HUMAN SERVICES
DEPARTMENT

Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

Letter of Direction #3

Date: **December 31, 2018**

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

From: **Nancy Smith-Leslie, Director, Medical Assistance Division** dm for NSL

Subject: **Tracking Measure Reporting Requirements Centennial Care 2.0**

Title: **TM 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 after 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.

In order for HSD to remain in compliance with federal reporting requirements, the data for TM #2, Diabetes Short-Term Complications Admission Rate, must be submitted within fifteen (15) calendar days after 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 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:

ICD9	ICD10	CPT Codes
V15.88	Z91.81	0518F
E880.0-E880.9	W10.0XXA-W10.9XXD	1100F-1101F
E881.0-E881.1	W10.2XXA-W12.XXXD	3288F
E882	W13.0XXA-W13.9XXD	
E883.0-E883.9	W16.011A-W17.4XXD	
E884.0-E884.9	W09.0XXA-W17.89	
E885.0-E885.9	V00.141A-W18.49XD	
E886.0-E886.9	W03.XXXA-V00.388D	
E887	W19.XXXA	
E888.0-888.9	W01.10XA-W19.XXD	
781.2	R26.0-R26.9	
781.3	R21.0-R27.9	
781.99	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-9-CM/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 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 the purpose of 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 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 9/10, CPT, HCPCS and NDC codes in Table 2, LARC Utilization Codes.

Table 2

LARC Utilization Codes:

ICD9	ICD10	CPT	HCPCS	NDC
V25.11	Z30.430	11981	J7300	52027201
V25.13	Z30.433	11983	J7301	52027401
V25.42	Z30.431	58300	J7302	52433001
V25.43	Z30.49		J7306	50419042101
V25.5	Z97.5		J7307	50419042201
V45.51	T83.6XXA		S4981	5128520401
V45.52	T83.6XA		S4989	
996.65			Q0090	
69.7				

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 Utilization

Medications/Drugs
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) chewing gum
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) patch
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) lozenge
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) spray
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) inhaler
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) tablet
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) Bupropion
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) Chantix
Unduplicated Members receiving nicotine replacement therapy/treatment (NRT) Other
(If applicable, please identify under separate cover.)

Counseling Services
Unduplicated Members receiving smoking cessation counseling
CPT code = 99406 (intermediate)
Unduplicated Members receiving smoking cessation counseling
CPT code = 99407 (intensive)

Quitline Coaching
Quitline utilization by Unduplicated Members and 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 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 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 relevant reporting year.

Attachments: LOD #3 Quarterly Reporting Templates

LOD 22 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

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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 9/10 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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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 9/10 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**	**Q2**	**Q3**	**Q4**
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 9/10 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. State 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 22 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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
All inpatient hospital admissions with ICD-9-CM/ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. 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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
All inpatient hospital admissions with ICD-9-CM/ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. 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	Q2	Q3	Q4
All inpatient hospital admissions with ICD-9-CM/ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-64. 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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
All inpatient hospital admissions with ICD-9-CM/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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
All inpatient hospital admissions with ICD-9-CM/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**	**Q2**	**Q3**	**Q4**
All inpatient hospital admissions with ICD-9-CM/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!

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. State 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 22 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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
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	Q2	Q3	Q4
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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
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	Q2	Q3	Q4
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. State 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 22 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			CY18 Q1-Q4			CY19 Q1			CY19 Q1-Q2			CY19 Q1-Q3			CY19 Q1-Q4		
Measures	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage	Numerator	Denominator	Percentage
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+)																								

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

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

Product lines	Centennial Care
Ages	6 years and older as of the date of discharge.
Enrollment	Members who are enrolled with the MCO at the time of the member's discharge and are eligible for Medicaid services under New Mexico's State Plan. For purposes of this calculation, use age at time of discharge. Members who are enrolled through the 7 days after discharge with the MCO at the time of the member's discharge and are eligible for Medicaid services under New Mexico's State Plan.
Anchor date	None.
Event/ diagnosis	An acute inpatient discharge following a hospitalization for treatment of mental health disorders for a continuous period of four days or more (discharge date more than three days after admission date)(Mental Illness Value Set) on or between January 1 and December 24 of the measurement year. To identify acute inpatient discharges: 1. Identify all hospitilizations from the "Intpatient 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: Intpatient Hospitalization – Psychiatric Free Standing or Psych. Unit (INPATIENT Category) code set

