HUMAN SERVICES
DEPARTMENT

Michelle Lujan Grisham, Governor
David R. Scrase, M.D., Secretary Designate
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Letter of Direction #16

Date: **September 16, 2019**

To: **Centennial Care 2.0 Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division** KLA for NC

Subject: **Tracking Measure Reporting Requirements <u>Repeal & Replace LOD #3</u>**

Title: **Tracking Measure Reporting Requirements**

Pursuant to the Centennial Care 2.0 Professional Services Agreement, Centennial Care Managed Care Organizations (MCOs) are required to submit regular reports to the Human Services Department (HSD), Medical Assistance Division (MAD), Quality Bureau (QB) for the following Tracking Measures (TM):

TM #1 - Fall Risk Management
TM #2 - Diabetes Short-Term Complications Admission Rate
TM #3 - Screening for Clinical Depression and Follow-up Plan
TM #4 - Follow-up after Hospitalization for Mental Illness
TM #5 - Immunizations for Adolescents
TM #6 - Long Acting Reversible Contraceptive (LARC)
TM #7 - Smoking Cessation
TM #8 - Ambulatory Care
TM #9 - Annual Dental Visit
TM #10 - Controlling High Blood Pressure

Reporting elements and data are to be provided to HSD in the same format as the template attached to this Letter of Direction. The reporting period is based upon one (1) quarter of a calendar year (e.g., Q1 Total=January-March). For the measurement period, please refer to the relevant technical specifications. A MCO may only refresh data for up to two (2) quarters of the current calendar year which precedes the reporting period. If a report includes data which has been refreshed beyond two (2) quarters, the report will be rejected by HSD. The report must be submitted within twenty-five (25) calendar days from the end of each reporting period. If the twenty-fifth (25^{th}) calendar day is not a business day, then the report must be submitted the following business day. If HSD requests any revisions to reports previously submitted by a MCO, the MCO shall make the changes and re-submit the reports according to the time frame set forth by HSD.

For HSD to remain in compliance with reporting requirements, the data for TM #2, Diabetes Short-Term Complications Admission Rate, must be submitted within fifteen (15) calendar days from the end of each reporting period. If the fifteenth (15^{th}) calendar day is not a business day, then the report must be submitted the following business day.

The naming convention for this report is: MCO.HSDLODX.QXCYXX.vX. If the proper naming convention is not used, the report will be rejected by HSD.

The following specifications shall be used for reporting on TM #1 - Fall Risk Management: The percentage of Medicaid Members, sixty-five (65) years of age and older, who had a fall or had problems with balance or walking in the past twelve (12) months, who were seen by a practitioner in the past twelve (12) months and who received fall risk intervention from their current practitioner.

Numerator: Number of Medicaid Members, sixty-five (65) years of age and older, that have a claim with a date of service in the measurement period with an ICD/CPT code in Table 1, Fall Risk Management Codes.

Denominator: Number of Medicaid Members, sixty-five (65) years of age and older, during the measurement period.

Table 1
Fall Risk Management Codes:

ICD10	CPT Codes
Z91.81	0518F
W10.0XXA-W10.9XXD	1100F-1101F
W10.2XXA-W12.XXXD	3288F
W13.0XXA-W13.9XXD	
W16.011A-W17.4XXD	
W09.0XXA-W17.89	
V00.141A-W18.49XD	
W03.XXXA-V00.388D	
W19.XXXA	
W01.10XA-W19.XXD	
R26.0-R26.9	
R21.0-R27.9	
R29.6-R29.91	

The following specifications shall be used for reporting TM #2, Diabetes Short-Term Complications Admission Rate: The number of inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for Medicaid Members age eighteen (18) and older. The MCO must use the CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year.

The following specifications shall be used for reporting TM #3, Screening for Clinical Depression and Follow-Up Plan: The percentage of Medicaid Members age eighteen (18) and older screened 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. The MCO must use the CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for the relevant reporting year.

The following specifications shall be used for reporting TM #4, Follow-up after Hospitalization for Mental Illness: Percent of seven-day follow-up visits into community-based behavioral health care for child and for adult Members released from inpatient psychiatric hospitalizations stays of four (4) or more days.

