
ODM Methods for Clinical Performance Measures

**For
Medicaid Health Homes**

DRAFT

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OVERVIEW

Methodology

These methods are, for the most part, consistent with the HEDIS performance measurement methods, as outlined in the NCQA HEDIS 2013 Technical Specifications manual. They were modified according to ODM's preferences. All HEDIS requirements for continuous enrollment were removed; in general, the primary enrollment requirement for the Health Homes measures is that members must be enrolled in a Health Home during the last month of the report period.

Unless otherwise noted, codes in HEDIS are stated to the minimum specificity required. For example, if a code is presented to the third digit, any valid fourth or fifth digits may be used for HEDIS reporting. When necessary, a code may be specified with an "x," representing a required digit, which is consistent with the HEDIS 2013 Technical Specifications manual.

Data Sources

All appropriate managed care plan (MCP) encounter data, fee-for-service (FFS) claims data, and Health Home data will be used for the purposes of calculating these performance measures. The encounter and claims data will not be limited to Health Home claims.

Report Period

Report periods vary by measure due to the implementation of Health Homes on October 1, 2012. CPT Category II codes were not submitted prior to October 1, 2012; therefore, numerators that exclusively rely on CPT Category II codes will be limited to the period after the implementation of the Health Homes Initiative. However, where appropriate, denominators will be selected from a full year of data.

ASTHMA

Use of Appropriate Medications for People with Asthma (ASM)

The percentage of members 5 through 64 years of age with persistent asthma who were enrolled in a Health Home during the last month of the report period and received prescribed medications acceptable as primary therapy for long-term control of asthma.

Numerator: For each member in the denominator, those who had at least one dispensed prescription for inhaled corticosteroids, inhaled steroid combinations, antibody inhibitor, antiasthmatic combinations, leukotriene modifiers, mast cell stabilizers, or methylxanthines during the report period (Table ASM-E).

Denominator: Members 5 through 64 years of age who were enrolled in the Health Home during the last month of the reporting period and were identified as having persistent asthma during both the report period and the year prior to the report period (Table ASM-A).

Exclusions: Exclude from the eligible population (i.e., denominator) all members diagnosed with emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, or acute respiratory failure (Table ASM-F) any time on or prior to the last day of the reporting period.

Report Periods:

- Report Period 1: TBD
- Report Period 2: TBD

Table ASM-A: Methods to Identify Members with Persistent Asthma

Members must meet one of the four criteria below during both the reporting year and the year prior to the reporting year (criteria need not be the same across both years).

1. Member has at least one emergency department visit (Table ASM-C) with asthma as the principal diagnosis (Table ASM-B).
2. Member has at least one acute inpatient discharge (Table ASM-C) with asthma as the principal diagnosis (Table ASM-B).
3. Member has at least four outpatient asthma visits (Table ASM-C) on different dates of service, with asthma as one of the listed diagnoses (Table ASM-B) and at least two asthma medication dispensing events (Table ASM-D).
4. Member has at least four asthma medication dispensing events (i.e., an asthma medication dispensed on four occasions) (Table ASM-D).** A member with at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed will be excluded from the denominator unless the member also has at least one diagnosis of asthma (Table ASM-B) in any setting in the same year as the leukotriene modifier.

A list of NDC codes for the appropriate denominator (i.e., members with persistent asthma) asthma medications may be found at www.ncqa.org.

****Note:** The definition of dispensing event differs depending on whether the drug is oral or an inhaler/injection. For oral medications, a dispensing event for oral medications is defined as one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions lasting longer than 30 days, divide the drug quantity by 30 and rounded down to convert. For example, a 100-day prescription is equal to 3 dispensing events ($100/30=3.33$, rounded down to 3).

Multiple prescriptions for different oral medications dispensed on the same day should be assessed separately. If multiple prescriptions for the same oral medication are dispensed on the same day, the organization should sum the days supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different (the Drug ID is obtained from NCQA’s list of NDC codes).

- Two prescriptions for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each)
- Two prescriptions for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each)
- Two prescriptions for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days supply for a total of 30 days)
- Two prescriptions for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days supply for a total of 120 days)

Inhalers and injections count as one dispensing event. For example, an inhaler with a 90-days supply is considered one dispensing event. Multiple inhalers or injections of the same medication (as identified by Drug ID in NCQA’s NDC list) filled on the same date of service should be counted as multiple dispensing events. The organization should allocate the dispensing events to the appropriate year based on the date on which the prescription is filled.

Table ASM-B: Codes to Identify Asthma

Diagnosis	ICD-9-CM Diagnosis Codes
Asthma	493.0, 493.1, 493.8, 493.9

Table ASM-C: Codes to Visit Type

Description	CPT Codes	UB Revenue Codes
Acute Inpatient	99221-99223, 99231-99233, 99238-99239, 99251-99255, 99291	010X, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987
Emergency Department (ED) services	99281-99285	045x, 0981
Outpatient Visit	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983

Table ASM-D: Asthma Medications

Description	Prescriptions		
Antiasthmatic combinations	<ul style="list-style-type: none"> • dyphylline-guaifenesin 	<ul style="list-style-type: none"> • guaifenesin-theophylline 	<ul style="list-style-type: none"> • potassium iodide-theophylline
Antibody inhibitor	<ul style="list-style-type: none"> • omalizumab 		
Inhaled steroid combinations	<ul style="list-style-type: none"> • budesonide-formoterol 	<ul style="list-style-type: none"> • fluticasone-salmeterol 	<ul style="list-style-type: none"> • mometasone-formoterol
Inhaled corticosteroids	<ul style="list-style-type: none"> • beclomethasone • budesonide • ciclesonide 	<ul style="list-style-type: none"> • flunisolide • fluticasone CFC free 	<ul style="list-style-type: none"> • mometasone • triamcinolone
Leukotriene modifiers	<ul style="list-style-type: none"> • montelukast 	<ul style="list-style-type: none"> • zafirlukast 	<ul style="list-style-type: none"> • zileuton
Long-acting, inhaled beta-2 agonists	<ul style="list-style-type: none"> • aformoterol • indacaterol 	<ul style="list-style-type: none"> • formoterol 	<ul style="list-style-type: none"> • salmeterol
Mast cell stabilizers	<ul style="list-style-type: none"> • cromolyn 	<ul style="list-style-type: none"> • nedocromil 	
Methylxanthines	<ul style="list-style-type: none"> • aminophylline • dyphylline 	<ul style="list-style-type: none"> • oxtriphylline • theophylline 	
Short-acting, inhaled beta-2 agonists	<ul style="list-style-type: none"> • albuterol • levalbuterol 	<ul style="list-style-type: none"> • metaproterenol • pirbuterol 	
<p><i>NCQA provides a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org).</i></p>			

Table ASM-E: Asthma Controller Medications

Description	Prescriptions		
Antiasthmatic combinations	<ul style="list-style-type: none"> • dyphylline-guaifenesin 	<ul style="list-style-type: none"> • guaifenesin-theophylline 	<ul style="list-style-type: none"> • potassium iodide-theophylline
Antibody inhibitor	<ul style="list-style-type: none"> • omalizumab 		
Inhaled steroid combinations	<ul style="list-style-type: none"> • budesonide-formoterol 	<ul style="list-style-type: none"> • fluticasone-salmeterol 	<ul style="list-style-type: none"> • mometasone-formoterol
Inhaled corticosteroids	<ul style="list-style-type: none"> • beclomethasone • budesonide • ciclesonide 	<ul style="list-style-type: none"> • flunisolide • fluticasone CFC free 	<ul style="list-style-type: none"> • mometasone • triamcinolone
Leukotriene modifiers	<ul style="list-style-type: none"> • montelukast 	<ul style="list-style-type: none"> • zafirlukast 	<ul style="list-style-type: none"> • zileuton
Mast cell stabilizers	<ul style="list-style-type: none"> • cromolyn 	<ul style="list-style-type: none"> • nedocromil 	
Methylxanthines	<ul style="list-style-type: none"> • aminophylline • dyphylline 	<ul style="list-style-type: none"> • oxtriphylline • theophylline 	
<p><i>NCQA provides a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org).</i></p>			

Table ASM-F: Codes to Identify Required Exclusions

Description	ICD-9-CM Diagnosis Codes
Emphysema	492, 518.1, 518.2
COPD	491.2, 493.2, 496, 506.4
Cystic fibrosis	277.0
Acute respiratory failure	518.81

CARDIOVASCULAR CARE

Cholesterol Management for Patients with Cardiovascular Condition (CMC)

The percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) during the first ten months of the year prior to the report period, or who had a diagnosis of ischemic vascular disease (IVD) during the report period and the year prior to the report period, who had an LDL-C level of less than 100 mg/dL.

