SUMMARY OF UPDATES TO THE HEALTH HOME CORE SET MEASURES TECHNICAL SPECIFICATIONS AND RESOURCE MANUAL MARCH 2019

Overall Changes

- Updated reporting year to FFY 2019, and data collection timeframe to 2018.
- Updated specifications, value set codes, copyright, and table source information to HEDIS 2019 Vol. 2 for all HEDIS measures.
- Deleted electronic specification section and added links to electronic specifications in the Guidance for Reporting section for the following measures: CBP-HH, CDF-HH, and IET-HH.
- Revised specifications and changed name for one measure:
  - NFU-HH: Nursing Facility Utilization revised to AIF-HH: Admission to an Institution from the Community
- Replaced sampling guidance in the measure specifications with reference to sampling guidance in Section II. Data Collection and Reporting of the Health Home Core Set for the following measures: ABA-HH and CBP-HH.

II. Data Collection and Reporting of the Child Core Set

- Added bullet about how to obtain value sets for electronic specifications. This applies to the following Health Home Core Set measures: CBP-HH, CDF-HH, and IET-HH.
- Clarified that documentation that a beneficiary is near the end of life (e.g. comfort care, Do Not Resuscitate, Do Not Intubate) or is in palliative care does not meet criteria for hospice exclusion.
- Updated guidance on not reporting measures due to small numbers:
  - If a measure has a denominator that is less than 30 (for all measures except PCR-HH) or a Count of Index Hospital Stays less than 10 (for PCR-HH) and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.

III. Technical Specifications for the Health Home Core Set Measures

Measure CBP-HH: Controlling High Blood Pressure

- Removed requirement to identify and use different thresholds for enrollees ages 60 to 85 without a diagnosis of diabetes.
- Added administrative method for reporting.
- Revised the definition of representative blood pressure (BP) to indicate that the BP reading must occur on or after the second diagnosis of hypertension.

- Revised the event/diagnosis criteria to include enrollees who had at least two visits on different dates of service with a diagnosis of hypertension during the measurement year or the year prior to the measurement year.
- Removed the diabetes flag identification from the event/diagnosis criteria.
- Incorporated telehealth into the measure specifications.
- Added exclusions for enrollees with advanced illness and frailty.
- Added blood pressure readings taken from remote patient monitoring devices that are electronically submitted directly to the provider for numerator compliance.
- Updated the Hybrid specification to indicate that sample size reduction is not allowed.
- Removed the requirement to confirm the hypertension diagnosis in the medical record.
- Updated the Notes to clarify that BP readings taken the same day as lidocaine injections and wart or mole removals should not be excluded for the numerator.

Measure CDF-HH: Screening for Depression and Follow-Up Plan

- Updated data collection method from Hybrid or EHR to Administrative or EHR.
- Added Guidance for Reporting:
  - 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 the measure.
  - 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.
  - For a Health Home enrollee to meet the depression or bipolar disorder exclusion criteria, there must be an active diagnosis for one of these conditions documented prior to any encounter during the measurement period. An active diagnosis for depression/bipolar disorder in this case indicates the absence of an end date/time of the diagnosis. Patients with active antidepressant medications listed in their medical record without an active bipolar/depression diagnosis documented in their record should not be excluded from the measure.
  - When multiple encounters that meet criteria for inclusion in the measure denominator take place in the measurement year, the most recent eligible encounter at which the screening took place should be used. The enrollee should be counted in the denominator and numerator only once based on the most recent screening documented at the eligible encounter.

    - For example, if a Health Home enrollee had a qualifying encounter in January of the measurement year and no depression screening was performed and then had a qualifying encounter in December of the same measurement year and had a depression screening, the encounter during December would be used for the measure denominator. If an enrollee had an eligible encounter during January with a depression screening performed and an encounter during December with no screening performed, the January encounter would be used for the measure denominator.
  - Include all paid, suspended, pending, and denied claims.
- Added examples of standardized Adolescent, Adult, and Perinatal Screening Tools.
- Added guidance about pharmacologic treatment for depression during pregnancy and/or lactation.
- Updated codes in Tables CDF-A and CDF-C.
- Added Table CDF-D. Codes to Identify Active Diagnosis of Depression (Exclusions), Table CDF-E. Codes to Identify Diagnosed Bipolar Disorder (Exclusions), and Table CDF-F. Code to Identify Exceptions.

Measure FUH-HH: Follow-Up After Hospitalization for Mental Illness

- Revised the measure description and denominator to include enrollees with a principal diagnosis of intentional self-harm.
- Clarified and reordered the instructions for acute and nonacute readmissions and direct transfers.
- Renamed "Exclusions" to "Nonacute readmission or direct transfer" in the Eligible Population.
- Restructured the codes and value sets for identifying the numerators. Refer to the Value Set Directory for a detailed summary of changes.
- Removed the use of a mental health diagnosis as a proxy for a visit with a mental health practitioner (all numerator events require a visit with a mental health practitioner).

Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

- Replaced MAT references with reference to "medication treatment."
- Added the Observation Value Set to the measure to account for the removal of observation codes from the IET Stand Alone Visits Value Set. Codes remain unchanged.
- Clarified the Engagement of AOD Treatment numerator.
- Clarified in the Notes that for enrollees in the "other drug abuse or dependence" cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment and that methadone is not included in the medication lists for the measure.

Measure PCR-HH: Plan All-Cause Readmissions

- Replaced the "Expected Readmission Rate" reporting category with "Count of Expected 30-Day Readmissions."
- Added Guidance for Reporting:
  - Report the Count of Expected 30-Day Readmissions for this measure to four decimal places.
  - When applying risk adjustment, include all services, whether or not the state paid for them or expects to pay for them (i.e., include denied claims). When identifying all other events, do not include denied services (i.e., only include paid services and services expected to be paid).
  - If this measure has a Count of Index Hospital Stays less than 10 and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- Revised the Planned Hospital Stay definition:
  - Removed exclusion for planned hospital stays from the Count of Index Hospital Stays and added exclusion about planned admissions to step 3 in the Count of Observed 30-Day Readmissions.
- For Risk Adjustment Weighting:
  - Revised step 6 and renamed "Expected Readmission Rate" to "Estimated Readmission Risk."
  - Added step 7 and guidance on how to calculate the "Count of Expected Readmissions."
- Updated Additional Notes:
  - 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
- Updated column headers in Table PCR-A.

Measure PQI92-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

- Added Guidance for Reporting:
  - 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.
- Added Note to measure description: "A lower rate indicates better performance."

- Removed exclusions for admissions with missing gender (SEX=missing), quarter (DQTR=missing), and county (PSTCO=missing).

IV. Technical Specifications for the Health Home Utilization Measures

Measure AIF-HH: Admission to an Institution from the Community

- Revised the measure description:
  - Include only admissions to an institution for enrollees age 18 and older who were residing in the community for at least one month.
  - Include three rates for reporting: Short-Term Stay (1 to 20 days), Medium-Term Stay (21 to 100 days), and Long-Term Stay (greater than or equal to 101 days) 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.
- Divided 65 and older age group into three age groups for reporting: 65 to 74, 75 to 84, and 85 and older.
- Added guidance to include paid claims only.
- Revised Definitions table:
  - Clarified that "Enrollee months" should only include those months during which the enrollee resided in the community for at least one day, and should not include the month that an enrollee dies or any subsequent months.
  - Replaced "Nursing Facility" with "Institutional Facility," expanding the definition to include Medicaid-certified Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs).
  - Replaced "Admission" with "Institutional Facility Admission (IFA)," clarifying that the definition includes admissions to an institutional facility from the community or from the hospital (where the hospital admission originated in the community).
  - Clarified that "community residence" can include assisted living, adult foster care, or other care in another setting that is not defined as an institution.
  - Deleted definitions of "Short-term nursing facility stay" and "Long-term nursing facility stay."
- Changed measurement period to August 1 of the year prior to the measurement year to July 31 of the measurement year.
- Changed the date for determining whether an enrollee is 18 and older and therefore eligible for the measure to the first day of the measurement year.
- Added continuous enrollment criteria requiring that an enrollee be continuously enrolled in a Health Home program for at least 30 days from August 1 of the year prior to the measurement year through July 31 of the measurement year.
- Added steps to remove from the denominator enrollee months during which the Health Home enrollee was residing in an institutional facility for the entire month, the month that

an enrollee dies, and any subsequent months after the enrollee's death (step 3 and step 4 of the denominator).

- Added step to calculate continuous enrollment and remove enrollee months for individuals who do not meet continuous enrollment criteria (step 5 of the denominator).
- Clarified in step 2 of the numerator the definition of "direct transfer:" when the discharge date from the first institutional facility setting precedes the admission date to a second institutional facility setting by one calendar day or less.
- Clarified in step 3 of the numerator that when admissions from the hospital that originated from an institution are removed from the numerator, the original IFA date should be used as the date of the new institutional facility admission.
- Added step to remove admissions from the numerator that result in death in the institution or death within 1 day of discharge (step 4 of the numerator).
- Clarified in step 5 of the numerator the process for calculating the length of stay.
- Added steps for assigning admissions to type of stay (short-, medium-, or long-term stay) and age group (18 to 64, 65 to 74, 75 to 84, and 85 and older).

Measure AMB-HH: Ambulatory Care: Emergency Department (ED) Visits

- Clarified how to identify ED visits that result in an inpatient stay.

Measure IU-HH: Inpatient Utilization

- Removed use of MS-DRGs for identification of inpatient discharge.

Appendix C: Definition of Health Home Core Set Practitioner Types

- Updated definition of Primary Care Practitioner (PCP) to include guidance on federally qualified health centers (FQHCs).