Inpatient Psychiatric Facility/Unit (IPF) – Discharges: Discharges for Members, six (6) years of age or older at the time of discharge, who were hospitalized for treatment of mental health disorders for a continuous period of four (4) days or more (i.e., discharge date more than three days after admission date). Includes only psychiatric units in general hospitals and freestanding psychiatric hospitals. For tracking discharges and follow-ups, claims data should be used.

Follow-up after Hospitalization for Mental Illness: Discharges for Members six years of age or older at the time of discharge, who were hospitalized for treatment of mental health disorders for a continuous period of four (4) days or more and who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within seven (7) calendar days of discharge. The follow-up service can be any service considered as outpatient, intensive outpatient or recovery treatment.

The following specifications shall be used for reporting TM #5, Immunizations for Adolescents: The percentage of adolescents thirteen (13) years of age who had one dose of meningococcal vaccine, and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), or one tetanus, diphtheria toxoids vaccine (Td), by their thirteenth (13^{th}) birthday. Report rates for each vaccine and the Combination 1 rate using the most current HEDIS technical specifications for the relevant reporting year, excluding the human papillomavirus (HPV) vaccine.

The following specifications shall be used for reporting TM #6, Long Acting Reversible Contraceptive (LARC): The MCO shall measure the use of Long-Acting Reversible Contraceptives (LARC) among Members ages fifteen (15) to nineteen (19). The MCO shall report LARC insertion/utilization data for this measure to the HSD on a quarterly and annual basis using ICD 10, CPT, HCPCS and NDC codes in Table 2, LARC Utilization Codes.

Table 2

LARC Utilization Codes:

ICD10	CPT	HCPCS	NDC
Z30.430	11981	J7300	52027201
Z30.433	11983	J7301	52027401
Z30.431	58300	J7302	52433001
Z30.49		J7306	50419042101
Z97.5		J7307	50419042201
T83.6XXA		J7297	5128520401
		J7298	

The following specifications shall be used for reporting TM #7, Smoking Cessation: The MCO shall monitor the use of smoking cessation products and counseling utilized as identified in Table 3, Smoking Cessation Utilization.

Table 3

Smoking Cessation Product and Service Utilization

Unduplicated Members receiving nicotine replacement therapy/treatment (NRT)	
Medication/Drug	**Pharmacy GPI Code**
Bupropion 150 MG	62100002107430
Chantix 0.5 MG	62100080200320
Chantix 1 MG	62100080200330
Chantix starting box	62100080206320
Chewing gum 4 MG	62100010002820
Chewing gum 2 MG	62100010002810
Patch 21-12-7 MG 24 HR	62100005006430
Nicotine Patch (OTC)	62100005008520
Nicotine Patch (OTC)	62100005008530
Nicotine Patch (OTC)	62100008005540
Lozenge 4 MG	62100010004720
Lozenge 2 MG	62100010004710
Transdermal System	62100005006430
Nasal Spray 10 MG	62100005002020
Inhaler	62100005002410
Unduplicated Members receiving smoking cessation counseling	
Counseling Services	**CPT**
Intermediate	99406
Intensive	99407
Non-physician classes	S9453
Counseling in absence of	G9016

or addition to any other E&M code (6-10 min)	
Quitline Coaching	
Number of calls/quit coach interactions	
Other	
Any other cessation treatments not previously listed.	

The following specifications shall be used for reporting TM #8, Ambulatory Care: Utilization of outpatient visits, including telehealth, and emergency department (ED) visits reported by all Member months for the measurement year. The MCO must use current HEDIS technical specifications for the relevant reporting year.

The following specifications shall be used for reporting TM #9, Annual Dental Visit: The percentage of enrolled Members ages two (2) to twenty (20) years who had at least one (1) dental visit during the measurement year. The MCO must use current HEDIS technical specifications for the relevant reporting year.

The following specifications shall be used for reporting TM #10, Controlling High Blood Pressure: The percentage of Members ages eighteen (18) to eighty-five (85) who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year. The MCO must use current HEDIS technical specifications for the relevant reporting year.