Numerator: The number of members in the denominator whose most recent LDL-C test (Table CMC-D) was less than 100 mg/dL (CPT II code 3048F).¹

Denominator: The number of members 18 to 75 years of age who were enrolled in a Health Home during the last month of the report period and meet one of the following:

- Discharged alive for AMI, CABG, or PCI (Table CMC-A) during the first ten months of the year prior to the report period. AMI and CABG should be from inpatient claims/encounters only (Table CMC-C). All cases of PCI should be included, regardless of setting (e.g., inpatient, outpatient, emergency department [ED]).
- At least one IVD diagnosis (Table CMC-B) during either an outpatient or an acute inpatient encounter (Table CMC-C) in both the report period and the year prior to the report period.

Report Periods:

- Report Period 1: TBD
- Report Period 2: TBD

¹ Note: The numerator for this measure may be lower than actual results given that the Health Homes began submitting CPT Category II codes October 1, 2012.

Table CMC-A: Codes to Identify AMI, PCI, and CABG

Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes
AMI (include only inpatient claims)			410.x1	
CABG (include only inpatient claims)	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209		36.1, 36.2
PCI	92980, 92982, 92995	G0290		00.66, 36.06, 36.07

Table CMC-B: Codes to Identify IVD

Description	ICD-9-CM Diagnosis Codes
IVD	411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445

Table CMC-C: Codes to Identify Visit Type

Description	CPT Codes	UB Revenue Codes
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 0982, 0983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 0987

Table CMC-D: Codes to Identify LDL-C Screening

Description	CPT Category II Codes
LDL-C less than 100 mg/dL	3048F
LDL-C 100-129 mg/dL	3049F
LDL-C greater than or equal to 130 mg/dL	3050F

Controlling High Blood Pressure (CBP) *

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the report period.

Numerator: The number of members in the denominator whose most recent BP (Table CBP-C) after the diagnosis of hypertension is adequately controlled. For a member’s BP to be adequately controlled, the systolic BP must be less than 140 (CPT II codes 3074F or 3075F) and the diastolic BP must be less than 90 (CPT II codes 3078F or 3079F).²

Denominator: The number of members age 18 to 85 who were enrolled during the last month of the report period and had at least one outpatient visit (Table CBP-B) with a diagnosis of hypertension (Table CBP-A) during the first six months of the report period.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table CBP-A: Codes to Identify Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

Table CBP-B: Codes to Identify Outpatient Visits

Description	CPT Codes
Outpatient visits	99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

² Note: The numerator for this measure may be lower than actual results given that the Health Homes only began submitting CPT Category II codes October 1, 2012.

Table CBP-C: Codes to Identify BP Measurements

Description	CPT Category II Codes
Systolic blood pressure less than 130	3074F
Systolic blood pressure 130-139	3075F
Systolic blood pressure 140 or greater	3077F
Diastolic blood pressure less than 80	3078F
Diastolic blood pressure 80-89	3079F
Diastolic blood pressure 90 or greater	3080F

DIABETES CARE

Comprehensive Diabetes Care: HbA1c Level Below 7.0 Percent (CDC1)

The percentage of members 18–75 years of age with diabetes (Types 1 and 2) who were enrolled in a Health Home during the last month of the report period, and who had a Hemoglobin A1c (HbA1c) less than 7.0 percent.

Numerator: The number of members in the denominator whose most recent Hemoglobin A1c (HbA1c) test (Table CDC-F) had levels less than 7.0 percent (CPT Category II Code 3044F) during the report period (Table CDC-F). The member is not numerator compliant if the result for the most recent HbA1c test is greater than or equal to 7.0 percent or if an HbA1c test was not performed during the report period.

Denominator: The number of members with Type 1 or 2 diabetes (Table CDC-A) age 18 through 75 who were enrolled in a Health Home during the last month of the report period.

Exclusions for HbA1c rate: For the HbA1c rate, exclude members from the denominator who meet any of the criteria provided below. Use Table CMC-E unless otherwise specified.

- 65 years of age and older as of the last day of the report period.

CABG or PCI: Members discharged alive for CABG or PCI in the report period or the year prior to the report period. Refer to Table CDC-E and use codes for PCI and CABG only. CABG cases should be from inpatient claims/encounters only. Use both facility and professional claims to identify CABG.

- Include all cases of PCI, regardless of setting (e.g., inpatient, outpatient, ED).
- **IVD:** Members who met at least one of the following criteria during both the report period and the year prior to the report period. Criteria need not be the same across both years.
 - At least one outpatient visit (Table CDC-D) with an IVD diagnosis (Table CDC-E), **or**
 - At least one acute inpatient claim/encounter (Table CDC-D) with an IVD diagnosis (Table CDC-E)
- **Thoracic aortic aneurysm:** Members who met at least one of the following criteria during both the report period and the year prior to the report period. Criteria need not be the same across both years.
 - At least one outpatient visit (Table CDC-D) with a thoracic aortic aneurysm diagnosis (Table CDC-E), **or**
 - At least one acute inpatient claim/encounter (Table CDC-D) with a thoracic aortic aneurysm diagnosis (Table CDC-E).
- **Chronic heart failure (CHF):** Members who had at least one encounter, in any setting, with a code to identify CHF (Table CDC-E). Look as far back as possible in the member's history through of the end of report period.

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- *Prior myocardial infarction (MI)*: Members who had at least one encounter, in any setting, with any code to identify (Table CDC-E). Look as far back as possible in the member’s history through of the end of report period.
- *Chronic renal failure (CRF)/end stage renal disease (ESRD)*: Members who had at least one encounter, in any setting, with a code to identify CRF/ESRD (Table CDC-E). Look as far back as possible in the member’s history through of the end of report period.
- *Dementia*: Members who had at least one encounter, in any setting, with a code to identify dementia (Table CDC-E). Look as far back as possible in the member’s history through of the end of report period.
- *Blindness*. Members who had at least one encounter, in any setting, with a code to identify blindness (Table CDC-E). Look as far back as possible in the member’s history through of the end of report period.
- *Amputation (lower extremity)*: Members who had at least one encounter, in any setting, with a code to identify lower extremity amputation (Table CDC-E). Look as far back as possible in the member’s history through of the end of report period.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table CDC-A: Methods to Identify Diabetic Members

