added to: ADD-CH	
Outpatient POS	Added	Added to: ADD-CH	
Partial Hospitalization POS	Added	Added to: ADD-CH	
Partial Hospitalization/Intensive Outpatient	Added	Added to: ADD-CH	
Visit Setting Unspecified	Added	Added to: ADD-CH	

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

This page left blank for double-sided copying.

This appendix provides additional information on when it may be feasible to use a sample size of less than 411 when the hybrid method is used. The sample size is based on the current year's administrative rate or the prior year's reported rate. The guidance in the table below is designed to minimize the burden of medical record review, while providing an adequate sample size for calculating the measure. More information on the use of the hybrid method for Child Core Set Reporting is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf.

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

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

Current Year's Administrative Rate or the Prior Year's Reported Rate	Minimum Sample Size
77%	296
78%	288
79%	279
80%	270
81%	260
82%	250
83%	240
84%	229
85%	219
86%	207
87%	196
88%	184
89%	172
90%	159
91%	147
92%	134
93%	120
94%	106
≥ 95%	100

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

Appendix C
Definition of Medicaid/CHIP Core Set Practitioner Types

This page left blank for double-sided copying.

Practitioner Type	Definition
Mental Health Practitioner	A practitioner who provides mental health services and meets any of the following criteria: • An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice • A Registered Nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC)
Obstetrical/Gynecological (OB/GYN) and Other Prenatal Care Practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology • Certified nurse midwives, nurse practitioners, or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)

Practitioner Type	Definition
Primary Care Practitioner (PCP)	• A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services • Licensed practical nurses and registered nurses are not considered PCPs • Federally Qualified Health Centers (FQHCs) are only considered PCPs if they are certified as FQHCs. To be certified as an FQHC, an entity must meet any one of the following criteria: - Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements - Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration - Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990 - Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991 • For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): - Provide comprehensive services and have an ongoing quality assurance program - Meet other health and safety requirements - Not be concurrently approved as a Rural Health Clinic
Prescribing Practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications

Appendix D
Interpreting Rates for Contraceptive Care Measures

This page left blank for double-sided copying.

Centers for Medicare & Medicaid Services
MATERNAL & INFANT HEALTH Initiative

TECHNICAL ASSISTANCE RESOURCE
December 2017

Interpreting Rates for Contraceptive Care Measures

Contraceptive care measures may be used by health care providers, payers, purchasers, health plans, and policy makers to assess access to and quality of contraceptive services. The measures assess the percentage of women ages 15 to 44 provided a most or moderately effective method of contraception and the percentage provided a long-acting reversible method of contraception (LARC) (Table D.1). *Most effective* methods include female sterilization, implants, or intrauterine devices or systems (IUD or IUS). *Moderately effective* methods include injectables, oral pills, patch, ring, or diaphragm. LARC methods include contraceptive implants, IUD, or IUS. This document describes interpretation of the contraceptive care measures calculated using claims data.

Table D.1. Contraceptive Care Measures

Contraceptive Care – All Women Ages 15–20 (CCW-CH)
Among women ages 15 to 20 at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund), the percentage that was provided: 1. A most effective or moderately effective method of contraception. 2. A long-acting reversible method of contraception (LARC).
Contraceptive Care – All Women Ages 21–44 (CCW-AD)
Among women ages 21 to 44 at risk of unintended pregnancy (defined as those that have ever had sex, are not pregnant or seeking pregnancy, and are fecund), the percentage that was provided: 1. A most effective or moderately effective method of contraception. 2. A long-acting reversible method of contraception (LARC).
Contraceptive Care – Postpartum Women Ages 15–20 (CCP-CH)
Among women ages 15 to 20 who had a live birth, the percentage that was provided within 3 and 60 days of delivery: 1. A most effective or moderately effective method of contraception. 2. A long-acting reversible method of contraception (LARC).
Contraceptive Care – Postpartum Women Ages 21–44 (CCP-AD)
Among women ages 21 to 44 who had a live birth, the percentage provided within 3 and 60 days of delivery: 1. A most effective or moderately effective method of contraception. 2. A long-acting reversible method of contraception (LARC).

There are some differences in how to interpret the measure rates. Examples for each are provided below.

EXAMPLE 1: Provision of Most and Moderately Effective Methods Among All Women at Risk of Unintended Pregnancy

EXAMPLE 2: Provision of LARC Methods Among All Women at Risk of Unintended Pregnancy

EXAMPLE 3: Provision of Contraceptive Methods to Postpartum Women

EXAMPLE 1: Provision of Most and Moderately Effective Methods Among All Women at Risk of Unintended Pregnancy

Table D.2 illustrates the process for interpreting the provision of most and moderately effective methods of contraception among all women at risk of unintended pregnancy. The example is based on Iowa Medicaid claims data from 2013 and data from the National Survey of Family Growth (NSFG).[1] The table shows the rates for women by age and type of benefit, that is, the family planning waiver versus general Medicaid.

Table D.2. Provision of most and moderately effective contraceptive methods among women, by type of Medicaid benefit in Iowa, 2013

Type of benefit	Women ages 15 to 20 (n = 11,699)	Women ages 21 to 44 (n = 33,051)
General Medicaid	40.4%	28.0%
Family Planning Waiver	79.3%	72.7%

Source: Iowa Department of Public Health

Calculating the measures using claims data affects interpretation of the rates. Claims data have several advantages: they are relatively accessible and easy to collect and compile, document the actual services provided, and can readily be used to identify pregnant women.

However, claims data also have some limitations when used to assess access to contraceptive care. One key limitation is that claims data do not capture several aspects of women's risk of unintended pregnancy: sexual experience, pregnancy intention, sterilization or LARC insertion in a year preceding the measurement year, and infecundity for non-contraceptive reasons (unless the woman had a procedure during the measurement year).

These limitations have implications for one of the measures, that is, the provision of most or moderately effective methods among all women at risk. The limitations can be partially addressed by using data from the National Survey of Family Growth (NSFG) to help interpret the performance measure rates for provision of most and moderately effective methods of contraception.

NSFG estimates were used to adjust the rates obtained from Iowa Medicaid claims data (see Tables D.3, D.4, and D.5):

- The rate from the Iowa Medicaid Enterprise data show that 40.4 percent of adolescent women enrolled in the general Medicaid program were using a most or moderately effective method of contraception. NSFG estimates indicate that about 53 percent of the adolescent Medicaid clients are not in need of contraceptive services because they have never had sex (51.6 percent) or received LARC in a year preceding the measurement year (1.1 percent). To adjust for the limitations of claims data, Iowa Medicaid might sum the measure rate (40.4 percent) with the NSFG estimate of adolescents not in need of contraceptive services (53 percent). This gives an adjusted estimate of 93 percent of adolescents whose contraceptive needs are met, and leaves about a 7 percentage point opportunity for improvement.
- The measurement rates also show that 28.0 percent of adult women enrolled in the general Medicaid program were using a most or moderately effective method of contraception. NSFG estimates suggest that about 44 percent of the adult Medicaid sample described above are not in need of contraceptive services because they have never had sex (3.4 percent), are seeking pregnancy (4.4 percent), are infecund for non-contraceptive reasons (3.5 percent), received LARC in a year preceding the measurement year (9.7 percent), or have been sterilized for contraceptive reasons in a year preceding the measurement year (23.3 percent). To adjust for the limitations of claims data, Iowa Medicaid might sum the measure rate (28 percent) with the NSFG estimate of adults not

[1] https://www.cdc.gov/nchs/nsfg/index.htm

in need of contraceptive services (44 percent). This gives an adjusted estimate of 72 percent of adults whose contraceptive needs are met, and leaves about a 28 percentage point opportunity for improvement (Table D.3).

Table D.3. Use of NSFG data to interpret provision of most and moderately effective contraceptive methods: An example from Medicaid

		Ages 15 to 20	Ages 21 to 44
NSFG	Have never had sex	51.6%	3.4%
	Seeking pregnancy	0.0%	4.4%
	Infecund for non-contraceptive reasons	0.0%	3.5%
	Received LARC in a year preceding the measurement year	1.1%	9.7%
	Sterilized for contraceptive reasons in a year preceding the measurement year	0.0%	23.3%
	Not in need of contraceptive services	52.7%	44.3%
	Women enrolled in general Medicaid using a most or moderately effective method of contraception	+ 40.4%	+ 28.0%
	Contraceptive needs are met	93.1%	72.3%
	Opportunity for improvement	**6.9%**	**27.7%**

Since the purpose of Iowa's family planning waiver program is pregnancy prevention and birth spacing, clients who receive services from this program are seeking contraceptive services and can therefore be considered at risk of unintended pregnancy. Therefore, for Iowa Medicaid's family planning waiver program, no adjustment with NSFG data is needed. The rates show that 79.3 percent of adolescent and 72.7 percent of adult Iowa Medicaid Enterprise clients who participated in the family planning waiver program were provided a most or moderately effective method of contraception (Table D.2).