Attachments: LOD #3 Quarterly Reporting Templates
LFC TM2 Deliverable Template

LOD #16 Attachment 1 - TM #1 Fall Risk Management

Percentage of Medicaid Members ≥ 65 yrs. of age who had a fall or had problems with balance/walking in the past 12 months; who were seen by a practitioner in the past 12 months; and who received fall risk intervention from their current practitioner.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** April 2018-March 2019	**Q2** July 2018- June 2019	**Q3** Oct 2018- Sept 2019	**Q4** Jan 2019- Dec 2019
Number of Medicaid Members ≥65 years of age that have a claim with a date of service in the measurement period (past 12 months). Please refer to the Crosswalk tab for TM #1 Fall Risk Management ICD 10 and CPT codes. (Numerator)				
Number of Medicaid Members ≥ 65 years of age during the measurement period (past 12 months). (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** April 2019-March 2020	**Q2** July 2019- June 2020	**Q3** Oct 2019- Sept 2020	**Q4** Jan 2020- Dec 2020
Number of Medicaid Members ≥65 years of age that have a claim with a date of service in the measurement period (past 12 months). Please refer to the Crosswalk tab for TM #1 Fall Risk Management ICD 10 and CPT codes. (Numerator)				
Number of Medicaid Members ≥ 65 years of age during the measurement period (past 12 months). (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** April 2020-March 2021	**Q2** July 2020- June 2021	**Q3** Oct 2020- Sept 2021	**Q4** Jan 2021- Dec 2021
Number of Medicaid Members ≥65 years of age that have a claim with a date of service in the measurement period (past 12 months). Please refer to the Crosswalk tab for TM #1 Fall Risk Management ICD 10 and CPT codes. (Numerator)				
Number of Medicaid Members ≥ 65 years of age during the measurement period (past 12 months). (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** April 2021-March 2022	**Q2** July 2021- June 2022	**Q3** Oct 2021- Sept 2022	**Q4** Jan 2022- Dec 2022
Number of Medicaid Members ≥65 years of age that have a claim with a date of service in the measurement period (past 12 months). Please refer to the Crosswalk tab for TM #1 Fall Risk Management ICD 10 and CPT codes. (Numerator)				
Number of Medicaid Members ≥ 65 years of age during the measurement period (past 12 months). (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

*The reporting metric for this measure utilizes rolling quarters to ensure the measurement period is a minimum of 12 months.

TM #1 Fall Risk Management Analysis		through	
Reporting Period			
MCO Name			
Report Run Date			

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

LOD #16 Attachment 1 - TM #2 - Diabetes Short-Term Complications Admission Rate

Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees age 18-64.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18-64 during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18-64 during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18-64 during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18-64 during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees age 65 and older.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 65 and older. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 65 and older during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 65 and older. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 65 and older during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 65 and older. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 65 and older during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18-64 during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TM #2 - Diabetes, Short-Term Complications Admission Rate

Reporting Period		through
MCO Name		
Report Run Date		

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

LOD #16 Attachment 1 - TM #3 - Screening for Clinical Depression and Follow-Up Plan

Percentage of Medicaid enrollees age 18 to 64 screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 18-64 years of age with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 18-64 years of age with an outpatient visit during the measurement year. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 18-64 years of age with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 18-64 years of age with an outpatient visit during the measurement year. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 18-64 years of age with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 18-64 years of age with an outpatient visit during the measurement year. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 18-64 years of age with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 18-64 years of age with an outpatient visit during the measurement year. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Percentage of Medicaid enrollees age 65 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan-March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan-Dec
Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TM #3 - Screening for Clinical Depression and Follow-Up Plan

Reporting Period		through
MCO Name		
Report Run Date		

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

TRACKING MEASURE #4

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

DESCRIPTION

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of mental health disorders for four days or more and who had a follow-up visit with a mental health practitioner on or after the discharge date, within seven calendar days of discharge. Measure should be reported for two member age groups:

1. The percentage of discharges for members ages 6-17 (as of the day of discharge) which the member received follow-up within 7 days of discharge.

2. The percentage of discharges for members 18 and older (as of the day of discharge) which the member received follow-up within 7 days of discharge.

ELIGIBLE POPULATION

Medicaid beneficiaries who are enrolled with a Managed Care Organization (MCO) within Centennial Care state plan. The beneficiary must be enrolled within an MCO at the time of discharge.

Note: Members in hospice are excluded from the eligible population. Refer to General Guideline 20: Members in Hospice.

