Core Set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set)

Technical Specifications and Resource Manual for
Federal Fiscal Year 2024 Reporting

February 2024

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

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I. THE CORE SET OF HEALTH CARE QUALITY MEASURES FOR MEDICAID HEALTH HOME PROGRAMS

Background

Section 1945 of the Social Security Act allows states to elect a health homes service option to provide comprehensive care coordination for individuals with chronic conditions under the Medicaid state plan and to receive additional federal support for the first eight quarters of implementation to support the roll out of this new care model. States are responsible for designating qualified health home providers to coordinate primary, acute, behavioral health (mental health and substance use services), and long-term services and supports for Medicaid-eligible individuals with chronic illness. Overall, it provides an opportunity for states to build a person-centered care delivery model that focuses on improving outcomes and disease management for enrollees with chronic conditions and obtaining better value for state Medicaid programs.

For more information, refer to the following links:

Health Home Information Resource Center

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/index.html

Health Home Quality Reporting

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/quality-reporting/index.html

Frequently Asked Questions about Health Homes

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/health-homes-faq-12-18-17.pdf

Identifying the Health Home Core Set

To support ongoing assessment and monitoring of the health home model, the Centers for Medicare & Medicaid Services (CMS) established a Core Set of health care quality measures. These recommended health home quality measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for Medicaid beneficiaries. This effort is aligned closely with the Department of Health and Human Services' (HHS) National Strategy for Quality Improvement in Health Care, as well as other quality initiatives.

CMS consulted with states considering health home programs and conducted technical assistance calls, presentations, and webinars in order to identify the Core Set of Health Home quality measures for Medicaid-eligible children and adults. CMS also worked with federal partners, including the Office of the Assistant Secretary for Planning and Evaluation and the Substance Abuse and Mental Health Services Administration. The recommended Core Set of Health Home measures were chosen because they reflect key priority areas such as behavioral health and preventive care, and they align with the Core Set of health care quality measures for adults enrolled in Medicaid and the National Quality Strategy.

The 2024 Health Home Core Set includes 10 Core Measures and 3 Utilization Measures. No measures were added to the 2024 Health Home Core Set.

How the Health Home Core Set Is Used

The 2024 Health Home Core Set is used to evaluate the health homes model. The Health Home Core Set is used to assess quality outcomes and performance, as well as to inform ongoing quality monitoring of the health home program. Health home providers are expected to report to the state Medicaid program, which reports the data in aggregate to CMS at the at the health home program level. States are expected to report the Health Home Core Set measures when their state plan amendment (SPA) has been in effect for six or more months of the measurement period. For SPA amendments, states are expected to include data affected by the amendment combined with data from the original SPA when the amendment is in effect for six or more months of the measurement period. More information on the states expected to report for FFY 2024 is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/health-home-reporting-table.pdf.

As part of Section 50102 of the Bipartisan Budget Act of 2018, mandatory reporting of the Health Home Core Set measures will take effect for FFY 2024 reporting. Mandatory reporting of the Health Home Core Set will further advance CMS's efforts to ensure a standardized system for quality measurement with the goal of improving the quality of care for health home enrollees.[1]

Health Home Core Set Measures

Table 1 lists the 2024 Health Home Core Set measures, the CMS Measures Inventory Tool (CMIT) number, 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), and electronic health record (EHR, also referred to as the electronic specification method). The technical specifications in Chapters III and IV of this manual provide additional details for each measure.

More information on the Health Home Core Set is available on Medicaid.gov at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

Table 1. 2024 Health Home Core Set

CMIT#*	Measure Steward[a]	Measure Name	Data Collection Method(s)
Core Measures			
394	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-HH)	Administrative or EHR
167	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, hybrid, or EHR
139	NCQA	Colorectal Cancer Screening (COL-HH)	Administrative or EHR[b]
672	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative or EHR

[1] Legislation making reporting of the Health Home Core Set measures mandatory: Bipartisan Budget Act of 2018 available at https://www.congress.gov/115/bills/hr1892/BILLS115hr1892enr.xml.

CMIT#*	Measure Steward[a]	Measure Name	Data Collection Method(s)
268	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
561	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
750	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)	Administrative
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)	Administrative
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 6 and Older (FUM-HH)	Administrative
593	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Administrative
Utilization Measures			
20	CMS	Admission to a Facility from the Community (AIF-HH)	Administrative
49	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	Administrative
397	CMS	Inpatient Utilization (IU-HH)	Administrative

AHRQ = Agency for Healthcare Research & Quality; CMIT = CMS Measure Inventory Tool; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; NCQA = National Committee for Quality Assurance;

*The CMS Measures Inventory Tool (CMIT) is the repository of record for information about the measures that CMS uses to promote health care quality and quality improvement. More information is available at https://cmit.cms.gov/cmit/. PA public access quick start guide for CMIT is available at https://cmit.cms.gov/cmit/assets/CMIT-QuickStartPublicAccess.pdf. [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] The Colorectal Cancer Screening measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Health Home Core Set reporting.

II. DATA COLLECTION AND REPORTING OF THE HEALTH HOME CORE SET

Mandatory reporting of the 2024 Health Home Set requires that states adhere to reporting guidance issued by CMS. Adherence to the reporting guidance is essential to provide effective comparisons across programs on standardized quality measure performance and to derive national performance rates for the care provided to Medicaid health home enrollees.

To support consistency in reporting the Health Home Core Set measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapters III and IV 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.

Refer to Table 1 in Chapter 1 for a list of 2024 Health Home Core Set measures, measure acronyms, measure stewards, and data collection methods.

Data Collection and Preparation for Reporting

- **Version of specifications.** This manual includes the most applicable version of the measure specifications provided by the measure stewards to CMS as of December 2023. The 2024 Health Home Core Set generally covers services provided during calendar year 2023. For Healthcare Effectiveness Data and Information Set (HEDIS)[1] measures, this manual follows HEDIS measurement year (MY) 2023 specifications. For non-HEDIS measures, the manual includes the most applicable version of the specifications available from the measure steward for reporting 2023 data.
- **Value sets.** Many of the Health Home 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/state-resource-center/medicaid-state-technical-assistance/downloads/2024-Health-Home-Directory.zip. HEDIS value set references are underlined in the specifications (e.g., Acute Inpatient Value Set). Refer to Appendix A for a HEDIS Value Set Directory User Manual.
  - Value sets for the CDF-HH and PQI92-HH measures are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip.
  - The value set for the AIF-HH measure is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip.
  - The value set for the IU-HH measure is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-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://www.nlm.nih.gov/databases/umls.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 2024 Health Home

[1] For FFY 2024, all Health Home Core Set measures with NCQA as the measure steward are HEDIS measures.

Core Set measures, use the version of the value sets associated with the March 2023 release. This applies to the following Health Home Core Set measures that have electronic specifications: CBP-HH, CDF-HH, COL-HH and IET-HH.

- **Medication lists.** Several HEDIS measures in the Health Home Core Set reference medication lists, which are a list of codes and medications used to identify dispensed medications. The Medication List Directory is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). This applies to the following Health Home Core Set measures: CBP-HH, COL-HH, FUA-HH, and IET-HH.
- **Data collection time frames for measures.** States must adhere to the measurement periods identified in the technical specifications for each measure. Some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a hospital discharge for a mental health condition. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2023 data should be reported for FFY 2024.. For many measures, the denominator measurement period for FFY 2024 corresponds to calendar year 2023 (January 1, 2023–December 31, 2023).

  Some measures also require states to review utilization or enrollment prior to this period. Further information about measurement periods for the 2024 Health Home Core Set is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/hh-core-set-measurement-period-table-2024.pdf.
- **Continuous enrollment.** Continuous enrollment specifies the minimum amount of time that an enrollee must be eligible for Medicaid benefits and enrolled in a health home before becoming eligible for a measure. It ensures that the state has enough time to render services during the measurement period. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, an individual 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). The dates used to determine continuous enrollment may be defined by the policies of each health home program and do not need to match the health home program effective date. For the purpose of Core Set reporting, states should combine data across health home providers, delivery systems (e.g., managed care and fee-for-service), and managed care plans when analyzing continuous enrollment for a beneficiary. For example, an enrollee might switch between health home providers or between managed care plans, and should be included in the numerator and denominator for the measure as long as the enrollee is continuously enrolled in Medicaid for the period specified in the measure.
- **Allowable gap.** Some measures specify an allowable gap that can occur any time during continuous enrollment. For example, the CBP-HH measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in health home enrollment of up to 45 days. Thus, an enrollee 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 enrollee has one 38-day gap (January 1–February 7). An enrollee who switches between health home providers, delivery systems, or managed care plans should be included in a measure as long as there is no gap in health home enrollment that exceeds the allowable gap specified in the measure.

- **Anchor date.** Some measures include an anchor date, which is the date that an individual must be enrolled in a health home 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 2024 measurement period (December 31, 2023). For other measures, the anchor date is based on a specific event, such as a birthdate. 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. There are instances when documentation of the year alone is adequate; for example, most 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.
- **Reporting unit.** CMS defines the reporting unit for each measure as each state's health home program. This means that states should collect data across all health home providers[2] within a specific health home program, as defined by the approved SPA applicable to the program. States should aggregate data from all health home providers into one health home program-level rate before reporting data to CMS. States with more than one approved health home program should report separately for each health home program, as defined in their SPA. SPA amendments should be included with the original SPA and not as a separate report. For more guidance about developing a health home program-level rate, see the bullet on "aggregating information for health home program-level reporting" below.
- **Eligible population for measurement.** Health home enrollees are Medicaid beneficiaries (adults and children) who are enrolled in a state health home program and assigned a health home provider. For all measures, the denominator must include all health home enrollees who satisfy all specified criteria (including age, continuous enrollment, benefit, event, and anchor date enrollment requirements). Some measures require a period of continuous enrollment for inclusion in the measure.
- **Enrollees with partial benefits.** For each measure, states should include only the health home enrollees who are eligible to receive the services assessed in the numerator. If an enrollee is not eligible to receive the services assessed in the measure, the enrollee 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 enrollees in their state.
- **Aggregating information for health home program-level reporting.** To obtain a health home program-level rate for a measure that is developed from the rates of multiple reporting units (such as across health home providers), the state should calculate a weighted average of the individual rates. How much any one entity (e.g., each health home provider) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that health home providers serving larger eligible populations will contribute more toward the rate than those with smaller eligible populations.

[2] Section 1945(g) of the Social Security Act requires designated providers of health home services to report to the state on all applicable quality measures as a condition for receiving payment. When appropriate and feasible, quality measure reporting is to be done through the use of health information technology.