Table D.4. Provision of contraception among selected women[a] ages 15 to 44 whose current insurance is Medicaid, National Survey of Family Growth, 2013–2015

		Most effective methods										
		Vasectomy % (SE)	Procedure within past 12 months % (SE)	Procedure prior to last 12 months % (SE)	Received in past 12 months % (SE)	Received prior to last 12 months % (SE)	Moderately effective methods % (SE)	Least effective methods % (SE)	No method % (SE)	Never had sex % (SE)	Seeking pregnancy % (SE)	Sterile % (SE)
Total	**100%**	**1.0 (0.3)**	**2.0 (0.6)**	**16.8 (1.9)**	**3.9 (1.0)**	**7.4 (1.0)**	**17.6 (1.3)**	**14.2 (1.4)**	**15.8 (1.3)**	**15.2 (1.3)**	**3.5 (0.7)**	**2.5 (0.6)**
Age												
15–20	100%	--	--	--	1.6 (0.7)	1.1 (0.5)	21.7 (3.1)	11.2 (3.0)	12.6 (1.9)	51.6 (3.3)	*	*
21–44	100%	1.3 (0.5)	2.8 (0.8)	23.3 (2.3)	4.7 (1.3)	9.7 (1.4)	15.5 (1.4)	14.7 (1.6)	16.7 (1.6)	3.4 (0.9)	4.4 (0.9)	3.5 (0.8)
Race/Ethnicity												
Hispanic	100%	*	2.0 (1.1)	14.4 (3.7)	4.3 (2.4)	6.9 (1.4)	14.6 (2.9)	14.0 (2.8)	18.7 (2.9)	20.4 (2.9)	2.7 (0.8)	*
NH White	100%	1.1 (0.4)	3.0 (1.1)	19.7 (2.6)	4.6 (1.8)	7.5 (1.8)	18.1 (1.9)	15.6 (2.5)	11.1 (1.3)	11.8 (1.7)	4.2 (1.5)	3.3 (0.9)
NH Black	100%	*	*	14.5 (2.0)	2.5 (1.0)	7.3 (2.1)	22.3 (2.5)	14.4 (2.5)	19.6 (2.2)	12.1 (1.6)	3.2 (1.2)	2.4 (0.8)
Marital status												
Married	100%	*	5.4 (2.4)	24.9 (4.2)	4.6 (2.2)	8.8 (2.3)	17.5 (3.7)	14.8 (2.9)	8.2 (2.3)	--	9.0 (2.8)	4.6 (1.6)
Cohabitating	100%	2.1 (0.9)	3.5 (1.5)	21.7 (3.8)	8.3 (4.2)	13.8 (3.5)	16.6 (2.6)	17.4 (3.6)	8.8 (2.0)	--	5.3 (1.6)	2.6 (2.2)
Widowed, divorced, or separated	100%	--	*	38.5 (5.3)	1.8 (1.0)	4.4 (1.5)	10.8 (3.1)	10.6 (3.5)	27.5 (6.6)	--	*	4.3 (1.5)
Never Married	100%	*	0.4 (0.2)	7.1 (1.1)	2.5 (1.0)	5.3 (0.9)	19.6 (1.8)	13.7 (1.8)	18.5 (1.5)	29.9 (2.2)	1.3 (0.5)	1.4 (0.5)

Source: Office of Population Affairs analysis of National Survey of Family Growth 2013–15 data

[a] Women whose pregnancy ended within 2 months of the interview or who were pregnant at the time of the interview are not included so that the NSFG sample most closely matches the denominator obtained with claims data

SE= standard error; -- indicates no cases in that category; * data statistically not reliable due to low number of cases in that category

Table D.5. Provision of contraception among all women[a] ages 15 to 44, National Survey of Family Growth, 2013–2015

		Most effective methods										
			Female sterilization		LARC							
		Vasectomy % (SE)	Procedure within past 12 months % (SE)	Procedure prior to last 12 months % (SE)	Received in past 12 months % (SE)	Received prior to last 12 months % (SE)	Moderately effective methods % (SE)	Least effective methods % (SE)	No method % (SE)	Never had sex % (SE)	Seeking pregnancy % (SE)	Sterile % (SE)
Total	**100%**	**3.9 (0.4)**	**1.6 (0.3)**	**12.6 (0.9)**	**2.6 (0.4)**	**7.0 (0.5)**	**21.3 (0.8)**	**16.4 (1.0)**	**15.8 (0.8)**	**11.9 (0.6)**	**5.1 (0.4)**	**2.0 (0.3)**
Age												
15–20	100%	--	--	--	2.4 (0.8)	0.8 (0.3)	22.9 (1.9)	8.2 (1.2)	12.0 (1.5)	53.3 (2.4)	*	0.5 (0.2)
21–44	100%	4.8 (0.5)	2.0 (0.3)	15.5 (1.1)	2.6 (0.4)	8.3 (0.6)	20.3 (0.9)	18.0 (1.1)	16.5 (0.8)	3.8 (0.5)	6.1 (0.5)	2.2 (0.3)
Race/Ethnicity												
Hispanic	100%	2.8 (0.7)	0.7 (0.3)	14.7 (1.6)	3.4 (0.8)	7.9 (1.0)	16.4 (1.4)	16.7 (1.5)	16.3 (1.6)	14.8 (1.3)	4.3 (0.6)	2.1 (0.5)
NH White	100%	7.9 (0.9)	2.3 (0.4)	12.0 (1.3)	2.5 (0.6)	7.0 (0.7)	24.9 (1.3)	15.7 (1.4)	13.5 (0.9)	10.2 (0.8)	5.2 (0.6)	2.0 (0.4)
NH Black	100%	0.9 (0.2)	1.0 (0.4)	13.4 (1.4)	2.3 (0.5)	6.6 (1.1)	18.5 (2.0)	15.3 (1.6)	24.3 (1.8)	11.0 (1.2)	4.7 (1.1)	1.7 (0.4)
Marital status												
Married	100%	8.8 (0.9)	3.0 (0.6)	18.8 (1.5)	2.0 (0.5)	9.2 (1.0)	15.5 (1.2)	21.6 (1.8)	9.1 (0.9)	--	9.3 (0.9)	2.8 (0.6)
Cohabitating	100%	1.8 (0.6)	1.4 (0.5)	14.3 (1.7)	5.5 (1.6)	9.0 (1.4)	26.1 (2.0)	22.6 (2.1)	9.0 (1.5)	--	8.8 (1.8)	1.4 (0.4)
Widowed, divorced, or separated	100%	2.2 (1.2)	2.2 (1.2)	28.6 (3.2)	3.1 (1.6)	6.6 (1.9)	16.9 (2.3)	8.4 (2.0)	28.2 (3.4)	*	1.1 (0.5)	3.3 (0.8)
Never Married	100%	0.5 (0.3)	0.4 (0.1)	3.4 (0.5)	2.0 (0.6)	4.4 (0.5)	25.7 (1.3)	11.1 (0.9)	21.9 (1.3)	28.8 (1.4)	0.8 (0.2)	1.1 (0.3)

Source: Office of Population Affairs analysis of National Survey of Family Growth 2013–15 data

[a] Women whose pregnancy ended within 2 months of the interview or who were pregnant at the time of the interview are not included so that the NSFG sample most closely matches the denominator obtained with claims data

SE= standard error; -- indicates no cases in that category; * data statistically not reliable due to low number of cases in that category

EXAMPLE 2: Provision of LARC Methods Among All Women at Risk of Unintended Pregnancy

The primary intent of the LARC measure is to identify very low rates of LARC provision (less than 1–2%) which could be an indicator of barriers to LARC access that may be explored. The LARC measure should not be used to encourage high rates of use or provision. For this same reason, it is not appropriate to use the LARC measure in a pay-for-performance context. Accordingly, NSFG data are not used to interpret the LARC rates.

To illustrate this process, Iowa Medicaid claims data from 2013 were used to calculate the performance measures for all women by public health region (Table D.6).

Table D.6. Provision of LARC among women, overall and by public health region in Iowa, 2013

	Women ages 15 to 20 (n = 5,254)	Women ages 21 to 44 (n = 9,483)
Public Health Regions	**LARC**	**LARC**
Overall	**4.7%**	**5.1%**
Public Health Region 1	4.7%	4.8%
Public Health Region 2	5.4%	5.8%
Public Health Region 3	3.5%	6.3%
Public Health Region 4	4.7%	4.9%
Public Health Region 5	5.3%	4.9%
Public Health Region 6	4.6%	5.1%

Source: Iowa Department of Public Health

In the Iowa general Medicaid population, provision of LARC methods to adolescents is 4.7 percent and among adults it is 5.1 percent. The provision of LARC does not fall below 1 to 2 percent in any public health region and there do not appear to be substantial differences in LARC access across public health regions. These data suggest that there is some access to LARC in the state overall and in each region of the state. Public health regions with percentages lower than the state average may indicate barriers to providing most and moderately effective contraceptive methods that could be addressed.

EXAMPLE 3: Provision of Contraceptive Methods to Postpartum Women

Providing contraception in the postpartum period can help women space pregnancies to their desired inter-pregnancy interval. Healthy People 2020[2] and the World Health Organization recommend an inter-pregnancy interval of at least 18 months, therefore, providing contraception in the postpartum period can be considered an indicator of quality care. All postpartum women may be considered generally at risk of unintended pregnancy for that period of time. As a result, no adjustment using NSFG data is needed to interpret the rates.