Age

Six (6) years and older at of the date the member was discharged

Event/Diagnosis

An acute inpatient discharge following a hospitalization for treatment of a mental health disorders (using the Mental Illness Value Set) for a continuous period of four (4) days or more (discharge date more than three days after admission date) during the measurement year.

To identify acute inpatient discharges:

1. Identify all hospitalizations from the "Inpatient Hospitalization – Psychiatric Free Standing or Psych. Unit (INPATIENT Category) code set table from Addendum A of HSD UM Report #41 (Table DSIT-1).
2. Identify the discharge date for hospital stays for a period of four or more continuous days.

The denominator for this measure is based on discharges for hospitalizations four days or longer, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 24 of the measurement year. Table DSIT-1: Inpatient Hospitalization – Psychiatric Free Standing or Psych. Unit (INPATIENT Category) code set

Codes: Rev/CPT/ HCPC	Description	Type and/or Age Category
Inpatient Services Category		
Inpatient Hospitalization - Psychiatric Fee Standing or Psych. Unit (INPATIENT CATEGORY)		
0114	Inpatient - Room & Board	Provider Type: 204 & 205

0124	Inpatient - Room & Board	Provider Type: 204 & 205
0134	Inpatient - Room & Board	Provider Type: 204 & 205
0144	Inpatient - Room & Board	Provider Type: 204 & 205
0154	Inpatient - Room & Board	Provider Type: 204 & 205
0204	Inpatient - Psych. ICU service	Provider Type: 201, 204, and 205

Reference: Centennial Care Reporting Instructions *Utilization Management - Report#41, Appendix A,* page 15.

Acute readmission or direct transfer

If the discharge is followed by readmission or direct transfer to an inpatient psychiatric unit of a hospital or free standing inpatient psychiatric facility (Table DSIT-1) within the 7-day follow-up period, the last discharge if the subsequent inpatient stay covered at least 4 continuous days. In the case where a member is readmitted within 7 days of discharge date but is then discharged after less than 4 continuous days both the original discharge (due to readmission within 7 days) and the readmission are excluded from the report (second stay was for less than 4 days) Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 24 of the measurement year.

To identify readmissions and direct transfers to an inpatient psychiatric unit of a hospital or free standing inpatient psychiatric facility:

1. Identify the admission date for the stay.

Exclusions

Exclude discharges followed by readmission or direct transfer to any acute or nonacute out of home based care including behavioral health residential treatment programs, group homes, foster care treatment and nursing facilities, within the 7-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) or Treatment Foster Care (HCPCS code (S5145) on the claim.
3. Identify the admission date for the stay.

Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 7-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions and direct transfers to an acute inpatient care setting:

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

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

ADMINISTRATIVE SPECIFICATION

Denominators

Ages six (6) to seventeen (17): The eligible population stated above.

Ages eighteen (18) and above: The eligible population state above.

Numerators

Seven (7) Day Follow-up for Ages six (6) to seventeen (17): A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

Seven (7) Day Follow-up for Ages eighteen (18) and above: A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

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

- A visit (FUH Stand Alone Visits Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 1 Value Set **AND** FUH POS Group 1 Value Set) with a mental health practitioner.
- A visit (FUH Visits Group 2 Value Set **AND** FUH POS Group 2 Value Set) with a mental health practitioner.
- A visit in a behavioral healthcare setting (FUH Rev Codes Group 1 Value Set).
- A visit in a non-behavioral healthcare setting (FUH Rev Codes Group 2 Value Set) with a mental health practitioner.
- A visit in a non-behavioral healthcare setting (FUH Rev Codes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).
- Transitional care management services (TCM 7 Day Value Set), where the date of service on the claim is 29 days after the eligible population event/diagnosis date of discharge.

Centennial Care Follow-Up Service Criteria: The follow-up service can be any service considered as outpatient, intensive outpatient, or recovery treatment as they are classified in Addendum A to the Report 41 Instructions.

(See Report 41, Addendum A pages 19-32 for the table of applicable services and codes)

- A visit with a Centennial Care follow-up service code. These are service codes not included in the HEDIS FUH specification but included in Addendum A to the Report 41 Instructions (Table DSIT-2).