Hybrid and administrative data from different sources can be combined to develop a health home program-level rate as long as the specifications allow the use of these data collection methods or sources to construct the measure. For additional guidance on developing a program-level rate, refer to the TA Brief titled, "Calculating State-Level Rates Using Data from Multiple Reporting Units."[3] Although CMS encourages health home providers and states to use the methods and data sources listed in the specification for each measure, states and providers may use alternative methods and data sources, when necessary. When reporting an aggregated rate that uses alternative data sources or combines data from multiple sources and methods, states should report the data sources and methods used, and the combined rate.

- **Reporting stratified data.** Reporting stratified results for Core Set measures is a priority for CMS as it supports CMS's goal of advancing health equity. For FFY 2024 Core Set reporting, states are encouraged to report stratified data for the following stratification categories: Race, Ethnicity, Sex, and Geography. CMS defines these categories as the following:
  - Race and ethnicity, using the disaggregation of the 1997 Office of Management and Budget (OMB) minimum race and ethnicity categories, as specified in the 2011 HHS standards;
  - Sex, defined as biologic sex, using the 2011 HHS standards; and
  - Geography, using a minimum standard of core-based statistical area (CBSA) with recommendation to move towards Rural-Urban Commuting Area Codes.

  More information is available at https://www.medicaid.gov/medicaid/quality-ofcare/downloads/QMR-stratification-resource.pdf.
- **Reporting a weighted rate.** When a state develops a weighted rate combining data across multiple reporting units (health home providers), 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 Home Providers) to Create a Health Home Program-Level Rate?" The information entered in the numerator and denominator fields will vary depending on the method used to calculate a health home program-level rate:
  - If a program-level rate is calculated using only administrative method data, states should enter the numerator and denominator totals in the Numerator and Denominator fields.
  - If a program-level rate is calculated using only hybrid method data, states should enter the total size of the sample used to calculate the measure across reporting units in the Denominator field and sum the numerators for each reporting unit in the Numerator field.
  - If the program-level rate is calculated using a combination of administrative and hybrid method data, states should enter the total measure-eligible population in the Denominator field to denote that denominators are a mix of sample sizes and measure-eligible populations and enter 0 in the Numerator field. In the "Data Sources" section, the state should identify the number of reporting units that used each method (administrative and hybrid).
- **Age criteria.** The age criteria vary by measure. Some measures have an upper age limit, while others include an age range above age 64 and/or under age 18. For the purpose of Health Home Core Set reporting, states should calculate and report such measures for three

[3] The TA Brief, "Calculating State-Level Rates Using Data from Multiple Reporting Units," is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf.

age groups where applicable: enrollees under age 18, enrollees between the ages of 18 and 64, and those age 65 and older. States should also report for the total population. States should note any deviations from the specifications in the "Deviations from Measure Specifications" field.

- **Exclusions.** Some measure specifications contain required exclusions. An enrollee who meets required exclusion criteria should be removed from the measure denominator.
- **Supplemental data.** Supplemental data are data other than claims and encounters and medical record data abstracted for hybrid reporting used by organizations to collect information about delivery of health services to their enrollees. Examples of supplemental data include immunization registries or case management program data.
- **Hospice exclusion.** Selected HEDIS measures in the Health Home Core Set include a required hospice exclusion: CBP-HH, COL-HH, FUA-HH, FUH-HH, FUM-HH, IET-HH, PCR-HH, AMB-HH, and IU-HH. For these measures, states should exclude enrollees who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These enrollees may be identified using various methods, which may include but are not limited to, enrollment data, medical record, or claims/encounter data (Hospice Encounter Value Set; Hospice Intervention Value Set) or supplemental data for this required exclusion.

  States should remove these enrollees as they determine the measure's eligible population. For hybrid measures, states should remove enrollees prior to drawing the sample. If an enrollee is found to be in hospice or using hospice services during medical record review, the enrollee is removed as a valid data error from the sample and replaced by an enrollee from the oversample. Documentation that an enrollee 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.

  Supplemental data can be used for the hospice exclusion for all applicable measures, including measures that say "supplemental data may not be used for the measure" (e.g., PCR-HH).
- **Deceased enrollees exclusion.** Selected HEDIS measures in the Health Home Core Set include a deceased enrollee exclusion: CBP-HH, COL-HH, FUA-HH, FUH-HH, FUM-HH, and IET-HH. For these measures, enrollees who die any time during the measurement year should be excluded consistently from all the HEDIS measures listed above. These enrollees may be identified using various methods that include, but are not limited to, enrollment data, medical record review, claims/encounter data or supplemental data for this required exclusion.

  States should attempt to remove these enrollees prior to determining a measure's eligible population and drawing the sample for hybrid measures. A deceased enrollee found during medical record review is removed as a valid data error from the sample and replaced by an enrollee from the oversample.

  Supplemental data can be used for excluding deceased enrollees for all applicable measures, including measures that say, "supplemental data may not be used for the measure" (e.g., AMB-HH, IU-HH, PCR-HH).

  This is an enrollee-level exclusion. For episode-based measures, remove all enrollee events/episodes from the measure.
- **Telehealth.** HEDIS measures consider synchronous telehealth visits, telephone visits, and asynchronous telehealth (e-visits, virtual check-ins) as separate modalities.

  - Synchronous telehealth requires real-time interactive audio and video telecommunications. A HEDIS measure specification that is silent about telehealth includes synchronous telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A HEDIS measure specification will indicate when telehealth is not eligible for use and should be excluded.
  - A HEDIS measure specification will indicate when telephone visits are eligible for use by referencing the Telephone Visits Value Set.
  - Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the enrollee and the provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email. A HEDIS measure specification will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments Value Set.
  - Non-HEDIS measures will specify whether telehealth is allowed and what type of telehealth is included, if applicable.

- **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 health home program(s) (including individuals simultaneously enrolled in Medicare and Medicaid, also known as dually eligible beneficiaries, where applicable). This includes enrollees enrolled in all Medicaid delivery systems as well as services received in all applicable health care settings (such as hospitals, outpatient settings, federally qualified health centers, rural health centers, and Indian Health Services or Tribal or Urban Indian Health Program facility). For a measure based on administrative data, all enrollees who meet the eligible population requirements for the measure should be included in the denominator. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire health home eligible population for the measure.
- **Data collection methods.** The measures in the Health Home Core Set have three possible data collection methods: administrative, hybrid, and electronic health record (EHR, also referred to as the electronic specification method). Each measure specifies the data collection method(s) that can be used. If a measure includes a choice of methods, any of the listed methods may be used.
  - The administrative method uses transaction data (such as claims and encounters) or other administrative data sources (such as vital records and registries) 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 enrollees in the systematic sample received the service, and medical record data are reviewed for enrollees who do not meet the numerator criteria through administrative data. The denominator consists of a systematic sample of enrollees drawn from the measure's eligible population. The hybrid method, when available, should be used when administrative data and EHR data are incomplete or may be of poor quality.
  - The electronic specification method uses EHR data to calculate the measure. A link to the electronic specifications is included in the following measure specifications: CBP-HH,

CDF-HH, COL-HH, and IET-HH. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system.

- **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. If a health home program has fewer than 411 enrollees, all enrollees should be included in the sample. 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.
- **Alternative data collection methods and data sources.** States may choose to report on any of these measures using the methods listed in the specifications, or using an alternative method (e.g., medical record review without systematic sample) or data source (e.g., patient registry) if the administrative, hybrid, and medical record/electronic specification methods are not feasible. The data collection method and data source should be explained in the “Deviations from Measure Specification” field.
- **Small numbers.** If a measure has a denominator less than 30 (for all measures except the PCR-HH measure) or a Count of Index Hospital Stays less than 150 (for PCR-HH) and the state chooses not to report the measure due to the small numbers criterion, please note this in the question that asks “Why are you not reporting on this measure?” and specify the denominator size. The denominator for the Plan All-Cause Readmissions measure is the Count of Index Hospital Stays among non-outlier enrollees. Outliers should not be considered.
- **Risk adjustment.** One measure in the Health Home Core Set, the PCR-HH measure, requires risk adjustment. Risk adjustment guidelines are included in the specification for the measure.
- **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 all Health Home Core Set measures, the Guidance for Reporting within each measure’s technical specification indicates which claims (paid, suspended, pending, and/or denied) should be included. This applies to the following measures: AIF-HH, AMB-HH, CBP-HH, CDF-HH, COL-HH, FUA-HH, FUH-HH, FUM-HH, IET-HH, IU-HH, PCR-HH, and PQI92-HH.
- **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 specification or in the corresponding Value Set Directory (see above). ICD-9-CM and ICD-9-PCS codes are still included in measures where the lookback period plus one year prior includes services before October 1, 2015 and in measures that require looking for a code anytime during an enrollee’s history through December 31 of the measurement year. ICD-9 codes are still relevant to the following measures: CBP-HH, COL-HH, and PCR-HH.

- **Visits that result in an inpatient stay.** Some HEDIS measures in the Health Home Core Set require exclusion of visits that result in an inpatient stay or observation stay. A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). This applies to the following Health Home Core Set measures: AMB-HH, CBP-HH, COL-HH, FUA-HH, FUH-HH, FUM-HH, IET-HH, IU-HH, and PCR-HH.

Definitions

- **Health home program.** A state Medicaid program defined in an approved SPA that authorizes the provision of comprehensive care management; care coordination and health promotion; comprehensive transitional care/follow-up; patient and family support; referral to community and social support services; and use of health information technology (HIT) to link services. A health home program may be made up of multiple qualified health home providers.
- **Health home provider.** An individual provider, team of health care professionals, or health team that provides the health home services and meets established standards. States can adopt a mix of these three types of providers identified in the legislation:
  - Designated provider: May be physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other.
  - Team of health professionals: May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, or other.
  - Health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral healthcare providers, chiropractors, licensed complementary and alternative medical practitioners, and physician assistants.
- **Health home enrollee (Enrollee).** Medicaid beneficiary (adult or child) enrolled in a state health home program. Medicaid beneficiaries eligible for health home services:
  - Have two or more chronic conditions, or
  - Have one chronic condition and are at risk for a second, or
  - Have a serious and persistent mental health condition.
  - Health home enrollees may include beneficiaries dually eligible for both Medicare and Medicaid.

Reporting and Submission

Procedures for reporting the Health Home Core Set measures are provided below.

