# SUMMARY OF UPDATES TO THE HEALTH HOME CORE SET MEASURES TECHNICAL SPECIFICATIONS AND RESOURCE MANUAL JULY 2016

## Overall Changes

- Updated reporting year to FFY 2016, and data collection timeframe to 2015.
- Added information about coding systems used in each measure.
- Updated specifications, value set codes, copyright, and table source information to HEDIS 2016 for all HEDIS measures.

## I. The Core Set of Health Care Quality Measures for Medicaid Health Home Programs

- Updated for more information links.

## II. Data Collection and Reporting of the Health Home Core Set

- Added guidance on using MACPro for quality measure reporting:
  - CMS has designated the Medicaid and CHIP Program (MACPro) system as the online tool that states should use when reporting Adult Core Set measures. More information on the use of MACPro for quality measure reporting is available at https://www.medicaid.gov/state-resource-center/medicaid-and-chip-program-portal/medicaid-and-chip-program-portal.html. Further information on technical assistance for MACPro is provided at the end of this chapter.
- Added guidance to the Data Collection Time Frames for Measures bullet that the look-back period should not be included in the measure start and end dates:
  - For each measure, the measurement period used to calculate the denominator should be reported in the "Start Date" and "End Date" fields in MACPro. For many measures, the denominator measurement period for FFY 2016 corresponds to calendar year 2015 (January 1, 2015–December 31, 2015). Some measures, however, also require states to review utilization or enrollment prior to this period to identify the measure-eligible population. States should not include these review periods (sometimes referred to as "look-back" periods) in the Start and End date range. Further information regarding measurement periods is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/fy-2016-hh-measurement-periods.pdf.
- Added bullet on the Anchor Date with guidance on determining an individual's eligibility for a measure:
  - Some measures include an anchor date, which is the date that an individual must be enrolled and have the required benefit to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure's FFY 2016

measurement period (December 31, 2015). For other measures, the anchor date is based on a specific event, such as a birthdate or a delivery date. States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.

- Added bullet on Enrollees with Partial Benefits with guidance about when to include enrollees with partial benefits in the measure denominator.
  - 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.
- Updated the bullet on Reporting a Weighted Rate with guidance for how to enter measure information in MACPro:
  - 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 MACPro. If the state has the numerator and denominator that were used to calculate the Health Home Program-Level rate, they should be entered in the Numerator and Denominator fields. If this information is not available, a state can enter "0" in the Numerator and Denominator fields, report the Health Home Program-Level rate in the "Rate" field, and explain the missing information in the "Additional Notes/Comments on Measure" section. If possible, the state should also provide the numerators, denominators, measure-eligible population, and rates for each Health Home provider in this section as well as a description of the method used to calculate the Health Home Program-Level rate (including the approach used for weighting).
- Added bullet with information about how to calculate measures affected by the conversation from ICD-9 to ICD-10 codes:
  - 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. The following Adult Core Set measures are affected by this conversion: ABA, PCR, PQI92, FUH, CBP, IET, AMB, and IU.
  - For HEDIS measures, the ICD-10 codes are included in the value set directory. For PQI-92, the ICD-10 codes are available at http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2016-HH-ICD10-Codes.zip.
- Added information on Reporting and Submission to include information about MACPro.

## III. Technical Specifications

### Measure ABA: Adult Body Mass Index Assessment

- Modified age references from "19 years" to "20 years."

- Revised numerator language for the administrative method:
  - For Health Home enrollees age 20 or older on the date of service, BMI (BMI Value Set) during the measurement year or the year prior to the measurement year.
  - For Health Home enrollees younger than age 20 on the date of service, BMI percentile (BMI Percentile Value Set) during the measurement year or the year prior to the measurement year.
- Revised medical record review language for the hybrid method:
  - For Health Home enrollees age 20 and older on the date of service, documentation in the medical record must indicate the weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The weight and BMI must be from the same data source.
  - For Health Home enrollees younger than age 20 on the date of service, documentation in the medical record must indicate the height, weight and BMI percentile, dated during the measurement year or year prior to the measurement year. The weight and BMI percentile must be from the same data source.

### Measure CDF: Screening for Clinical Depression and Follow-Up Plan

- Updated CPT codes in Table CDF-A to align with Version 9.1 of the measure specifications.
- Updated e-measure specification to 2015.

### Measure PCR: Plan All-Cause Readmission Rate

- Added definition of the classification period for the measure.
- Added instructions and value sets to identify acute inpatient admissions and discharges.
- Added language clarifying which stay should be used to identify exclusions in cases of acute-to-acute transfers.
- Added language clarifying that states must use their own methods to identify "transfers."

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

- Updated Guidance for Reporting:
  - Follow the detailed specifications to (1) include the appropriate discharge when the patient 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 patient was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- Added guidance to include benefit of Medical and mental health (inpatient and outpatient).
- Added instructions and value sets to identify acute inpatient discharges, readmissions, and transfers.
- Added language clarifying that states must use their own methods to identify "transfers."