Table DSIT-2: Centennial Care follow-up visit code set

Code	Procedure Code Description
90785	PSYTX COMPLEX INTERACTIVE
90801	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAMINATION
90804	PSYTX OFFICE 20-30 MIN
90806	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING FACE-TO-FACE 45 TO 50
90807	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING 45 TO 50

90808	INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING 75 TO 80
90814	INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIEN
90862	PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION, USE, AND REVIEW OF MEDICATION
90863	PHARMACOLOGIC MGMT W/PSYTX
90865	NARCOSYNTHESIS FOR PSYCHIATRIC DIAGNOSTIC AND THERAPEUTIC PURPOSES
90889	PREPARATION OF REPORT
90899	UNLISTED PSYCHIATRIC SERVICE OR PROCEDUR
96101	PSYCHO TESTING BY PSYCH/PHYS
96102	PSYCHO TESTING BY TECHNICIAN
96103	PSYCHO TESTING ADMIN BY COMP
96105	ASSESSMENT OF APHASIA (INCLUDES ASSESSME
96110	DEVELOPMENTAL SCREEN W/SCORE
96111	DEVELOPMENTAL TEST EXTEND
96116	NEUROBEHAVIORAL STATUS EXAM
96118	NEUROPSYCH TST BY PSYCH/PHYS
96119	NEUROPSYCH TESTING BY TEC
96120	NEUROPSYCH TST ADMIN W/COMP
96150	ASSESS HLTH/BEHAVE INIT
96151	ASSESS HLTH/BEHAVE SUBSEQ
99199	UNLISTED SPECIAL SERVICE OR REPORT
99354	PROLONGED SERVICE OFFICE
99355	PROLONGED SERVICE OFFICE
99499	UNLISTED EVALUATION AND MANAGEMENT SERVICE
G0434	DRUG SCREEN MULTI DRUG CLASS
G0436	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT
H0001	ALCOHOL AND/OR DRUG ASSESSMENT
H0010	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE
H0015	ALCOHOL AND/OR DRUG SERVICES; INTENSIVE
H0018	BEHAVIORAL HEALTH; SHORT-TERM RESIDENTIAL (NON-HOSPITAL RESIDENTIAL TREATMENT PROGRAM)
H0019	ALCOHOL AND/OR DRUG SERVICES
H0020	ALCOHOL AND/OR DRUG SERVICES; METHADONE
H0033	ORAL MED ADM DIRECT OBSERVE
H0041	FOSTER CARE, CHILD, NON-THERAPEUTIC, PER DIEM

H2023	SUPPORTED EMPLOY, PER 15 MIN
H2030	MENTAL HEALTH CLUBHOUSE SERVICES, PER 15
H2032	ACTIVITY THERAPY, PER 15 MINUTES
H2033	MULTISYSTEMIC THERAPY FOR JUVENILES, PER
H2034	ALCOHOL AND/OR DRUG ABUSE HALFWAY HOUSE SERVICES, PER DIEM
H2036	ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM
Q3014	TELEHEALTH FACILITY FEE
S5110	DAY CARE SERVICES, ADULT, PER 15 MINUTES
S5145	FOSTER CARE THERAPEUTIC, PER DIEM
S9075	SMOKING CESSATION TREATMENT
S9446	PT EDUCATION NOC GROUP
S9453	SMOKING CESSATION CLASSES, NON-PHYSICIAN PROVIDER, PER SESSION
S9482	FAMILY STABILIZATION 15 MIN
T1007	TREATMENT PLAN DEVELOPMENT
T1023	PROGRAM INTAKE ASSESSMENT
T1024	EVALUATION AND TREATMENT BY AN INTEGRATED, SPECIALTY TEAM
T1502	MEDICATION ADMIN VISIT

LOD #16 Attachment 1 - TM #4 - Follow-up after Hospitalization for Mental Illness

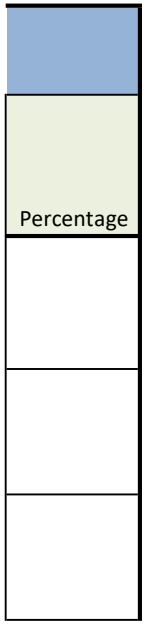
The percent of seven-day follow-up visits into community-based Behavioral Health care for child and for adult members released from inpatient psychiatric hospitalizations stays of four or more days.