- **Reporting eligibility.** States are expected to report the Health Home Core Set measures when their SPA has been in effect for six months or more of the measurement period. A health home program that had an effective date before July 1, 2023, or during a previous year should report for FFY 2024. While some measures may have a continuous enrollment requirement that exceeds the time that enrollees were in a health home, states should report as many measures as possible for which their enrollees meet the continuous enrollment requirements. The continuous enrollment requirements are specified in the eligible population section for each measure.

- **Submission deadline.** The deadline for submitting final data on the Health Home Core Set measures for FFY 2024 is December 31, 2024. 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 applicable to each measure. States should complete each applicable 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.
- **Reasons for not reporting a measure.** If a state is unable to report a measure, the state should explain its reason for not reporting the measure. We recognize that there may be unique circumstances where a state is unable to report a measure. If a state is unable to report a measure, the state should note that in QMR and in addition send an email to the TA mailbox (MACQualityTA@cms.hhs.gov) explaining why the state cannot report. This information will assist CMS in understanding why each state or why all states as a group may not be reporting on specific measures and design technical assistance to help all states with reporting.
- **Noting variations from the measure technical specifications.** As per the Core Set final rule, CMS expects states to report measures adhering to the methods provided in the specifications. However, there may be unique circumstances where this is not possible. In those circumstances, states should provide additional information and context about the rates reported. Examples of variations 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. States that have questions about the technical specifications (such as data sources, code sets, or methodologies for identifying numerators and denominators) should contact CMS through the TA mailbox at MACQualityTA@cms.hhs.gov.
- **Reporting by population.** For each Health Home Core Set measure reported to CMS, states should specify the population included in the measure: Medicaid, Dually eligible beneficiaries, and Other as appropriate. Any populations excluded from the denominator should be noted in the "Definition of Population Included in Measure" section of the online reporting system.
- **Data auditing.** For FFY 2024, 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 Health Home Core Set rates through another process, states should describe these processes in the applicable fields in the state-level Core Set Question in the web-based reporting system.

Technical Assistance

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

For access instructions or technical questions regarding use of the Quality Measures Reporting (QMR) application, please reach out to MDCT_Help@cms.hhs.gov.

For states needing further resources for integrating Medicare and Medicaid data Dually-eligible beneficiaries, please go to https://www.cms.gov/data-research/research/statistical-resources-dually-eligible-beneficiaries/state-access-medicare-data. 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 questions about the Child Core Set and the Adult Core Set measures should also contact MACQualityTA@cms.hhs.gov.

III. TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME CORE SET MEASURES

This chapter presents the technical specifications for each measure in the Health Home 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 other relevant measure information.

These specifications have been modified from their original version for use in the Medicaid Health Home Core Set. They also may differ slightly from the specifications used in the Medicaid Child or Adult Core Sets. Where applicable, substantive differences between the Health Home Core Set specifications and the original specifications provided by the measure steward are listed in the Additional Notes section for each measure.

These specifications represent the most applicable version available from the measure steward as of December 2023.

MEASURE CBP-HH: CONTROLLING HIGH BLOOD PRESSURE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of health home enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64, ages 65 to 85, and total (ages 18 to 85).
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) for Dementia Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2024 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2023/cms165v11. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the health home enrollee is "not controlled."

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 as of December 31 of the measurement year.
Continuous enrollment	Enrolled in a Medicaid health home program for the measurement year.

Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a health home enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (e.g., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify enrollees who had at least two visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Visit type need not be the same for the two visits. Any of the following code combinations meet criteria: • Outpatient visit (Outpatient Without UBREV Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • A telephone visit (Telephone Visits Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) • An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of hypertension (Essential Hypertension Value Set) Step 2 Remove enrollees who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 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.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet either of the following criteria: • Enrollees in hospice or using hospice services anytime during the measurement year. If a state reports this measure using the Hybrid method, and an enrollee is found to be in hospice or using hospice services during medical record review, the enrollee is removed from the sample and replaced by an enrollee from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set. • Enrollees who died any time during the measurement year. For additional information, refer to the deceased enrollees exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Enrollees receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year. • Enrollees with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) any time during the enrollee's history on or prior to December 31 of the measurement year. • Enrollees with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year.
Exclusions (Supplemental and medical record data may not be used for these exclusions)	Note: Supplemental and medical record data may not be used for these exclusions. Exclude enrollees who meet either of the following criteria: • Enrollees ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. Enrollees must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:

Exclusions (continued) (Supplemental and medical record data may not be used for these exclusions)	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 discharge date for the stay. o At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) o At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 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. o A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above). • Enrollees age 81 and older as of December 31 of the measurement year with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. Exclude BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; ED POS Value Set).

The BP reading must occur on or after the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The enrollee is numerator compliant if the BP is <140/90 mm Hg. The enrollee is not compliant if the BP is ≥ 140/90 mm Hg, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

States that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels.

Value Set	Numerator Compliance
Systolic Less Than 140 Value Set	Systolic compliant
Systolic Greater Than or Equal To 140 Value Set	Systolic not compliant
Diastolic Less Than 80 Value Set	Diastolic compliant
Diastolic 80-89 Value Set	Diastolic compliant
Diastolic Greater Than or Equal To 90 Value Set	Diastolic not compliant

E. 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 Health Home Core Set for additional information.

Identifying the Medical Record

All eligible BP measurements recorded in the record must be considered. If an enrollee's medical record cannot be found, the enrollee remains in this measure denominator and is considered noncompliant for the numerator.

Use the following guidance to find the appropriate medical record to review.

- Identify the enrollee's PCP.
- If the enrollee had more than one PCP for the time-period, identify the PCP who most recently provided care to the enrollee.
- If the enrollee did not visit a PCP for the time-period or does not have a PCP, identify the practitioner who most recently provided care to the enrollee.
- If a practitioner other than the enrollee's PCP manages the hypertension, the state may use the medical record of that practitioner.

Numerator

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

Administrative Data

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

Medical Record Review

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or ED visit
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests
- Taken by the enrollee using a non-digital device such as with a manual blood pressure cuff and a stethoscope

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

BP readings taken by the enrollee and documented in the enrollee's medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist.

The enrollee is not numerator compliant if the BP reading is ≥ 140/90 mm Hg or is missing, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.

F. ADDITIONAL NOTES

- When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).
- An electronic medical record (EMR) can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.
- When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet, or a change in medication. Examples of such procedures include colonoscopies; dialysis, infusions, and chemotherapy; and nebulizer treatments with albuterol. An enrollee forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.
- BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. These include procedures such as vaccinations; injections (e.g., allergy, vitamin B-12, insulin, steroid, Toradol, Depo-Provera, testosterone, lidocaine); tuberculosis tests; intrauterine device (IUD) insertions; eye exams; or wart or mole removal.

MEASURE CDF-HH: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of enrollees age 12 and older screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure includes enrollees age 12 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 12 to 17, ages 18 to 64, age 65 and older, and total (age 12 and older).
- The intent of the measure is to screen for depression in enrollees who have never had a diagnosis of depression or bipolar disorder prior to the qualifying encounter used to evaluate the numerator. Enrollees who have been diagnosed with depression or bipolar disorder will be excluded from the measure.
- The denominator for this measure includes enrollees age 12 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  1. Those enrollees with a positive screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool with a follow-up plan documented.
  2. Those enrollees with a negative screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool.
- The QPP claims/CQM specifications for this measure include six G codes intended to capture whether individual providers reported on this measure. For the purpose of Health Home Core Set reporting, there are two G codes included in the numerator to capture whether depression screening using an age-appropriate standardized tool was done on the date of the eligible encounter or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.
- An age-appropriate, standardized, and validated depression screening tool must be used and results documented as positive or negative for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. The screening should occur on the date of a qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter. The depression screening must be reviewed and addressed by the provider on the date of the encounter. Positive pre-screening results indicating an enrollee is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.

- The measure assesses the most recent depression screening completed either during the qualifying encounter or within the 14 calendar days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for an enrollee screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which includes one or more of the following:
  - Referral to a provider for additional evaluation
  - Pharmacological interventions
  - Other interventions for the treatment of depression
- For beneficiaries with multiple qualifying encounters, the beneficiary does not need to be screened at every encounter, only once during the performance year.
- A follow-up plan must be documented on the date of the qualifying encounter for a positive depression screen.
- Should an enrollee screen positive for depression:
  - A clinician should only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
  - A clinician could opt to complete a suicide risk assessment when appropriate and based on individual enrollee characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.
- 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.
- This measure contains both exclusions and exceptions:
  - Denominator exclusion criteria are evaluated before checking if an enrollee meets the numerator criteria; an enrollee who qualifies for the denominator exclusion should be removed from the denominator.
  - Denominator exception criteria are only evaluated if the enrollee does not meet the numerator criteria; enrollees 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.
- 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.
- Include all paid, suspended, pending, and denied claims.
- Tables CDF-A through CDF-F are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip.
- The electronic specification for FFY 2023 is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v12.html. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system.

This measure includes the following coding systems: CPT, HCPCS, ICD-9-CM, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the population in which it is being utilized. Examples of depression screening tools include but are not limited to: • Adolescent Screening Tools (ages 12 to 17) 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. • Adult Screening Tools (age 18 and older) Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), and Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD). • 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	Documented follow-up for a positive depression screening must include one or more of the following: • Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression

Follow-up plan (continued)	Examples of a follow-up plan include but are not limited to: • Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. • Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. 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	Age 12 or older 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 available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Numerator

Enrollees screened for depression on the date of the encounter or 14 days prior to 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 qualifying encounter using one of the codes in Table CDF-B available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip.

Exclusions

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

- Enrollees who have been diagnosed with depression or bipolar disorder

Use the codes in Table CDF-C, CDF-D, and CDF-E (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip) to identify exclusions.

Exceptions

An enrollee that does not meet the numerator criteria and meets the following exception criteria should be removed from the measure denominator. However, if the enrollee meets the numerator criteria, the enrollee would be included in the measure denominator.

- Enrollee reason:
  - Enrollee refuses to participate.
- Medical reason:
  - Enrollee is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the enrollee's health status.
  - Situations where the enrollee's cognitive, functional, or motivational limitations may impact the accuracy of results.

Use the code in Table CDF-F (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip) to identify exceptions.

MEASURE COL-HH: COLORECTAL CANCER SCREENING

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of enrollees ages 45 to 75 who had appropriate screening for colorectal cancer.

Data Collection Method: Administrative or EHR[1]

Guidance for Reporting:

- This measure applies to enrollees ages 46 to 75 to account for the lookback period (to ensure that the enrollee was at least age 45 for the entire measurement period). For HEDIS, this measure has two reportable age groups and a total rate: ages 46 to 50, ages 51 to 75, and total (ages 46 to 75). For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): ages 46 to 50, ages 51 to 65, and ages 66 to 75.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) for Dementia Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2024 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2023/cms130v11. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, ICD-9-CM, ICD-9-PCS, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Enrollees ages 46 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical.
Event/ diagnosis	None.