To illustrate interpretation of the postpartum rates, Iowa Medicaid data were used from 2013 to calculate the measure statewide and by Iowa public health region (Table D.7).

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning/objectives

Table D.7. Provision of postpartum contraception among female Medicaid beneficiaries ages 15 to 44, overall and by public health region in Iowa, 2013

Postpartum (n = 12,369)	Ages 15 to 20 (n = 2,290)		Ages 21 to 44 (n = 10,079)	
3 days postpartum	**Most/moderate**	**LARC**	**Most/moderate**	**LARC**
Overall	**3.5%**	**0.6%**	**12.0%**	**0.3%**
Public Health Region 1	1.2%	0.0%	9.8%	0.0%
Public Health Region 2	4.5%	0.0%	13.0%	0.1%
Public Health Region 3	2.1%	0.6%	11.9%	0.1%
Public Health Region 4	3.1%	0.0%	11.7%	0.0%
Public Health Region 5	6.5%	0.8%	13.7%	0.7%
Public Health Region 6	5.2%	1.5%	13.5%	0.8%
60 days postpartum				
Overall	**40.8%**	**13.9%**	**41.2%**	**9.5%**
Public Health Region 1	39.3%	13.8%	38.0%	8.8%
Public Health Region 2	43.8%	13.7%	46.2%	11.5%
Public Health Region 3	36.0%	10.2%	37.0%	7.8%
Public Health Region 4	42.0%	13.3%	45.2%	8.5%
Public Health Region 5	44.2%	14.9%	45.4%	10.2%
Public Health Region 6	41.8%	15.8%	42.3%	10.7%

Source: Iowa Department of Public Health

Provision of most and moderately effective methods

The percentage of women provided a most or moderately effective method in the immediate postpartum period was 3.5 percent for adolescents and 12 percent for adult women. By 60 days postpartum, approximately 41 percent of adolescent and adult women were using a most or moderately effective method of contraception. Consequently, there is about a 59 percentage point opportunity for improvement.

Provision of LARC methods

Immediate postpartum LARC provision (within 3 days) among postpartum women is very low, less than 1 percent overall, and there is very little difference across public health regions. This result is not surprising given that Iowa Medicaid had only recently begun reimbursing for this service. By 60 days postpartum, no public health region has a rate less than 2 percent. These data suggest that there is some access to LARC in the state overall and in each region of the state.

This page left blank for double-sided copying.

Appendix E
Secondary Bloodstream Infection (BSI) Guide For CLABSI-CH Measure

This page left blank for double-sided copying.

This appendix[1] provides new guidance on determining if the bloodstream infection is related to infection at another site and therefore secondary and not a laboratory confirmed bloodstream infection (LCBI).

The purpose of using the CDC/National Healthcare Safety Network (NHSN) infection criteria is to identify and consistently categorize infections that are healthcare-associated into major and specific infection sites or types. LCBI criteria include the caveat that the organism(s) identified from the blood cannot be related to infection at another site (i.e., must be a primary bloodstream infection [BSI]). One must be sure that there is no other CDC/NHSN defined primary site-specific infection that may have seeded the bloodstream secondarily; otherwise the bloodstream infection may be misclassified as a primary BSI and erroneously associated with the use of a central line, i.e., called a CLABSI. For locations performing in-plan ventilator-associated events (VAE) surveillance, refer to Figure E.2 in this appendix, as well as the VAE chapter of the Patient Safety Component manual for specific guidance on assigning a secondary BSI to a VAE. The Patient Safety Component Manual is available under '2018 Resources' at https://www.cdc.gov/nhsn/validation/index.html.

Secondary BSI Scenarios

For purposes of NHSN, in order for a bloodstream infection to be determined secondary to a primary infection site, (i.e., related to an infection at another site, such that the primary site of infection may have seeded the bloodstream secondarily), the following requirements must be met:[2]

1. The Patient must meet one of the NHSN site specific definitions (CDC/NHSN Surveillance Definitions for Specific Types of Infections, UTI, PNEU, or SSI), AND either Scenario 1 or Scenario 2 must also be true:
2. Scenario 1: An organism identified from the site specific infection is used as an element to meet the site-specific infection criterion, AND the blood specimen contains at least one matching organism to that site specific specimen, and is collected during the secondary BSI attribution period, OR
3. Scenario 2: The positive blood specimen is an element used to meet the site-specific infection criterion, and is collected during the site specific infection's infection window period

Below are examples with guidance on how to distinguish between the primary or secondary nature of a BSI. The definition of "matching organisms," and important notes and reporting instructions are also provided. See Figure E.1: Secondary BSI Guide for an algorithmic display of the following instructions.

[1] The material in this appendix comes from "Appendix 1: Secondary Bloodstream Infection (BSI) Guide" of the NHSN Patient Safety Component Manual (January 2016).

[2] Necrotizing enterocolitis (NEC) criteria include neither a site-specific specimen nor organism identified from blood specimen, however an exception for assigning a BSI secondary to NEC is provided.

A BSI is considered secondary to NEC if the patient meets one of the two NEC criteria AND an organism identified from blood specimen collected during the secondary BSI attribution period is an LCBI pathogen, or the same common commensal is identified from two or more blood specimens drawn on separate occasions on the same or consecutive days.

Scenario 1: An organism identified from the site-specific infection is used as an element to meet the site-specific infection criterion, AND the blood specimen contains at least one matching organism to that site-specific specimen. The positive blood specimen must be collected during the site-specific infection's secondary BSI attribution period.

a. **Example:** Patient meets NHSN criteria for a symptomatic urinary tract infection (SUTI) (suprapubic tenderness and > 10^5 CFU/ml of E. coli) and blood specimen collected during the SUTI secondary BSI attribution period is positive for E. coli. This is a SUTI with a secondary BSI and the reported organism is E. coli.

b. **Example:** Patient meets NHSN criteria for a symptomatic urinary tract infection (suprapubic tenderness and > 10^5 CFU/ml of E. coli) and blood specimen collected during the SUTI secondary BSI attribution period grows E. coli and P. aeruginosa. This is a SUTI with a secondary BSI and the reported organisms are E. coli and P. aeruginosa, since both site and blood culture are positive for at least one matching pathogen.

c. **Example:** Patient meets NHSN criteria for a symptomatic urinary tract infection (suprapubic tenderness and > 10^5 CFU/ml of E. coli) and a single blood specimen collected during the SUTI secondary BSI attribution period is positive for E. coli and S. epidermidis. This is a SUTI with a secondary BSI and the reported organism is only E. coli, since the single common commensal S. epidermidis positive blood specimen by itself does not meet BSI criteria.

Scenario 2: The positive blood specimen is an element used to meet the site-specific infection criterion, and is collected during the site-specific infection's infection window period. (For your convenience, a list of infection criteria that include positive blood culture as an element are included in Table E.1 below).

a. **Example:** patient becomes febrile and complains of nausea and abdominal pain. A CT scan done that day shows fluid collection suggestive of infection. Blood specimen collected that day results in identification of Bacteroides fragilis. Because the patient meets IAB criterion 3b, using the identification of an organism from the blood specimen as an element (fever, nausea, or abdominal pain, positive blood specimen and CT scan showing infection in abdominal cavity, the BSI is considered secondary to IAB.

b. **Example:** Patient is febrile, has a new onset of cough and has positive chest imaging test indicating the presence of an infiltrate. Blood specimens collected identify Pseudomonas aeruginosa. Because the patient can meet PNU2 definition by using identification of organisms from blood specimen as one of the elements of the infection criterion (i.e. infiltrate on chest imagine test, fever, new onset of cough and organism identified from blood specimen), the BSI is considered a secondary to PNEU.

Note: In scenarios where an NHSN infection definition can be met using more than one criterion of the infection definition, it is possible that identification of organism from blood and site-specific specimens may not match and a BSI may still be considered as a secondary BSI. Consider the following:

c. **Example:** During the SSI surveillance period, a postoperative patient becomes febrile and complains of nausea and abdominal pain. CT scan done that day shows fluid collection suggestive of infection. Culture results show Escherichia coli from the T-tube drainage specimen and the blood specimen grows Bacteroides fragilis. Although the organisms in the blood culture and site-specific culture do not match for at least one organism, the blood culture is considered secondary to IAB. This is because the patient meets organ/space SSI IAB criterion 3b, using the identification of organism in blood specimen as an element (fever, nausea or abdominal pain, organisms identified from blood specimen and CT scan showing infection in abdominal cavity). This patient also meets IAB criterion 3a using the positive site culture plus fever, and nausea or

abdominal pain even though the organism involved is different from that used for IAB criterion 3b. In this case, the BSI is considered secondary to the organ/space SSI IAB and both organisms would be listed as IAB infection pathogens.

d. **Example:** Patient is febrile, has a new onset of cough and has positive chest imaging test indicating the presence of an infiltrate. Blood and bronchoalveolar lavage (BAL) specimens are collected. Results identify Klebsiella pneumoniae > 104 CFU/ml from the BAL and Pseudomonas aeruginosa from the blood. Although the organisms in the blood specimen and site-specific specimen do not match for at least one organism, because the patient can meet PNU2 definition using either the identification of organism from blood specimen or BAL specimen as one of the elements of the infection criterion (i.e. infiltrate on chest imaging test, fever, new onset of cough and organism identified from blood specimen or identified from BAL specimen), the blood is considered a secondary BSI to PNEU and both organisms would be listed as PNEU pathogens.