Methods to Identify Diabetic Members*	
Method 1: Pharmacy	
Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics (Table CDC-B).	
Method 2: Inpatient, Outpatient, & Emergency Department Visits	
Members who had:	
i.	Two (2) visits with different dates of service in an outpatient or nonacute inpatient setting (Table CDC-D) with a diagnosis of diabetes (Table CDC-C), OR
ii.	One (1) visit in an acute inpatient <u>or</u> emergency department setting (Table CDC-D) with a diagnosis of diabetes (Table CDC-C)
<i>*To be included in the measure, a member needs to be identified using <u>only one</u> method. Members are included in the denominator if they are identified as diabetic in either the report period or the year prior to the report period.</i>	

Table CDC-B: Prescriptions to Identify Diabetics Using Pharmacy Data

Description	Prescription
Alpha-glucosidase inhibitors	<ul style="list-style-type: none"> • acarbose • miglitol
Amylin analogs	<ul style="list-style-type: none"> • pramlintide
Antidiabetic combinations	<ul style="list-style-type: none"> • glimepiride-pioglitazone • glimepiride-rosiglitazone • glipizide-metformin • glyburide-metformin • metformin-pioglitazone • metformin-rosiglitazone • metformin-sitagliptin • saxagliptan • sitagliptan-simvastatin
Insulin	<ul style="list-style-type: none"> • insulin aspart • insulin aspart-insulin aspart protamine • insulin detemir • insulin glargine • insulin glulisine • insulin inhalation • insulin isophane beef-pork • insulin isophane human • insulin isophane-insulin regular • insulin lispro • insulin lispro-insulin lispro protamine • insulin regular human • insulin zinc human
Meglitinides	<ul style="list-style-type: none"> • nateglinide • repaglinide
Miscellaneous antidiabetic agents	<ul style="list-style-type: none"> • exenatide • liraglutide • sitagliptin • metformin-repaglinide
Sulfonylureas	<ul style="list-style-type: none"> • acetohexamide • chlorpropamide • glimepiride • glipizide • glyburide • tolazamide • tolbutamide
Thiazolidinediones	<ul style="list-style-type: none"> • pioglitazone • rosiglitazone
<p>Note: Glucophage/metformin is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only. A comprehensive list of medications and NDC codes are available on NCQA's Web site, www.ncqa.org.</p>	

Table CDC-C: Codes to Identify Diabetes

Description	ICD-9-CM Diagnosis Codes
Diabetes	250, 357.2, 362.0, 366.41, 648.0

Table CDC-D: Codes to Identify Visit Type

Description	CPT Codes	UB Revenue Codes
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	051x, 0520-0523, 0526-0529, 057x-059x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337	0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987
Emergency Department	99281-99285	045x, 0981

Table CDC-E: Codes to Identify HbA1c Denominator Exclusions

Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes	UB Revenue Codes	UB Type of Bill	POS Codes
CABG or PCI	33510-33514, 33516-33519, 33521-33523, 33533-33536, 92980, 92982, 92995	S2205-S2209, G0290		36.1, 36.2, 00.66, 36.06, 36.07			
IVD			411, 413, 414.0, 414.2, 414.8, 414.9, 429.2, 433-434, 440.1, 440.2, 440.4, 444, 445				
Thoracic aortic aneurysm			441.01, 441.03, 441.1, 441.2, 441.6, 441.7				
MI			410, 412				

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Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes	UB Revenue Codes	UB Type of Bill	POS Codes
CRF/ESRD	36145, 36147, 36800, 36810, 36815, 36818-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512	G0257, G0311-G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339	585.4, 585.5, 585.6, V42.0, V45.1	38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98	080x, 082x-085x, 088x	72x	65
Blindness			369.0, 369.1, 369.2, 369.4, 369.6, 369.7				
Amputation (lower extremity)	27290, 27295, 27590-27592, 27594, 27596, 27598, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28800, 28805, 28810, 28820, 28825			84.1			
CHF			425, 428				
Dementia			290, 291.2, 292.82, 294.0-294.2, 331.0, 331.1, 331.82				

Table CDC-F: Codes to Identify HbA1c Levels

Description	CPT Category II Codes
HbA1c <7.0%	3044F
HbA1c ≥7.0%	3045F, 3046F

Comprehensive Diabetes Care: Cholesterol Management (CDC2)

The percentage of members 18–75 years of age with diabetes (Types 1 and 2) who were enrolled in a Health Home during the last month of the report period, and who had (1) LDL-C screening and (2) LDL-C level less than 100 mg/dL.

Numerator: The number of members in the denominator who met each of the following:

1. Had an LDL-C screening (Table CDC-G)
2. Whose most recent LDL-C screening (Table CDC-H) during the report period is less than 100 mg/dL (CPT Category II code 3048F). If the result for the most recent LDL-C test during the last quarter of the report period is ≥ 100 mg/dL or if an LDL-C test was not performed during the report period, the member is not numerator compliant.³

Denominator: The number of members with diabetes (Table CDC-A) age 18 through 75 who were enrolled in a Health Home during the last month of the report period.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table CDC-G: Codes to Identify LDL-C Screening

CPT	CPT Category II Codes
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F

Table CDC-H: Codes to Identify LDL-C Levels

Description	CPT Category II Codes
LDL-C <100 mg/dL	3048F
LDL-C 100-129 mg/dL	3049F
LDL-C ≥ 130 mg/dL	3050F

³ Note: The numerator for this measure may be lower than actual results given that the Health Homes only began submitting CPT Category II codes October 1, 2012.

MENTAL ILLNESS OUTCOMES

Screening for Clinical Depression and Follow-up Plan (SCD)*

The percentage of members 18 years of age and older who were enrolled in a Health Home during the last month of the report period who received screening for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Numerator: The number of members in the denominator who received screening and follow-up for depression. Members are included in the numerator if they 1) were screened for depression and the screen was negative, or 2) were screened for depression with a positive result and had either a follow-up plan documented or a follow-up mental health visit. Numerator compliance can be determined with either of two methods:

1. Codes that indicate both screening and appropriate follow-up (Table SCD-B).
2. Codes that indicate screening for depression (Table SCD-C) occurring in conjunction with an ODMH service or visit with a mental health practitioner (Table SCD-D).

Denominator: Members age 18 years and older (as of the encounter date) who were enrolled in the health home during the last month of the report period and who had a qualifying encounter (Table SCD-A).

Exclusion: Members with a diagnosis of depression (SCD-C) or bipolar disorder (Table SSD-E).

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table SCD-A: Codes to Identify Qualifying Encounters

CPT	HCPCS
90791, 90792, 90832, 90834, 90837, 90839, 90801, 90802, 90804- 90809, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201-99205, 99212-99215	G0101, G0402, G0438, G0439, G0444

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table SCD-B: Codes to Identify Compliance for both Screening and Follow-Up

Description	HCPCS
Positive screen, follow-up plan documented	G8431
Negative screen	G8510
Screen not appropriate	G8433

Table SCD-C: Codes to Identify Screening for Depression

CPT Codes	HCPCS
90801	H0031, G8511

Table SCD-D: Codes to Identify Mental Health Practitioner

Provider Type		Specialty Code
04	<i>AND</i>	042
20		213
42		420
51		511, 512
65		213
72		213
84		840, 841

Follow-up After Hospitalization for Mental Illness (FUH)*

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner, and who received follow-up within seven days of discharge.

Numerator: The number of discharges for which the member received follow-up on the date of discharge or within seven days of discharge. Follow-up includes an outpatient visit, intensive outpatient encounter, or partial hospitalization (Table FUH-E) with a mental health practitioner.

Denominator: The number of discharges for members 6 years of age and older who were enrolled in a health home during the last month of the report period and were discharged alive from an acute inpatient setting with a principal mental health diagnosis (Table FUH-A) during the first 11 months of the report period. Use only facility claims to identify discharges. Do not use diagnoses from professional claims. In addition, the member must have been enrolled in Medicaid on discharge through seven days after discharge.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table FUH-A: Codes to Identify Mental Health Diagnosis

Description	ICD-9-CM Diagnosis Codes
Mental health diagnosis	295–299, 300.3, 300.4, 301, 308, 309, 311–314

If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (Table FUH-B or FUH-C) within the seven-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after the 11th month of the report period.