[1] The Colorectal Cancer Screening measure is also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Health Home Core Set reporting.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet either of the following criteria: • Enrollees who had colorectal cancer (Colorectal Cancer Value Set) or a total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set) any time during the enrollee's history through December 31 of the measurement year. • Enrollees in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set. • Enrollees who died any time during the measurement year. For additional information, refer to the deceased enrollees exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set. • Enrollees receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year.
Exclusions (Supplemental and medical record data may not be used for these exclusions)	Note: Supplemental and medical record data may not be used for these exclusions. Exclude enrollees who meet the following criteria: • Enrollees age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Enrollees must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): o At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay.

Exclusions (continued) (Supplemental and medical record data may not be used for these exclusions)	○ At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) ○ At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 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. ○ A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above)

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; History of Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.
- CT colonography (CT Colonography Value Set) during the measurement year or the four years prior to the measurement year.
- Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; sDNA FIT Test Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.

MEASURE FUA-HH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for enrollees age 13 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- Percentage of ED visits for which the enrollee received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for which the enrollee received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older).
- The denominator should be the same for the 30-day rate and the 7-day rate within each age group.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of a mental health provider. States must develop their own methods to identify mental health providers.
- NCQA's Medication List Directory (MLD) for Alcohol Use Disorder Treatment and Opioid Use Disorder Treatment medications are available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

[1] Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 13 and older as of the ED visit.
Continuous enrollment	The date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical, chemical dependency and pharmacy. Note: Enrollees with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the enrollee was age 13 or older on the date of the visit. The denominator for this measure is based on ED visits, not on enrollees. If an enrollee has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If an enrollee has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an enrollee has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.

ED visits followed by residential treatment	Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. A code from any of the following meets criteria for residential treatment: • Residential Behavioral Health Treatment Value Set • Psychiatric Residential Treatment Center (POS code 56) • Residential Substance Abuse Treatment Facility (POS code 55) • Residential Program Detoxification Value Set These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet either of the following criteria: • Enrollees in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set. • Enrollees who died any time during the measurement year. For additional information, refer to the deceased enrollees exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

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 any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (BH Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with any diagnosis of SUD

(AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health provider
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with a mental health provider
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with a mental health provider
- An observation visit (Observation Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An observation visit (Observation Value Set) with a mental health provider
- A peer support service (Peer Support Services Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider
- A telephone visit (Telephone Visits Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telephone visit (Telephone Visits Value Set), with a mental health provider
- An e-visit or virtual check-in (Online Assessments Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

- An e-visit or virtual check-in (Online Assessments Value Set), with a mental health provider
- A substance use disorder service (Substance Use Disorder Services Value Set)
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set)
- A substance use service (Substance Use Services Value Set)
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List, Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service 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 required period for the rate (e.g., within 30 days after the ED visit or within 7 days after the ED visit).

MEASURE FUH-HH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for enrollees age 6 and older 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 provider. Two rates are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older).
- Follow the detailed specifications to (1) include the appropriate discharge when the enrollee 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 enrollee 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 within each age group.
- 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 from the same visit.
  - 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 from the same visit).
  - 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.
- Refer to Appendix C for the definition of mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 6 and older as of the date of discharge.
Continuous enrollment	Enrolled in a Medicaid health home program from the date of discharge through 30 days after discharge.
Allowable gap	No allowable gaps in 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 the discharge claim 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. The denominator for this measure is based on discharges, not on enrollees. If enrollees 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 stay (the admission date must occur during the 30-day follow-up period). 4. Identify the discharge date for the stay. 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 (use only the principal diagnosis on the discharge claim) 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 (use only the principal diagnosis on the discharge claim), 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 the 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. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet either of the following criteria: • Enrollees in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set. • Enrollees who died any time during the measurement year. For additional information, refer to the deceased enrollees exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up visit with a mental health provider 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 provider 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 provider
- An outpatient visit (BH Outpatient Value Set) with a mental health provider
- 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 or Intensive Outpatient Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS 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)
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider
- An observation visit (Observation Value Set) with a mental health provider
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)
- A telephone visit (Telephone Visits Value Set) with a mental health provider
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management 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 required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

MEASURE FUM-HH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS: AGE 6 AND OLDER

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for enrollees age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:

- Percentage of ED visits for which the enrollee received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for which the enrollee received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older).
- The denominator 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 within each age group.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[1] Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

B. ELIGIBLE POPULATION

Age	Age 6 and older as of the date of the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set and Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the enrollee was age 6 or older on the date of the visit. The denominator for this measure is based on ED visits, not on enrollees. If an enrollee has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If an enrollee has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an enrollee has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet either of the following criteria: • Enrollees in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set. • Enrollees who died any time during the measurement year. For additional information, refer to the deceased enrollees exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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 principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis 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 principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis 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 principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis 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 required period specified for the rate (within 30 days after the ED visit or within 7 days after the ED visit).

MEASURE IET-HH: INITIATION AND ENGAGEMENT OF SUBSTANCE USE DISORDER TREATMENT

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- **Initiation of SUD Treatment.** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
- **Engagement of SUD Treatment**. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- For the purpose of Health Home Core Set reporting, states should calculate and report each of the rates listed above for three age groups (as applicable) and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older).
- Two rates are reported: initiation of SUD treatment and engagement of SUD treatment. For each rate, report the following SUD diagnosis cohorts for each age group:
  - Alcohol use disorder
  - Opioid use disorder
  - Other substance use disorder
  - Total (The total is the sum of the SUD diagnosis cohort stratifications)
- Exclude enrollees from the denominator for both rates (initiation of SUD treatment and engagement of SUD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.
- Include all paid, suspended, pending, and denied claims.
- This measure requires that medication assisted treatment (MAT) services match the diagnosis category of the index episode identified in the denominator in order to count towards the numerator of the engagement rate. Depending on the diagnosis used in the denominator (e.g., opioid abuse or dependence and alcohol abuse and dependence), a corresponding MAT medication should be used to satisfy the numerator.
- The SUD diagnosis in the Negative SUD Diagnosis History does not need to match the diagnosis on the claim for the given SUD episode.

- NCQA's Medication List Directory (MLD) for Alcohol Use Disorder Treatment Medications and Opioid Use Disorder Treatment Medications is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2023-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for FFY 2024 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2023/cms137v11. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	November 15 of the year prior to the measurement year to November 14 of the measurement year. The intake period is used to capture new SUD episodes.
SUD episode	An encounter during the Intake Period with a diagnosis of SUD. For visits that result in an inpatient stay, the inpatient discharge is the SUD episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD episode date	The date of service for an encounter during the Intake period with a diagnosis of SUD. For a visit not resulting in an inpatient stay, the SUD episode date is the date of service. For an inpatient stay or for withdrawal management (i.e., detoxification) that occurred during an inpatient stay, the SUD episode date is the date of discharge. For withdrawal management (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD episode date is the date of service. For direct transfers, the SUD episode date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

Dates of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD episode date, negative diagnosis history and numerator events).
Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

C. ELIGIBLE POPULATION

Age	Age 13 and older as of the SUD episode date.
SUD diagnosis cohort stratification	Report the following SUD diagnosis cohort stratifications and a total: • Alcohol use disorder • Opioid use disorder • Other substance use disorder • Total (The total is the sum of the SUD diagnosis cohort stratifications)
Continuous enrollment	Enrolled in a Medicaid health home program for at least 194 days prior to the SUD episode date through 47 days after the SUD episode date (242 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefits	Medical, pharmacy, and chemical dependency (inpatient and outpatient). Note: Enrollees with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.

Event/ diagnosis	New episode of SUD during the intake period. Follow the steps below to identify the denominator for both rates. Step 1 Identify all SUD episodes. Any of the following meet criteria: • An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An outpatient visit (BH Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A substance use disorder service (Substance Use Disorder Services Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A withdrawal management event (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Event/ diagnosis (continued)	• An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. • A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set). Step 2 Test for Negative SUD Diagnosis History. Remove SUD episodes if there was an encounter in any setting other than an ED visit (ED Value Set) or a withdrawal management event (Detoxification Value Set) with a diagnosis of SUD (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) during the 194 days prior to the SUD episode date. If the SUD episode was an inpatient stay, use the admission date to determine negative SUD history. For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD episode), use the earliest date of service to determine the negative SUD diagnosis history (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history). For direct transfers, use the first admission date to determine the negative SUD diagnosis history.

Event/ diagnosis (continued)	Step 3 Test for negative SUD medication history. Remove SUD episodes if any of the following occurred during the 194 days prior to the SUD episode date: • An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) • An SUD medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Injection Value Set; Buprenorphine Naloxone Value Set; Buprenorphine Implant Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set) Step 4 Remove SUD episodes that do not meet continuous enrollment criteria. Enrollees must be continuously enrolled from 194 days before the SUD episode date through 47 days after the SUD episode date (242 total days), with no gaps. Note: The denominator for this measure is based on episodes, not on enrollees. All eligible episodes that were not removed remain in the denominator. Step 5 Deduplicate eligible episodes. If an enrollee has more than one eligible episode on the same day, include only one eligible episode. For example, if a enrollee has two eligible episodes on January 1, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1. Note: The denominator for this measure is based on episodes, not on enrollees. All eligible episodes that were not removed or deduplicated remain in the denominator. Step 6 Identify the SUD diagnosis cohort for each SUD episode. • If the SUD episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort. • If the SUD episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort. • If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (Other Drug Abuse and Dependence Value Set), place the enrollees in the other substance use disorder cohort. Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet either of the following criteria: • Enrollees in hospice or using hospice services anytime during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set. • Enrollees who died any time during the measurement year. For additional information, refer to the deceased enrollees exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Initiation of SUD Treatment

Initiation of SUD treatment within 14 days of the SUD episode date.

Follow the steps below to identify numerator compliance.

Step 1

If the SUD episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the SUD episode is compliant.

Step 2

If the SUD episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the SUD episode is compliant.

Step 3

For remaining SUD episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD episode date or during the 13 days after the SUD episode date (14 total days).

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An outpatient visit (BH Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A substance use disorder service (Substance Use Disorder Services Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- Observation Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set)
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set)

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD episode date must be with different providers in order to count.

Remove the enrollee from the denominator for both indicators (Initiation of SUD Treatment and Engagement of SUD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of SUD Treatment

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1

Identify all SUD episodes compliant for the Initiation of SUD Treatment numerator. SUD episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

Step 2

Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant.