Note: This inpatient follow-up measure is **NOT calculated as a HEDIS measure**. It focuses on a smaller, targeted cohort of individuals who have had 4 or more days of hospitalization. The report will be submitted on a quarterly basis due 30 days afer the close of the quarter.

The CY19 Q1 data submission should include refreshed data for the prior year's (CY18 Q1-Q4) baseline. Subsequently, the quarterly submission will refresh all prior quarterly data of CY19.

Measure	CY17 Q1			CY17 Q1-Q2			CY17 Q1-Q3			
Measures	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator
NOT HEDIS MEASURE: Follow-Up after release from inpatient psychiatric hospitalization stays of four or more days.										
7- Day follow-up after release from inpatient psychiatirc hospitalization stays of four or more days for Mental Illness-within 7 days (6-17)										
7- Day follow-up after release from inpatient psychiatirc hospitalization stays of four or more days for Mental Illness-within 7 days (18+)										

CY18 Q1-Q4		CY19 Q1			CY19 Q1-Q2			CY19 Q1-Q3			CY19 Q1-Q4	
Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator


Percentage

TM #4 - Follow-up after Hospitalization for Mental Illness

Reporting Period		through
MCO Name		
Report Run Date		

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

LOD #16 Attachment 1 - TM #5 - Immunizations for Adolescents (IMA)

The percentage of adolescents thirteen years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and a cellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of adolescent Medicaid Members, who have received vaccines for meningococcal conjugate, Tdap, or combination 1 (meningococcal and Tdap) who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans, excluding the human papillomavirus (HPV) vaccine. (Numerator)				
Number of adolescent Medicaid Members, who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of adolescent Medicaid Members, who have received vaccines for meningococcal conjugate, Tdap, or combination 1 (meningococcal and Tdap) who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans, excluding the human papillomavirus (HPV) vaccine. (Numerator)				
Number of adolescent Medicaid Members, who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of adolescent Medicaid Members, who have received vaccines for meningococcal conjugate, Tdap, or combination 1 (meningococcal and Tdap) who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans, excluding the human papillomavirus (HPV) vaccine. (Numerator)				
Number of adolescent Medicaid Members, who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of adolescent Medicaid Members, who have received vaccines for meningococcal conjugate, Tdap, or combination 1 (meningococcal and Tdap) who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans, excluding the human papillomavirus (HPV) vaccine. (Numerator)				
Number of adolescent Medicaid Members, who turn 13 years of age during the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TM #5 - Immunizations for Adolescents

Reporting Period		through
MCO Name		
Report Run Date		

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

LOD #16 Attachment 1 - TM #6 - Long Acting Reversible Contraceptive (LARC)

Utilization of Long Acting Reversible Contraceptives (LARCs)

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of LARCs utilized in female Medicaid Members, 15 - 19 years of age. Please refer to Crosswalk tab for TM 6 Utilization of Long Acting Reversible Contraceptive utilization codes.				

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of LARCs utilized in female Medicaid Members, 15 - 19 years of age. Please refer to Crosswalk tab for TM 6 Utilization of Long Acting Reversible Contraceptive utilization codes.				

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan - March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of LARCs utilized in female Medicaid Members, 15 - 19 years of age. Please refer to Crosswalk tab for TM 6 Utilization of Long Acting Reversible Contraceptive utilization codes.				

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of LARCs utilized in female Medicaid Members, 15 - 19 years of age. Please refer to Crosswalk tab for TM 6 Utilization of Long Acting Reversible Contraceptive utilization codes.				

LOD #16 Attachment 1 TM #7- Smoking Cessation

Utilization of smoking and tobacco cessation products and counseling services.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan - March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan - Dec
1. Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications). Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				
2.Total number of units for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				
3.Total dollar amount for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.
1. Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications). Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.
2.Total number of units for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.
3.Total dollar amount for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan - March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan - Dec
1. Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications). Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				
2.Total number of units for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				
3.Total dollar amount for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.
1. Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications). Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.
2.Total number of units for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.
3.Total dollar amount for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.