If there is no matching organism identified from blood and site-specific specimen which is used to meet the site-specific infection definition, nor is an organism identified from blood specimen used to meet the site-specific infection criterion, secondary BSI attribution cannot be assigned.

a. **Example:** Patient has pustules on their abdomen with tenderness and swelling. Purulent material is obtained from the pustules and is positive for Streptococccus Group B. A blood specimen collected the same day identifies methicillin resistant Staphylococcus aureus. Because the organisms from the site and blood specimens do not match, and there is no site-specific criterion for SKIN that includes organisms identified from blood specimen, both a site-specific infection, SKIN (criteria 1 and 2a) and a primary BSI would be reported.

b. **Example:** A patient has an abscess in the soft tissue around a percutaneous endoscopic gastrostomy (PEG) tube, identified by CT scan, and there is also purulent drainage from that site. No site-specific specimen was collected, but a blood specimen is positive for Staphylococcus aureus. No other sites of infection are identified. Because no culture of the site was collected, and the patient therefore cannot meet ST criterion 1, and because there is no ST criterion which uses identification of organism from blood specimen as an element, this patient has a ST infection with unknown pathogen (criterion 2), and a primary BSI with the pathogen Staphylococcus aureus for NHSN purposes.

Table E.1. Site-specific criteria that require blood cultures

Organisms identified from blood as an element		**Organisms identified from blood with imaging test evidence of infection**	
Site	Element	Site	Element
BURN: Burn Infection	1	BONE: Osteomyelitis	3a
JNT: Joint or bursa infection	3c	DISC: Disc Space Infection	3a
MEN: Meningitis or ventriculitis	2c & 3c	GIT: Gastrointestinal tract infection	2c
OREP: Other infection of the male or female reproductive tract	3a	IAB: Intraabdominal infection	3b
Clinically defined pneumonia	2 or 3 Lab finding	SA: Spinal abscess without meningitis	3a

Organisms identified from blood as an element		**Organisms identified from blood with imaging test evidence of infection**	
SUTI	1a, 1b, or 2	USI: Urinary system infection	3b & 4b
UMB: Omphalitis	1b	ENDO: Endocarditis	4a, 4b, 5a & 5b (specific organisms) 6e & 7e plus other criteria as listed

Note: Refers to the Patient Safety Component manual available at http://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf.

A matching organism is defined as one of the following:

1. If genus and species are identified in both cultures, they must be the same.
   a. **Example:** A blood specimen reported as Enterobacter cloacae and an intraabdominal specimen of Enterobacter cloacae are matching organisms.
   b. **Example:** A blood specimen reported as Enterobacter cloacae and an intraabdominal specimen of Enterobacter aerogenes are NOT matching organisms as the species are different.
2. If the organism is less definitively identified in one specimen than the other, the identifications must be complementary.
   a. **Example:** A surgical wound growing Pseudomonas spp. and a blood specimen growing Pseudomonas aeruginosa are considered a match at the genus level and therefore the BSI is reported as secondary to the SSI.
   b. **Example:** A blood specimen reported as Candida albicans and a culture from a decubitus reported as yeast not otherwise specified are considered to have matching organisms because the organisms are complementary, i.e. Candida is a type of yeast.

Notes:

Antibiograms of the blood and potential primary site isolates do not have to match.

If the blood specimen by itself does not meet LCBI criteria (e.g., only one positive blood specimen positive for a common commensal), then that specimen may not be used to indicate the presence of a secondary BSI (see Scenario 1c).

Reporting Instructions:

- For reporting secondary BSI for possible ventilator-associated pneumonia (PVAP), see Figure E.2 and Chapter 10 of the Patient Safety Component manual available under '2018 Resources' at https://www.cdc.gov/nhsn/validation/index.html.
- Do not report secondary bloodstream infection for vascular (VASC) infections, Ventilator-Associated Conditions (VAC), or Infection-related Ventilator-Associated Complications (IVAC), pneumonia 1 (PNEU 1).
- When a BSI is suspected to be secondary to a lower respiratory tract infection and the BSI cannot be determined to be secondary to VAE, the PNEU definitions are available for secondary BSI assignment (see Figure E.2).

Site-specific organism exclusions apply to secondary BSI attribution as well.

Pathogen Assignment

Pathogens identified from secondary BSIs, should be added to those pathogens reported for the primary infection type. The Secondary BSI data collection field should be checked yes.

A secondary BSI pathogen may be assigned to two different primary site infections (e.g., UTI and an IAB infection). In example 1 below, two primary site infections have been identified and a blood specimen is collected within both the SUTI and the IAB secondary BSI attribution period. The blood specimen pathogen matches both primary site infection pathogens (SUTI and IAB). Therefore, the pathogen is reported for both primary sites of infection as a secondary bloodstream infection.

Example E.1. Pathogen Assignment

Hospital Day	BSI	RIT	Infection Window Period	Infection Window Period		BSI
1						
2						
3						
4		1	**Urine culture**: >100,000 cfu/ml *K. pneumoniae*			
5		2	Fever > 38.0 C			
6		3				
7		4				
8		5		Fever >38.0 C, Abdominal pain		
9		6		CT Scan : Abdominal abscess		
10		7	Blood culture: *K. pneumoniae*	Blood culture: *K. pneumoniae*		
11		8				
12		9				
13		10				
14		11				
15		12				
16		13				
17		14				
18						
19						
20						
21						
22						
23						
			SUTI & Secondary BSI Date of Event = 4 Pathogen: *K. pneumoniae*	**IAB & Secondary BSI Date of Event = 8 Pathogen: *K. pneumoniae***		

Infection Window Period
(First positive diagnostic test, 3 days before and 3 days after)

Repeat Infection Timeframe (RIT)
(date of event = day 1)

Secondary BSI Attribution Period (Infection Window Period + RIT)

Date of Event (DOE)
(Date the first element occurs for the first time within the infection window period)

Pathogens excluded from specific infection definitions (e.g., yeast in UTI, or Enterococcus spp. for PNEU) are also excluded as pathogens for BSIs secondary to that type of infection (i.e., they cannot be added on to one of these infections as a pathogen). In example 2 below, the excluded organism must be accounted for as either 1) a primary bloodstream infection (BSI/CLABSI) or, 2) a secondary bloodstream infection attributed to another primary infection (e.g., IAB, SINU). A blood culture with yeast and E. faecalis is collected during the SUTI RIT. A BSI secondary to SUTI is identified. E. faecalis is already documented as a pathogen, but the yeast will not be reported as a secondary BSI pathogen, because yeasts are excluded as organisms in the UTI definition. Because no other primary source of infection for which the yeast BSI can be assigned as secondary is found, a primary BSI with yeast is identified.

Note: The Enterococcus faecalis is not reported as a pathogen for the primary BSI because if an excluded organism had not been identified, a primary BSI would not have been reported.

Example E.2. Pathogen Assignment

Hospital Day	BSI	RIT	Infection Window Period	Infection Window Period	RIT
1					
2					
3		1	Dysuria		
4		2	**Urine culture**: > 100,000 cfu/ml *E. faecalis*		
5		3			
6		4			
7		5			
8		6			
9		7			
10		8			
11		9	Blood culture: *E.faecalis* / Yeast	**Blood culture:** *E. faecalis* / Yeast	1
12		10			2
13		11			3
14		12			4
15		13			5
16		14			6
17					7
18					8
19					9
20					10
21					11
22					12
23					13
24					14
25					
			UTI & Secondary BSI Date of Event = 3 Pathogen: *E. faecalis*	**Primary BSI Date of Event = 11 Pathogen: Yeast**	