Exclude discharges followed by readmission or direct transfer to a *nonacute facility* for a mental health principal diagnosis (Table FUH-B or FUH-C) within the seven-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place. Refer to Table FUH-D for codes to identify nonacute care.

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Exclude discharges in which the beneficiary was transferred directly or readmitted within the seven days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. This includes an ICD-9-CM Diagnosis code or DRG code other than those in Tables FUH-B and FUH-C. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Table FUH-B: Codes to Mental Health Diagnosis for Readmissions/Transfers

Description	ICD-9-CM Diagnosis Codes
Mental health diagnosis	290, 293-302, 306-316

Table FUH-C: Codes to Identify Inpatient Services

Description	DRGs	AND NOT	ICD-9-CM Principal Diagnosis Codes
Inpatient Services	876, 880-887	<i>AND NOT</i>	317-319

Table FUH-D: Codes to Identify Nonacute Care

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

Table FUH-E: Codes to Identify Visits

CPT Codes		HCPCS
Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner (Table FUH-F).		
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510		G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485
CPT Codes		POS
Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner (Table FUH-F).		
90801*, 90792**, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862*, 90863**, 90870, 90875, 90876	<i>WITH</i>	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72
99221-99223, 99231-99233, 99238, 99239, 99251-99255	<i>WITH</i>	52, 53
*This code is to be used on all discharges prior to January 1, 2013. ** This code is to be used on all discharges on or after January 1, 2013.		
CPT Category II		Modifier
1110F	<i>WITH</i>	U4
UB Revenue Codes		
The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes.		
0513, 0900-0905, 0907, 0911-0917, 0919		
Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code from Table FUH-A.		
0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983		

Table FUH-F: Methods to Identify Mental Health Practitioner

Provider Type	WITH	Specialty Codes
04	<i>WITH</i>	042
20	<i>WITH</i>	213
42	<i>WITH</i>	420
51	<i>WITH</i>	511 or 512
65	<i>WITH</i>	213
72	<i>WITH</i>	213
84	<i>WITH</i>	840 or 841

SUBSTANCE ABUSE

Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)*

***Initiation:** The percentage of members diagnosed with AOD dependence who initiate treatment through an inpatient AOD admission, or an outpatient service with an AOD service within 14 days of diagnosis.*

***Engagement:** The percentage of members who initiated treatment and who have two or more additional AOD services within 30 days after the date of the initiation visit (inclusive).*

Numerator:

Initiation of AOD Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

1. Identify all members in the denominator whose index episode was an inpatient discharge with any AOD diagnosis. This visit counts as the initiation event.
2. Identify all members in the denominator whose index episode start date was an outpatient, intensive outpatient, partial hospitalization, detoxification, or emergency department visit. Use Table IET-B and Table IET-A to determine if the members had an additional outpatient visit or inpatient admission with any AOD diagnosis within 14 days of the index episode start date (inclusive). If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the index episode start date (inclusive).
3. Exclude from the denominator members whose initiation service was an inpatient stay with a discharge date during the last month of the report period.
4. Note: Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as being initiation of treatment.

Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions (Table IET-P), outpatient visits, intensive outpatient encounters or partial hospitalizations (Table IET-B) with any AOD diagnosis (Table IET-A) within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 30-day engagement period. If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 30 days of the Initiation encounter (inclusive). Do not count engagement encounters that include detoxification codes (including inpatient detoxification)

Denominator: Members 13 years and older who were enrolled in a Health Home during the last month of the report period and had a new episode of AOD during the first ten and a half months of the report period. Follow the steps below to determine new episodes of AOD.

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Step 1: Identify the index episode. Identify members who had one of the following during the first ten and a half months of the report period.

- An outpatient visit, intensive outpatient encounter, or partial hospitalization (Table IET-B) with a diagnosis of AOD (Table IET-A)
- A detoxification visit (Table IET-C)
- An ED visit (Table IET-D) with a diagnosis of AOD (Table IET-A)
- An inpatient discharge with a diagnosis of AOD as identified by either of the following.
 - An inpatient facility code (Table IET-F) in conjunction with a diagnosis of AOD (Table IET-A)
 - An inpatient facility code (Table IET-F) in conjunction with an AOD procedure code (Table IET-E)

Step 2: Determine the index episode start date. For each member identified in step 1, determine the index episode start date by identifying the date of the member’s earliest encounter during the report period (e.g., outpatient, detoxification or emergency department visit date; inpatient discharge date). For members whose first episode was an ED visit that resulted in an inpatient stay, use the inpatient discharge.

Step 3: Determine if the index episode start date is a new episode. Members with a new episode of AOD dependence have a negative diagnosis history, defined as a period of 60 days prior to the Index Episode Start date, during which the member had no claims/encounters with any diagnosis of AOD dependence (Table IET-A). For members with an inpatient visit, use the admission date to determine negative diagnosis history. For ED visits that result in an inpatient admission, use the ED date of service to determine the negative diagnosis history.

Step 4: Calculate continuous enrollment. The member must be continuously enrolled in Medicaid without any gaps for 60 days prior through 44 days after the index episode start date.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table IET-A: Codes to Identify AOD Dependence

ICD-9-CM Diagnosis Codes
291-292, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

Table IET-B: Codes to Identify Outpatient, Intensive Outpatient, and Partial Hospitalization Visits

CPT Codes		HCPCS Codes	UB Revenue Codes	
90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99408, 99409, 99411, 99412, 99510	<i>OR</i>	G0155, G0176, G0177, G0396, G0397, G0409-G0411, G0443, H0001, H0002, H0004, H0005, H0007, H0015, H0016, H0020, H0022, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2035, H2036, M0064, S0201, S9480, S9484, S9485, T1006, T1012	<i>OR</i>	0510, 0513, 0515-0517, 0519-0523, 0526-0529, 0900, 0902-0907, 0911-0917, 0919, 0944, 0945, 0982, 0983
CPT Codes		POS Codes		
90801, 90802, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876	<i>WITH</i>	03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 57, 71, 72		
90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99233, 99238, 99239, 99251-99255	<i>WITH</i>	52, 53		

Table IET-C: Detoxification Services Codes

HCPCS Codes		ICD-9-CM Procedure Codes		UB Revenue Codes
H0008-H0014	<i>OR</i>	94.62, 94.65, 94.68	<i>OR</i>	0116, 0126, 0136, 0146, 0156

Table IET-D: Emergency Department Services Codes

CPT Codes		UB Revenue Codes
99281-99285	<i>OR</i>	045x, 0981

Table IET-E: Codes to Identify AOD Procedures

ICD-9-CM Procedure Codes	HCPCS Codes		UB Revenue Codes	Provider Type
94.61, 94.63, 94.64, 94.66, 94.67, 94.69		<i>WITH</i>	11x, 12x, 18x, 21x, 22x, 41x, 42x, 84x	
	H0003-H0005, H0007, H0014-H0016, H0020, A9999	<i>WITH</i>		95

Table IET-F: Codes to Identify Inpatient Services

UB Bill Type Codes
11x, 12x, 18x, 21x, 22x, 41x, 42x, 84x

Smoking & Tobacco Use Cessation (MSC)

The percentage of tobacco-using members who received a tobacco cessation intervention.

Numerator: The number of tobacco-using members who received a tobacco cessation intervention (Table MSC-B) during the report period.⁴

Denominator: The number of members who were enrolled in the Health Home during the last month of the report period who were identified as tobacco users during the report period (Table MSC-A).