Step 3

Identify SUD Episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD episode is compliant. Any of the following meet criteria:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set)
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set; Buprenorphine Injection Value Set; Buprenorphine Implant Value Set)

Step 4

For remaining SUD episodes identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit
- Engagement medication treatment event

Two engagement visits may be on the same date of service but they must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement Visits

Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An outpatient visit (BH Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
  - A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
  - A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
  - A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
  - A substance use disorder service (Substance Use Disorder Services Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
  - Observation Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
  - A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
  - An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

- An opioid treatment service (OUD Weekly Non Drug Service Value Set)

Engagement Medication Treatment Events

Either of the following meets criteria for a medication treatment event:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above)
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Buprenorphine Oral Medications List; Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Buprenorphine Oral Value Set; Buprenorphine Oral Weekly Value Set; Buprenorphine Naloxone Value Set; Methadone Oral Value Set; Methadone Oral Weekly Value Set).

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	Naltrexone (oral)	Naltrexone Oral Medications List
Antagonist	Naltrexone (injectable)	Naltrexone Injection Medications List
Partial agonist	Buprenorphine (sublingual tablet)	Buprenorphine Oral Medications List
Partial agonist	Buprenorphine (injection)	Buprenorphine Injection Medications List
Partial agonist	Buprenorphine (implant)	Buprenorphine Implant Medications List
Partial agonist	Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	Buprenorphine Naloxone Medications List

E. ADDITIONAL NOTES

- There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required time frame for the rate.
- Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally-certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

MEASURE OUD-HH: USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of enrollees ages 18 to 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

- A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1)
- Four separate rates representing the following types of FDA-approved drug products:
  - Buprenorphine (Rate 2)
  - Oral naltrexone (Rate 3)
  - Long-acting, injectable naltrexone (Rate 4)
  - Methadone (Rate 5)

Data Collection Method: Administrative

Guidance for Reporting:

- The measure includes a total rate (Rate 1) and four separate rates for the following four types of FDA-approved drug products:
  - Buprenorphine (Rate 2)
  - Oral naltrexone (Rate 3)
  - Long-acting, injectable naltrexone (Rate 4)
  - Methadone (Rate 5)
- Tables OUD-A and OUD-B are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip. Table OUD-B designates which medications are assigned to the separate rates. Filter on the 'Numerator' column to identify which NDC codes are assigned to each rate.
- The measure uses inpatient, outpatient, residential, long-term care, and pharmacy claims and encounters.
- The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count enrollees in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report enrollees with multiple drug products only once for the numerator for the total rate.
- Only formulations with an OUD indication (not pain management) are included in value sets for measure calculation.

This measure includes the following coding systems: HCPCS, NDC, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 years. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/ diagnosis	Enrollees who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in Table OUD-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip.
Care settings	Inpatient/hospital, outpatient, emergency department.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

For each enrollee in the denominator population, follow the steps below to identify enrollees for the total numerator and the numerator for each rate.

Total

Identify enrollees with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip.

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count enrollees in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report enrollees with multiple drug products only once for the numerator for the total rate.

Buprenorphine

Identify enrollees with evidence of at least one prescription for buprenorphine at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 2 in the Numerator column in Table OUD-B.

Oral Naltrexone

Identify enrollees with evidence of at least one prescription for oral naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 3 in the Numerator column in Table OUD-B.

Long-Acting, Injectable Naltrexone

Identify enrollees with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip. Include NDC codes assigned to Numerator 4 in the Numerator column in Table OUD-B.

Methadone

Identify enrollees with evidence of at least one dose of methadone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip. This rate includes HCPCS codes only. There are no NDC codes assigned to this rate.

Rates

The total rate is calculated by dividing the number of enrollees with evidence of at least one prescription (Numerator 1) by the number of enrollees with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (e.g., the Denominator).

To calculate the separate rates for each of the four FDA-approved medications for OUD, divide the Numerator for the medication by the Denominator. For example, to calculate the buprenorphine rate, divide the number of enrollees with evidence of at least one prescription for buprenorphine during the measurement year (Numerator 2) by the number of enrollees with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (e.g., the Denominator).

E. ADDITIONAL NOTES

None.

MEASURE PCR-HH: PLAN ALL-CAUSE READMISSIONS

National Committee for Quality Assurance

A. DESCRIPTION

For enrollees ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays (IHS)
- Count of Observed 30-Day Readmissions
- Count of Expected 30-Day Readmissions

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to enrollees ages 18 to 64. Although the HEDIS measure includes stratified reporting by age, for the Health Home Core Set, states should calculate and report only the Total rate.
- This measure requires risk adjustment. Risk adjustment guidelines are provided in the administrative specification. Please note that in the risk adjustment tables, clinical conditions (CCs) and hierarchical clinical conditions (HCCs) not listed receive a weight of ZERO (e.g., 0.0000).
- Report the Count of Expected 30-Day Readmissions for this measure to four decimal places.
- As shown in Table PCR-A, the data elements in columns 1, 2, 4, 7, and 8 are reported by the state. The data elements in columns 3, 5, 6 and 9 will be derived from the reported data.
- Supplemental data may not be used for this measure.
- When applying risk adjustment, include all services, whether or not the state paid for them or expects to pay for them (e.g., include denied claims). When identifying all other events, do not include denied services (e.g., only include paid services and services expected to be paid).
- If this measure has a Count of Index Hospital Stays less than 150 and the state chooses not to report this measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Index hospital stay (IHS)	An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The Index Discharge Date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described under step 3, Count of Observed 30-Day Readmissions
Direct transfer	A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example: • A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer. • A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer. • A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct inpatient stays. • A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer. Direct transfers may occur from and between different facilities and/or different services levels.
Count of Enrollees in the Health Home Population	Enrollees in the eligible population prior to exclusion of outliers (denominator steps 1-5). The Count of Enrollees in the Health Home Population is only used as a denominator for the Outlier rate. Enrollees must be ages 18 to 64 as of the earliest Index Discharge Date. The Count of Enrollees in the Health Home Population is based on enrollees, not discharges. Count enrollees only once.
Outlier	Enrollees in the eligible population with four or more index hospital stays (IHS) between January 1 and December 1 of the measurement year.
Nonoutlier	Enrollees in the eligible population who are not considered outliers.
Classification period	365 days prior to and including Index Discharge Date.

Risk Adjustment Tables

The PCR measure leverages the Risk Adjustment Tables, which define condition-based risk-adjustment variables. The table helps users determine an enrollee's condition-based risk-adjustment variables and select the proper risk weights.

Table	Table Description
Table CC-Mapping	Discharge Clinical Condition category codes for Risk Adjustment Determination. Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2.
Table HCC–Rank	HCC rankings for Risk Adjustment Determination step 3.
Table HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5.
PCR Risk Adjustment Table, Medicaid	Medicaid primary discharge weights for Risk Adjustment Weighting step 3. Medicaid comorbidity weights for Risk Adjustment Weighting step 4. Medicaid observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, and 5.

Source: Please refer to the HEDIS® MY 2023 Volume 2 Risk Adjustment Utilization Tables User Manual for technical detail on table format and content.

Note: The risk adjustment tables and Risk Adjustment Utilization Tables User Manual are available to order free of charge in the NCQA store at https://store.ncqa.org/hedis-my-2023-risk-adjustment-tables.html. Once ordered, the risk adjustment tables can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). The tables needed to calculate this measure are found in both the PCR Risk Adjustment Tables and the RAU Table - PCR Medicaid MY2023 (which includes the CC-Mapping, HCC-Rank, and HCC-Comb tables).

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 as of the Index Discharge Date.
Continuous enrollment	Enrolled in a Medicaid health home program for at least 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.

Event/ diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not enrollees. Include all acute inpatient or observation stay discharges for nonoutlier enrollees who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.
Required exclusion (Supplemental and medical record data may be used for this exclusion)	Enrollees in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set.

D. ADMINISTRATIVE SPECIFICATION

Count of Index Hospital Stays (IHS)

The eligible population as defined above.

Step 1

Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year.

To identify acute inpatient and observation stay discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

This measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of “direct transfer” above.

Exclude the hospital stay if the direct transfer’s discharge date occurs after December 1 of the measurement year.

Step 3

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

Step 4

Exclude hospital stays for the following reasons:

- The enrollee died during the stay.
- Enrollees with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 5

Calculate continuous enrollment.

Step 6

Remove hospital stays for outlier enrollees and report these enrollees as outliers.

Note: Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier enrollees.

Risk Adjustment Determination

For each IHS among nonoutlier enrollees, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age and gender.

Observation Stay	Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.
Surgeries	Determine if the enrollee underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.
Discharge Condition	Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its principal discharge diagnosis, using Table CC-Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table CC-Mapping.
Comorbidities	Assign Risk Adjustment Comorbidity Category Determination based on all the encounters during the classification period, as described in the Steps for Risk Adjustment Comorbidity Category Determination.

Steps for Risk Adjustment Comorbidity Category Determination

Follow the steps below for Risk Adjustment Comorbidity Category Determination.

Step 1

Identify all diagnoses for encounters during the classification period for each index hospital stay (IHS). Include the following when identifying encounters:

- Outpatient visits (Outpatient Value Set)
- Telephone Visits (Telephone Visits Value Set)
- Observation visits (Observation Value Set)
- ED visits (ED Value Set)
- Inpatient events:
  - Nonacute inpatient encounters (Nonacute Inpatient Value Set)
  - Acute inpatient encounters (Acute Inpatient Value Set)
  - Acute and nonacute inpatient discharges (Inpatient Stay Value Set)

Use the date of service for outpatient, observation, and ED visits. Use the discharge date for inpatient events.

Exclude the principal discharge diagnosis on the index hospital stay (IHS).

Step 2

Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Mapping, available at https://store.ncqa.org/hedis-my-2023-risk-adjustment-tables.html. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

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

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

Step 3

Determine Hierarchical Condition Categories (HCCs) for each comorbid CC identified. Refer to Table HCC—Rank, available at https://store.ncqa.org/hedis-my-2023-risk-adjustment-tables.html.

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

- The ranking group
- The rank
- The HCC

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

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

Step 4

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

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

Example

Assume a denominator unit with the following comorbid CCs: CC-85, CC-17, and CC-19 (assume no other CCs).

- CC-85 does not have a map to the ranking table and becomes HCC-85.
- HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
- The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Example: Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
Not Applicable (NA)	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes without Complication	3	HCC-19

Step 5

Identify combination HCCs listed in Table HCC—Comb, available at https://store.ncqa.org/hedis-my-2023-risk-adjustment-tables.html.