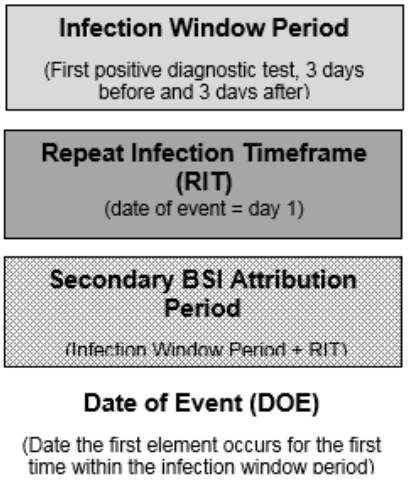
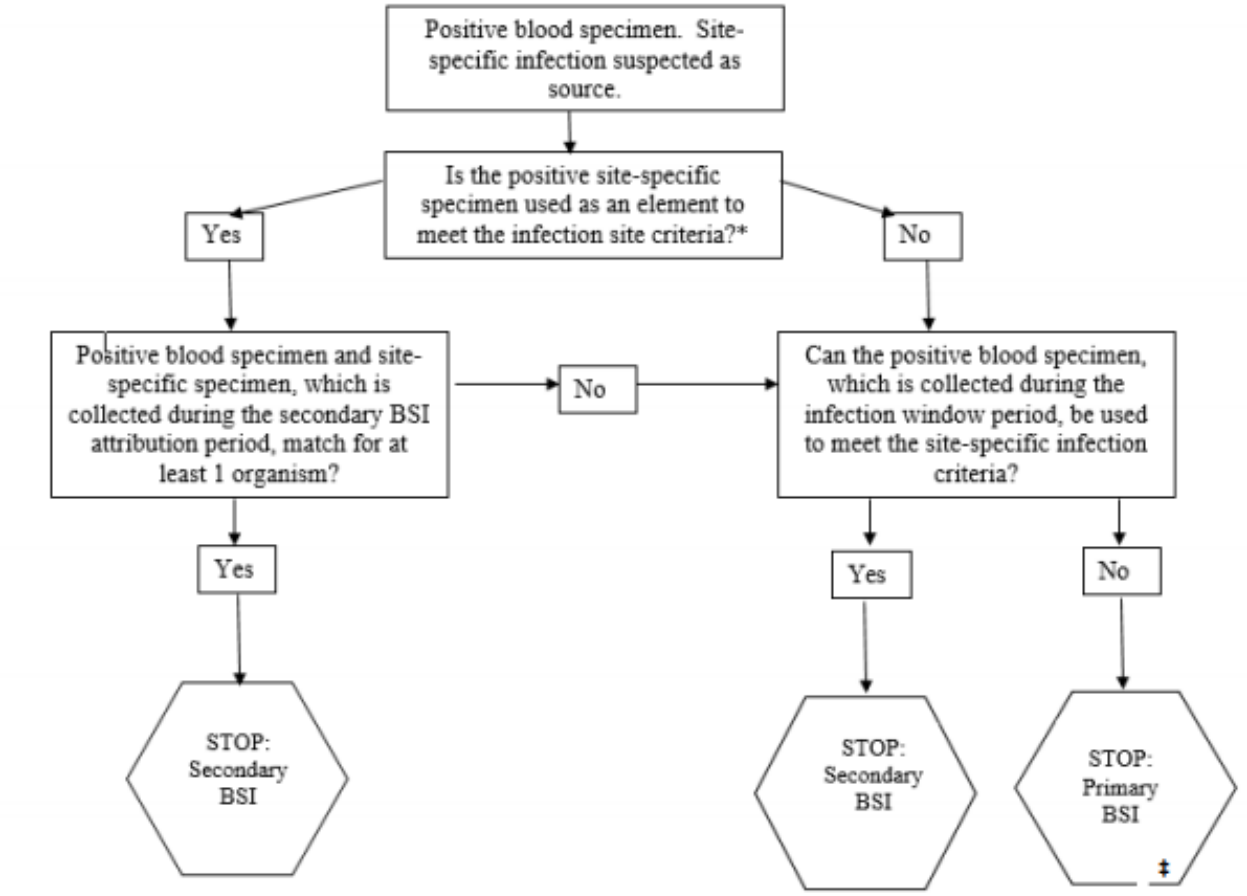


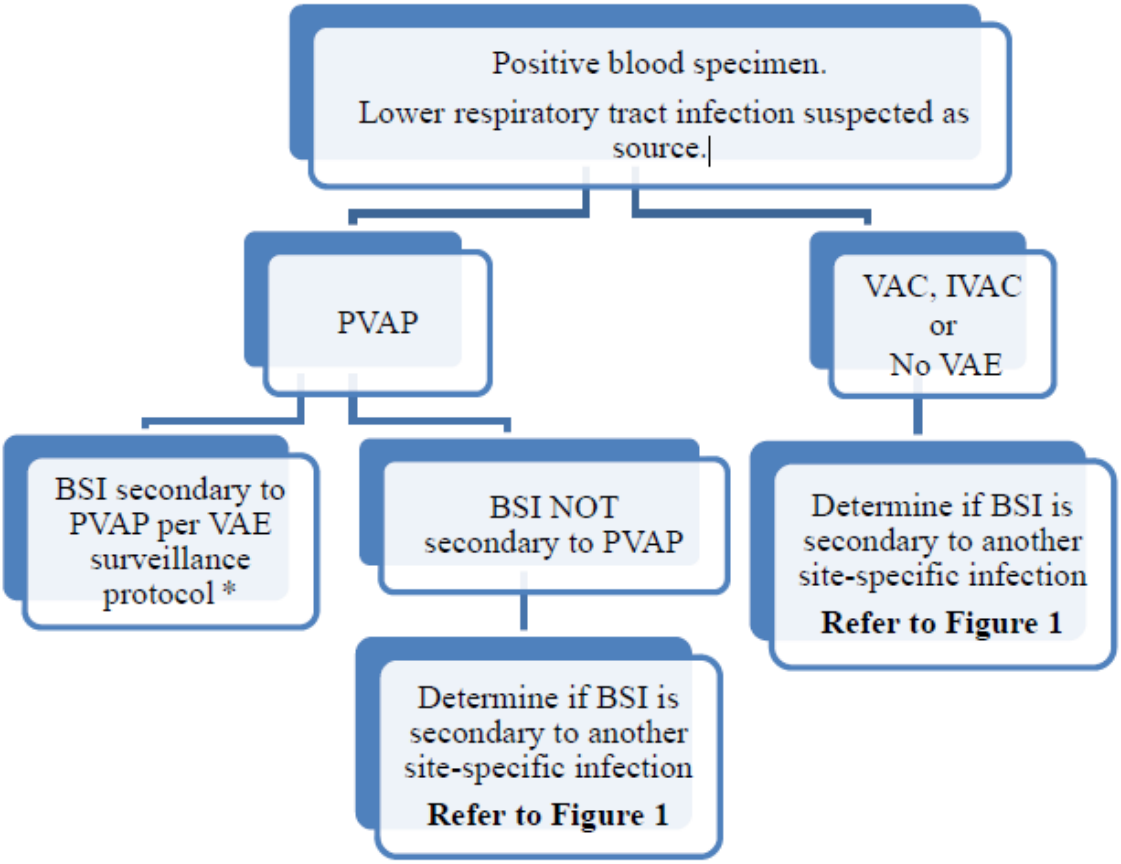
Figure E.1. Secondary BSI Guide for eligible organisms*

(Not applicable to Ventilator-associated Events [VAE], see Figure E.2)



‡Exception: Necrotizing enterocolitis (NEC) criteria include neither a site specific culture nor organism identified from blood specimen, however, an exception for assigning a BSI secondary to NEC is provided. A BSI is considered secondary to NEC if the patient meets one of the 2 NEC criteria AND an organism identified from blood specimen collected during the secondary BSI attribution period is an LCBI pathogen or the same common commensal is identified from 2 or more blood specimens drawn on separate occasions collected on the same or consecutive days.

Figure E.2. VAE Guidance for Secondary BSI Determination



*Secondary BSIs may be reported for possible VAP (PVAP) events, provided that at least one organism identified from the blood specimen matches an organism isolated from an appropriate respiratory tract specimen (including respiratory secretions, pleural fluid and lung tissue). The respiratory tract specimen must have been collected on or after the 3rd day of mechanical ventilation and within 2 calendar days before or after the day of onset of worsening oxygenation to be considered as a criterion for meeting the PVAP definitions. In addition, the positive blood culture must have been collected during the 14-day event period, where day 1 is the day of onset of worsening oxygenation.

- In cases where PVAP is met with only the histopathology criterion and no culture or non-culture is performed on an eligible respiratory specimen, and there is also a positive blood specimen, a secondary BSI to VAE is not reported.
- In cases where a culture or non-culture of respiratory secretions, pleural fluid or lung tissue is performed and does not identify an organism that matches an organism identified from blood, a secondary BSI to VAE is not reported.

Note: Candida species or yeast not otherwise specified, coagulase-negative Staphylococcus species, and Enterococcus species cultured from blood cannot be deemed secondary to a PVAP, unless the organism was also identified from pleural fluid or lung tissue.

Appendix F
CAHPS® Health Plan Survey 5.0H
Child Questionnaire
(With CCC Supplemental Items)

This page left blank for double-sided copying.

CAHPS® 5.0H, Child Questionnaire (With CCC Supplemental Items)

SURVEY INSTRUCTIONS

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

☑ Yes → If Yes, Go to Question 1

☐ No

{This box should be placed on the Cover Page}

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

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

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

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

   1☐ Yes →If Yes, Go to Question 3

   2☐ No

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

   _____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

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

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

   1☐ Yes

   2☐ No →If No, Go to Question 5

4. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

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

   1☐ Yes

   2☐ No →If No, Go to Question 7

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

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

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

   0☐ None → If None, Go to Question 16

   1☐ 1 time

   2☐ 2

   3☐ 3

   4☐ 4

   5☐ 5 to 9

   6☐ 10 or more times

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

   1☐ Yes

   2☐ No

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

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

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

    1☐ Yes

    2☐ No →If No, Go to Question 14

11. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?