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table MSC-A: Codes to Identify Tobacco Users

ICD-9-CM Diagnosis Codes	CPT Category II Codes
305.1, 649.0, 989.84	1034F, 1035F

Table MSC-B: Codes to Identify Tobacco Cessation Interventions

CPT Category II Codes	Prescription
4000F, 4001F, 4004F	<i>OR</i> Chantix, smoking cessation patch (therapeutic classes J3A, J3C, or H7N)

⁴ Note: The numerator and denominator may differ from actual results given that the Health Homes began submitting CPT Category II codes October 1, 2012.

PREVENTIVE CARE

Timeliness of Prenatal Care (PPC1)

NOTE: This measure will not be calculated until a full year of Health Home data are available.

The percentage of deliveries who had their first prenatal visit within 42 days of Health Home enrollment or by the end of the first trimester for those women who were enrolled in the Health Home during the early stage of pregnancy.

Numerator: One (or more) prenatal care visit(s) within 42 days of enrollment in the Health Home or within the first trimester if the member was already enrolled in the Health Home.

Denominator: The eligible population.

Report Period: TBD

Denominator:

Step 1: Identify all women with a live birth between November 6 of the year prior to the report year, and November 5 of the report year. Women who are identified through the codes listed in Table PPC-A are automatically included in the eligible population and require no further verification of the outcome.

Women who were not identified through the codes listed in Table PPC-A may be identified through any of the codes listed in the Table PPC-B. Deliveries not resulting in a live birth should be excluded.

Step 2: For women identified in Step 1, determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.

Table PPC-A: Codes to Identify Live Births

ICD-9-CM Diagnosis Codes	ICD-9-CM Diagnosis Codes (must have a matching delivery encounter)
650 -Normal Delivery	V30 - Single liveborn
V27.0 - Single liveborn	V31 - Twin, mate liveborn
V27.2 - Twins, both liveborn	V32 - Twin, mate stillborn
V27.3 - Twins, one liveborn and one stillborn	V33 - Twin, unspecified
V27.5 - Other multiple birth, all liveborn	V34 - Other multiple, mates all liveborn
V27.6 - Other multiple birth, some liveborn	V35 - Other multiple, mates all stillborn
	V36 - Other multiple, mates live- and stillborn
	V37 - Other multiple, unspecified
	V39 - Unspecified

Table PPC-B: Codes Used To Identify Deliveries and Verify Live Births

Identify Deliveries
<p><u>ICD-9-CM Procedure Codes:</u></p> <p>72.x Forceps, vacuum, and breech delivery 73.x Other procedures inducing or assisting delivery 74.0 Cesarean section and removal of fetus; Classical cesarean section 74.1 Cesarean section and removal of fetus; Low cervical cesarean section 74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section 74.4 Cesarean section and removal of fetus; Cesarean section of other specified type 74.99 Cesarean section of unspecified type</p> <p><u>ICD-9-CM Diagnosis Codes:</u></p> <p>640.x1, 641.x1, 642.x1, 642.x2, 643.x1, 644.21, 645.x1, 646.x1, 646.x2, 647.x1, 647.x2, 648.x1, 648.x2, 649.x1, 649.x2, 651.x1, 652.x1, 653.x1, 654.x1, 654.x2, 655.x1, 656.01, 656.11, 656.21, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.x1, 659.x1, 660.x1, 661.x1, 662.x1, 663.x1, 664.x1, 665.x1, 665.x2, 666.x2, 667.x2, 668.x1, 668.x2, 669.x1, 669.x2, 670.02, 671.x1, 671.x2, 672.02, 673.x1, 673.x2, 674.x1, 674.x2, 675.x1, 675.x2, 676.x1, 676.x2, 678.x1, 679.x1, 679.x2</p>

IDENTIFY DELIVERIES (Continued)

CPT Codes:

59400 Routine obstetrical care including antepartum and postpartum care and vaginal delivery
59409 Vaginal delivery (with or without episiotomy and/or forceps)
59410 Obstetrical care for vaginal delivery only, including postpartum care
59510 Cesarean delivery
59514 Cesarean delivery only
59515 Cesarean delivery only; including postpartum care
59610 VBAC delivery
59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614 VBAC care after delivery; vaginal delivery only, after previous cesarean delivery, including postpartum care
59618 Attempted VBAC delivery
59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622 Attempted VBAC after care, cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery, including postpartum care

Exclude Deliveries Not Resulting in a Live Birth:

ICD-9-CM Diagnosis Codes:

630-637 Other abnormal product of conception, hydatidiform mole, ectopic or abdominal pregnancy, missed or spontaneous abortion, legally/illegally induced abortion, legally unspecified abortion
639 Complications following abortion or ectopic and molar pregnancies
656.4 Intrauterine death affecting management of mother
768.0 Fetal death from asphyxia or anoxia before onset of labor or at unspecified time
768.1 Fetal death from asphyxia or anoxia during labor
V27.1 Outcome of delivery, single stillborn
V27.4 Outcome of delivery, twins, both stillborn
V27.7 Outcome of delivery, other multiple birth, all stillborn

The infant record contains (or is supposed to contain) the infant's Medicaid identification number. Therefore, it is necessary to match these encounters against the delivery encounters to obtain the mother's recipient identification number, which is used to obtain the prenatal visits and to identify whether a C-section delivery occurred. Listed below are the codes used to identify deliveries.

Mother and baby claims are unduplicated by Medicaid recipient ID, with preference given to Inpatient type bill.

Mothers who deliver twice in the same year are included twice in this analysis.

Table PPC-C: Methods for Matching Infants and Mothers

Methods for Matching Infants and Mothers Encounters

The infants and mothers encounters are matched using the following two methods:

1) Same last name, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay;

OR

2) Same address and zip code, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay.

If a newborn encounter matches to more than one mother delivery encounter and, consequently, it is not possible to determine which mother the newborn is associated with, then the matched encounter will not be included in the denominator. However, it continues to be possible for the mother's encounter to be included in the denominator if the mother's encounter contains one of the following diagnosis codes:

- 650 - Normal Delivery
- V27.0 - Single liveborn
- V27.2 - Twins, both liveborn
- V27.3 - Twins, one liveborn and one stillborn
- V27.5 - Other multiple birth, all liveborn
- V27.6 - Other multiple birth, some liveborn

Numerator Specifications:

Only include visits that occur while member was enrolled.

Step 3: Determine if women identified in step 2 were enrolled on or before 280 days prior to delivery or estimated date of delivery (EDD). For these women, go to step 4. For women not enrolled on or before 280 days prior to delivery or EDD, go to step 6.

Step 4: Determine if women identified in step 3 were continuously enrolled during the first trimester (176-280 days prior to delivery or EDD) with no gaps in enrollment. For these women, use one of the four decision rules to determine if there was a prenatal visit during the first trimester. For women not continuously enrolled during the first trimester, go to step 5.

Step 5: For women who had a gap between 176-280 days prior to delivery, proceed to step 6.

Step 6: For women identified in steps 3 and 5, determine the last enrollment start date (i.e., the enrollment start date during the pregnancy that is closest to the delivery date).

For women whose last enrollment started on or between 219-279 days prior to delivery, go to step 7. For women whose last enrollment started less than 219 days prior to delivery, go to step 8.

Step 7: If the last enrollment segment started on or between 219-279 days prior to delivery, determine numerator compliance using the Table PPC-D and find a visit between the last enrollment start date and 176 days prior to delivery.

Step 8: If the last enrollment segment started less than 219 days prior to delivery, determine numerator compliance using the Table PPC-D and find a visit within 42 days after enrollment.