Codes: Revenue, CPT and or HCPC	Description	Type and/or Age Category
INPATIENT SERVICES CATEGORY		
Inpatient Hospitalization – Psychiatric Free Standing or Psych. Unit (INPATIENT Category)		
0114	Inpatient – Room & Board	Provider Type 204 & Provider Type 205
0124	Inpatient – Room & Board	Provider Type 204 & Provider Type 205
0134	Inpatient – Room & Board	Provider Type 204 & Provider Type 205
0144	Inpatient – Room & Board	Provider Type 204 & Provider Type 205
0154	Inpatient – Room & Board	Provider Type 204 & Provider Type 205
0204	Inpatient – Psych. ICU service	Provider Type 201, 204, & 205

Reference: Centennial Care Reporting Instructions Utilization Management – Report #41, Appendix A p.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 aninpatient 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 6 to 17	The eligible population
Ages 18 and above	The eligible population

Numerators

7-Day Follow-Up Ages 6 to 17 A follow-up visit with a mental health practitioner within 7 days after discharge. Include visits that occur on the date of discharge.

7-Day Follow-Up Ages 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 RevCodes Group 1 Value Set).
- A visit in a nonbehavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner.
- A visit in a nonbehavioral healthcare setting (FUH RevCodes 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

codes not included in the HEDIS PCR 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	Proc_Cd_Desc
90785	PSYTX COMPLEX INTERACTIVE
90801	
90804	PSYTX OFFICE 20-30 MIN
90806	
90807	
90808	
90814	
90846	FAMILY PSYCHOTHERAPY (WITHOUT THE PATIEN
90862	
90863	PHARMACOLOGIC MGMT W/PSYTX
90865	
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	
G0434	DRUG SCREEN MULTI DRUG CLASS
G0436	
H0001	ALCOHOL AND/OR DRUG ASSESSMENT
H0010	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE
H0015	ALCOHOL AND/OR DRUG SERVICES; INTENSIVE
H0018	
H0019	ALCOHOL AND/OR DRUG SERVICES
H0020	ALCOHOL AND/OR DRUG SERVICES; METHADONE
H0033	ORAL MED ADM DIRECT OBSERVE
H0041	
H2023	SUPPORTED EMPLOY, PER 15 MIN
H2030	MENTAL HEALTH CLUBHOUSE SERVICES, PER 15

H2032	
H2033	MULTISYSTEMIC THERAPY FOR JUVENILES, PER
H2034	
H2036	
Q3014	TELEHEALTH FACILITY FEE
S5110	DAY CARE SERVICES, ADULT, PER 15 MINUTES
S5145	FOSTER CARE THERAPEUTIC, PER DIEM
S9075	
S9446	PT EDUCATION NOC GROUP
S9453	

S9482	FAMILY STABILIZATION 15 MIN
T1007	TREATMENT PLAN DEVELOPMENT
T1023	PROGRAM INTAKE ASSESSMENT
T1024	
T1502	MEDICATION ADMIN VISIT

Note

- *Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).*
- *Refer to Appendix 3 for the definition of* mental health practitioner.

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table FUH-1/2/3: Data Elements for Follow-Up After Hospitalization for Mental Illness

	Administrative
Measurement year	✓
Data collection methodology (Administrative)	✓
Eligible population	✓
Numerator events by administrative data	*Each of the 2 rates*
Numerator events by supplemental data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*
Lower 95% confidence interval	*Each of the 2 rates*
Upper 95% confidence interval	*Each of the 2 rates*

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. State 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 22 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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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**	**Q2**	**Q3**	**Q4**
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. State 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 22 Attachment 1 - TM #6 - Long Acting Reversible Contraceptive (LARC)

Utilization of Long Acting Reversible Contraceptives (LARCs)

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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.				

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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**	**Q2**	**Q3**	**Q4**
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 22 Attachment 1 TM #7- Smoking Cessation

Utilization of smoking and tobacco cessation products and counseling services

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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.				

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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.	**Q1**	**Q2**	**Q3**	**Q4**
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.				

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. State 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 22 Attachment 1 - TM #8 - Ambulatory Care (AMB)

Utilization of ambulatory care for Outpatient Visits.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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**	**Q2**	**Q3**	**Q4**
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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1	Q2	Q3	Q4
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	Q2	Q3	Q4
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. State 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 22 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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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**	**Q2**	**Q3**	**Q4**
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. State 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 22 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.

2018 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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!

2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	**Q1**	**Q2**	**Q3**	**Q4**
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**	**Q2**	**Q3**	**Q4**

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. State 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.	