    1☐ Yes

    2☐ No

12. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No

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

    00☐ 0 Worst health care possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best health care possible

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No→ If No, Go to Question 19

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

    1☐ Yes

    2☐ No →If No, Go to Question 19

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

    1☐ Yes

    2☐ No

SPECIALIZED SERVICES

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

    1☐ Yes

    2☐ No→ If No, Go to Question 22

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No→ If No, Go to Question 25

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No → If No, Go to Question 28

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No → If No, Go to Question 30

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

    1☐ Yes

    2☐ No

YOUR CHILD'S PERSONAL DOCTOR

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

    1☐ Yes

    2☐ No → If No, Go to Question 45

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

    0☐ None → If None, Go to Question 41

    1☐ 1 time

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 to 9

    6☐ 10 or more times

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No →If No, Go to Question 37

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No → If No, Go to Question 41

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    00☐ 0 Worst personal doctor possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best personal doctor possible

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

    1☐ Yes

    2☐ No → If No, Go to Question 45

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

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No

GETTING HEALTH CARE FROM SPECIALISTS

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

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

    1☐ Yes

    2☐ No → If No, Go to Question 49

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    0☐ None → If None, Go to Question 49

    1☐ 1 specialist

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 or more specialists

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

    00☐ 0 Worst specialist possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best specialist possible

YOUR CHILD'S HEALTH PLAN

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

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

    1☐ Yes

    2☐ No → If No, Go to Question 52

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No →If No, Go to Question 54

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    00☐ 0 Worst health plan possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best health plan possible

PRESCRIPTION MEDICINES

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

    1☐ Yes

    2☐ No → If No, Go to Question 58

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No

ABOUT YOUR CHILD AND YOU

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

    1☐ Excellent

    2☐ Very Good

    3☐ Good

    4☐ Fair

    5☐ Poor

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

    1☐ Excellent

    2☐ Very Good

    3☐ Good

    4☐ Fair

    5☐ Poor

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

    1☐ Yes

    2☐ No → If No, Go to Question 63

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

    1☐ Yes

    2☐ No →If No, Go to Question 63

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

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No → If No, Go to Question 66

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

    1☐ Yes

    2☐ No → If No, Go to Question 66

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

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No → If No, Go to Question 69

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

    1☐ Yes

    2☐ No →If No, Go to Question 69

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

    1☐ Yes

    2☐ No

69. Does your child need or get special therapy such as physical, occupational, or speech therapy?
    - 1☐ Yes
    - 2☐ No → If No, Go to Question 72
70. Is this because of any medical, behavioral, or other health condition?
    - 1☐ Yes
    - 2☐ No → If No, Go to Question 72
71. Is this a condition that has lasted or is expected to last for at least 12 months?
    - 1☐ Yes
    - 2☐ No
72. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?
    - 1☐ Yes
    - 2☐ No → If No, Go to Question 74
73. Has this problem lasted or is it expected to last for at least 12 months?
    - 1☐ Yes
    - 2☐ No
74. What is your child's age?
    - 00☐ Less than 1 year old
    - _____ YEARS OLD (write in)
75. Is your child male or female?
    - 1☐ Male
    - 2☐ Female
76. Is your child of Hispanic or Latino origin or descent?
    - 1☐ Yes, Hispanic or Latino
    - 2☐ No, not Hispanic or Latino
77. What is your child's race? Mark one or more.
    - a☐ White
    - b☐ Black or African American
    - c☐ Asian
    - d☐ Native Hawaiian or other Pacific Islander
    - e☐ American Indian or Alaska Native
    - f☐ Other
78. What is your age?
    - 0☐ Under 18
    - 1☐ 18 to 24
    - 2☐ 25 to 34
    - 3☐ 35 to 44
    - 4☐ 45 to 54
    - 5☐ 55 to 64
    - 6☐ 65 to 74
    - 7☐ 75 or older
79. Are you male or female?
    - 1☐ Male
    - 2☐ Female

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

    1☐ 8th grade or less

    2☐ Some high school, but did not graduate

    3☐ High school graduate or GED

    4☐ Some college or 2-year degree

    5☐ 4-year college graduate

    6☐ More than 4-year college degree

81. How are you related to the child?

    1☐ Mother or father

    2☐ Grandparent

    3☐ Aunt or uncle

    4☐ Older brother or sister

    5☐ Other relative

    6☐ Legal guardian

    7☐ Someone else

82. Did someone help you complete this survey?

    1☐ Yes → If yes, go to question 83

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

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

    a☐ Read the question to me

    b☐ Wrote down the answer I gave

    c☐ Answered the questions for me

    d☐ Translated the questions into my language

    e☐ Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope.

This page left blank for double-sided copying.

Appendix G
CAHPS® Health Plan Survey 5.0H
Child Questionnaire

This page left blank for double-sided copying.

CAHPS® 5.0H, Child Questionnaire (Without CCC Supplemental Items)

SURVEY INSTRUCTIONS

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

☑ Yes → If Yes, Go to Question 1

☐ No

{This box should be placed on the Cover Page}

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

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

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

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

   1☐ Yes →If yes, go to question 3

   2☐ No

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

   _____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

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

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

   1☐ Yes

   2☐ No →If No, Go to Question 5

4. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

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

   1☐ Yes

   2☐ No →If No, Go to Question 7

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

   1☐ Never

   2☐ Sometimes

   3☐ Usually

   4☐ Always

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

   0☐ None → If None, Go to Question 15

   1☐ 1 time

   2☐ 2

   3☐ 3

   4☐ 4

   5☐ 5 to 9

   6☐ 10 or more times

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

   1☐ Yes

   2☐ No

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

   1☐ Yes

   2☐ No → If No, Go to Question 13

10. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?

    1☐ Yes

    2☐ No

11. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?

    1☐ Yes

    2☐ No

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

    1☐ Yes

    2☐ No

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

    00☐ 0 Worst health care possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best health care possible

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

YOUR CHILD'S PERSONAL DOCTOR

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

    1☐ Yes

    2☐ No → If No, Go to Question 27

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

    0☐ None → If None, Go to Question 26

    1☐ 1 time

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 to 9

    6☐ 10 or more times

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

19. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?
    - 1☐ Never
    - 2☐ Sometimes
    - 3☐ Usually
    - 4☐ Always
20. Is your child able to talk with doctors about his or her health care?
    - 1☐ Yes
    - 2☐ No →If No, Go to Question 22
21. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?
    - 1☐ Never
    - 2☐ Sometimes
    - 3☐ Usually
    - 4☐ Always
22. In the last 6 months, how often did your child's personal doctor spend enough time with your child?
    - 1☐ Never
    - 2☐ Sometimes
    - 3☐ Usually
    - 4☐ Always
23. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?
    - 1☐ Yes
    - 2☐ No
24. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?
    - 1☐ Yes
    - 2☐ No → If No, Go to Question 26
25. In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?
    - 1☐ Never
    - 2☐ Sometimes
    - 3☐ Usually
    - 4☐ Always
26. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?
    - 00☐ 0 Worst personal doctor possible
    - 01☐ 1
    - 02☐ 2
    - 03☐ 3
    - 04☐ 4
    - 05☐ 5
    - 06☐ 6
    - 07☐ 7
    - 08☐ 8
    - 09☐ 9
    - 10☐ 10 Best personal doctor possible

GETTING HEALTH CARE
FROM SPECIALISTS

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

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

    1☐ Yes

    2☐ No →If No, Go to Question 31

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    0☐ None → If None, Go to Question 31

    1☐ 1 specialist

    2☐ 2

    3☐ 3

    4☐ 4

    5☐ 5 or more specialists

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

    00☐ 0 Worst specialist possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best specialist possible

YOUR CHILD'S HEALTH PLAN

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

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

    1☐ Yes

    2☐ No →If No, Go to Question 34

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    1☐ Yes

    2☐ No →If No, Go to Question 36

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

    1☐ Never

    2☐ Sometimes

    3☐ Usually

    4☐ Always

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

    00☐ 0 Worst health plan possible

    01☐ 1

    02☐ 2

    03☐ 3

    04☐ 4

    05☐ 5

    06☐ 6

    07☐ 7

    08☐ 8

    09☐ 9

    10☐ 10 Best health plan possible

ABOUT YOUR CHILD AND YOU

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

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

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

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

39. What is your child's age?

00☐ Less than 1 year old

_____ YEARS OLD (write in)

40. Is your child male or female?

1☐ Male
2☐ Female

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

1☐ Yes, Hispanic or Latino
2☐ No, not Hispanic or Latino

42. What is your child's race? Mark one or more.

a☐ White
b☐ Black or African American
c☐ Asian
d☐ Native Hawaiian or other Pacific Islander
e☐ American Indian or Alaska Native
f☐ Other

43. What is your age?

0☐ Under 18
1☐ 18 to 24
2☐ 25 to 34
3☐ 35 to 44
4☐ 45 to 54
5☐ 55 to 64
6☐ 65 to 74
7☐ 75 or older

44. Are you male or female?

1☐ Male
2☐ Female

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

1☐ 8th grade or less
2☐ Some high school, but did not graduate
3☐ High school graduate or GED
4☐ Some college or 2-year degree
5☐ 4-year college graduate
6☐ More than 4-year college degree

46. How are you related to the child?

    1☐ Mother or father

    2☐ Grandparent

    3☐ Aunt or uncle

    4☐ Older brother or sister

    5☐ Other relative

    6☐ Legal guardian

    7☐ Someone else

47. Did someone help you complete this survey?

    1☐ Yes → If yes, go to question 48

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

48. How did that person help you?

    Mark one or more.

    a☐ Read the question to me

    b☐ Wrote down the answer I gave

    c☐ Answered the questions for me

    d☐ Translated the questions into my language

    e☐ Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope.