Prenatal Care Visit Codes

There are four decision rules for identifying prenatal visits.

Decision Rule 1:	
Any prenatal care visit to an OB practitioner, a midwife or family practitioner or other PCP* with documentation of when prenatal care was initiated.	
CPT	Description
59400	Routine obstetric care including antepartum care, vaginal delivery and postpartum care
59425	Antepartum care only; 4-6 visits
59426	Antepartum care, 7 or more visits
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care, after previous cesarean delivery
59618	Routine obstetric care including antepartum care, vaginal delivery, and postpartum care following attempted vaginal delivery after previous cesarean delivery
CPT	Description
Category II	Description
0500F	Initial prenatal care visit
0501F	Prenatal flow sheet
0502F	Subsequent prenatal care

* See Table PPC-E.

Decision Rule 2: The member must meet criteria in [Part A and (Part B or Part C)] or Part D.		
Any visit to an OB practitioner or midwife* with one of the following: <ul style="list-style-type: none"> • Obstetric panel • TORCH antibody panel • Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing) • Ultrasound (echocardiography) of pregnant uterus • Pregnancy-related diagnosis code 		
PART A: Any one code		
CPT Codes		UB Revenue Codes
99201-99205, 99211-99215, 99241-99245, 99500		0514
PART B: Any one code		
CPT Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes
76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 80055	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28	88.78
PART C: A code for each of the following:		
CPT = 86644 (Cytomegalovirus) CPT = 86694, 86695, 86696 (Herpes simplex) CPT = 86762 (Rubella) CPT = 86777 (Toxoplasma) OR A code for Rubella <i>and</i> (ABO <i>or</i> Rh): CPT = 86762 (Rubella) CPT = 86900 (ABO) CPT = 86901 (Rh)		
PART D:		
HCPCS		CPT Codes
H1000-H1004, H1005		99500

* Provider Type = 71 or 72, **OR** Physician Specialty Code = 212, 219, 275, or 290.

Decision Rule 3: The member must meet criteria in Part A and (Part B or Part C).

Any visit to a family practitioner or other PCP* with a pregnancy related ICD-9-CM Diagnosis code AND one of the following:

- Obstetric panel
- TORCH antibody panel
- Rubella antibody/titer with Rh incompatibility (ABO/Rh blood typing)
- Ultrasound of the pregnant uterus

PART A: (CPT with ICD-9-CM Diagnosis Code) or (UB Revenue Code with ICD-9-CM Diagnosis Code). The diagnosis code must be the same as the CPT/UB revenue code.

CPT Codes	UB Revenue Codes	ICD-9-CM Diagnosis
99201-99205, 99211-99215, 99241-99245	0514	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28

PART B: Any one code

CPT Codes	ICD-9-CM Procedure Codes
76801, 76805, 76811, 76813, 76815-76821, 76825-76828, 80055	88.78

PART C: A code for each of the following—

CPT = 86644 (Cytomegalovirus)
 CPT = 86694, 86695, 86696 (Herpes simplex)
 CPT = 86762 (Rubella)
 CPT = 86777 (Toxoplasma)
 OR
 A code for Rubella *and* (ABO *or* Rh):
 CPT = 86762 (Rubella)
 CPT = 86900 (ABO)
 CPT = 86901 (Rh)

* See Table PPC-E.

Decision Rule 4: The member must meet criteria in Part A or Part B.

Any visit to a family practitioner or other PCP* with diagnosis-based evidence of prenatal care in the form of a documented EDD with either a complete obstetric history or risk assessment and counseling/education.

PART A: Any one code.

CPT Codes	UB Revenue Code
99201-99205, 99211-99215, 99241-99245	0514

PART B: (Any one code)

HCPCS	CPT Codes
H1000-H1004, H1005	99500

* See Table PPC-E.

Table PPC-D: Markers for Prenatal Care

Markers for Prenatal Care: The member must meet criteria in Part A or (Part B and Part C).		
PART A: Any one code.		
CPT Codes	HCPCS Codes	CPT Category II Codes
59400, 59425, 59426, 59510, 59610, 59618, 99500	H1000-H1004, H1005	0500F, 0501F, 0502F
PART B: Any one code.		
CPT Codes	ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes
76801, 76805, 76811, 76813, 76815-76821, 76825-76828	640.x3, 641.x3, 642.x3, 643.x3, 644.x3, 645.x3, 646.x3, 647.x3, 648.x3, 649.x3, 651.x3, 652.x3, 653.x3, 654.x3, 655.x3, 656.x3, 657.x3, 658.x3, 659.x3, 678.x3, 679.x3, V22-V23, V28	88.78
PART C: Any one code.		
CPT Codes	UB Revenue Codes	
99201-99205, 99211-99215, 99241-99245	0514	

Table PPC-E: Codes to Identify Primary Care Practitioners (PCPs)

Provider Type	Physician Specialty Code	Other
01 (General Hospital) 04 (Outpatient Health Facility) 05 (Rural Health Facility) 09 (Maternal/Child Health Clinic - 9 mo.) 12 (Federally Qualified Health Center) 50 (Comprehensive Clinic) 52 (Public Health Dept. Clinic) 65 (Certified Nurse, Specialist) 71 (Certified Nurse, Midwife) 72 (Certified Nurse, Practitioner)	201, 203, 205, 206, 207, 208, 209, 210, 212, 213, 214, 215, 219, 229, 233, 234, 235, 263, 264, 274, 275, 290, 297, 320, 321, 324, 325, 326, 327, 328, 329, 330, 331, 333, 335, 337, 341, 342, 363, 721	Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where specialty code is 362 (unspecified) or is not indicated.

Adult BMI Assessment (ABA)*

The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the report period or the year prior to the report period.

Numerator: The number of members meeting denominator criteria who had a BMI assessment during the report period or the year prior to the report period.

Denominator: The number of members 18 to 74 years of age who were enrolled in a Health Home during the last month of the report period and had an outpatient visit (Table ABA-A) during the report period or the year prior to the report period.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table ABA-A: Codes to Identify Outpatient Visits

CPT Codes	HCPCS Codes	UB Revenue Codes
99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456	G0402	051x, 0520-0523, 0526-0529, 0982, 0983

Table ABA-B: Codes to Identify BMI/Weight Assessments

CPT Codes	CPT Category II Codes	ICD-9-CM Diagnosis Codes
G8417-G8420	3008F, 2001F	V85.0-V85.5

Exclusion: Exclude members who had a diagnosis of pregnancy during the report period or the year prior to the report period (Table ABA-C).

Table ABA-C: Codes to Identify Pregnancies

Description	ICD-9-CM Diagnosis Codes
Pregnancy	630-679, V22, V23, V28

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Adolescent Well-Care Visits (AWC)

The percentage of members 12 - 21 years of age during the report year who were enrolled in a Health Home during the last month of the report year and who received at least one comprehensive well-care visit with a PCP or OB/GYN during the report year.

Numerator: Members with at least one comprehensive well-child visit (Table AWC-A) with a PCP or OB/GYN (Table AWA-B) practitioner during the report year.