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

Compare each denominator unit's list of unique HCCs to those in the Comorbid HCC columns in Table HCC—Comb and assign any additional HCC conditions.

If there are fully nested combinations, use only the more comprehensive pattern. For example, if the diabetes/CHF combination is nested in the diabetes/CHF/renal combination, count only the diabetes/CHF/renal combination.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a denominator unit can have none, one, or more than one of these added HCCs.

Example:

For a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.

Example: Table HCC—Comb HERE

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk Adjustment Weighting

For each index hospital stay (IHS) among nonoutlier enrollees, use the following steps to identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

Step 1	For each IHS discharge that is an observation stay, link the observation stay IHS weight.
Step 2	For each IHS with a surgery, link the surgery weight.
Step 3	For each IHS with a discharge CC Category, link the primary discharge weights.
Step 4	For each IHS with a comorbidity HCC Category, link the comorbidity weights.
Step 5	Link the age and gender weights for each IHS.
Step 6	Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, principal discharge diagnosis, comorbidities, age, and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS. $$\text{Estimated Readmission Risk} = \frac{e^{(\sum WeightsforIHS)}}{1 + e^{(\sum WeightsforIHS)}}$$ OR Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)] Note: “Exp” refers to the exponential or antilog function. Truncate the estimated readmission risk for each IHS to 10 decimal places. Do not truncate or round in previous steps.
Step 7	Calculate the Count of Expected Readmissions. The Count of Expected Readmissions is the sum of the Estimated Readmissions Risk calculated in step 6 for each IHS. *Count of Expected Readmissions = ∑ (Estimated Readmission Risk)*

Step 8	Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS. Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk) Truncate the variance *for each IHS* to 10 decimal places. For example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475.

Count of Observed 30-Day Readmissions

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

Step 1

Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Identify the admission date for the stay.

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of “direct transfer” above.

Step 3

Exclude acute hospitalizations meeting any of the following criteria on the discharge claim:

- Enrollees with a principal diagnosis of pregnancy (Pregnancy Value Set)
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set)
- A planned hospital stay using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set)
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set)
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set)
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set)

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 4

For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: Count each acute hospitalization only once toward the numerator for the last denominator event.

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- Acute Inpatient Stay 1: May 1–10
- Acute Inpatient Stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy)
- Acute Inpatient Stay 3: May 30–June 5.

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only towards the last denominator event (Stay 2, May 15–25).

Reporting: Count of Index Hospital Stays (IHS)

Count the number of IHS among nonoutlier enrollees and enter this value into the reporting table under Count of Index Hospital Stays (Table PCR-A, column 1).

Reporting: Count of 30-Day Readmissions

Count the number of observed IHS among nonoutlier enrollees with a readmission within 30 days of discharge and enter this value into the reporting table under Count of Observed 30-Day Readmissions (Table PCR-A, column 2).

Reporting: Count of Expected 30-Day Readmissions

Step 1

Sum the Expected Readmission Risk for each IHS among nonoutlier enrollees to calculate the Count of Expected Readmissions.

Step 2

Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting table (Table PCR-A, column 4).

Reporting: Count of Enrollees in Health Home Population

Step 1

Determine the enrollee’s age as of the earliest Index Discharge Date.

Step 2

Report the count of enrollees in the health home population and enter this value into the reporting table under Count of Enrollees in Health Home Population (Table PCR-A, column 7).

Reporting: Number of Outliers

Step 1

Determine the enrollee’s age as of the earliest Index Discharge Date.

Step 2

Report the count of outlier enrollees and enter this value into the reporting table under Number of Outliers (Table PCR-A, column 8).

E. ADDITIONAL NOTES

The following data elements will be calculated based on the five reported data elements:

- Observed Readmission Rate: Count of Observed 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 3).
- Expected Readmission Rate: Count of Expected 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 5).
- Observed-to-Expected Ratio (O/E): Count of Observed 30-Day Readmissions divided by Count of Expected 30-Day Readmissions (Table PCR-A, column 6).
- Outlier Rate: Number of Outlier enrollees divided by Count of Enrollees in Health Home Population (Table PCR-A, column 9), displayed as a permillage (multiplied by 1,000).
- Note: The O/E ratio is interpreted as “lower-is-better”:
  - O/E ratio <1.0 means the state had fewer readmissions than expected given the case mix
  - O/E ratio = 1.0 means that the number of readmissions was the same as expected given the case mix
  - O/E ratio >1.0 means that the state had more readmissions than expected given the case mix

Table PCR-A. Plan All-Cause Readmissions Rates

	Count of Index Hospital Stays (1)	Count of Observed 30-Day Readmissions (2)	Observed Readmission Rate (3)	Count of Expected 30-Day Readmissions (4)	Expected Readmission Rate (5)	O/E Ratio (Count of Observed 30-Day Readmissions/ Count of Expected 30-Day Readmissions) (6)	Count of Enrollees in Health Home Population (7)	Number of Outliers (8)	Outlier Rate (9)
Total			Calculated		Calculated	Calculated			Calculated

MEASURE PQI92-HH: PREVENTION QUALITY INDICATOR (PQI) 92: CHRONIC CONDITIONS COMPOSITE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Hospitalizations for ambulatory care sensitive chronic conditions per 100,000 enrollee months for enrollees age 18 and older. This measure includes adult hospitalizations for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, or heart failure without a cardiac procedure.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- For the purpose of Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64, age 65 and older, and total (age 18 and older).
- States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 enrollees.
- A two-step process should be used to determine whether enrollees should be counted in this measure:
  - For each enrollee month considered for the denominator, assess the enrollee's age at either the 15th or 30th of the month (or the 28th of the month in February). If the enrollee was age 18 or older by that date, the enrollee month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and an enrollee is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital discharge representing a qualifying numerator event, assess the enrollee's age on the date of admission. Only discharges for enrollees age 18 or older should be included in the numerator.
- Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the PQIs included in the composite are counted only once in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI92-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at https://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the “Deviations from Measurement Specifications” field.
- Include paid claims only.

https://qualityindicators.ahrq.gov/Downloads/Modules/PQI/V2023/TechSpecs/PQI_92_Prevention_Quality_Chronic_Composite.pdf

This measure includes the following coding systems: 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

Enrollee months	All enrollee months for enrollees age 18 and older as of the 15th or 30th of the month. Date for counting enrollee months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of health home enrollment for enrollees age 18 and older during the measurement period.

Numerator

Discharges for patients age 18 and older, that meet the inclusion and exclusion rules for the numerator in any of the following Prevention Quality Indicators (PQIs):

- PQI 01: Diabetes Short-Term Complications Admission Rate
- PQI 03: Diabetes Long-Term Complications Admission Rate
- PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
- PQI 07: Hypertension Admission Rate
- PQI 08: Heart Failure Admission Rate
- PQI 14: Uncontrolled Diabetes Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate
- PQI 16: Lower-Extremity Amputations Among Patients with Diabetes Rate

Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

PQI 01: Diabetes Short-Term Complications Admission

All inpatient hospital discharges of enrollees age 18 and older with an ICD-10-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, or coma) (Table PQI92-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B below for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)

- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of diabetes with short-term complications cannot be obstetric discharges. Thus, obstetric discharges are not included in the PQI rate.)

Table PQI92-B. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital 3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital 5 – Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility (NF) 6 – Transfer from another health care facility F – Transfer from a hospice facility

PQI 03: Diabetes Long-Term Complications Admission

All inpatient hospital discharges of enrollees age 18 and older with an ICD-10-CM principal diagnosis code for long-term complications of diabetes (renal, eye, neurological, circulatory, or complications not otherwise specified) (Table PQI92-C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B above for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of diabetes with long-term complications cannot be obstetric discharges. Thus, obstetric discharges are not included in the PQI rate.)

PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission

All inpatient hospital discharges of enrollees age 40 and older with an ICD-10-CM principal diagnosis code for COPD (excluding acute bronchitis) (PQI92-D-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip) or asthma in adults age 40 and older (Table PQI92-D-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B above for admission codes for transfers)

- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of COPD, asthma or acute bronchitis cannot be obstetric discharges. Thus, obstetric discharges are not included in the PQI rate.)
- Cases with any listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Table PQI92-E, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip)

PQI 07: Hypertension Admission

All inpatient hospital discharges of enrollees age 18 and older with an ICD-10-CM principal diagnosis code for hypertension (Table PQI92-F, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B above for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of hypertension cannot be obstetric discharges. Thus, obstetric discharges are not included in the PQI rate.)
- Cases with any-listed ICD-10-PCS procedure code for cardiac procedure (Table PQI92-G, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip)
- Cases with any listed ICD-10-CM diagnosis codes for Stage I–IV kidney disease if the diagnosis is accompanied by any listed ICD-10-PCS procedure codes for dialysis access (Tables PQI92-H-A and PQI92-H-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip)

PQI 08: Heart Failure Admission

All inpatient hospital discharges of enrollees age 18 and older with an ICD-10-CM principal diagnosis code for heart failure (Table PQI92-I, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B above for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)

- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of heart failure cannot be obstetric discharges. Thus, obstetric discharges are not included in the PQI rate.)
- Cases with any listed ICD-10-PCS procedure codes for cardiac procedure (Table PQI92-G, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip)

PQI 14: Uncontrolled Diabetes Admission

All inpatient hospital discharges of enrollees age 18 and older with an ICD-10-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term (ketoacidosis, hyperosmolarity, or coma) or long-term (renal, eye, neurological, circulatory, or other unspecified) complication (Table PQI92-J, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B above for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of uncontrolled diabetes without mention of short-term or long-term complications cannot be obstetric discharges. Thus, obstetric discharges are not included in the PQI rate.)

PQI 15: Asthma in Younger Adults Admission

All inpatient hospital discharges of enrollees between ages 18 and 39 with an ICD-10-CM principal diagnosis code of asthma (Table PQI92-K, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B above for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of asthma cannot be obstetric discharges. Thus, obstetric discharges are not included in the PQI rate.)
- Cases with any listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Table PQI92-E, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip)

PQI 16: Lower-Extremity Amputations Among Patients with Diabetes

All inpatient hospital discharges of enrollees age 18 and older with any listed ICD-10-PCS procedure code for lower-extremity amputation and any listed ICD-10-CM diagnosis code for diabetes (Tables PQI92-L-A and PQI92-L-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI92-B above for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Cases with any listed ICD-10-CM diagnosis codes for traumatic amputation of the lower extremity (Table PQI92-M, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2024-HH-non-hedis-value-set-directory.zip)
- Discharges with a principal ICD-10-CM diagnosis code assigned to MDC 14 (pregnancy, childbirth, and puerperium)

IV. TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME UTILIZATION MEASURES

This chapter presents the technical specifications for each enrollee utilization measure. 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 other relevant measure information.