Q1 Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec

Q1 Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec

LOD #16 Attachment 1 TM #7- Smoking Cessation					
Provide details on the tobacco cessation services and products offered. Indicate if the service or product listed below is provided along with requirements and limitations, length of coverage, frequency and barriers to access.					
	MCO Name:				
Service	**Requirements**	**Limitations**	**Length of Coverage**	**Frequency**	**Barriers to Access**
Nicotine Gum					
Nicotine Patch					
Nicotine Nasal Spray					
Nicotine Inhaler					
Nicotine Lozenge					
Chantix					
Zyban (Wellbutrin, Bupropion)					
Wellbutrin (Zyban, Bupropion)					
Bupropion SR (Zyban, Wellbutrin)					
Face-to-face counseling					
Group counseling					
Proactive telephone counseling					
Smokeless Tobacco Coverage (chewing tobacco, snuff)					

TM #7- Smoking Cessation

Reporting Period		through
MCO Name		
Report Run Date		

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

LOD #16 Attachment 1 - TM #8 - Ambulatory Care (AMB)

Utilization of ambulatory care for Outpatient Visits.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ambulatory out patient visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ambulatory out patient visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ambulatory out patient visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ambulatory out patient visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Utilization of ambulatory care for ED Visits.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ED visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ED visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ED visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of ED visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TM #8 - Ambulatory Care

Reporting Period		through
MCO Name		
Report Run Date		

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

LOD #16 Attachment 1 - TM #9 - Annual Dental Visit (ADV)

The percentage of enrolled Members ages two (2) to twenty (20) years who had at least one (1) dental visit during the measurement year.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of Medicaid Members, who have had at least one (1) dental visit during the measurement year and are ages two (2) to twenty (20). Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Number of Medicaid Members, who are ages two (2) to twenty (20) years as of December 31 of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of Medicaid Members, who have had at least one (1) dental visit during the measurement year and are ages two (2) to twenty (20). Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Number of Medicaid Members, who are ages two (2) to twenty (20) years as of December 31 of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of Medicaid Members, who have had at least one (1) dental visit during the measurement year and are ages two (2) to twenty (20). Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Number of Medicaid Members, who are ages two (2) to twenty (20) years as of December 31 of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
Number of Medicaid Members, who have had at least one (1) dental visit during the measurement year and are ages two (2) to twenty (20). Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Number of Medicaid Members, who are ages two (2) to twenty (20) years as of December 31 of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TM #9 - Annual Dental Visit			
Reporting Period		through	
MCO Name			
Report Run Date			

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

LOD #16 Attachment 1 - TM #10 - Controlling High Blood Pressure (CBP)

The percentage of adults ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90) during the measurement year.

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Medicaid Members 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 (count services that occur over both years). Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Medicaid Members 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 (count services that occur over both years). Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Medicaid Members 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 (count services that occur over both years). Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2022 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1** Jan-March	**Q2** Jan - June	**Q3** Jan - Sept	**Q4** Jan-Dec
The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Medicaid Members 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 (count services that occur over both years). Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TM #10 - Controlling High Blood Pressure

Reporting Period		through	
MCO Name			
Report Run Date			

1. Identify any changes from the previous reporting period, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Discuss action plans implemented for performance improvement activities addressing any negative changes.	
4. Provide additional information pertinent to the reporting period.	
5. Was there a 5% or more shift in the data provided compared to the previous quarter? If so, what was the cause?	
6. Please provide the name and title of the individual who populated the data provided.	
7. Please provide the name and title of the individual who validated the data provided.	
8. Was there a quality check completed before being submitted? If so, please provide the name and title of the individual who completed it.	

Diabetes Short-Term Complications Admission Rate	
Reporting Period	through
MCO Name	
Report Run Date	

Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid enrollees age 18 and older.

2019	Q1 Total Jan-Mar	Q2 Total Jan-Jun	Q3 Total Jan-Sep	Q4 Total Jan-Dec
All inpatient hospital admissions with ICD-9-CM/ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18 and older. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18 and older during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2020	Q1 Total Jan-Mar	Q2 Total Jan-Jun	Q3 Total Jan-Sep	Q4 Total Jan-Dec
All inpatient hospital admissions with ICD-9-CM/ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18 and older. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18 and older during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

1. Identify any changes from the previous reporting periods, as well as trends identified over time.	
2. Explanation of changes (positive or negative).	
3. Action plans implemented for performance improvement activities addressing any negative changes.	
4. Additional information pertinent to the current reporting period.	