Denominator: Members age 12 to 21 who were enrolled in a Health Home during the last month of the report period.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table AWC-A: Codes to Identify Adolescent Well-Care Visits

CPT	HCPCS Codes	ICD-9-CM Diagnosis Codes
99383-99385, 99393-99395	G0438, G0439	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Table AWC-B: Codes to Identify Primary Care Providers

Provider Type	Physician Specialty Code	Other
01 (General Hospital) 04 (Outpatient Health Facility) 05 (Rural Health Facility) 09 (Maternal/Child Health Clinic - 9 mo.) 12 (Federally Qualified Health Center) 50 (Comprehensive Clinic) 52 (Public Health Dept. Clinic) 65 (Certified Nurse, Specialist) 71 (Certified Nurse, Midwife) 72 (Certified Nurse, Practitioner)	201, 203, 205, 206, 207, 208, 209, 210, 212, 213, 214, 215, 219, 229, 233, 234, 235, 263, 264, 274, 275, 290, 297, 320, 321, 324, 325, 326, 327, 328, 329, 330, 331, 333, 335, 337, 341, 342, 363, 721	Provider Type of 20 (Physician, Individual), 21 (Physician, Group), 22 (Osteopath, Individual), or 23 (Osteopath, Group) where specialty code is 362 (unspecified) or is not indicated.

Adults' Access to Preventive/Ambulatory Health Services (AAP)

The percentage of members 20 years and older enrolled in a Health Home during the last month of the report period who had an ambulatory or preventive care visit.

Numerator: The number of members who meet the denominator criteria and had an ambulatory or preventive care visit during the report period (Table AAP-A).

Denominator: The number of members 20 year of age and older enrolled in a Health Home during the last month of the report period.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table AAP-A: Codes to Preventive/Ambulatory Health Services

Description	CPT Codes	HCPCS Codes	ICD-9-CM Diagnosis Codes	UB Revenue Codes
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Appropriate Treatment for Children with Upper Respiratory Infections (URI)

The percentage of children 3 months–18 years of age given a diagnosis of upper respiratory infection (URI) who were not dispensed an antibiotic prescription.

Numerator: The number of members in the denominator who were dispensed an antibiotic prescription (Table URI-D) within three days of the episode date.

Denominator: Children 3 months – 18 years of age who were given a diagnosis of URI (Table URI-A), had a 30 day negative medication history prior to the episode date, and did not have a competing diagnosis (Table URI-C) on the same day as or for three days after the episode date. To be included in the measure, members must be enrolled in the Health Home for the month the episode occurs, and have been enrolled in Medicaid the month prior to the episode date. Determine qualifying occurrences of URI as outlined below.

Step 1: Identify all members who had an outpatient or ED visit (Table URI-B) with only a diagnosis of URI (Table URI-A) during the 12 month window beginning 6 months prior to the start of the measurement year. Exclude claims/encounters with more than one diagnosis.

Step 2: Determine all URI Episode Dates. For each member identified in Step 1, determine all outpatient or ED claims/encounters with only a URI diagnosis.

Step 3: Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table URI-D) was filled 30 days prior to the Episode Date or was active on the Episode Date.

Step 4: Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing diagnosis (Table URI-C) on or three days after the Episode Date.

Step 5: Calculate continuous enrollment. The member must be continuously enrolled in Medicaid without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date.

Step 6: Select the Index Episode Start Date. This measure examines the earliest eligible episode per member.

Calculation: The measure is reported as an inverted rate [$1 - (\text{numerator}/\text{eligible population})$]. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed).

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table URI-A: Codes to Identify URI

Description	ICD-9-CM Diagnosis Codes
Acute nasopharyngitis (common cold)	460
URI	465

Table URI-B: Codes to Identify Visit Type

Description	CPT Codes	UB Revenue Codes
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99381-99385, 99391-99395, 99401-99404, 99411, 99412, 99420, 99429	051x, 0520-0523, 0526-0529, 0982, 0983
ED*	99281-99285	045x, 0981

*Do not include ED visits that result in an inpatient admission.

Table URI-C: Codes to Identify Competing Diagnoses

Description	ICD-9-CM Diagnosis Codes
Intestinal infections	001-009
Pertussis	033
Bacterial infection unspecified	041.9
Lyme disease and other arthropod-borne diseases	088
Otitis media	382
Acute sinusitis	461
Acute pharyngitis	034.0, 462
Acute tonsillitis	463
Chronic sinusitis	473
Infections of the pharynx, larynx, tonsils, adenoids	464.1-464.3, 474, 478.21-478.24, 478.29, 478.71, 478.79, 478.9
Prostatitis	601
Cellulitis, mastoiditis, other bone infections	383, 681, 682, 730
Acute lymphadenitis	683
Impetigo	684
Skin staph infections	686
Pneumonia	481- 486
Gonococcal infections and venereal diseases	098, 099, V01.6, V02.7, V02.8
Syphilis	090-097
Chlamydia	078.88, 079.88, 079.98
Inflammatory diseases (female reproductive organs)	131, 614-616
Infections of the kidney	590
Cystitis or UTI	595, 599.0
Acne	706.0, 706.1

Table URI-D: Antibiotic Medications

Description	Prescription	
Aminopenicillins	<ul style="list-style-type: none"> • Amoxicillin 	<ul style="list-style-type: none"> • Ampicillin
Beta-lactamase inhibitors	<ul style="list-style-type: none"> • Amoxicillin-clavulanate 	
First generation cephalosporins	<ul style="list-style-type: none"> • Cefadroxil • Cefazolin 	<ul style="list-style-type: none"> • Cephalexin
Folate antagonist	<ul style="list-style-type: none"> • Trimethoprim 	
Lincomycin derivatives	<ul style="list-style-type: none"> • Clindamycin 	
Macrolides	<ul style="list-style-type: none"> • Azithromycin • Clarithromycin • Erythromycin • Erythromycin ethylsuccinate 	<ul style="list-style-type: none"> • Erythromycin lactobionate • Erythromycin stearate
Miscellaneous antibiotics	<ul style="list-style-type: none"> • Erythromycin-sulfisoxazole 	
Natural penicillins	<ul style="list-style-type: none"> • Penicillin G potassium • Penicillin G sodium 	<ul style="list-style-type: none"> • Penicillin V potassium
Penicillinase-resistant penicillins	<ul style="list-style-type: none"> • Dicloxacillin 	
Quinolones	<ul style="list-style-type: none"> • Ciprofloxacin • Levofloxacin 	<ul style="list-style-type: none"> • Moxifloxacin • Ofloxacin
Second generation cephalosporins	<ul style="list-style-type: none"> • Cefaclor • Cefprozil 	<ul style="list-style-type: none"> • Cefuroxime • Loracarbef
Sulfonamides	<ul style="list-style-type: none"> • Sulfamethoxazole-trimethoprim 	<ul style="list-style-type: none"> • Sulfisoxazole
Tetracyclines	<ul style="list-style-type: none"> • Doxycycline • Minocycline 	<ul style="list-style-type: none"> • Tetracycline
Third generation cephalosporins	<ul style="list-style-type: none"> • Cefdinir • Cefixime • Cefpodoxime 	<ul style="list-style-type: none"> • Ceftibuten • Cefditoren • Ceftriaxone
<p><i>NCQA provides a comprehensive list of medications and NDC codes on its Web site (www.ncqa.org).</i></p>		

UTILIZATION

Ambulatory Care—Sensitive Condition Admission (SCA)*

The acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital, per 100,000 population younger than 75 years of age.

Numerator: The total number of acute care hospitalizations for members under 75 years of age with an ambulatory care sensitive condition as a primary diagnosis (Table SCA-A).

Denominator: The total number of Health Home members under 75 years of age at the midpoint of the report period.

Exclusions: Deaths prior to discharge.