- Updated acute facility readmission or direct transfer language:
  - If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

### Measure CBP: Controlling High Blood Pressure

- Updated Guidance for Reporting:
  - To identify the eligible population for this measure, states should use administrative data to select all enrollees who had an outpatient visit with a diagnosis of hypertension during the first six months of the measurement year (January 1, 2015–June 30, 2015). To identify the denominator, states should then review the enrollee's medical record to confirm the hypertension diagnosis, which can be recorded anytime during the enrollee's history on or before June 30 of the measurement year. If the enrollee's diagnosis cannot be confirmed then exclude the enrollee.
- Updated event/diagnosis section:
  - Added HCPCS codes to the value set to identify outpatient visits. The new value set name is Outpatient Without UBREV Value Set.
- Revised the diabetes flag for the numerator:
  - Updated how the diabetes flag is assigned. Removed the criteria for polycystic ovaries when assigning a flag of "not diabetic."
  - Added that those who are not initially assigned a diabetes flag are classified as "not diabetic."
- Updated Table CBP-A to reflect the current NDC list.
- Added language to the hybrid denominator section:
  - If the diagnosis of hypertension cannot be confirmed, the Health Home enrollee is excluded and replaced by the next enrollee from the oversample.
- Updated the optional exclusions section to include instructions and value sets for identifying nonacute inpatient admissions.
- Clarified that a problem list found in an office visit note should be considered a dated problem list and the date of the visit must be used.
- Added a note to clarify when states may change a diabetes flag that was assigned based on administrative data.
- Updated e-measure specification to 2015.

### Measure CTR: Timely Transmission of Transition Record

- Updated Guidance for Reporting:

- Age groups should be based on age as of December 31st of the measurement year.
- The measure includes transfers between hospitals, but excludes transfers within the same facility.
- The intent of the measure is to capture whether the inpatient facility sent a transition record including all required elements, as shown in Figure CTR-A. It is not necessary to confirm the transition record was received by the health care provider designated for follow-up care.

- Added language to the definition of "transmitted":
  - The time and method of transmission should be documented to assess whether transmission was timely.
- Added language to the definition of "current medication list":
  - The current medication list should include, at a minimum, medications in the following categories (including prescription, herbal products and over-the-counter medications):

    Medications to be TAKEN by patient: Medications prescribed or recommended prior to inpatient stay to be continued after discharge, AND new medications started during the inpatient stay to be continued after discharge. Prescribed or recommended dosage, instructions, and intended duration must be included for each continued and new medication listed.

    Medications NOT to be taken by patient: Medications (prescriptions, herbal products and over-the-counter medications) taken by patient before the inpatient stay that should be discontinued or held after discharge, AND medications administered during the inpatient stay that caused an allergic reaction, AND medications with which current prescriptions may react.
- Modified the definition of "contact information/plan for follow-up care":
  - For enrollees discharged to an inpatient facility, the transition record may indicate that the four elements of 24-hour/7-day contact information are to be discussed between the discharging and the "receiving" facilities, including (1) physician for emergencies related to inpatient stay, (2) contact information for obtaining results of studies pending at discharge, (3) plan for follow-up care, and (4) primary physician, other healthcare professional, or site designated for follow-up care.
- Added a code for "discharged/transferred to court/law enforcement" to Table CTR-B to align with the current version of the measure specifications.
- Added a field for "principal diagnosis at discharge" to Figure CTR-A to align with the current version of the measure specifications.

### Measure IET: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

- Modified the "IESD" definition:
  - For direct transfers, the IESD is the discharge date from the last admission.

- Added guidance to include benefit of medical and chemical dependency (inpatient and outpatient) but that Health Home enrollees with detoxification-only chemical dependency benefits do not meet these criteria.
- Updated event/diagnosis section and numerator specification to include instructions and a value set for identifying acute and nonacute inpatient discharges.
- Clarified that the timeframe for initiation of AOD treatment (rate 1) is on the IESD or in the 13 days after the IESD (14 total days), if the Index Episode was an outpatient, intensive outpatient, partial hospitalization, detoxification, or ED visit.
- Clarified the timeframe for engagement of AOD treatment (rate 2):
  - For Health Home enrollees who initiated treatment via an inpatient admission, the 29-day period for the two engagement visits begins the day after discharge.
  - The time frame for engagement, which includes the initiation event, is 30 total days.
- Updated e-measure specification to 2015.

### Measure PQI92: PQI 92 Chronic Conditions Composite

- Updated Guidance for Reporting:
  - 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" section in MACPro.
  - In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/2016-HH-ICD10-Codes.zip.
- Updated ICD-9-CM codes in Table PQI92-D, Table PQI92-G, Table PQI92-I, Table PQI92-L, and Table PQI92-M to align with Version 5.0 of the measure specifications.

### Measure IU: Inpatient Utilization

- Added instructions and value sets to identify acute inpatient discharges.