This page left blank for double-sided copying.

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

This page left blank for double-sided copying.

Assessing patient experiences with health care is an important dimension of the quality of care. The Child Core Set includes a measure of experiences with health care based on the CAHPS® Survey.[1] This appendix provides additional guidance to states in carrying out CAHPS data collection, including information on the version of CAHPS used for Child Core Set reporting, contracting with a survey vendor, instructions on how to identify children with chronic conditions, guidance for generating a sample frame, and conducting the survey using standard protocols.

A. VERSION OF CAHPS FOR CHILD CORE SET REPORTING

CAHPS is a family of surveys designed to assess consumer experiences with care. Different versions of the survey are available for use among various populations, payers, and settings. The version of the CAHPS Survey specified in the Child Core Set is the CAHPS Health Plan Survey 5.0H, Child Questionnaire, with the Children With Chronic Conditions (CCC) Supplemental Items. The core child questionnaire captures families' overall experiences with their children's health care. The CCC Supplemental items focus on components of care essential for the successful treatment, management, and support of children with chronic conditions. Inclusion of the CCC Supplemental Items is encouraged by the Centers for Medicare & Medicaid Services (CMS), but the decision to do so is up to each state. Appendix F and Appendix G contain the survey instruments.

States and health plans that collect the CAHPS 5.0H Survey with CCC Supplemental Items produce two separate sets of results: one for the general child population and one for the population of children with chronic conditions. For each population, results include the same ratings, composites, and individual question summary rates as those reported for the CAHPS Health Plan Survey 5.0H, Child Questionnaire. In addition, five CCC-specific results are calculated for each population: (1) Access to Specialized Services, (2) Family Centered Care: Personal Doctor Who Knows Child, (3) Coordination of Care for Children With Chronic Conditions, (4) Access to Prescription Medicines, and (5) Family Centered Care: Getting Needed Information. CCC results for the general population are provided so that survey sponsors can compare the experiences of the general child population and children with chronic conditions population.

B. CONTRACTING WITH A SURVEY VENDOR

To adhere to CAHPS 5.0H measure specifications, states must create a sample frame and contract with an NCQA-certified HEDIS 2019 survey vendor that will administer the survey according to HEDIS protocols. The survey vendor draws the actual samples and fields the survey.

NCQA maintains a list of survey vendors that have been trained and certified to administer the CAHPS 5.0H survey. Each survey vendor is assigned a maximum capacity of samples. The capacity reflects the firm's and NCQA's projection of resources available to be dedicated to administer the survey. A current listing of NCQA-certified HEDIS 2019 survey vendors is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-0h-survey-certification/vendor-directory/.

C. IDENTIFYING THE SUPPLEMENTAL SAMPLE OF CHILDREN WITH CHRONIC CONDITIONS

To identify children with chronic conditions, states should search claims and encounter data for the measurement year and the year prior to the measurement year to assign a prescreen status

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

code to each child in the CAHPS survey sample frame data file. The prescreen status code identifies children who are more likely to have a chronic condition. The prescreen status codes are defined as follows:

1 = No claims or encounters during the measurement year or the year prior to the measurement year that meet the criteria listed for prescreen status code 2.

2 = The child has claims or encounters during the measurement year or the year prior to the measurement year that indicate the child is likely to have a chronic condition. To identify a sample of children with chronic conditions, refer to the CCC-CH value sets in the 2019 Child Core Set HEDIS Value Set Directory. Any of the following meet criteria.

- At least one outpatient visit (Outpatient Value Set), observation visit (Observation Value Set) nonacute inpatient encounter (Nonacute Inpatient Value Set), acute inpatient encounter (Acute Inpatient Value Set; Newborn/Pediatric Acute Inpatient Value Set) or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year with a diagnosis code from the Chronic Conditions Value Set. The diagnosis does not have to be the principal diagnosis.
- At least one psychiatry visit (Psychiatry Value Set) with a diagnosis code from the Chronic Conditions Value Set and a place of service code from one of the following:
  - Acute Inpatient POS Value Set
  - Nonacute Inpatient POS Value Set
  - ED POS Value Set
  - Outpatient POS Value Set
  - Partial Hospitalization POS Value Set
  - Community Mental Health Center POS Value Set
- At least two outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set) on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis. The visit codes need not be from the same value set (for example, one visit with a code from the Outpatient Value Set and another visit with a code from the Observation Value Set qualifies).
  - Conduct Disorder Value Set
  - Emotional Disturbance Value Set
  - Hyperkinetic Syndrome Value Set
  - Asthma Value Set
  - Failure To Thrive Value Set
- At least two psychiatry visits (Psychiatry Value Set) on different dates of service during the measurement year or the year prior to the measurement year with a place of service code (Outpatient POS Value Set; Partial Hospitalization POS Value Set; Community Mental Health Center POS Value Set) and a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis.

  - Conduct Disorder Value Set
  - Emotional Disturbance Value Set
  - Hyperkinetic Syndrome Value Set
  - Asthma Value Set
  - Failure To Thrive Value Set
- At least one acute inpatient encounter (Acute Inpatient Value Set; Newborn/ Pediatric Acute Inpatient Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set) or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year with a diagnosis code from any of the value sets listed below. The diagnosis does not have to be the principal diagnosis.
  - Conduct Disorder Value Set
  - Emotional Disturbance Value Set
  - Hyperkinetic Syndrome Value Set
  - Asthma Value Set
  - Failure To Thrive Value Set
- At least one psychiatry visit (Psychiatry Value Set) with a diagnosis code (the diagnosis does not have to be the principal diagnosis) and a place of service code from the lists below.

Diagnosis Code Value Sets	Place of Service Code Value Sets
• Conduct Disorder Value Set • Emotional Disturbance Value Set • Hyperkinetic Syndrome Value Set • Asthma Value Set • Failure To Thrive Value Set	• Acute Inpatient POS Value Set • Nonacute Inpatient POS Value Set • ED POS Value Set

D. GENERATING A SAMPLE FRAME

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

Table H.1. Eligible Population for Child CAHPS 5.0H

Ages	Age 17 and younger as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Source: HEDIS 2019 Volume 3: Specifications for Survey Measures (http://store.ncqa.org/index.php/performance-measurement.html#vol3).

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

If a state collects CAHPS data for both its Medicaid and CHIP programs, states must generate separate sample frames for children in CHIP and Medicaid to meet CHIPRA requirements8F[2]
If each managed care plan carries out its own CAHPS survey, a separate sample frame must be generated for each plan.
If a state has children enrolled in multiple delivery systems (managed care, primary care case management, and/or fee for service), the sample frame(s) should be representative of all children covered by the entire program. A state may generate one statewide sample frame that includes children in all delivery systems or separate sample frames for each delivery system. The sample frame(s) should represent all children that meet the eligibility criteria specified in Table G.1.

E. DRAWING THE SAMPLE

The survey vendor is responsible for drawing the survey samples from the sample frame generated by the state. For each survey administered, the survey vendor draws a systematic sample of 1,650 children from the general child population and then, if the state has decided to collect the additional items, draws the CCC supplemental sample. The survey vendor selects 1,840 children for the CCC supplemental sample from the set of beneficiaries with a prescreen status code of 2 who were not already selected for the general child population sample. The survey vendor combines the general child population sample (n=1,650) and the CCC supplemental sample (n=1,840) for survey administration and submission of survey results.

Deduplication

To reduce respondent burden, the survey vendor should deduplicate samples so that only one child per household is included in the sample. The survey vendor must use the deduplication method included in HEDIS 2019 Volume 3 before pulling the systematic sample.

Oversampling

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

If its prior response rates or the number of completed surveys is expected to fall below the 411 completed surveys required, the survey vendor should oversample to achieve the goal of 411 completed surveys. For example, if the vendor increases the sample by 5 percent, the final sample size would be 1,733. If the vendor increases the sample by 20 percent, the final sample

[2] The CAHPS CHIPRA requirement applies to all Title XXI (CHIP) programs. States must submit data that are representative of all children covered by their entire Title XXI program (CHIP Medicaid Expansion, Separate CHIP Program, or Combination CHIP Program) beginning in 2013. If a state chooses to collect CAHPS data for children in both Medicaid and CHIP, the state must separately sample children enrolled in the Title XIX (Medicaid) and Title XXI (CHIP) programs and must separate data for children enrolled in Medicaid and CHIP when submitting data to CMS to fulfill the CHIPRA requirement.

size would be 1,980. The survey vendor will work with the state to determine an appropriate sampling strategy. For a detailed discussion of oversampling, see "HEDIS 2019 Volume 3: Specifications for Survey Measures," Appendix 7, "General Recommendations for Oversampling Survey Measures."