These specifications represent the most applicable version available from the measure steward as of December 2022.

MEASURE AIF-HH: ADMISSION TO A FACILITY FROM THE COMMUNITY

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The number of admissions to a facility among enrollees age 18 and older residing in the community for at least one month. The number of short-term, medium-term, or long-term admissions is reported per 1,000 enrollee months. Enrollee months reflect the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month.

The following three performance rates are reported across four age groups (ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older):

- **Short-Term Stay.** The rate of admissions resulting in a short-term stay (1 to 20 days) per 1,000 enrollee months.
- **Medium-Term Stay.** The rate of admissions resulting in a medium-term stay (21 to 100 days) per 1,000 enrollee months.
- **Long-Term Stay.** The rate of admissions resulting in a long-term stay (greater than or equal to 101 days) per 1,000 enrollee months.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to enrollees age 18 and older. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for four age groups (as applicable) and a total performance rate: ages 18 to 64, ages 65 to 74, ages 75 to 84, age 85 and older, and total (age 18 and older).
- Three rates are reported for each age group: short-term stay, medium-term stay, and long-term stay.
- Include paid claims only.

The measure includes the following coding systems: UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Enrollee months	Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month from August 1 of the year prior to the measurement year through July 31 of the measurement year. Enrollee months do not include the month that an enrollee dies or any subsequent months. See Section D for guidance on calculating enrollee months.
Facility	A Medicaid- or Medicare-certified nursing facility providing skilled nursing or medical care or both; rehabilitation needed because of injury, illness or disability; or long-term care (also referred to as "custodial care"). A Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

Community residence	Any residence that is not a facility (see definition above). Note: Community residence may include assisted living, adult foster care, or other care in another setting that is not defined as a facility.
Facility admission (FA)	An admission to a facility from the community or from the hospital (where the hospital admission originated in the community) from August 1 of the year prior to the measurement year through July 31 of the measurement year. Facility admission (FA) is based on paid claims only.
Index admission date	The index admission date is the first date of the facility admission.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the first day of the measurement year.
Continuous enrollment	Enrollee must be continuously enrolled in a health home program for at least 30 days from August 1 of the year prior to the measurement year and July 31 of the measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	Medical.
Event/ diagnosis	None.
Required exclusions	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of enrollee months where the enrollee was residing in the community for at least one day of the month.[1]

Step 1

Identify the eligible population as defined above.

Step 2

Determine enrollee months between August 1 of the year prior to the measurement year and July 31 of the measurement year 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. For example, if the state tallies enrollment on the 15th of the month and an enrollee is enrolled in the health home program on January 15, the enrollee contributes one enrollee month in January. The day selected must be consistent from person to person, month to month, and year to year.

[1] For example, if an enrollee was admitted to a facility on February 12 and discharged on April 15, February and April would count in the denominator, but March would not. States should only count months when there is an opportunity for an admission.

Step 3

Identify the months where the enrollee was residing in a facility for the entire month (e.g., no days in the month were spent residing in the community). Remove these months from the denominator.

Step 4

Remove from the measure denominator the month when an enrollee dies, and any subsequent months.

Step 5

Calculate the continuous enrollment. Remove months for individuals who do not meet the continuous enrollment criteria.

Step 6

Divide the population into age stratification groups. Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be attributed. For example, if the state tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled from August 1 of the year prior to the measurement year through July 31 of the measurement year, then the enrollee contributes eight enrollee months to the 18 to 64 age group category and four enrollee months to the 65 to 74 age category.

Numerator

The number of facility admissions (FA) from a community residence from August 1 of the year prior to the measurement year through July 31 of the measurement year.

FAs are reported in three categories: (1) short-term stay (1 to 20 days), (2) medium-term stay (21 to 100 days), and (3) long-term stay (greater than or equal to 101 days).

Use the steps below to identify numerator events.

Step 1

Identify all FAs between August 1 of the year prior to the measurement year and July 31 of the measurement year (MLTSS-6-8 Value Sets Facility Uniform Bill Codes).

Step 2

Remove FAs that are direct transfers from another facility. Keep the original admission date as the date of the new FA. A direct transfer is when the discharge date from the first facility setting precedes the admission date to a second facility setting by one calendar day or less. For example:

- Facility discharge on June 1, followed by an admission to another facility setting on June 1, is a direct transfer.
- Facility discharge on June 1, followed by an admission to another facility setting on June 2, is a direct transfer.
- Facility discharge on June 1, followed by an admission to another facility setting on June 3, is <u>not</u> a direct transfer; these are two distinct new facility stays.

Step 3

Remove admissions from the hospital that originated from a facility. Keep the original FA date (that preceded the admission to the hospital) as a new FA date.

Step 4

Remove admissions that result in death in the facility or death within one day of discharge from the facility.

Step 5

For all FAs, look for location of the first discharge in the measurement year.

- If the enrollee is discharged to the community, calculate length of stay (LOS) as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus the index admission date.
- If the enrollee is discharged to the hospital, look for the hospital discharge and location of discharge. If the enrollee is discharged from the hospital to the community, calculate LOS as the date of hospital discharge minus the FA date.
- If the enrollee is discharged to the hospital and dies in the hospital, exclude the admission from the numerator.
- If the enrollee is discharged to the hospital and remains in the hospital at the end of the measurement year, exclude the admission from the numerator.
- If the enrollee is discharged to the hospital and then admitted back to the facility, repeat Step 5 until there is a discharge to the community or the end of the measurement year. When calculating the LOS, include all hospital days between the FA date and discharge to the community or end of the measurement year.
- If the enrollee is discharged to a different facility (e.g., a transfer), repeat Step 5 until there is a discharge to the community or the end of the measurement year. When calculating the LOS, include all facility days between the FA date and discharge to the community or the end of the measurement year.
- When counting the duration of each stay within a measurement year, include the day of entry (admission) but not the day of discharge, unless the admission and discharge occurred on the same day, in which case the number of days in the stay is equal to one.

Step 6

Classify LOS for each FA as short-term (1 to 20 days), medium-term (21 to 100 days), or long-term (greater than or equal to 101 days).

Step 7

Determine the enrollee's age at the time of admission and assign to an age category: 18 to 64, 65 to 74, 75 to 84, or 85 or older.

Calculating Performance Rate

Calculate the admission rate for each type of stay and age category by dividing the number of admissions by the number of enrollee months and multiplying by 1,000 as follows:

- Short-term admission rate = (Number of short-term admissions / number of enrollee months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.
- Medium-term admission rate = (Number of medium-term admissions / number of enrollee months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.

- Long-term admission rate = (Number of long-term admissions / number of enrollee months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.

Table AIF-A. Table for Reporting Admissions to a Facility from the Community

Age Category	Number of Enrollee Months	Number of Short-term Admissions	Short-term Admissions/ 1,000 Enrollee Months	Number of Medium-term Admissions	Medium-term Admissions/ 1,000 Enrollee Months	Long-Term Admissions	Long-Term Admissions/ 1,000 Enrollee Months
18 to 64							
65 to 74							
75 to 84							
85 and Older							
Total: Age 18 and Older							

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

National Committee for Quality Assurance

A. DESCRIPTION

Rate of emergency department (ED) visits per 1,000 enrollee months among health home enrollees.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure includes all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 0 to 17, ages 18 to 64, age 65 and older, and total (all ages).
- States should report this measure as a rate per 1,000 enrollee months.
- 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.
- When confirming that an ED visit does not result in an inpatient stay, all inpatient stays must be considered, regardless of payment status (paid, suspended, pending, denied). 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.
- Supplemental data may not be used for this measure. In addition, supplemental data may not be used for the mental health and chemical dependency required exclusion.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

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

C. ELIGIBLE POPULATION

Age	All health home enrollees.
Continuous enrollment	None.

Required exclusion (Supplemental and medical record data may be used for this exclusion)	• Enrollees in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Health Home Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of enrollee months.

Step 1

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

Step 2

Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if a health home program tallies enrollment on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months (January, February, and March) to the ages 18 to 64 category and nine enrollee months to the age 65 and older category.

Numerator

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).

A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date).

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

Matching Enrollment with Utilization: Run enrollment reports used for enrollee month calculations to determine utilization rates (such as ED visits/1,000 enrollee months) within 30 days of the claims reports and for the same time period. States that report utilization services must also report benefit enrollment (medical beneficiary months).

Counting Multiple Services: If an enrollee receives the same service two different times (e.g., ED visits six months apart), count them as two visits. Count services, not the frequency of procedure codes billed (e.g., if a physician and a hospital submit separate bills

pertaining to the same ED visit with the same date of service, only one should be included). The state must develop its own systems to avoid double counting.

E. CALCULATION OF THE ED VISIT RATES

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

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

Table AMB-HA. ED Visits Per 1,000 Health Home Enrollee Months, By Age

Age	ED Visits	Enrollee Months	ED Visits per 1,000 Enrollee Months
0–17			
18–64			
65 and Older			
Unknown			
Total			

Source: Refer to Table AMB-1: Data Elements for Ambulatory Care in HEDIS specifications (MY 2020 & MY 2021 version).

F. ADDITIONAL NOTES

This measure has been adapted from the NCQA HEDIS measure Ambulatory Care: Emergency Department (ED) Visits measure. The Health Home Core Set measure specification includes additional language from the HEDIS section, “Guidelines for Utilization Measures,” modifies the age stratifications, and does not exclude behavioral health and chemical dependency services.

MEASURE IU-HH: INPATIENT UTILIZATION

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Rate of acute inpatient care and services (total and mental and behavioral disorders) per 1,000 enrollee months among enrollees.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to enrollees of all ages. For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 0 to 17, ages 18 to 64, age 65 and older, and total (all ages).
- Report all services the state paid for or expects to pay for (e.g., claims incurred but not paid). Do not include services and days denied for any reason.
- This measure includes discharges and days for total inpatient use and mental and behavioral disorders and neurodevelopmental disorders. Stratified reporting for maternity, surgery, and medicine discharges is no longer required.
- Supplemental data may not be used for this measure.
- Enrollees 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 Health Home Core Set.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

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

C. ELIGIBLE POPULATION

Age	All health home enrollees.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of enrollee months.

Step 1

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

Step 2

Use the enrollee's age on the specified day of each month to determine the age group the enrollee months will be contributed. For example, if a state tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months to the ages 18 to 64 category and nine enrollee months to the age 65 and older category.