Formula: (Total number of acute care hospitalizations for ambulatory care sensitive conditions younger than 75 years of age / total mid-year population younger than 75 years of age) x 100,000.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table SCA-A: Codes to Identify Sensitive Conditions

Description	Primary ICD-9-CM Diagnosis Codes		Secondary ICD-9-CM Diagnosis Codes
Grand mal status and other epileptic convulsions	345		
COPD	491, 492, 494, 496		
	466, 480–486, 487.0	<i>AND</i>	496
Asthma	493		
Diabetes	250.0, 250.1, 250.2, 250.8		
Heart failure and pulmonary edema	428, 518.4	<i>AND NOT</i>	336, 35xx, 36xx, 373x, 375x, 377x, 378x, 379.4–379.8
Hypertension	401.0, 401.9, 402.0, 402.1, 402.9		
Angina	411.1, 411.8, 413		

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Inpatient & ED Utilization—Rates (UTL)

The number of inpatient, emergency department, AOD, and mental health inpatient discharges per thousand member months.

Numerators:

1. Total Inpatient Discharges (Table UTL-A) excluding the services in Table UTL-B.
2. Total ED visits (Table UTL-C) excluding mental health and chemical dependency services (Table UTL-D). ED visits that result in an inpatient stay should not be counted toward this measure. In addition, only one ED visit should be counted per date of service.
3. Total AOD Inpatient Discharges, as determined by either of the following criteria.
 - a. An inpatient facility code (Table UTL-A) in conjunction with any diagnosis of chemical dependency (Table UTL-E), *or*
 - b. A code in Table UTL-F
4. Total Mental Health Discharges, as determined by either of the following criteria.
 - a. An inpatient facility code (Table UTL-A) in conjunction with a principal mental health diagnosis (Table UTL-G), *or*
 - b. DRGs (Table UTL-H)

Denominator: The number of Health Home member months.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table UTL-A: Codes to Identify Inpatient Discharges

Principal ICD-9-CM Diagnosis Codes		MS-DRG
001-289, 317-999, V01-V29, V40-V90	<i>OR</i>	001-008, 010-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999
<i>WITH</i>		
UB Type of Bill		
11x, 12x, 41x, 84x	<i>OR</i>	Any acute inpatient facility code

Table UTL-B: Codes to Identify Exclusions

Principal ICD-9-CM Diagnosis Codes	<i>WITH</i>	Secondary ICD-9-CM Diagnosis Codes
960-979		291-292, 303-305

Table UTL-C: Codes to Identify ED Visits

CPT Codes		UB Revenue Codes
99281-99285		045x, 0981
<i>OR</i>		
CPT Codes	<i>WITH</i>	POS Codes
10040-69979		23

Table UTL-D: Codes to Identify Exclusions for Emergency Department Visits

CPT Codes	Principal ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Codes
90801-90899	290-316	94.26, 94.27, 94.6
<i>OR</i>		
Principal ICD-9-CM Diagnosis Codes	Secondary ICD-9-CM Diagnosis Codes	
960-979	<i>WITH</i>	
		291-292, 303-305

Table ULT-E: Codes to Identify Chemical Dependency Diagnosis

ICD-9-CM Diagnosis Codes
291-292, 303-304, 305.0, 305.2-305.9, 535.3, 571.1

Table UTL-F: Codes to Identify Inpatient Services

ICD-9-CM Procedure Codes	MS—DRG Codes
94.6x <i>WITH</i> an inpatient facility code	894-897

Table UTL-G: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis Codes
290, 293-302, 306-316

Table UTL-H: Codes to Identify Inpatient Services

MS-DRG Codes
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

All-Cause Readmission (ACR)*

For members 18 years of age and older, the percentage of acute inpatient stays during the report period that were followed by an acute readmission for any diagnosis within 30 days.

Numerator: The number of acute 30-day readmissions for any diagnosis.

Denominator: All Health Home member acute inpatient discharges that occur during the report period prior to the first day of the last month of the report period for members 18 years of age and older in which the beneficiary is enrolled in a Health Home in the last month of the report period. In addition, the member had to be enrolled in Medicaid through 30 days after discharge.

Step 1: Using only institutional claims (Table ACR-A), identify all acute inpatient stays (Table ACR-B) with a discharge date during the report period prior to the first day of the last month of the report period. Include acute admissions to behavioral healthcare facilities. Exclude nonacute inpatient rehabilitation services, including nonacute inpatient stays at rehabilitation facilities.

Step 2: Acute-to-acute transfers: Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date.

Step 3: Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4: Exclude any acute inpatient stay with a discharge date in the 30 days prior to the Index Admission Date.

Step 5: Exclude stays for the following reasons:

- Inpatient stays with discharges for death.
- Acute inpatient discharge with a principal diagnosis for pregnancy or for any other condition originating in the perinatal period in Table ACR-C.

Step 6: Calculate continuous enrollment.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table ACR-A: Codes to Identify Institutional Claims

Type of Bill
0111, 0121, 0114, 0124

Table ACR-B: Codes to Identify Visit Type

Description	CPT	UB Revenue
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x, 021x, 072x, 080x, 0987

Table ACR-C: Codes to Identify Maternity Related Inpatient Discharges

Description	ICD-9-CM Diagnosis Codes
Pregnancy	630-679, V22, V23, V28
Conditions originating in the perinatal period	760-779, V21, V29-V39

CARE COORDINATION

Timely Transmission of Transition Record (TTR)*

Percentage of members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the Health Home within 24 hours of discharge.

Numerator: Members for whom a transition record was transmitted to the Health Home within 24 hours of discharge for each discharge during the report period (Table TTR-C).

Denominator: All members enrolled in a Health Home during the last month of the report period, regardless of age, who were discharged from an inpatient facility to home/self-care or any other site of care, excluding members who died, left against medical advice, or discontinued care.

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table TTR-A: Codes to Identify Members Discharged from an Inpatient Facility

Description	Type of Bill Codes	Discharge Status
Hospital inpatient	0111, 0121, 0114, 0124	AND 01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70

Table TTR-B: Codes to Identify Denominator Exclusions

Description	Discharge State
Left against medical advice	07
Expired	20
Expired at home	40
Expired in a medical facility	41
Expired—place unknown	42

* This measure is a CMS Health Home Core Quality Measure. Methodology provided for these Core Measures may undergo revisions once CMS releases the full measure specifications.

Table TTR-C: Codes to Identify Transition Record Transmission

Description	CPT Category II Codes		Modifier
Discharge with transition record within 24 hours	1110F	AND	U3

Medication Reconciliation Post-Discharge (MRP)

Percentage of members, regardless of age, discharged to home or self-care from an inpatient facility for whom medications were reconciled on or within 30 days of discharge.

Numerator: Members in the denominator for whom medication reconciliation (i.e. discharge medications are reconciled with the most recent medication list in the outpatient medical record) was conducted by a prescribing practitioner, clinical pharmacist or registered nurse on or within 30 days of discharge. A member had medication reconciliation if a claim contains a code in Table MRP-A: Codes to Identify Discharge Medications Reconciled With Medication List.

Denominator: All members enrolled in a health home during the last month of the report period, regardless of age, who were discharged from an inpatient facility (Table MRP-B), excluding members who died, left against medical advice, or discontinued care (Table TTR-B).

Readmission or direct transfer: Exclude discharges where the discharge was followed by readmission or direct transfer to an acute or nonacute facility within the 30-day follow-up period.

Ages: Report two age stratifications and a total rate:

- 18 years and younger on the date of discharge
- 19 years and older on the date of discharge
- Total – sum of the age stratifications

Report Period:

- Report Period 1: TBD
- Report Period 2: TBD

Table MRP-A: Codes to Identify Discharge Medications Reconciled With Medication List

Description	CPT Category II Codes
Discharge medications reconciled with the current medication list in outpatient medical record	1111F

Table MRP-B: Codes to Identify Members Discharged from an Inpatient Facility

Description	Type of Bill Codes	Discharge Status
Hospital Inpatient	0111, 0121, 0114, 0124	AND 01, 06, 50
Skilled nursing facility	0211, 0214, 0221, 0224, 0281, 0284	