F. SURVEY ADMINISTRATION

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

1. The mail-only methodology, a five-wave mail protocol with three questionnaire mailings and two reminder postcards (81 days)
2. The mixed methodology, a four-wave mail protocol (two questionnaires and two reminder postcards) with telephone follow-up of a minimum of three and a maximum of six telephone attempts (70 days)

The basic tasks and time frames for the two protocol options are detailed in Tables G.2 and G.3. Regardless of the approach selected, the survey vendor is expected to maximize the final survey response rate and to pursue contacts with potential respondents until completing the selected data collection protocol. Achieving the targeted number of completed surveys does not justify ceasing the survey protocol.

Neither the state nor the survey vendor may offer incentives of any kind for completion of the survey. Either a parent or caretaker who is familiar with the child's health care may complete the child survey. The vendor is expected to maintain the confidentiality of systematically sampled children.

Table H.2. Survey Vendor Tasks and Time Frames for the Mail-Only Methodology

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

Source: HEDIS 2019 Volume 3: Specifications for Survey Measures.

Table H.3. Survey Vendor Tasks and Time Frames for the Mixed Methodology

Vendor Tasks	Time Frame (Days)
Send first questionnaire and cover letter to the surveyed child's family	0
Send a postcard reminder to nonrespondents 4–10 days after mailing the first questionnaire	4–10
Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire	35
Send a second postcard reminder to nonrespondents 4–10 days after mailing the second questionnaire	39–45
Initiate telephone interviews for nonrespondents approximately 21 days after mailing the second questionnaire	56
Initiate systematic contact for all nonrespondents so that at least 3 telephone calls (and no more than 6 telephone calls) are attempted at different times of the day, on different days of the week, and in different weeks	56–70
Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all nonrespondents) approximately 14 days after initiation	70

Source: HEDIS 2019 Volume 3: Specifications for Survey Measures.

G. FOR FURTHER INFORMATION

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

Information about the NCQA's HEDIS Survey Vendor Certification program can be found at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-0h-survey-certification/.

Information on "HEDIS 2019 Volume 3: Specifications for Survey Measures" is available at http://store.ncqa.org/index.php/performance-measurement.html.

This page left blank for double-sided copying.

Appendix I
Additional Information on Data Elements for Measure PC02-CH: PC-02: Cesarean Birth

This page left blank for double-sided copying.

This appendix provides additional information on the data elements required to calculate the rates for PC-02: Cesarean Birth using medical record review. For the purposes of state reporting, it is acceptable to use vital records data if available to collect gestational age and parity. Table I.1 lists the data elements required for the denominator.

Table I.1. Denominator Data Elements Requiring Medical Record Review

Data element	**Admission Date**
Definition	The month, day, and year of admission to acute inpatient care.
Suggested data collection question	What is the date the patient was admitted to acute inpatient care?
Allowable values	MM = Month (01-12) DD = Day (01-31) YYYY = Year (20XX)
Notes for abstraction	The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value. If using claim information, the 'Statement Covers Period' is not synonymous with the 'Admission Date' and should not be used to abstract this data element. These are two distinctly different identifiers: • The Admission Date is purely the date the patient was admitted as an inpatient to the facility. • The Statement Covers Period ("From" and "Through" dates) identifies the span of service dates included in a particular claim. The "From" Date is the earliest date of service on the claim. For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation. Example: Medical record documentation reflects that the patient was admitted to observation on 04-05-2017. On 04-06-2017 the physician writes an order to admit to acute inpatient effective 04-05-2017. The Admission Date would be abstracted as 04-06-2017; the date the determination was made to admit to acute inpatient care and the order was written.

Data element	Admission Date
Notes for abstraction (continued)	The admission date should not be abstracted from the earliest admission order without regard to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, the date should not be used. Example: Preoperative Orders are dated as 04-05-2017 with an order to admit to Inpatient. Postoperative Orders, dated 05-01-2017, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-2017. The admission date would be abstracted as 05-01-2017. If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. For newborns that are born within this hospital, the admission date is the date the baby was born.
Only allowable data sources	Physician orders Face sheet UB-04 Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other “only allowable sources” to determine the Admission Date.
Excluded data sources	UB-04, “From” and “Through” dates

Data element	Birth Date
Definition	The month, day, and year the patient was born. Note: Patient's age (in years) is calculated by Admission Date minus Birth date. The algorithm to calculate age must use the month and day portion of admission date and birth date to yield the most accurate age.
Suggested data collection question	What is the patient’s date of birth?
Allowable values	MM = Month (01-12) DD = Day (01-31) YYYY = Year (1880-Current Year)
Notes for abstraction	Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birth date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birth date through chart review, she/he should default to the date of birth on the claim information.

Data element	Birth Date
Suggested data sources	Emergency department record Face sheet Registration form UB-04

Data element	Discharge Date
Definition	The month, day, and year the patient was discharged from acute care, left against medical advice, or expired during this stay.
Suggested data Collection Question	What is the date the patient was discharged from acute care, left against medical advice (AMA), or expired?
Allowable values	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2001-Current Year)
Notes for abstraction	Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.
Suggested data sources	Face sheet Progress notes Physician orders Discharge summary Nursing discharge notes Transfer note UB-04

Data element	Gestational Age
Definition	The weeks of gestation completed at the time of delivery. Gestational age is defined as the best obstetrical estimate (OE) of the newborn's gestation in completed weeks based on the birth attendant's final estimate of gestation, irrespective of whether the gestation results in a live birth or a fetal death. This estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the newborn exam. Ultrasound taken early in pregnancy is preferred (source: American College of Obstetricians and Gynecologists reVITALize Initiative).
Suggested data collection question	How many weeks of gestation were completed at the time of delivery?
Allowable values	1-50 UTD=Unable to Determine

Data element	Gestational Age
Notes for abstraction	Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks. Gestational age should be documented by the clinician as a numeric value between 1 and 50. Gestational age (written with both weeks and days, e.g., 39 weeks and 0 days) is calculated using the best obstetrical Estimated Due Date (EDD) based on the following formula: Gestational Age = (280 - (EDD - Reference Date)) / 7 (Source: American College of Obstetricians and Gynecologists reVITALize Initiative) The clinician, not the abstractor, should perform the calculation to determine gestational age. The delivery or operating room record should be reviewed first for gestational age; documentation of a valid number should be abstracted. If gestational age in the delivery or operating room record is missing, obviously incorrect (e.g., 3.6), or there is conflicting data, then continue to review the following data sources, starting with the document completed closest to the delivery until a positive finding for gestational age is found: • History and physical • Clinician admission progress notes • Prenatal forms • Discharge summary Gestational age documented closest to the time of delivery (not including the newborn exam) should be abstracted. The phrase "estimated gestational age" is an acceptable descriptor for gestational age. If no gestational age was documented (e.g., the patient has not received prenatal care), select allowable value UTD. Documentation in the acceptable data sources may be written by the following clinicians: physicians, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN). It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs, or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below. The EHR takes precedence over a hand written entry if different gestational ages are documented in equivalent data sources, e.g., delivery record and delivery summary.

Data element	Gestational Age
Only allowable data sources (in order of preference)	Delivery or Operating Room record, note, or summary History and physical Admission clinician progress notes Prenatal forms Discharge summary Note: It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs, or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed above.

Data element	Number of Previous Live Births
Definition	The number of deliveries resulting in a live birth the patient experienced prior to current hospitalization.
Suggested data collection question	How many deliveries resulting in a live birth did the patient experience prior to current hospitalization?
Allowable values	0-50 UTD=Unable to Determine
Notes for abstraction	Parity may be used in the absence of documentation of the number of previous live births. If the number for parity documented in the EHR is "one" and includes the delivery for the current hospitalization, abstract zero for previous live births. The delivery or operating room record should be reviewed first for the number of previous live births. If the number of previous live births is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for the number of previous live births is found. In cases where there is conflicting data, the number of previous live births found in the first document according to the order listed in the Only Acceptable Sources should be used. If gravidity is documented as one, the number of previous live births should be considered zero. The previous delivery of live twins or any live multiple gestation is considered one live birth event. Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).

Data element	Number of Previous Live Births
Notes for abstraction (continued)	It is acceptable to use data derived from vital records reports received from state or local departments of public health, delivery logs or clinical information systems if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the Only Acceptable Sources listed below. If primagravida or nulliparous is documented select zero for the number of previous live births. GTPAL documentation may be used in the absence of documentation of the number of previous live births. When GTPAL terminology is documented G= Gravida, T= Term, P= Preterm, A= Abortions and L= Living, all previous term and preterm deliveries prior to this hospitalization should be added together to determine the number of previous live births. If the number of previous live births entered by the clinician in the first document listed is obviously incorrect (in error) but it is a valid number or two different numbers are listed in the first document and the correct number can be supported with documentation in the other acceptable data sources in the medical record, the correct number may be entered.
Only allowable data sources in order of preference	Delivery or Operating Room record, note or summary History and physical Prenatal forms Admission clinician progress notes Discharge summary