Numerator

Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year, using the following steps.

Step 1

Identify all acute inpatient discharges on or between January 1 and December 31 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.

Step 2

Exclude newborn care rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery discharge). Identify newborn care by a principal diagnosis of live-born infant (Deliveries Infant Record Value Set). States must develop methods to differentiate between the mother’s claim and the newborn’s claim, if needed.

Step 3

Report total inpatient, using all discharges identified after completing steps 1 and 2.

Step 4

Report mental and behavioral disorders. From total inpatient (identified in step 3), identify mental health and chemical dependency (Mental and Behavioral Disorders Value Set and Mental, Behavioral, and Neurodevelopmental Disorders Value Set).

Step 5

Use the formulas below to report length of stay (LOS)

- LOS: All approved days from admission to discharge. The last day of the stay is not counted unless the admission and discharge date are the same.
- LOS = Discharge date – admit date – denied days
- Note: When an inpatient revenue code (UB or equivalent code) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admission date

are the same, then the discharge date minus the admission date equals one day, not zero days.

Step 6

Report tables IU-A and IU-B use the following instructions to calculate these measures:

- Discharge: Total discharges associated with specified diagnosis codes. If the state cannot report by discharge date, report data by admission date and indicate the reason in the "Additional Notes/Comments on Measure" section.
- Discharge / 1,000 enrollee months: (Total discharges / enrollee months) x 1,000
- Total days incurred: The sum of the LOS for all discharges during a measurement year. The total does not include the last day of the stay (unless the last day of stay is also the admit day) or denied days.
  - Total days incurred includes days before January 1 of the measurement year for discharge dates occurring during the measurement year.
  - Total days incurred does not include days during the measurement year that are associated with discharge dates in the year after the measurement year.
- Total days incurred / 1,000 enrollee months: (Total days incurred / enrollee months) x 1,000.
- Average Length of Stay: Total days / total discharges.

Table IU-A. Table for Reporting Enrollee Months, by Age

Age	Enrollee Months
0–17	
18–64	
65 and Older	
Unknown	
Total	

Table IU-B. Table for Reporting Inpatient Utilization per 1,000 Enrollee Months, by Age and Type of Inpatient Utilization

Age and Type of Inpatient Utilization	Discharges	Discharges/ 1,000 Enrollee Months	Days	Days/ 1,000 Enrollee Months	Average Length of Stay
Inpatient					
0–17					
18–64					
65 and Older					
Unknown					
Total Inpatient					

Age and Type of Inpatient Utilization	Discharges	Discharges/ 1,000 Enrollee Months	Days	Days/ 1,000 Enrollee Months	Average Length of Stay
Mental and Behavioral Disorders					
0–17					
18–64					
65 and Older					
Unknown					
Total Mental and Behavioral Disorders					

E. ADDITIONAL NOTES

This measure has been adapted from the NCQA HEDIS measure Inpatient Utilization—General Hospital/Acute Care. The Health Home Core Set measure specification includes value sets for mental and behavioral disorders-related inpatient care; excludes stratification for maternity-related stays; includes additional language from the HEDIS section, Guidelines for Utilization Measures; and modifies the age stratifications."

APPENDIX A: HEALTH HOME CORE SET HEDIS® VALUE SET DIRECTORY USER MANUAL

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A. What is the HEDIS Health Home Value Set Directory?

Measure specifications for HEDIS® measures included in the Heath Home 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 HEDIS Health Home Value Set Directory (VSD) includes all value sets and codes needed to report HEDIS measurement year 2023 measures included in the 2024 Health Home Core Set. This appendix describes how to use value sets in calculating measures in the Health Home Core Set.

B. Structure of the Value Set Directory

The VSD (Excel workbook) contains the following spreadsheets:

- Copyright & Licensing
- Measures to Value Sets*
- Value Sets to Codes*
- Summary of Changes – Codes
- Summary of Changes – Value Sets
- Direct Reference Codes

* Elements are based on those included in the National Library of Medicine Value Set Authority Center (VSAC) standardized value set file. Not all elements are needed for Health Home Core Set reporting.

C. What's New in the Value Set Directory?

The Value Set for the Inpatient Utilization (IU-HH) measure is now a standalone value set and is not included in the HEDIS Health Home Value Set Directory.

D. HH Measures to Value Sets

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

Table A.1. Health Home - Measures to Value Sets

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

Use the "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 "AMB-HH" demonstrates that the Ambulatory Care: Emergency Department (ED) Visits measure uses the following value sets:

Measure ID	Measure Name	Value Set Name	Value Set OID
AMB-HH	Ambulatory Care - Emergency Department Visits	ED	2.16.840.1.113883.3.464.1004.1086
AMB-HH	Ambulatory Care - Emergency Department Visits	ED POS	2.16.840.1.113883.3.464.1004.1087
AMB-HH	Ambulatory Care - Emergency Department Visits	ED Procedure Code	2.16.840.1.113883.3.464.1004.1088
AMB-HH	Ambulatory Care - Emergency Department Visits	Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
AMB-HH	Ambulatory Care - Emergency Department Visits	Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
AMB-HH	Ambulatory Care - Emergency Department Visits	Inpatient Stay	2.16.840.1.113883.3.464.1004.1395

Setting the Value Set Name filter to “Outpatient” demonstrates the measures that use the value set.

Measure ID	Measure Name	Value Set Name	Value Set OID
CBP-HH	Controlling High Blood Pressure	Outpatient	2.16.840.1.113883.3.464.1004.1202
COL-HH	Colorectal Cancer Screening	Outpatient	2.16.840.1.113883.3.464.1004.1202
PCR-HH	Plan All-Cause Readmissions	Outpatient	2.16.840.1.113883.3.464.1004.1202

E. HH Value Sets to Codes

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

Table A.2. HH 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	Version date for the value set (10/27/2023 for federal fiscal year 2024 reporting).
Code	The code.

Element Name	Element Description
Definition	The code definition. Note: The definition is not included for Uniform Bill or CPT 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 • 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, Procedure Coding System (Procedure codes) • LOINC: Logical Observation Identifiers Names and Codes • POS: CMS Place of Service • SNOMED CT US Edition: Systematized Nomenclature of Medicine—Clinical Terms US Edition • UBREV: Uniform Bill (Revenue codes) • UBTOB: Uniform Bill (Type of Bill codes)
Code System OID	Unique identifier for the code system, if available.
Code System Version	Code system version tracking number, if available.

Use the 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 “Chemotherapy Encounter” 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
Chemotherapy Encounter	2.16.840.1.113883.3.464.1004.1519	2023-10-27	Z51.0	[Z51.0] Encounter for antineoplastic radiation therapy	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA
Chemotherapy Encounter	2.16.840.1.113883.3.464.1004.1519	2023-10-27	Z51.11	[Z51.11] Encounter for antineoplastic chemotherapy	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA
Chemotherapy Encounter	2.16.840.1.113883.3.464.1004.1519	2023-10-27	Z51.12	[Z51.12] Encounter for antineoplastic immunotherapy	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA

Setting the Code filter to “F16.121” 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
Acute Condition	2.16.840.1.113883.3.464.1004.1324	2023-10-27	F16.121	[F16.121] Hallucinogen abuse with intoxication with delirium	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013	2023-10-27	F16.121	[F16.121] Hallucinogen abuse with intoxication with delirium	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Mental and Behavioral Disorders	2.16.840.1.113883.3.464.1004.1300	2023-10-27	F16.121	[F16.121] Hallucinogen abuse with intoxication with delirium	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426	2023-10-27	F16.121	[F16.121] Hallucinogen abuse with intoxication with delirium	ICD10CM	2.16.840.1.113883.6.90	2023.1.22AA

F. Summary of Changes – Codes

The Summary of Changes – Codes spreadsheet lists code changes in FFY 2024 by value set and includes the elements in Table A.3.

Table A.3. HH 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.

Use the Summary of Changes - Codes spreadsheet to identify codes added to or deleted from a concept. For example, setting the Value Set filter to “Acute Inpatient” will result in the following codes:

Value Set	Change	Code System	Code
Acute Inpatient	Added	CPT	99234
Acute Inpatient	Added	CPT	99235
Acute Inpatient	Added	CPT	99236

Codes for new value sets are not listed individually in the Summary of Changes – Codes spreadsheet.

Codes for deleted value sets are not listed individually in the Summary of Changes – Codes spreadsheet.

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 the FFY 2024 changes to 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 value set.
Change	The change (Added; Deleted; Revised).
Description	Describes the affected measures or, for renamed value sets, the new value set name.

For example, the following shows an excerpt for the FUM-HH measure:

Value Set Name	Change	Description
Mental Illness	Deleted from	FUM-HH
Mental Illness and Intentional Self-Harm	Added to	FUM-HH

H. Direct Reference Codes

A direct reference code is a single code that meets criteria for a service or condition. Direct reference codes are listed in the measure specification and are also included in the Direct Reference Codes spreadsheet of the VSD (as are direct reference codes used for measures reported using ECDS).

Table A-5. Direct Reference Codes

Element Name	Element Description
Measure ID	The measure abbreviation.
Measure Name	The measure name.
Code	The code.
Description	The description of the code.
Code System	The code system.

For example, the following shows an excerpt for the CBP-HH measure:

Measure ID	Measure Name	Code	Description	Code System
CBP-HH	Controlling High Blood Pressure	Z51.5	Encounter for palliative care	ICD10CM

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

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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. States may use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the sample size. 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.

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

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
≤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
77%	296
78%	288

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
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

Notes: Table B.1 reflects the minimum required sample size. When reducing, a state's sample size may be between the allowed minimum sample size in Table B.1 and 411.

States that report using socioeconomic status (SES) categories must use the total rate for sample size reduction, not the cohort rates based on SES stratification.

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

Appendix C: Definitions of Medicaid/CHIP Core Set Practitioner Types

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Practitioner Type	Definition
Mental Health Provider	A provider who delivers 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 a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC) • A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry • A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC)

Practitioner Type	Definition
Mental Health Provider (continued)	- Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria: o The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act). o The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or country in which it is located. - Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria: o Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a)(42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC o Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grants or funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC
Obstetrician/ Gynecologist (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, and physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)
Primary Care Practitioner (PCP)	A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwives) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHCs) are considered PCPs. • To be certified as an FQHC, an entity must meet any one of the following criteria:

Practitioner Type	Definition
Primary Care Practitioner (PCP) (continued)	- 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 (RHC) o Only certified RHCs are considered PCPs. o To be certified as a RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
Prescribing Practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications