

Core Set of Children’s Health Care Quality Measures for Medicaid
and CHIP (Child Core Set)

Technical Specifications and Resource Manual for
Federal Fiscal Year 2016 Reporting

June 2016

Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services



This page left blank for double-sided copying.

ACKNOWLEDGMENTS

For National Committee for Quality Assurance (NCQA) measures in the Child Core Set:

© 1994-2016 by NCQA, 1100 13th Street, NW, Suite 1000, Washington, D.C. 20005. All rights reserved. Reprinted with the permission of NCQA. Inclusion of NCQA performance measures or specifications in any commercial product requires permission of NCQA and is subject to a license at the discretion of NCQA. NCQA performance measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. HEDIS® is a registered trademark of NCQA.

For The Joint Commission measure in the Child Core Set:

Acknowledgement: The Specifications Manual for Joint Commission National Quality Core Measures [Version 2015A1, January 2015] is periodically updated by The Joint Commission. Users of the Specifications Manual for Joint Commission National Quality Core Measures must update their software and associated documentation based on the published manual production timelines.

For AMA-PCPI measures in the Child Core Set:

Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI®). These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed, or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA (on behalf of the PCPI). Neither the AMA, PCPI, nor its members shall be responsible for any use of the Measures.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

© 2009, 2013 American Medical Association. All Rights Reserved.

For the Developmental Screening measure:

Copyright established November 7, 2013 to the Oregon Pediatric Improvement Partnership at Oregon Health and Science University. The copyright is 2010 - Oregon Pediatric Improvement Partnership at Oregon Health and Science University.

For the Dental Sealant measure:

© 2016 American Dental Association on behalf of the Dental Quality Alliance (DQA). All rights reserved. Use by individuals or other entities for purposes consistent with the DQA's mission and that is not for commercial or other direct revenue generating purposes is permitted without charge.

Dental Quality Alliance Measures (Measures) and related data specifications, developed by the Dental Quality Alliance (DQA), are intended to facilitate quality improvement activities. These Measures are intended to assist stakeholders in enhancing quality of care. These performance Measures are not clinical guidelines and do not establish a standard of care. The DQA has not tested its Measures for all potential applications.

Measures are subject to review and may be revised or rescinded at any time by the DQA. The Measures may not be altered without the prior written approval of the DQA. Measures developed by the DQA, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and DQA. Neither the DQA nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

Limited proprietary coding is contained in the measure specifications for convenience.

Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The DQA, American Dental Association (ADA), and its members disclaim all liability for use or accuracy of any terminologies or other coding contained in the specifications.

For Proprietary Codes:

The Code on Dental Procedures and Nomenclature is published in Current Dental Terminology (CDT), Copyright © 2014 American Dental Association (ADA). All rights reserved.

CPT® codes copyright 2015 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

CPT(R) contained in the Measure specifications is copyright 2004-2013 American Medical Association. LOINC(R) copyright 2004-2013 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004-2013 International Health Terminology Standards Development Organisation. All Rights Reserved. ICD-10 copyright 2013 World Health Organization. All Rights Reserved.

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the World Health Organization (WHO). ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 9th Revision, Procedure Coding System (ICD-9-PCS) is published by the World Health Organization (WHO). ICD-9-PCS is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is published by the World Health Organization (WHO). ICD-10-CM is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) is published by the World Health Organization (WHO). ICD-10-PCS is an official Health Insurance Portability and Accountability Act standard.

This material contains content from LOINC® (<http://loinc.org>). The LOINC table, LOINC codes, and LOINC panels and forms file are copyright © 1995-2015, Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and available at no cost under the license at <http://loinc.org/terms-of-use>.”

The National Drug Code (NDC) Directory is published by the U.S. Food and Drug Administration and is made available under the Open Database License: <http://opendatacommons.org/licenses/odbl/1.0/>. Any rights in individual contents of the database are licensed under the Database Contents License: <http://opendatacommons.org/licenses/dbcl/1.0/>.

Uniform Bill Codes (“UB Codes”) are protected under federal copyright laws and are owned by the American Hospital Association (AHA). The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Software vendors and all others desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other use, must obtain a commercial use license directly from the AHA. To inquire about licensing, please contact ub04@healthforum.com.

CONTENTS

ACKNOWLEDGMENTS	iii
I. THE CORE SET OF CHILDREN’S HEALTH CARE QUALITY MEASURES (CHILD CORE SET)	1
Background	1
Description of the Child Core Set	1
II. DATA COLLECTION AND REPORTING OF THE CHILD CORE SET	5
Data Collection and Preparation for Reporting	5
Reporting and Submission	9
Technical Assistance	10
III. TECHNICAL SPECIFICATIONS	11
Measure ADD-CH: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	12
Measure AMB-CH: Ambulatory Care – Emergency Department Visits	17
Measure APC-CH: Use of Multiple Concurrent Antipsychotics in Children and Adolescents	20
Measure AUD-CH: Audiological Evaluation no Later than Three Months of Age	25
Measure AWC-CH: Adolescent Well-Care Visit	27
Measure BHRA-CH: Behavioral Health Risk Assessment (for Pregnant Women)	30
Measure CAP-CH: Children and Adolescent Access to Primary Care Practitioners	42
Measure CHL-CH: Chlamydia Screening in Women	44
Measure CIS-CH: Childhood Immunization Status	47
Measure CLABSI-CH: Pediatric Central Line-Associated Blood Stream Infections	53
Measure CPC-CH: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items	58
Measure DEV-CH: Developmental Screening in the First Three Years of Life	61
Measure FPC-CH: Frequency of Ongoing Prenatal Care	66
Measure FUH-CH: Follow-Up After Hospitalization for Mental Illness	72
Measure HPV-CH: Human Papillomavirus (HPV) Vaccine for Female Adolescents	76
Measure IMA-CH: Immunizations for Adolescents	78
Measure LBW-CH: Live Births Weighing Less Than 2,500 Grams	81
Measure MMA-CH: Medication Management for People with Asthma	82
Measure PC02-CH: Cesarean Section for Nulliparous Singleton Vertex (NSV)	88
Measure PIDENT-CH: Percentage of Eligibles Who Received Preventive Dental Services	102
Measure PPC-CH: Timeliness of Prenatal Care	104
Measure SEAL-CH: Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	111
Measure SRA-CH: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	115

Measure W15-CH: Well-Child Visits in the First 15 Months of Life..... 120

Measure W34-CH: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life 123

Measure WCC-CH: Weight Assessment and Counseling for Nutrition and Physical Activity
for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents 125

APPENDIX A: CHILD CORE SET HEDIS® VALUE SET DIRECTORY USER MANUALA-129

APPENDIX B: GUIDANCE FOR SELECTING SAMPLE SIZES FOR HEDIS® HYBRID
MEASURESB-137

APPENDIX C: DEFINITION OF MEDICAID/CHIP CORE SET PRACTITIONER TYPES C-141

APPENDIX D: ADDITIONAL INFORMATION ON DATA ELEMENTS FOR MEASURE PC02:
CESAREAN SECTION FOR NULLIPAROUS SINGLETON VERTEX..... D-145

APPENDIX E: E-MEASURE FLOW FOR REPORTING THE SUICIDE RISK ASSESSMENT
(SRA) MEASUREE-155

APPENDIX F: SECONDARY BLOODSTREAM INFECTION (BSI) GUIDE FOR CLABSI
MEASUREF-163

APPENDIX G: CAHPS® HEALTH PLAN SURVEY 5.0H CHILD QUESTIONNAIRE (WITH CCC
SUPPLEMENTAL ITEMS) G-175

APPENDIX H: CAHPS® HEALTH PLAN SURVEY 5.0H CHILD QUESTIONNAIRE H-191

APPENDIX I: GUIDANCE FOR CONDUCTING THE CHILD CONSUMER ASSESSMENT OF
HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) HEALTH PLAN SURVEY 5.0H
(MEDICAID) I-203

I. THE CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES (CHILD CORE SET)

Background

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (Pub.L. 111-3) added Section 1139A(a) to the Social Security Act and included broad mandates to strengthen the quality of care for and health outcomes of children in Medicaid and CHIP. Section 401 of CHIPRA called for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish an initial core set of children's health care quality measures for voluntary use by state programs administered under Titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP.

The legislation required the Secretary of Health and Human Services (HHS) to identify measures applicable to the duration of enrollment and health care coverage, preventive and health promotion services, and the treatment and management of acute and chronic conditions in children. The legislation also called for measures that could be used to assess families' experiences with health care, the availability of services, and care in the most integrated health settings. Ultimately, the goals of the Child Core Set are to provide a national estimate of the quality of health care for children; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

Implementation of a standardized Child Core Set is helping the Centers for Medicare & Medicaid Services (CMS) and states move toward a national system for quality measurement, reporting, and improvement. The data collected from these measures helps CMS to better understand the quality of health care children receive through Medicaid and CHIP programs. As required by CHIPRA, a Secretary's annual report on the quality of care for children enrolled in Medicaid and CHIP will be released every September summarizing state-specific and national information on the quality of health care furnished to children enrolled in Medicaid and CHIP. These reports are available on Medicaid.gov at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html>.

Description of the Child Core Set

The initial core set was published in February 2011. CHIPRA required the Secretary to publish annual changes to the Child Core Set beginning in January 2013. The following resources describe the initial core set and recent updates.

- **Initial Core Set:** Background on the Initial Core Set can be found at <http://www.cms.gov/smdl/downloads/SHO11001.pdf>.
- **2013 Child Core Set Updates:** Three measures were added to the 2013 Child Core Set and one measure was retired. Additional information on the 2013 Child Core Set can be found at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf>.
- **2014 Child Core Set Updates:** Three measures were retired. Additional information can be found at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf>.
- **2015 Child Core Set Updates:** Two measures were added to the 2015 Child Core Set and one measure was retired. In addition, CMS is conducting a pilot of the Child Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. Additional information on the 2015 Child Core Set can be found at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-30-2014.pdf>.

- 2016 Child Core Set Updates:** Two measures were added to the Child Core Set (Use of Multiple Concurrent Antipsychotics in Children and Adolescents; Audiological Evaluation No Later than Three Months of Age). Additional information on the 2016 Child Core Set is available in a December 2015 CMCS Informational Bulletin (<http://medicaid.gov/federal-policy-guidance/downloads/CIB-12-11-15.pdf>).

The following table lists each Child Core Set measure, the National Quality Forum (NQF) number (when the measure is NQF-endorsed), and the measure steward. The data collection methods include administrative (such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), electronic health records, and surveys. The technical specifications in Chapter III of this manual provide additional details for each measure.

NQF#	Measure Steward ^a	Measure Name	Data Collection Method(s)
Access to Care			
NA	NCQA	Child and Adolescents' Access to Primary Care Practitioners (CAP)	Administrative
Preventive Care			
0033	NCQA	Chlamydia Screening in Women (CHL)	Administrative
0038	NCQA	Childhood Immunization Status (CIS)	Administrative or hybrid
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15)	Administrative or hybrid
1407	NCQA	Immunizations for Adolescents (IMA)	Administrative or hybrid
1448	OHSU	Developmental Screening in the First Three Years of Life (DEV)	Administrative or hybrid
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	Administrative or hybrid
1959	NCQA	Human Papillomavirus Vaccine for Female Adolescents (HPV)	Administrative or hybrid
NA	NCQA	Adolescent Well-Care Visit (AWC)	Administrative or hybrid
Maternal and Perinatal Health			
0139	CDC	Pediatric Central Line-Associated Bloodstream Infections – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit (CLABSI)	Medical records (CDC's National Healthcare Safety Network)
0471	TJC	PC-02: Cesarean Section (PC02)	Hybrid
1382	CDC	Live Births Weighing Less Than 2,500 Grams (LBW)	State vital records
1391	NCQA	Frequency of Ongoing Prenatal Care (FPC)	Administrative or hybrid
1517	NCQA	Prenatal & Postpartum Care: Timeliness of Prenatal Care (PPC)	Administrative or hybrid
1360	CDC	Audiological Evaluation No Later Than 3 Months of Age (AUD)*	Electronic health record or survey
NA	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women) (BHRA)	Electronic health records
Behavioral Health			
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	Administrative
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH)	Administrative

NQF#	Measure Steward ^a	Measure Name	Data Collection Method(s)
1365	AMA-PCPI	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA)	Electronic health records
NA	AHRQ-CMS CHIPRA NCINQ	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) *	Administrative
Care of Acute and Chronic Conditions			
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC)	Administrative or hybrid
1799	NCQA	Medication Management for People with Asthma (MMA)	Administrative
NA	NCQA	Ambulatory Care – Emergency Department (ED) Visits (AMB)	Administrative
Oral Health			
2508	DQA (ADA)	Sealants for 6–9 Year Old Children at Elevated Caries Risk (SEAL)	Administrative
NA	CMS	Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	Administrative (Form CMS-416)
Experience of Care^b			
NA	NCQA	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC) ^c	Survey

AHRQ = Agency for Healthcare Research and Quality; AMA-PCPI = American Medical Association-Physician Consortium for Performance Improvement; CDC = Centers for Disease Control and Prevention; CHIPRA = Children's Health Insurance Program Reauthorization Act; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); NA = Measure is not NQF endorsed; NCINQ = National Collaborative for Innovation in Quality Measurement; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; OHSU = Oregon Health and Science University.

* This measure was added to the 2016 Child Core Set.

^a The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

^b The Centers for Medicare & Medicaid Services will pilot a reporting process for the Child Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey (NQF # 2548) to determine whether to include it as a measure in a future Child Core Set.

^c CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

This page left blank for double-sided copying.

II. DATA COLLECTION AND REPORTING OF THE CHILD CORE SET

To support consistency in reporting the Child Core Set measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapter III and provide detailed information on how to calculate each measure. For technical assistance with calculating and reporting these measures, contact the TA mailbox at MACqualityTA@cms.hhs.gov.

CMS has designated the Medicaid and CHIP Program (MACPro) system as the online tool that states should use when reporting Child Core Set measures. More information on the use of MACPro for quality measure reporting is available at <https://www.medicaid.gov/state-resource-center/medicaid-and-chip-program-portal/medicaid-and-chip-program-portal.html>. Further information on technical assistance for MACPro is provided at the end of this chapter.

Data Collection and Preparation for Reporting

- Version of specifications. This manual includes the most applicable version of the measure specifications available to CMS as of December 2015. For HEDIS measures, this manual follows HEDIS 2016 specifications (2015 measurement year). For non-HEDIS measures, the manual includes the most applicable version of the specifications available for reporting 2015 data.
- Value sets. HEDIS 2016, the Behavioral Health Risk Assessment (Measure BHRA-CH), and the Suicide Risk Assessment (Measure SRA-CH) specifications reference value sets that must be used for calculating the measures. A value set is the complete set of codes used to identify a service or condition included in a measure. The Value Set Directory (VSD) includes all value sets and codes needed to report all HEDIS measures included in the Child Core Set, Measure BHRA-CH, and Measure SRA-CH. Value set references are underlined in the specifications (e.g., BMI Percentile Value Set).
 - The HEDIS value set directory is available at <https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2016-child-hedis-value-set-directory.zip>. Refer to Appendix A for a HEDIS Value Set Directory User Manual.
 - The BHRA-CH value set directory is available at <https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2016-child-bhra-value-set-directory.zip>.
 - Value sets for the SRA-CH measure are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC), located at <https://vsac.nlm.nih.gov>. Access to the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a UMLS license at <https://uts.nlm.nih.gov/license.html>. When searching for value sets for the SRA measure, states should use the measure's associated eMeasure number (CMS177v3) or NQF number (1365). To report on 2015 data, use the version of the value sets associated with the 07-01-2014 release.
- Data collection time frames for measures. States should adhere to the measurement periods identified in the technical specifications for each measure. Some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a child's birthday or diagnosis. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2015 data should be reported for FFY 2016. For each measure, the measurement period used to calculate the denominator should be reported in the "Start Date" and "End Date" fields in MACPro. For many measures, the denominator measurement period for FFY 2016 corresponds to calendar year 2015

(January 1, 2015–December 31, 2015). Some measures, however, also require states to review utilization or enrollment prior to this period to identify the measure-eligible population. States should not include these review periods (sometimes referred to as “look-back” periods) in the Start and End date range. Further information regarding measurement periods is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/ffv-2016-child-core-set-measurement-periods.pdf>.

- Continuous enrollment. This refers to the time frame during which an enrollee must be eligible for benefits to be included in the measure denominator. The technical specifications provide the continuous enrollment requirement for each measure, if applicable.
- Allowable gap. Some measures specify an allowable gap that can occur during continuous enrollment. For example, the Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in enrollment of up to 45 days. Thus, an enrollee who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year, because this enrollee has one 38-day gap (January 1–February 7).
- Anchor date. Some measures include an anchor date, which is the date that an individual must be enrolled and have the required benefit to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure’s FFY 2016 measurement period (December 31, 2015). For other measures, the anchor date is based on a specific event, such as a birthdate or a delivery date. States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.
- Reporting unit. CMS defines the reporting unit for each measure as each state’s Medicaid and CHIP program. This means that states reporting any of the core measures should collect data across all of the health care delivery systems used in their state Medicaid and CHIP programs (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care [MC]). If data are collected separately across Medicaid and CHIP or across a state’s various health care delivery systems, states should aggregate data from all these sources into one state-level rate before reporting the data to CMS. For more guidance about developing a state-level rate, see the bullet on “aggregating information for state-level reporting” below.
- Eligible population for measurement. For all measures, the denominator includes Medicaid and CHIP enrollees who satisfy measure-specific eligibility criteria. The eligible Medicaid and CHIP population should include Title XIX and Title XXI populations, but not populations funded only by states (such as state-covered children that are above the Medicaid/CHIP eligibility levels).
- Enrollees with partial benefits. For each measure, states should include only the enrollees who are eligible to receive the services assessed in the numerator. If an enrollee is not eligible to receive the services assessed in the measure, the enrollee should not be included in the denominator for the measure. The technical specifications for some measures have guidance regarding which benefits an individual must be eligible for to be included, but each state should assess the specific benefit packages of the enrollees in their state.
- Aggregating information for state-level reporting. To obtain a state-level rate for a measure that is developed from the rates of multiple units of measurement (such as multiple managed care organizations [MCOs] or across MC and FFS delivery systems),

the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual MCOs) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid and administrative data from different sources can be combined to develop a state/program-level rate as long as the specifications allow the use of both data sources to construct the measure. For additional guidance on developing state-level rates, refer to the TA Brief titled “Approaches to Developing State-level Rates Using Data from Multiple Sources.”¹

- Reporting a weighted rate. When a state develops a weighted rate combining data across multiple reporting units, the state should report the rate for the combined data in the “Rate” field in MACPro. In addition, the state should check “Yes” under “Did you Combine Rates from Multiple Reporting Units (e.g., health plans, delivery systems, programs) to Create a State-Level Rate?” If the state has the numerator and denominator that were used to calculate the state-level rate, they should be entered in the Numerator and Denominator fields. If this information is not available, a state can enter “0” in the Numerator and Denominator fields, report the state-level rate in the “Rate” field, and explain the missing information in the “Additional Notes/Comments on Measure” section. If possible, the state should also provide the numerators, denominators, measure-eligible population, and rates for each health plan, delivery system, or program in this section as well as a description of the method used to calculate the state-level rate (including the approach used for weighting).
- Age criteria. The age criteria vary by measure. If a denominator for a measure specifies an age range beyond that eligible for a state’s Medicaid and CHIP programs, the state should include only the ages eligible for the program in the denominator and note any deviations from the specifications in the “Deviations from Measure Specifications” field in MACPro.
- Exclusions. Some measure specifications contain required or optional exclusions. A Medicaid or CHIP enrollee who meets required exclusion criteria should be removed from the measure denominator. Some exclusions are optional. States should note when reporting whether optional exclusions are applied.
- Representativeness of data. States should use the most complete data available and ensure that the rates reported are representative of the entire population enrolled in their Medicaid and CHIP programs. For a measure based on administrative data, all enrollees who meet the eligible population requirements for the measure should be included. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire eligible population for the measure.
- Data collection methods. The measures in the Child Core Set have four possible data collection methods: administrative, hybrid, survey, and medical records, including electronic health records (eMeasures):
 - The administrative method uses transaction data (for example, claims) or other administrative data to calculate the measure. These data can be used in cases in which the data are known to be complete, valid, and reliable. When administrative data are used, the entire eligible population is included in the denominator.

¹ The TA Brief, “Approaches to Developing State-level Rates Using Data from Multiple Sources,” is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf>.

- The hybrid method uses both administrative data sources and medical record data to determine numerator compliance. The denominator consists of a sample of the measure's eligible population. The hybrid method, when available, should be used when administrative data and electronic health record (EHR) data are incomplete or may be of poor quality, or the data elements for the measure are not captured in administrative data (e.g., Cesarean Section [PC-02]). More information on the use of the hybrid method for Core Set Reporting is available at <https://www.medicare.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf>.
- The survey method uses data collected through a survey to calculate the measure. This data collection method applies to the CAHPS 5.0H Health Plan Survey measure in the Child Core Set.
- The eMeasure method uses EHR data to calculate the measure. This data collection method applies to three measures in the Child Core Set: (1) the Behavioral Health Risk Assessment (for Pregnant Women), (2) Suicide Risk Assessment, and (3) Audiological Evaluation no Later than 3 Months of Age.
- Sampling. For measures that use the hybrid method, sampling guidance is included in the technical specification if available from the measure steward. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.
 - For HEDIS measures that use the hybrid method, the sample size should be 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.
 - For Developmental Screening in the First Three Years of Life, the sample is 411 divided across three age strata, or 137 in each age group.
 - For the CAHPS survey, the sample size should be 1,650, plus an oversample based on the state's prior experience with survey response rates, to yield at least 411 completed surveys. Additional information on sampling for CAHPS is available in Appendix I.
 - States should use the "Additional Notes/Comments" field in MACPro to describe the sampling approach used for each measure. Additional guidance on sampling for hybrid measures is available in the following TA brief: Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets (October 2014).²
- Small numbers. If a measure has a denominator that is less than 30 and the state chooses not to report the measure due to small numbers, please note this in the "Reason for Not Reporting" field in MACPro and specify the denominator size.
- Risk adjustment. No Child Core Set measure requires risk adjustment.
- Inclusion of paid, suspended, pending, and denied claims. A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided. For such measures, the inclusion of claims, regardless of whether they were paid, denied, or voided, would be appropriate. For HEDIS measures that rely on claims as a data source, the HEDIS Volume 2 manual provides guidance on which claims to include: <https://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx>.

² The TA Brief, "Using the Hybrid Method to Calculate Measures from the Child and Adult Core Sets," is available at <https://www.medicare.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf>.

- ICD-9/ICD-10 Conversion: In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, measures should be calculated using ICD-10 codes for claims with a date of service or date of discharge on or after October 1, 2015. The following Child Core Set measures are affected by this conversion: ADD, AMB, AWC, CAP, CHL, CIS, FPC, FUH, HPV, IMA, MMA, PC02, PPC, SRA, W15, W34, WCC.
- For HEDIS measures, ICD-10 codes are included in the Value Set Directory. For non-HEDIS measures, ICD-10 codes are available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-child-icd10-codes.zip>.

Reporting and Submission

Procedures for reporting the Child Core Set measures into MACPro are provided below.

- Submission deadline. CMS will announce the deadline for submitting and certifying final data on the Child Core Set measures for FFY 2016 in the fall of 2016. States can update data submitted into MACPro after the submission deadline; however, updates made after the deadline are not guaranteed to be used in the development of reports by CMS and states are encouraged to submit data that are as complete as possible by the submission deadline.
- Completing fields. Specific fields are provided for each measure. States should complete every field for each measure submitted to ensure consistent reporting across states. Details on how to enter data on the Child Core Set measures can be found in the MACPro Implementation Guides. A Consolidated Implementation Guide across all Child Core Set measures is available under the “Actions” tab in MACPro. Measure-specific Implementation Guides are available in each measure screen.
- Including attachments. MACPro includes an attachment facility that allows states to upload supporting documents related to measures. More information about submitting attachments can be found in the Report Documents section of the MACPro Implementation Guides.
- Reasons for not reporting a measure. Although reporting the Child Core Set is voluntary, states choosing not to report a measure are required to explain their reason for not reporting the measure. This information will assist CMS in understanding why each state or why all states as a group may not be reporting on specific measures.
- Noting deviations from the measure technical specifications. Although states are encouraged to report measures adhering to the methods provided in the specifications, this may not always be possible. It might also be necessary to provide additional information and context about the rates reported. Any deviations and clarifications should be recorded in the “Deviations from Measure Specifications” field in MACPro. Examples of deviations include eligible population definitions that differ from the specifications (age ranges, codes for identifying the population, or missing population segments); differences in data sources used; differences in codes used (added, excluded, or substituted codes); differences in the version used; issues encountered in calculating the measure; and caveats not specified elsewhere.
- Reporting by Medicaid and CHIP programs. For each Child Core Set measure reported to CMS, states should specify the population included in the measure: Medicaid program only; CHIP program only; or Medicaid and CHIP programs combined. CMS

prefers that states report Medicaid and CHIP data combined whenever possible.³ States choosing to report a combined Medicaid and CHIP rate should coordinate internally between the two programs (and among those reporting the measures within the state) when reporting. Any populations excluded from the denominator should be noted in the “Deviations from Measure Specifications” field in MACPro.

- Data auditing. For FFY 2016, CMS will not require certification or auditing of HEDIS or other measures. However, states are encouraged to do so when possible. If there are current state mechanisms for accreditation, certification, and managed care external quality review reporting, or if the state validates its Child Core Set rates, we ask that states describe these processes in MACPro.
- Reporting electronic health record (EHR) Medicaid Incentive Program measures. For states voluntarily reporting on a core measure that is also an EHR Medicaid incentive program measure (ADD, CHL, CIS, SRA, WCC) we ask that states indicate whether any information was extracted from EHRs in the “Additional Notes/Comments on Measure” field in MACPro.

Technical Assistance

To help states collect, report, and use the Child Core Set measures, CMS offers technical assistance. Please submit technical assistance requests specific to the Child Core Set to: MACqualityTA@cms.hhs.gov.⁴

For questions about the use of MACPro, please contact the MACPro Help Desk at MACPro_HelpDesk@cms.hhs.gov or (301) 547-4688.

³ Title XXI programs are required by CHIPRA to collect and separately sample CAHPS survey data beginning in December 2013. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf>.

⁴ States with technical assistance questions about the Medicaid Adult Core Set, Health Homes Core Set, and Maternal and Infant Health measures should also contact MACqualityTA@cms.hhs.gov.

III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for each measure in the Child Core Set. Each specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and any other relevant measure information.

These specifications represent the most applicable version available from the measure steward as of December 2015.

MEASURE ADD-CH: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) MEDICATION

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

Initiation Phase: Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Percentage of children 6 to 12 years old as of the IPSD with an ambulatory prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Data Collection Method: Administrative

Guidance for Reporting:

- Children who switch between Medicaid and CHIP and whom the state cannot identify as continuously enrolled between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1 (initiation phase).
- Many of the ADHD medications are also used in the treatment of narcolepsy. In order to have a precise ADHD measure, children with narcolepsy should be removed from the denominator of both indicators.
- Include all paid, suspended, pending, and denied claims.
- A comprehensive list of medications and NDC codes can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.
- Refer to Appendix C for the definition of a prescribing practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	The 12-month window starting March 1 of the year prior to the measurement year and ending February 28 of the measurement year.
Negative medication history	A period of 120 days (4 months) prior to the IPSD when the child had no ADHD medications dispensed for either new or refill prescriptions.

IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an ADHD medication where the date is in the Intake Period and there is a Negative Medication History.
Initiation phase	The 30 days following the IPSD.
C&M phase	The 300 days following the IPSD (10 months).
New episode	The child must have a 120-day (4-month) Negative Medication History on or before the IPSD.
Continuous medication treatment	The number of medication treatment days during the 10-month follow-up period must be ≥ 210 days (i.e., 300 treatment days – 90 gap days).
Treatment days (Covered days)	The actual number of calendar days covered with prescriptions within the specified 300-day measurement interval (e.g., a prescription of a 90 days' supply dispensed on the 220th day will have 80 days counted in the 300-day interval).

C. ELIGIBLE POPULATION

Eligible Population: Rate 1 – Initiation Phase

Ages	6 years old as of March 1 of the year prior to the measurement year to 12 years old as of February 28 of the measurement year.
Continuous enrollment	Children must be continuously enrolled in Medicaid/CHIP for 120 days (4 months) prior to the IPSD through 30 days (1 month) after the IPSD.
Allowable gap	None.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 1 - Initiation Phase (Section D) to identify the eligible population for the Initiation Phase.

Eligible Population: Rate 2 – Continuation and Maintenance Phase

Ages	6 years old as of March 1 of the year prior to the measurement year to 12 old years as of February 28 of the measurement year.
Continuous enrollment	Children must be continuously enrolled in Medicaid/CHIP for 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD. Children who switch between Medicaid and CHIP and whom the state cannot identify as continuously enrolled between the Rate 1 and Rate 2 continuous enrollment periods should only be included in Rate 1.

Allowable gap	One 45-day gap in enrollment between 31 days and 300 days (10 months) after the IPSD. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	None.
Benefits	Medical and pharmacy.
Event/diagnosis	Follow the steps under Administrative Specifications: Rate 2 – Continuation and Maintenance (Section D) to identify the eligible population for the Continuation and Maintenance Phase.

D. ADMINISTRATIVE SPECIFICATION

Rate 1 – Initiation Phase

Denominator

The Rate 1 eligible population.

Step 1

Identify all children in the specified age range who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period.

Table ADD-A. ADHD Medications

Description	Prescription
CNS stimulants	Amphetamine-dextroamphetamine Dexmethylphenidate Dextroamphetamine Lisdexamfetamine Methamphetamine Methylphenidate
Alpha-2 receptor agonists	Clonidine Guanfacine
Miscellaneous ADHD medications	Atomoxetine

Source: Refer to Table ADD-A in HEDIS specifications (2016 version).

Step 2

Test for Negative Medication History. For each child identified in step 1, test each ADHD prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3

Calculate continuous enrollment. Children must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD.

Step 4

Exclude children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the IPSD. Any of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Numerator

An outpatient, intensive outpatient, or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. Any of the following code combinations billed by a practitioner with prescribing authority meet the criteria:

- ADD Stand Alone Visits Value Set
- ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set
- ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set

Note: Do not count a visit on the IPSD as the Initiation Phase visit.

Rate 2 – Continuation and Maintenance

Denominator

The Rate 2 eligible population.

Step 1

Identify all children that meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2

Calculate continuous enrollment. Children must be continuously enrolled from 120 days (4 months) prior to the IPSD and 300 days (10 months) after the IPSD.

Step 3

Calculate the continuous medication treatment. Using the children in Step 2, determine if the child filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the IPSD. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4

Exclude children who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the IPSD. Any of the following meet criteria:

- An acute inpatient encounter (Acute Inpatient Value Set) with a principal mental health diagnosis (Mental Health Diagnosis Value Set)
- An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Numerator

Identify all children that meet the following criteria:

- Numerator compliant for Rate 1 Initiation Phase, and
- At least two follow-up visits with any practitioner, from 31–300 days (9 months) after the IPSPD

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

- ADD Stand Alone Visits Value Set
- ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set
- ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set
- Telephone Visits Value Set

Exclusions (optional)

Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

E. ADDITIONAL NOTES

For children who have multiple overlapping prescriptions, count the overlap days once toward the days' supply (whether the overlap is for the same drug or for a different drug).

There may be different methods for billing intensive outpatient encounters 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. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the time frame required for the rate (e.g., within 30 days after or from 31–300 days after the IPSPD).

MEASURE AMB-CH: AMBULATORY CARE – EMERGENCY DEPARTMENT VISITS

National Committee for Quality Assurance

A. DESCRIPTION

Rate of emergency department (ED) visits per 1,000 enrollee months among children up to age 19.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure includes all ages. For reporting the Child Core Set measure, include children up to age 19 when reporting the three measure rates (less than 1 year, 1 to 9 years, and 10 to 19 years).
- Report all services the state paid for or expects to pay for (i.e., claims incurred but not paid). Do not include services and days denied for any reason. If a child is enrolled retroactively, count all services for which the state paid or expects to pay.

The following coding systems are used in this measure: CPT, ICD-9, ICD-10, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Enrollee months	Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year.
-----------------	---

C. ELIGIBLE POPULATION

Age	Children up to age 19 enrolled in Medicaid or CHIP. This measure is calculated for three age groups: less than 1, 1 to 9, and 10 to 19.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of enrollee months.

Step 1: Determine enrollee months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The day selected must be consistent from person to person, month to month, and year to year. For example, if the state tallies enrollment on the 15th of the month and a child is enrolled in the Medicaid or CHIP program on January 15, the child contributes one enrollee month in January.

Retroactive enrollment. The state may include in these enrollee months, any months in which children were enrolled retrospectively and for which the state is responsible for providing benefit coverage.

Step 2: Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be contributed. For example, if a state tallies enrollment on the 15th of each month and a child turns 10 on April 3 and is enrolled for the entire year, then he or she contributes three enrollee months (January, February, and March) to the 1–9 age category and nine enrollee months to the 10–19 age category.

Numerator

Number of ED visits: To determine the number of ED visits, count the total number of visits the state paid for during the measurement year. Count each visit to an ED that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify ED visits using either of the following:

- An ED visit (ED Value Set)
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set)

Age of Enrollee: Report age as of the date of service.

Matching enrollment with utilization: Run enrollment reports used for enrollee month calculations to determine utilization rates (such as ED visits/1,000 enrollees months) within 30 days of the claims reports and for the same time period. Include retroactive additions and terminations in these reports.

Counting Multiple Services: If a child receives the same service two different times (e.g., ED visits six months apart), count them as two visits. Count services, not the frequency of procedure codes billed (e.g., if a physician and a hospital submit separate bills pertaining to the same ED visit with the same date of service, only one should be included). The state must develop its own systems to avoid double counting.

E. EXCLUSIONS (REQUIRED)

The measure does not include mental health or chemical dependency services.

Exclude claims and encounters that indicate the encounter was for mental health or chemical dependency. Any of the following meet criteria for exclusion:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set)
- Psychiatry (Psychiatry Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set)
- Alcohol or drug rehabilitation or detoxification (AOD Rehab and Detox Value Set)

F. CALCULATION OF THE ED VISIT RATES

Calculate the ED visit rate by dividing the number of ED visits by the number of enrollee months and multiply by 1,000, as follows:

- ED Visit Rate = (Number of ED visits/number of enrollee months) x 1,000

Table AMB-A. ED Visits per 1,000 Enrollee Months, by Age

Age	ED Visits	Enrollee Months	Visits per 1,000 Enrollee Months
<1			
1–9			
10–19			
Unknown			
Total			

Source: Refer to Table AMB-1 in HEDIS specifications (2016 version).

MEASURE APC-CH: USE OF MULTIPLE CONCURRENT ANTIPSYCHOTICS IN CHILDREN AND ADOLESCENTS

Agency for Healthcare Research and Quality - Centers for Medicare & Medicaid Services
Children's Health Insurance Program Reauthorization Act
National Collaborative for Innovation in Quality Measurement

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who were on two or more concurrent antipsychotic medications.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure was developed by the National Collaborative for Innovation in Quality Measurement, and is included in HEDIS® 2016. More information about this measure and six other measures developed for assessing safe and judicious use of antipsychotic medications in children and adolescents is available at http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra_1415-p011-1-ef_0.pdf.
- To be eligible for this measure, enrollees must have at least 90 days of continuous antipsychotic medication treatment during the measurement year. Continuous treatment can include different medications; however, first-time prescriptions for an enrollee must be dispensed prior to October 3 to meet the eligibility criteria as described in Step 5 of the Denominator Specifications.
- A comprehensive list of medications and NDC codes can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.
- Include all paid, suspended, pending, and denied claims.

The following coding system is used in this measure: NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	<p>1 to 17 years old as of December 31 of the measurement year. Report three age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 1–5 years • 6–11 years • 12–17 years • Total <p>The total rate is the sum of the numerators for the three age stratifications divided by the sum of the denominators for the three stratifications.</p>
Continuous enrollment	The measurement year.

Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	<p>Enrollees with 90 days of continuous antipsychotic medication treatment during the measurement year. Use the steps below to determine the eligible population.</p> <p>Step 1 Identify enrollees in the specified age range who were dispensed an antipsychotic medication (Table APC-A) during the measurement year.</p> <p>Step 2 Calculate continuous enrollment. The enrollee must be continuously enrolled during the measurement year.</p> <p>Step 3 For each enrollee, identify all antipsychotic medication dispensing events (prescriptions) during the measurement year.</p> <p>Step 4 Identify start and end dates for drug events. Drug events are defined separately by drug using the Drug ID field in the NDC list. For each drug ID, sort dispensing events chronologically by dispense date. If there is more than one prescription for the same medication dispensed on the same day, use only the prescription with the longest days supply in the calculation.</p> <p>Starting with the first prescription in the measurement year determine if there is a second dispense date with the same Drug ID.</p> <ul style="list-style-type: none"> • If there is no second dispensing event with the same Drug ID, the start date is the first prescription's dispense date and the end date is the start date plus the days supply minus one. For example, a January 1 prescription with a 30 days supply has an end date of January 30. • If there is a second dispensing event with the same Drug ID, determine if there are gap days (a gap of up to 32 days is allowed). Calculate the number of days between (but not including) the first prescription's dispense date and the second prescription's dispense date. If the number of days is less than or equal to the first prescription's days supply plus 32 days, the gap is less than or equal to 32 days and is allowed. The start date is the first prescription's dispense date and the end date is the second prescription's dispense date plus days supply minus one. Continue assessing all subsequent dispensing events with allowable gaps for the same Drug ID and adjust end dates as needed.

<p>Event/diagnosis (continued)</p>	<ul style="list-style-type: none"> - For example, an enrollee has two dispensing events with the same Drug ID. The first is on July 1, with a 30 days supply. The second is on September 1, with a 30 days supply. The number of days between (but not including) the dispense dates is 61 (July 2–August 31). The gap is allowed because 61 is less than the first prescription’s days supply plus 32 days (30 + 32 = 62). The start date is July 1 and the end date is September 30. • If there is a second dispensing event with the same Drug ID and there is a gap that exceeds the allowable gap, assign an end date for this drug event and follow the beginning of step 4 for the remaining dispensing events. An enrollee can have multiple start and end dates per Drug ID during the measurement year. <p>Continue assessing each dispensed prescription for each Drug ID until all dispensing events are exhausted. If a dispensing event goes beyond December 31 of the measurement year, assign the end date as December 31.</p> <p>Step 5</p> <p>For each enrollee, identify those with ≥90 consecutive treatment days.</p> <p>For each enrollee, using the start and end dates from all drug events identified in step 4 (which may include events for the same or different medications and may include events with allowable gaps), determine all calendar days covered by at least one antipsychotic medication. If there were ≥90 consecutive calendar days, include the enrollee in the measure.</p>
------------------------------------	---

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Table APC-A: Antipsychotic Medications

Description	Prescription
<p>First Generation Antipsychotic Medications</p>	<p>Chlorpromazine HCL Fluphenazine HCL Fluphenazine decanoate Haloperidol Haloperidol decanoate Haloperidol lactate Loxapine HCL Loxapine succinate Molindone HCL Perphenazine Pimozide</p>

Description	Prescription
First Generation Antipsychotic Medications (continued)	Thioridazine HCL Thiothixene Trifluoperazine HCL
Second Generation Antipsychotic Medications	Aripiprazole Clozapine Iloperidone Lurasidone Olanzapine Olanzapine pamoate Paliperidone Paliperidone palmitate Quetiapine fumarate Risperidone Risperidone microspheres Ziprasidone HCL Ziprasidone mesylate

Note: A comprehensive list of medications and NDC codes can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

Numerator

Enrollees on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. Use the steps below to determine the numerator.

Step 1

For each enrollee, identify all drug events by Drug ID field in the NDC list, start dates, and end dates (identified in step 4 of the event/diagnosis criteria used to identify the eligible population [denominator]).

Step 2

Identify concurrent antipsychotic medication treatment events as follows:

- For each enrollee, identify the first day during the measurement year when the enrollee was treated with two or more different antipsychotic medications (use the Drug ID field in the NDC list to identify different drugs). This is the concurrent antipsychotic medication treatment event start date.
- Beginning with (and including) the start date, identify the number of consecutive days the enrollee remains on two or more different antipsychotic medications. If the number of days is ≥ 90 days, the enrollee is numerator compliant.
- If the number of consecutive days on multiple antipsychotic medications is < 90 days, identify the end date and identify the next day during the measurement year when the enrollee was treated with two or more different antipsychotic medications. If the number of days between the end date and the next start date is ≤ 15 days, include the days in the concurrent antipsychotic medication treatment event (concurrent antipsychotic medication treatment events allow a gap of up to 15 days).
- If the number of days between the end date and the next start date is greater than 15 days, end the event; using the new start date, continue to assess for concurrent antipsychotic medication treatment events.

- Continue this process until the number of concurrent antipsychotic medication treatment days is ≥ 90 consecutive days (i.e., the enrollee is numerator compliant) or until the measurement year is exhausted (i.e., the enrollee is not numerator compliant because no concurrent antipsychotic medication treatment events were identified during the measurement year).

MEASURE AUD-CH: AUDIOLOGICAL EVALUATION NO LATER THAN THREE MONTHS OF AGE

Centers for Disease Control and Prevention

A. DESCRIPTION

Percentage of newborns who did not pass hearing screening and have an audiological evaluation no later than 3 months of age (90 days).

Data Collection Method: Electronic Health Record

Guidance for Reporting:

- This measure (NQF#1360) is one of three process measures developed by CDC's Early Hearing Detection and Intervention (EHDI) program for monitoring program performance and continuing quality improvement in the field of newborn hearing screening and follow-up services. More information about CDC's EHDI program is available at <http://www.cdc.gov/ncbddd/hearingloss/ehdi-programs.html>.
- State-level data from the 2013 CDC EHDI Hearing Screening and Follow-Up Survey (HSFS) are available at http://www.cdc.gov/ncbddd/hearingloss/2013-data/diag_2013_3month_web-c.pdf. The last column shows the percent diagnosed before 3 months of age.

The following coding systems are used in this measure: LOINC, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Infants enrolled in Medicaid or CHIP who were born between January 1 and December 31 of the measurement year.
Continuous enrollment	Date of birth to 90 days of age.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of birth.
Benefit	Medical.
Event/diagnosis	Has not passed a hearing screening as indicated by "Fail / Refer."

C. ELECTRONIC HEALTH RECORD SPECIFICATION

Denominator

The number of infants born during the measurement year who have not passed ("Fail / Refer") hearing screening as indicated by the following criteria:

- LOINC# 54109-4: Newborn hearing screen – right = Refer LA10393-9 OR
- LOINC# 54108-6: Newborn hearing screen – left = Refer LA10393-9

Numerator

The number of infants born during the measurement year who have not passed ("Fail / Refer") hearing screening and whose age is less than 91 days at the time of audiological diagnosis.

To be included in the numerator, infants must meet the following criteria:

- Hearing screening results indicate "Fail / Refer" (denominator population) AND
- Have an "Audiological Diagnosis" (SNOMED-CT equals Hearing Normal 164059009, Permanent Conductive 44057004, Sensorineural 60700002, Mixed 77507001, OR Auditory Neuropathy Spectrum Disorder 443805006) AND
- Age of diagnosis is less than 91 days at the time of diagnosis.

Exclusions

Newborns who died prior to 91 days of age, as indicated by the following discharge status codes found in Field Locator 17 of the UB-04 (CMS-1450) claim form:

UB-04 Code	Description
20	Expired
40 ^{ab}	Expired at home
41 ^a	Expired in a medical facility such as a hospital, skilled nursing facility, intermediate care facility, or freestanding hospice
42 ^{ab}	Expired – place unknown

^aThis code is for use only on hospice care claims.

^bThis code is for use only on Medicare and Tricare claims for hospice care.

MEASURE AWC-CH: ADOLESCENT WELL-CARE VISIT

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetric/gynecologic (OB/GYN) practitioner during the measurement year.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for definitions of PCP and OB/GYN practitioners.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	12 to 21 years old as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Adolescents who have had no more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the adolescent may not have more than a 1-month gap in coverage (i.e., an adolescent whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

At least one comprehensive well-care visit (Well-Care Value Set) with a PCP or an OB/GYN practitioner during the measurement year. The practitioner does not have to be the practitioner assigned to the adolescent.

D. HYBRID SPECIFICATION**Denominator**

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

At least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review. The PCP does not have to be assigned to the adolescent.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Documentation in the medical record must include a note indicating a visit to a PCP or OB/GYN practitioner, the date when the well-care visit occurred and evidence of all of the following:

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the state would consider PCPs may be counted if documentation that a well-care exam occurred is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the adolescent.

The state may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

E. ADDITIONAL NOTES

This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at <http://www.aap.org> and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at <http://www.Brightfutures.org> for more information about well-care visits.

MEASURE BHRA-CH: BEHAVIORAL HEALTH RISK ASSESSMENT (FOR
PREGNANT WOMEN)

American Medical Association-convened Physician Consortium for Performance Improvement ®
(AMA-PCPI)

A. DESCRIPTION

Percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: depression screening, alcohol use screening, tobacco use screening, drug use screening (illicit and prescription, over the counter), and intimate partner violence screening.

Data Collection Method: Electronic Health Records

Guidance for Reporting:

- This measure is only specified for calculation using electronic health records.
- To satisfactorily meet the numerator, all screening components must be performed.
- The specifications for this measure do not include upper or lower age restrictions.
- If an eligible woman has more than one birth during the measurement year, states should count each delivery separately in both the Initial Patient Population (IPP) and Denominator (D). To be counted toward the numerator, each delivery must have a BHRA conducted at the first prenatal visit within the specified time frame for each delivery.
- The BHRA-CH value set directory is available at <https://www.medicaid.gov/license-agreement-cpt-nubc.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2016-child-bhra-value-set-directory.zip>.

The following coding systems are used in this measure: CDC, CPT, HL7, LOINC, PHDSC, and SNOMED. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. SUMMARY OF E-SPECIFICATION

Clinical topic	Maternity care.
Measure title	Behavioral Health Risk Assessment.
Measure #	MC-3.
Measurement period	12 consecutive months.
Initial patient population	All patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care.
Denominator statement	Equals initial patient population.
Denominator exclusions	None.

<p>Numerator statement</p>	<p>Patients who received the following behavioral health screening risk assessments at the first prenatal visit.</p> <p>Depression screening</p> <ul style="list-style-type: none"> • Patients who were screened for depression at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer-administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool [e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)]. <p>Alcohol use screening</p> <ul style="list-style-type: none"> • Patients who were screened for any alcohol use at the first visit <p>Tobacco use screening</p> <ul style="list-style-type: none"> • Patients who were screened for tobacco use at the first visit <p>Drug use (illicit and prescription, over the counter) screening</p> <ul style="list-style-type: none"> • Patients who were screened for any drug use at the first visit <p>Intimate partner violence screening</p> <ul style="list-style-type: none"> • Patients who were screened for intimate partner violence/abuse at the first visit. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Intimate partner violence screening may include a self-reported validated depression screening tool (e.g., Hurt, Insult, Threaten, and Scream [HITS], Woman Abuse Screening Tool [WAST], Partner Violence Screen [PVS], Abuse Assessment Screen [AAS]). <p>To satisfactorily meet the numerator, ALL screening components must be performed.</p>
<p>Denominator exceptions</p>	<p>None.</p>

C. DEFINITIONS

Initial Patient Population (IPP)	Denominator (D)	Exclusions (EXCL)	Numerator (N)	Exceptions (EXCEP)
<p>Definition: The group of patients that a set of performance measures is designed to address; usually focused on a specific clinical condition (e.g., coronary artery disease, asthma). For example, a patient age 18 and older with a diagnosis of CAD who has at least 2 visits during the measurement period.</p>	<p>Definition: The specific group of patients for inclusion in a specific performance measure based on specific criteria (e.g., patient’s age, diagnosis, prior MI). In some cases, the denominator may be identical to the initial patient population.</p>	<p>Definition: The specific group of patients who should be subtracted from the measure population and denominator before determining if the numerator criteria are met.</p>	<p>Definition: The group of patients in the denominator for whom a process or outcome of care occurs (e.g., flu vaccine received).</p>	<p>Definition: The valid reasons why patients who are included in the denominator population did not receive a process or outcome of care (described in the numerator). Patients may have Exceptions for medical reasons (e.g., patient has an egg allergy so did not receive flu vaccine); patient reasons (e.g., patient declined flu vaccine); or system reasons (e.g., patient did not receive flu vaccine due to vaccine shortage). These cases are subtracted from the denominator population for the performance calculation; however, the number of patients with valid exceptions should be calculated and reported. This group of patients constitutes the Exception reporting population – patients for whom the numerator was not achieved and there is a valid Exception.</p>
<p>Find the patients who meet the Initial Patient Population criteria (IPP).</p>	<p>Find the patients who qualify for the Denominator (D): From the patients within the Patient Population Criteria (IPP), select those people who meet Denominator selection criteria. (In some cases the IPP and D are identical).</p>	<p>Find the patients who qualify for the Exclusion (EXCL): From the patients within the Denominator criteria, select those patients who meet Exclusion criteria. The patients meeting exclusion criteria should be removed from the Denominator.</p>	<p>Find the patients who qualify for the Numerator (N): From the patients within the Denominator (D) criteria, select those people who meet Numerator selection criteria. Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.</p>	<p>From the patients who did not meet the Numerator criteria, determine if the patient meets any criteria for the Exception (E1 +E2 +E3). If they meet any criteria, they should be removed from the Denominator for performance calculation. As a point of reference, these cases are removed from the denominator population for the performance calculation, however the number of patients with valid exceptions should be calculated and reported.</p>

D. MATERNITY CARE DATA REQUIREMENTS FOR HEALTH RISK ASSESSMENT E-SPECIFICATION

Table BHRA-A: Maternity Care Data Requirements: Supplemental Data Elements Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/Rationale
Individual characteristic	Patient characteristic	Age at Delivery	LOINC	2.16.840.1.113883.3.526.2.1434	During [Attribute, stop date time: Date of Delivery]	There are no restrictions on age for inclusion in the measure. This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual characteristic	Patient characteristic	Gender	HL7 (2.16.840.1.113883.5.1)	2.16.840.1.113883.1.11.1	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual characteristic	Patient characteristic	Race	CDC	2.16.840.1.114222.4.11.836	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual characteristic	Patient characteristic	Ethnicity	CDC	2.16.840.1.114222.4.11.837	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Individual characteristic	Patient characteristic	Preferred Language	CDC	2.16.840.1.114222.4.11.831	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual characteristic	Patient characteristic	Payer	Source of Payment Typology	2.16.840.1.113883.221.5	During measurement period	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

Table BHRA.B. Maternity Care Data Requirements: Initial Patient Population Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Measure timing	n.a.	Measurement Start Date	n.a.	n.a.	TBD by measure implementer	
Measure timing	n.a.	Measurement End Date	n.a.	n.a.	TBD by measure implementer	
Procedure	Procedure, performed	Vaginal Delivery	GROUPING CPT SNOMED-CT	2.16.840.1.113883.3.526.3.1341 2.16.840.1.113883.3.526.2.1411 2.16.840.1.113883.3.526.2.1412	During measurement period	
Procedure	Procedure, performed	Cesarean Section Delivery	GROUPING CPT SNOMED-CT	2.16.840.1.113883.3.526.3.1342 2.16.840.1.113883.3.526.2.1413 2.16.840.1.113883.3.526.2.1414	During measurement period	

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Attribute	Attribute: stop datetime	Date of Delivery	n.a.	n.a.	n.a.	This data element is the date associated with "Procedure, Performed: Vaginal Delivery" or "Procedure, Performed: Cesarean Section Delivery" collected for the purpose of a 'look back period'. The delivery is the trigger for the measure and the numerator quality actions will be limited to 44 weeks prior to delivery to associate the action with the reporting pregnancy.
Encounter	Encounter, performed	Prenatal visit	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1264 2.16.840.1.113883.3.526.2.338	Starts before start of [Procedure, Performed: Vaginal Delivery] <= 44 weeks; starts before start of [Procedure, Performed: Cesarean Section Delivery] <= 44 weeks	

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

n.a. = not applicable

Table BHRA.C. Maternity Care Data Requirements: Denominator and Denominator Exclusions Measure Component

Measure Component	QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Denominator							Equals Initial Patient Population
Denominator exclusions							None

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

Table BHRA.D. Maternity Care Data Requirements: Numerator Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Risk category/ Assessment	Risk category/ Assessment	Depression Screening Tools Related to Maternity Care	GROUPING LOINC	2.16.840.1.113883.3.526.3.1359 2.16.840.1.113883.3.526.2.1441	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	Depression screening may include a self-reported validated depression screening tool (e.g., PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS)).
Intervention	Intervention, result	Depression Screening-Procedure	GROUPING SNOMED-CT	2.16.840.1.113883.3.526.3.1360 2.16.840.1.113883.3.526.2.1442	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	-

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Risk category/ Assessment	Risk category/ Assessment	Alcohol Use Screening	GROUPING LOINC	2.16.840.1.113883.3.526.3.1361 2.16.840.1.113883.3.526.2.1443	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	
Risk category/ Assessment	Risk category/ Assessment	Tobacco Use Screening	GROUPING LOINC	2.16.840.1.113883.3.526.3.1362 2.16.840.1.113883.3.526.2.1444	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	For the purposes of this measure a 'positive' tobacco use screen will be admittance by patient of ANY use.
Risk category/ Assessment	Risk category/ Assessment	Illicit, Prescription and Over the Counter Drug Use Screening	GROUPING LOINC	2.16.840.1.113883.3.526.3.1363 2.16.840.1.113883.3.526.2.1445	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	This data element includes screening for illicit drug use, prescription drug use, and over the counter drug use.

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Risk category/ Assessment	Risk category/ Assessment	Intimate Partner Violence Screening-Tool	GROUPING LOINC	2.16.840.1.113883.3.526.3.1364 2.16.840.1.113883.3.526.2.1446	During FIRST [Encounter, Performed: Prenatal Visit] starts before the start of [Attribute, stop datetime: Date of Delivery] <= 44 weeks	Intimate partner violence screening may include a self-reported validated screening tool (e.g., Hurt, Insult, Threaten, and Scream (HITS), Woman Abuse Screening Tool (WAST), Partner Violence Screen (PVS), Abuse Assessment Screen (AAS)).
Attribute	Attribute: result	Present "X"	n.a.	n.a.	n.a.	This attribute can be applied to the value sets titled: 'Depression Screening Tools Related to Maternity Care,' 'Depression Screening-Procedure,' 'Alcohol Use Screening,' 'Tobacco Use Screening,' 'Drug Use Screening,' 'Intimate Partner Violence Screening-Tool.'

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

n.a. = not applicable

Table BHRA-E. Maternity Care Data Requirements: Denominator Exception Measure Component

QDM* Standard Category	QDM* Data Type	Value Set Name	Standard Terminology	OID	Constraints	Comments/ Rationale
Denominator exception						No Valid Denominator Exceptions.

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

Measure Performance Rate Calculation:

$$\text{Performance Rate} = N / (D - \text{EXCL} - \text{EXCEP})$$

The PCPI strongly recommends that exception rates also be computed and reported alongside performance rates as follows:

Measure Exception Rate Calculation:

$$\text{Exception Rate} = \text{EXCEP} / (D - \text{EXCL})$$

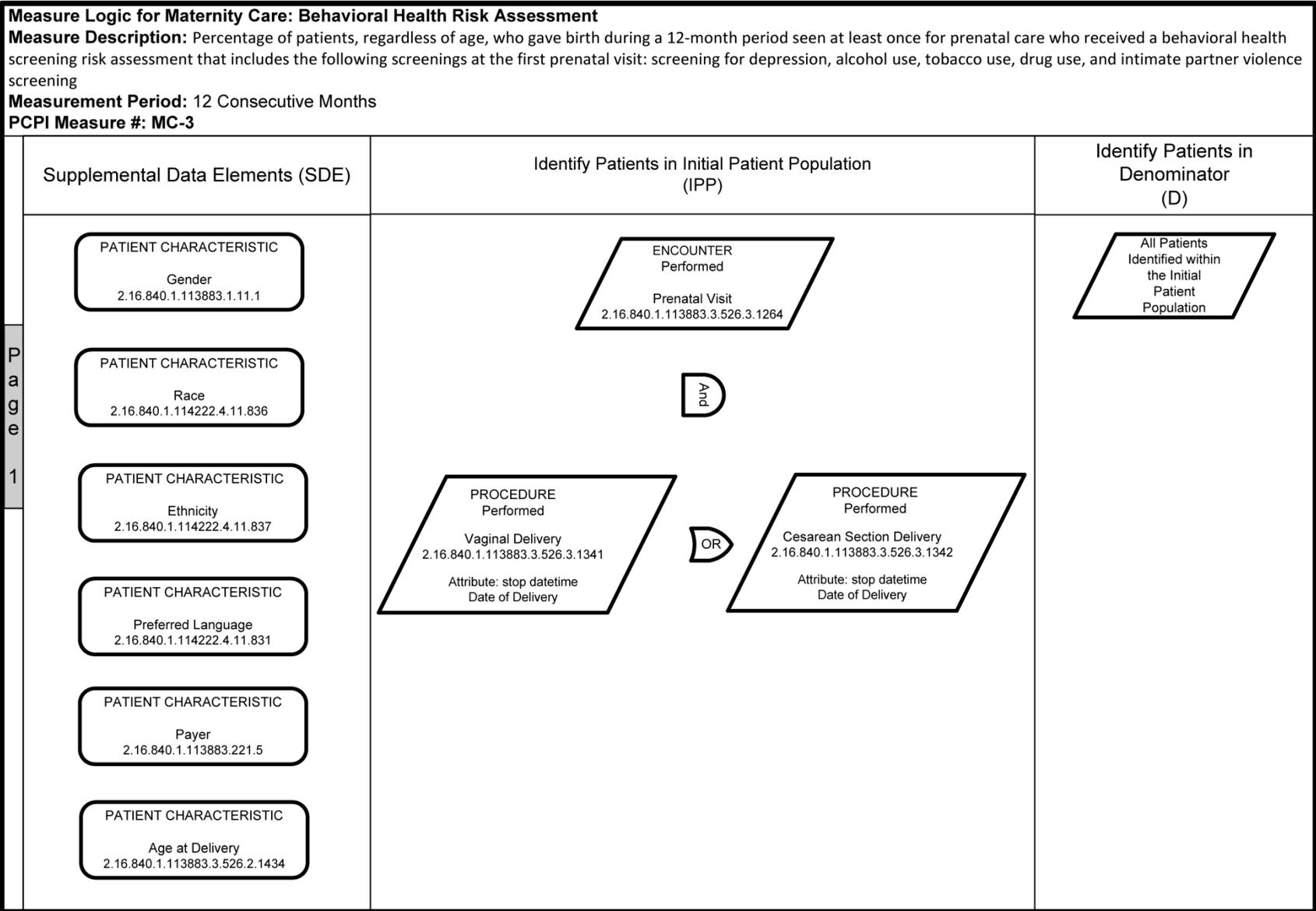
Exception Types:

$$\text{EXCEP} = \text{E1 (Medical Exceptions)} + \text{E2 (Patient Exceptions)} + \text{E3 (System Exceptions)}$$

For patients who have more than one valid exception, only one exception should be counted when calculating the exception rate.

Figure BHRA.A. PCPI E-Specification

PCPI eSpecification



See Data Requirements Table for timing constraints and relationship between data elements.

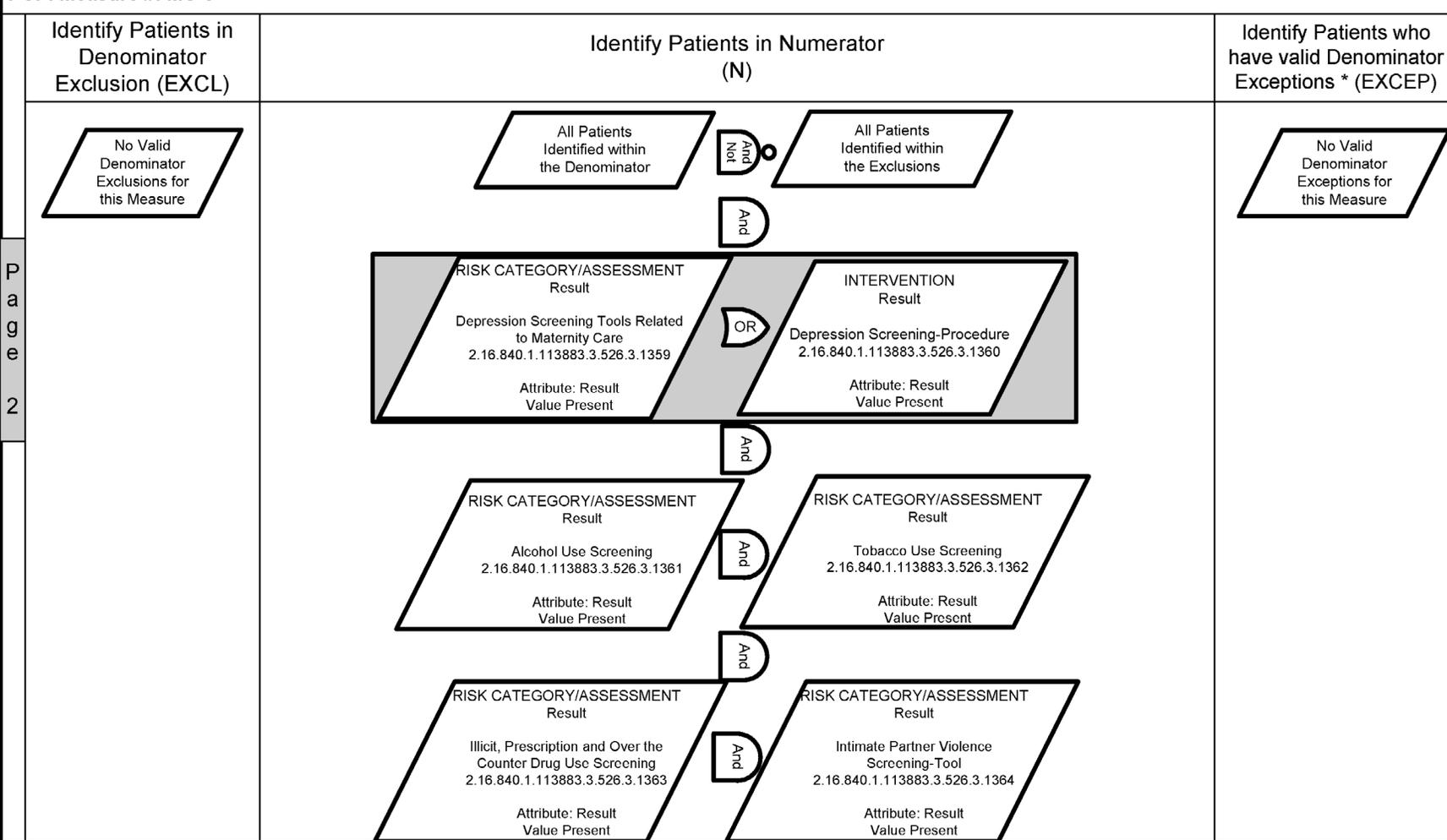
PCPI eSpecification

Measure Logic for Maternity Care: Behavioral Health Risk Assessment

Measure Description: Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence screening

Measurement Period: 12 Consecutive Months

PCPI Measure #: MC-3



See Data Requirements Table for timing constraints and relationship between data elements.

*Coded examples for exceptions are NOT intended to be an exhaustive list. Exceptions will vary for each patient and situation.

MEASURE CAP-CH: CHILDREN AND ADOLESCENT ACCESS TO PRIMARY CARE PRACTITIONERS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children and adolescents ages 12 months to 19 years who had a visit with a primary care practitioner (PCP). Four separate percentages are reported:

- Children ages 12 to 24 months and 25 months to 6 years who had a visit with a PCP during the measurement year
- Children ages 7 to 11 years and adolescents 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year

Data Collection Method: Administrative

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of a PCP.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	<p>12 months to 19 years old as of December 31 of the measurement year. Report four age stratifications:</p> <ul style="list-style-type: none"> • 12 to 24 months old as of December 31 of the measurement year. Include all children who are at least 12 months old but younger than 25 months old during the measurement year (i.e., born on or between December 1, 2013, and December 31, 2014). • 25 months to 6 years old as of December 31 of the measurement year. Include all children who are at least 2 years and 31 days old but not older than 6 years during the measurement year (i.e., born on or between January 1, 2009 and November 30, 2013). • 7 to 11 years old as of December 31 of the measurement year • 12 to 19 years old as of December 31 of the measurement year
Continuous enrollment	<p>For ages 12 to 24 months, ages 25 months to 6 years: The measurement year. For ages 7 to 11 years, ages 12 to 19 years: The measurement year and the year prior to the measurement year.</p>
Allowable gap	<p>For ages 12 to 24 months, ages 25 months to 6 years: No more than one gap in enrollment of up to 45 days during the measurement year. For ages 7 to 11 years, ages 12 to 19 years: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child/adolescent may not have more than a 1-month gap in coverage (i.e., a child/adolescent whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.</p>

Anchor date	December 31 of the measurement year.
Benefit	Medical.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

For ages 12 to 24 months, ages 25 months to 6 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year.

For ages 7 to 11 years, ages 12 to 19 years: One or more visits with a PCP (Ambulatory Visits Value Set) during the measurement year or the year prior to the measurement year.

Count all children/adolescents who had an ambulatory or preventive care visit to any PCP.

Exclude specialist visits.

MEASURE CHL-CH: CHLAMYDIA SCREENING IN WOMEN

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of women ages 16 to 20 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- In the original HEDIS specification, this measure has three reportable rates—ages 16 to 20 and 21 to 24 cohorts and a total (ages 16 to 24). For reporting of the Child Core Set measure, include the rate for ages 16 to 20 only.
- Include all paid, suspended, pending, and denied claims.
- NDC codes to identify contraceptives are listed at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, LOINC, NDC and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Women ages 16 to 20 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the woman may not have more than a 1-month gap in coverage (i.e., a woman whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/diagnosis	<p>Sexually active. Two methods identify sexually active women: pharmacy data and claim/encounter data. The state must use both methods to identify the eligible population; however, a woman only needs to be identified in one method to be eligible for the measure.</p> <p>Claim/encounter data. Women who had a claim or encounter indicating sexual activity during the measurement year. A code from any of the following meets criteria:</p> <ul style="list-style-type: none"> • <u>Pregnancy Value Set</u> • <u>Pregnancy Tests Value Set</u> • <u>Sexual Activity Value Set</u> <p>Pharmacy data. Women who were dispensed prescription contraceptives during the measurement year (Table CHL-A).</p>
-----------------	---

Table CHL-A. Prescriptions to Identify Contraceptives

Description	Prescription	
Contraceptives	Desogestrel-ethinyl estradiol Dienogest-estradiol multiphasic Drospirenone-ethinyl estradiol Drospirenone-ethinyl estradiol-levomefolate biphasic Ethinyl estradiol-ethynodiol Ethinyl estradiol-etonogestrel Ethinyl estradiol-levonorgestrel Ethinyl estradiol-norelgestromin	Ethinyl estradiol-norethindrone Ethinyl estradiol-norgestimate Ethinyl estradiol-norgestrel Etonogestrel Levonorgestrel Medroxyprogesterone Mestranol-norethindrone Norethindrone
Diaphragm	Diaphragm	
Spermicide	Nonxynol 9	

Source: Refer to Table CHL-A in HEDIS specifications (2016 version).

Note: A comprehensive list of medications and NDC codes can be found at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016/HEDIS2016NDCLicense.aspx>.

C. ADMINISTRATIVE SPECIFICATION**Denominator**

The eligible population.

Numerator

At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Exclusions (optional)

Exclude women who qualified for the denominator based on a pregnancy test (Pregnancy Tests Value Set) alone and who meet either of the following:

- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and a prescription for isotretinoin (Table CHL-B) on the date of the pregnancy test or within 6 days after the pregnancy test
- A pregnancy test (Pregnancy Test Exclusion Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or within 6 days after the pregnancy test

Table CHL-B. Medications to Identify Exclusions

Description	Prescription
Retinoid	Isotretinoin

Source: Refer to Table CHL-E in HEDIS specifications (2016 version).

MEASURE CIS-CH: CHILDHOOD IMMUNIZATION STATUS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children 2 years old who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- States should report a separate rate for each vaccine, as well as 9 combination rates.
- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all Medicaid and CHIP-enrolled children who turned 2 years old during the reporting year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, any immunizations missing from claims or registry data must be sought from medical records.
- For states reporting a Child Core Set measure that is also an Electronic Health Record (EHR) Medicaid Incentive Program measure, indicate whether any information was extracted from electronic health records. Please report this information in the "Other Comments on Measure" field.
- The 14-Day Rule specifies that the vaccinations (with the exception of MMR) must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. This rule does not apply to the MMR vaccine. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children who turn 2 years old during the measurement year.
Continuous enrollment	12 months prior to the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the child's second birthday.

Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

For MMR, hepatitis B, VZV and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine, or
- Documented history of the illness, or
- A seropositive test result for each antigen

For DTaP, IPV, HiB, pneumococcal conjugate, rotavirus and influenza, count only:

- Evidence of the antigen or combination vaccine

For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), evidence of all the antigens must be found.

DTaP

At least four DTaP vaccinations (DTaP Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

IPV

At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

MMR

Any of the following with a date of service on or before the child's second birthday meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set)
- At least one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) on the same date of service or on different dates of service
- At least one measles vaccination or history of the illness (Measles Vaccine Administered Value Set; Measles Value Set) and at least one mumps vaccination or history of the illness (Mumps Vaccine Administered Value Set; Mumps Value Set) and at least one rubella vaccination or history of the illness (Rubella Vaccine Administered Value Set; Rubella Value Set) on the same date of service or on different dates of service

Note: The "14-day rule" does not apply to the MMR vaccine.

HiB

At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis B

Either of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service
 - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the eight-day period that begins on the date of birth and ends seven days after the date of birth. For example, if the enrollee's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis illness (Hepatitis B Value Set)

VZV

Either of the following on or before the child's second birthday meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Administered Value Set), with a date of service on or before the child's second birthday
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set)

Pneumococcal Conjugate

At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth.

Hepatitis A

Either of the following on or before the child's second birthday meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Vaccine Administered Value Set), with a date of service on or before the child's second birthday
- History of hepatitis A illness (Hepatitis A Value Set)

Rotavirus

Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth:

- At least two doses of the two-dose rotavirus vaccine (Rotavirus Vaccine [2 Dose Schedule] Administered Value Set) on different dates of service
- At least three doses of the three-dose rotavirus vaccine (Rotavirus Vaccine [3 Dose Schedule] Administered Value Set) on different dates of service
- At least one dose of the two-dose rotavirus vaccine (Rotavirus Vaccine [2 Dose Schedule] Administered Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus Vaccine [3 Dose Schedule] Administered Value Set), all on different dates of service

Influenza

At least two influenza vaccinations (Influenza Vaccine Administered Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to six months (180 days) after birth.

Combination rates

Calculate the following rates for Combination 2–Combination 10 as shown in Table CIS-A.

Table CIS-A: Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 2	x	X	x	x	x	x				
Combination 3	x	X	x	x	x	x	x			
Combination 4	x	X	x	x	x	x	x	x		
Combination 5	x	X	x	x	x	x	x		x	
Combination 6	x	X	x	x	x	x	x			x
Combination 7	x	X	x	x	x	x	x	x	x	
Combination 8	x	X	x	x	x	x	x	x		x
Combination 9	x	X	x	x	x	x	x		x	x
Combination 10	x	X	x	x	x	x	x	x	x	x

Exclusion (optional)

Exclude children who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

Exclude contraindicated children only if administrative data do not indicate that the contraindicated immunization was rendered in its entirety.

Any of the following on or before the child's second birthday meet optional exclusion criteria:

Any particular vaccine:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set)

DTaP:

- Encephalopathy (Encephalopathy Due To Vaccination Value Set) with a vaccine adverse-effect code (Vaccine Causing Adverse Effect Value Set)

MMR, VZV and Influenza:

- Immunodeficiency (Disorders of the Immune System Value Set)
- HIV (HIV Value Set)
- Lymphoreticular cancer, multiple myeloma, or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set)
- Anaphylactic reaction to neomycin

IPV:

- Anaphylactic reaction to streptomycin, polymyxin B or neomycin

Hepatitis B:

- Anaphylactic reaction to common baker's yeast

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerators

For MMR, hepatitis B, VZV, and hepatitis A, count any of the following:

- Evidence of the antigen or combination vaccine
- Documented history of the illness
- A seropositive test result

For DTaP, HiB, IPV, pneumococcal conjugate, rotavirus, and influenza, count only:

- Evidence of the antigen or combination vaccine
- For combination vaccinations that require more than one antigen (i.e., DTaP and MMR), the state must find evidence of all the antigens.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

For immunization evidence obtained from the medical record, count children where there is evidence that the antigen was rendered from one of the following:

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered

For documented history of illness or a seropositive test result, there must be a note indicating the date of the event, which must have occurred by the child's second birthday.

Notes in the medical record indicating that the child received the immunization "at delivery" or "in the hospital" may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "child is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

Exclusion (Optional)

Refer to Administrative Specification for exclusion criteria. The exclusion must have occurred by the child's second birthday.

E. ADDITIONAL NOTES

This measure follows the Centers for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years, to account for the measure's look-back period and to allow the industry time to adapt to new guidelines.

MEASURE CLABSI-CH: PEDIATRIC CENTRAL LINE-ASSOCIATED BLOOD STREAM INFECTIONS

Centers for Disease Control and Prevention

A. DESCRIPTION

The Standardized Infection Ratio (SIR) of central line-associated bloodstream infections (CLABSI) in pediatric and neonatal intensive care units (ICUs) and pediatric wards. A bloodstream infection must first be determined to be a healthcare-associated infection (HAI) before it can be identified as a CLABSI. Only HAIs can be CLABSIs.

A bloodstream infection is considered an HAI if the date of event for a National Healthcare Surveillance Network (NHSN) defined laboratory-confirmed bloodstream infection (LCBI) is on or after day 3 of hospitalization, with day 1 being the date of admission to an inpatient location. A bloodstream infection is Present on Admission (POA) if the date of event of the NHSN defined LCBI was anytime during the two calendar days before the day of admission, the first day of admission, or the day after admission to an inpatient location. Symptoms must be documented in the chart by a health care professional during the POA time frame.

Once identified as an HAI, an LCBI is further identified as a CLABSI if a central line (CL) or umbilical catheter (UC) was in place for >2 calendar days on the date of event, with day of device placement being Day 1, and was in place on the date of event or the day before. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), day of first access in inpatient location is considered Day 1. The date of event is defined as the date that the first element used to meet the LCBI criteria occurred during the Infection Window Period (IWP). A device is considered accessed once it has been used for infusion or withdrawal of fluids.

The IWP is defined as the 7 days during which all site-specific infection criteria must be met. It includes the day the first positive diagnostic test that is an element of the site-specific infection criterion was obtained, the 3 calendar days before, and the 3 calendar days after. For purposes of defining the IWP for CLABSI, the positive blood culture is the diagnostic test, and in the case of LCBI criterion 2, the first positive blood culture of the matched pair of common commensals is used to set the IWP.

The date of an LCBI sets a 14-day Repeat Infection Timeframe (RIT) during which no additional BSIs will be reported. The RIT includes the date of the LCBI and the next 13 calendar days.

Data Collection Method: Medical records (CDC's National Healthcare Safety Network)

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted to the National Healthcare Safety Network. States will not be asked for, and will not be able to provide data for this measure in MACPro.
- Refer to Appendix F for guidance on identifying Secondary Bloodstream Infections.

B. DEFINITIONS

Intensive care unit	A nursing care area in which at least 80 percent of the patients match definitions for critical care locations found in chapter 15, Master CDC Locations and Descriptions, of the NHSN Patient Safety Component Manual. http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf . PICU and NICU descriptions can be found on pages 15-11 to 15-15.
CDC location	A CDC-defined designation given to a patient care area housing patients who have similar disease conditions or who are receiving care for similar medical or surgical specialties. Each facility location that is monitored is “mapped” to one CDC Location. The specific CDC Location code is determined by the type of patients cared for in that area according to the 80% Rule. That is, if 80% of patients are of a certain type (e.g., pediatric patients with orthopedic problems) then that area is designated as that type of location (in this case, an Inpatient Pediatric Orthopedic Ward). The admission/transfer diagnosis should be used when determining the appropriate location mapping. The admission diagnosis is considered the most accurate depiction of the patient’s illness and reason for being admitted to a particular unit. For detailed instructions on how to map locations, see “Instructions for Mapping Patient Care Locations in NHSN” in the Locations and Descriptions chapter. http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf
Central line	An intravascular catheter that terminates at, or close to the heart, or in one of the great vessels, which is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting CLABSI and counting central-line days: Aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, common iliac veins, femoral veins and in neonates, the umbilical artery/vein. Note: Neither the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart and be used for one of the purposes outlined above to qualify as a central line.
Infusion	The introduction of a solution through a blood vessel via a catheter lumen. This may include continuous infusions such as nutritional fluids or medications, or it may include intermittent infusions such as flushes or IV antimicrobial administration, or blood, in the case of transfusion or hemodialysis.
Umbilical catheter	A central vascular device inserted through the umbilical artery or vein in a neonate.
Temporary central line	A non-tunneled and non-implanted catheter.
Permanent central line	Includes tunneled catheters, including certain dialysis catheters and Implanted catheters (including ports).

C. MEDICAL RECORD SPECIFICATION

Anchor Date

Cases of healthcare-associated CLABSIs with dates of event during the timeframe of selected surveillance.

Denominator

Definition of device days: a daily count of the number of patients with a specific device (i.e. central line) in place in a patient care location. Device days are used for denominators in CLABSI rates. Device day denominator data that are collected differ according to the location of the patients being monitored.

For ICUs, the number of patients with one or more central lines of any type is collected daily, at the same time each day during the month. The totals for the month are entered. Alternatively, for non-oncology ICUs with 75 or more central line days per month in the previous year, the number of patients with one or more central lines of any type may be collected once weekly (during a weekday).

In NICUs, the number of patients with one or more central lines (including umbilical catheters) stratified by birth weight in five categories is collected daily, at the same time each day during the month. The totals for the month are entered.

Numerator

Total number of observed CLABSI that are LCBI 1, 2, or 3 (excluding Mucosal Barrier Injury-LCBI [MBI-LCBI] 1, 2, and 3) among patients in PICUs, NICUs, and pediatric ward locations. See Appendix F for guidance on determining if the bloodstream infection is “related to an infection at another site,” and therefore secondary and not an LCBI.

Laboratory-confirmed bloodstream infection (LCBI) must meet one of the following criteria:

- LCBI Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures and organism cultured from blood is not related to an infection at another site (Appendix F).
- LCBI Criterion 2: Patient has at least one of the following signs or symptoms: fever (>38.0 degrees Celsius), chills, or hypotension and positive laboratory results are not related to an infection at another site (Appendix F) and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B.anthraxis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.
- LCBI Criterion 3: Patient \leq 1 years old has at least one of the following signs or symptoms: fever (>38.0 degrees Celsius core) hypothermia (<36.0 degrees Celsius core), apnea, or bradycardia and positive laboratory results are not related to an infection at another site (Appendix F) and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions.

Mucosal Barrier Injury-LCBI [MBI-LCBI] must meet the following criteria:

- MBI-LCBI Criterion 1: Patient of any age meets criterion 1 for LCBI with at least one blood culture growing any of the following intestinal organisms with no other organisms isolated* (i.e., *Bacteroides* spp., *Candida* spp., *Clostridium* spp., *Enterococcus* spp., *Fusobacterium* spp., *Peptostreptococcus* spp., *Prevotella* spp., *Veillonella* spp., or *Enterobacteriaceae*), and patient meets at least one of the following:
 1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood culture:
 - a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
 - b. ≥ 1 liter diarrhea in a 24-hour period (or ≥ 20 mL/kg in a 24-hour period for patients < 18 years of age) with onset on or within 7 calendar days before the date the positive blood culture was collected.
 2. Is neutropenic, defined as at least 2 separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) < 500 cells/mm³ within a seven-day time period which includes the date the positive blood culture was collected (Day 1), the 3 calendar days before and the 3 calendar days after.
- MBI-LCBI Criterion 2: Patient of any age meets criterion 2 for LCBI when the blood cultures are growing only viridans group streptococci with no other organisms isolated* and patient meets at least one of the following:
 1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood culture:
 - a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
 - b. ≥ 1 liter diarrhea in a 24-hour period (or ≥ 20 mL/kg in a 24-hour period for patients < 18 years of age) with onset on or within 7 calendar days before the date the first positive blood culture was collected.
 2. Is neutropenic, defined as at least 2 separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) < 500 cells/mm³ within a seven-day time period which includes the date the positive blood culture was collected (Day 1), the 3 calendar days before and the 3 calendar days after.
- MBI-LCBI Criterion 3: Patient ≤ 1 year of age meets criterion 3 for LCBI when the blood cultures are growing only viridans group streptococci with no other organisms isolated* and patient meets at least one of the following:
 1. Is an allogeneic hematopoietic stem cell transplant recipient within the past year with one of the following documented during same hospitalization as positive blood culture:
 - a. Grade III or IV gastrointestinal graft versus host disease [GI GVHD]
 - b. ≥ 20 mL/kg diarrhea in a 24-hour period with onset on or within 7 calendar days before the date the first positive blood culture is collected.

Is neutropenic, defined as at least 2 separate days with values of absolute neutrophil count (ANC) or total white blood cell count (WBC) < 500 cells/mm³ on or within a seven-day time

* In MBI-LCBI 1, 2, and 3, "No other organisms isolated" means there is not isolation in a blood culture of another recognized pathogen (e.g., *S. aureus*) or common commensal (e.g., coagulase-negative staphylococci) other than listed in MBI-LCBI criterion 1, 2, or 3 that would otherwise meet LCBI criteria. If this occurs, the infection should not be classified as MBI-LCBI.

period which includes the date the positive blood culture was collected (Day 1), the 3 calendar days before and the 3 calendar days after.

Standardized Infection Ratio (SIR) Calculation

The SIR is calculated as follows:

1. Identify the number of CLABSI events in each location type

Total these numbers for an observed number of CLABSIs for the locations of interest (i.e., all pediatric and neonatal ICUs and pediatric wards).

Obtain the predicted number of CLABSIs in the same location types for the standard population from 2006-08 using the 2009 National Healthcare Safety Network (NHSN) annual rate report: (<http://www.cdc.gov/nhsn/PDFs/dataStat/2009NHSNReport.pdf>).

2. Identify the number of predicted CLABSIs for the locations of interest based on their location types and numbers of central line device days:
 - a. For each location type, multiply the number of central line device days experienced, by the 2006-08 standard population's CLABSI rate for that location, divided by 1,000.
 - b. Sum the number of predicted CLABSIs from all locations of interest
3. Divide the total number of observed CLABSI events ("1" above) by the total "predicted" number of CLABSI events ("2.b." above).

Result = CLABSI standardized infection ratio (SIR)

(The NHSN analysis tool will perform the calculations once the patient infection data and denominator information are entered into the system.)

The CLABSI SIR is a ratio of the actual number of CLABSIs reported to the predicted number according to the NHSN baseline data (i.e., $SIR = \# \text{ observed CLABSI} / \# \text{ predicted CLABSI}$). As a ratio, the SIR conveys either an equivalency between the number observed and number predicted, in which case the SIR is 1, or a difference, in which case the number of observed CLABSI is higher or lower than the number of predicted CLABSI. An SIR greater than 1 indicates that more CLABSIs were observed than predicted, taking into account variation in the types of patients followed; conversely, an SIR less than 1 indicates that fewer CLABSIs were observed than predicted.

Tests of significance are needed to tell whether the number of infections in a hospital is unusually high or low relative to the number of infections that would be predicted given the experience of the standard population (all NHSN hospitals reporting CLABSI data during 2006-08). A p-value provides one method for significance testing. The p-value is a probability that weighs the evidence for determining whether a facility's number of CLABSI events is unusually high or low in comparison to the standard population.

If the p-value is small (less than .05), there is sufficient evidence to suggest that the facility has seen significantly higher or lower numbers of CLABSI events than what would be predicted. If the p-value is greater than .05, then there is not enough evidence to conclude the facility has seen significantly higher or lower numbers of CLABSI events than what would be predicted.

Note: The steps above are in alignment with CDC's current CLABSI SIR methods. CDC will be updating the risk-adjustment of CLABSI data using 2015 data as the new baseline. It is anticipated that all MBI-LCBIs will be excluded from the numerator, when the updated risk-adjustment methods are implemented. In addition, CDC may change the method of calculating the predicted number of CLABSIs such that a risk model—and not risk-stratified rates—will be used.

**MEASURE CPC-CH: CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS
AND SYSTEMS (CAHPS) HEALTH PLAN SURVEY 5.0H – CHILD VERSION
INCLUDING MEDICAID AND CHILDREN WITH CHRONIC CONDITIONS
SUPPLEMENTAL ITEMS**

National Committee for Quality Assurance

A. DESCRIPTION

A.1 – CAHPS Health Plan Survey 5.0H, Child Version

This measure provides information on parents' experiences with their child's health care. Results summarize child experiences through ratings, composites, and individual question summary rates.

Four global rating questions reflect overall satisfaction:

- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

Five composite scores summarize responses in key areas:

- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Shared Decision Making

Item-specific question summary rates are reported for the rating questions and each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

- Health Promotion and Education (Q8)
- Coordination of Care (Q25, Without CCC version of questionnaire)

A.2 – Children With Chronic Conditions (CCC)

This measure provides information on parents' experience with their child's health care for the population of children with chronic conditions.

Results include the same ratings, composites, and individual question summary rates as those reported for the CAHPS Health Plan Survey 5.0H, Child Version. In addition, three CCC composites summarize satisfaction with basic components of care essential for successful treatment, management and support of children with chronic conditions: (1) Access to Specialized Services; (2) Family Centered Care: Personal Doctor Who Knows Child; (3) Coordination of Care for Children With Chronic Conditions.

Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts: (1) Access to Prescription Medicines; (2) Family Centered Care: Getting Needed Information.

Data Collection Method: Survey

Guidance for Reporting:

- For purposes of reporting for the Child Core Set, CAHPS Health Plan Survey 5.0H – Child Version should be used. The inclusion of Children with Chronic Conditions (CCC) supplemental items is encouraged, but not required by CMS. Appendix G contains the CAHPS 5.0H instrument with CCC supplemental items and Appendix H contains the CAHPS 5.0H instrument without the CCC supplemental items. Appendix I contains additional guidance on conducting the CAHPS 5.0H Child Survey, including the sampling protocol.
- The survey should be conducted by a third-party vendor certified by NCQA according to the HEDIS protocol. A current listing of NCQA-certified HEDIS survey vendors is available at http://www.ncqa.org/Portals/0/HEDISQM/Programs/SVC/2016_HEDIS_CAHPS-Vendor_Web_List.pdf.
- Any deviations in the questionnaire, data collection or survey administration, sampling, or data analysis should be reported in the field labeled “Additional Notes/Comments on Measure.”
- CHIPRA requirement for CAHPS: CHIPRA section 402 requires Title XXI programs to submit to CMS “data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality of care and consumer satisfaction measures included in the CAHPS survey.” CHIPRA requires Title XXI programs to conduct specific sampling and data collection. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf>.
- A technical assistance brief on collecting and reporting the CAHPS 5.0H survey is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsbrief.pdf>.

B. ELIGIBLE POPULATION

Age	17 years and younger as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	For a Medicaid enrollee in a state where enrollment is verified monthly, the child may not have more than a one-month gap in coverage (the child must be enrolled for five of the last six months of the measurement year). For a Medicaid enrollee in a state where enrollment is verified daily, the child may have no more than one gap in enrollment of up to 45 days during the last six months of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

C. IMPLEMENTING THE CAHPS SURVEY

Data collection	Description
Administration	Survey must be conducted by a third-party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol.
Collection mode	Mail only, or mixed (mail and telephone) mode protocols are recommended. Internet enhancement is accepted.
Sample size	The sample needs to be large enough to yield 411 completed surveys per reporting unit (e.g., health plan, PCCM program, or state), a cost-effective method shown to produce statistically valid survey comparisons.

D. COMPLETION CRITERIA

Survey vendors assign a disposition code of Complete and Valid Survey when responses indicate that the enrollee meets the eligible population criteria and three of the five questions listed in the table below are answered appropriately.

Survey Type	Questions for Complete and Valid Survey				
Children with Chronic Conditions Supplemental Items	Q3	Q30	Q45	Q49	Q54
Children without Chronic Conditions Supplemental Items	Q3	Q15	Q27	Q31	Q36

MEASURE DEV-CH: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE

Oregon Health and Sciences University

A. DESCRIPTION

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened by their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C). The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts. For example, a state could do a chart review on a sample of records where the CPT code was used to determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening. To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes on Measure" field to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).
- Only those tools cited in the specifications for this measure meet the criteria for the numerator. During the development of the measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (socioeconomic development or autism, respectively), rather than a full, general assessment of developmental delays. States should use the "Deviations from Measure Specifications" field to document any deviations from the specifications for this measure.

The following coding system is used in this measure: CPT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children who turn 1, 2, or 3 years of age between January 1 and December 31 of the measurement year.
Continuous enrollment	Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second, or third birthday. To determine continuous enrollment for a Medicaid enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months or 60 days is not considered continuously enrolled).
Anchor date	Enrolled on the child's first, second, or third birthday.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION**Denominator**

Denominator 1: The children in the eligible population who turned 1 during the measurement year.

Denominator 2: The children in the eligible population who turned 2 during the measurement year.

Denominator 3: The children in the eligible population who turned 3 during the measurement year.

Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

Numerators

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. The measure is based on three, age-specific indicators.

Numerator 1: Children in Denominator 1 who had a claim with CPT code 96110 by their first birthday.

Numerator 2: Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays.

Numerator 3: Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.

Numerator 4: Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data: CPT code 96110 (Developmental testing, with interpretation and report)

Important note about appropriate use of claims data: This measure is anchored to standardized tools that meet four criteria specified below in the paragraph beginning with “Tools must meet the following criteria.” States who have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

Claims NOT included in this measure: It is important to note that modified 96110 claims [e.g. modifiers added to claim indicating standardized screening for a specific domain of development (e.g. social emotional screening via the ASQ-SE, autism screening)] should not be included as this measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral and social delays.

Exclusions

None.

D. MEDICAL RECORD SPECIFICATION

Denominator

A systematic sample of 411 drawn from the eligible population stratified by age.

Denominator 1: 137 children from the sample who turned 1 during the measurement year.

Denominator 2: 137 children from the sample who turned 2 during the measurement year.

Denominator 3: 137 children from the sample who turned 3 during the measurement year.

Denominator 4: The entire sample of 411 children.

Numerators

Numerator 1: Children in Denominator 1 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented by their first birthday.

Numerator 2: Children in Denominator 2 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their first and before or on their second birthday.

Numerator 3: Children in Denominator 3 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their second and before or on their third birthday.

Numerator 4: Children in Denominator 4 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented in the 12 months preceding their first, second or third birthday (the sum of numerators 1, 2 and 3).

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed, and
- The standardized tool used (see below), and
- Evidence of a screening result or screening score

Tools must meet the following criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

The following tools are cited by Bright Futures (and the American Academy of Pediatrics statement on developmental screening) and meet the above criteria:

- Ages and Stages Questionnaire (ASQ) - 2 months to 5 years
- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Battelle Developmental Inventory Screening Tool (BDI-ST) – Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to 2 years
- Brigance Screens-II – Birth to 90 months
- Child Development Inventory (CDI) - 18 months to 6 years
- Infant Development Inventory – Birth to 18 months
- Parents' Evaluation of Developmental Status (PEDS) – Birth to 8 years
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

Tools NOT included in this measure: It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

Tools listed above: The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that have met the above criteria. Bright Futures cites the 2006 statement on Developmental Screening by the American Academy of Pediatrics. New and updated recommendations are anticipated and may include additional tools that meet these criteria. In addition, new tools meeting these criteria may be developed and may be included in future versions of Bright Futures.

Exclusions

None.

E. CALCULATION ALGORITHM

Step 1:

Determine the denominators.

From the total denominator, sort into three age cohorts: children who turned one, two or three years of age between January 1 and December 31 of the measurement year.

Step 2:

Determine the numerators.

For each age cohort, and for the total, identify children who had a screening for developmental, behavioral, and social delays performed by their birthday as found through claims data or documented in the medical chart.

Administrative Data: Children for whom a claim of 96110 was submitted for services in the 12 months preceding their birthday.

Medical Record Review: Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding their birthday. Documentation must include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.

Step 3:

Calculate the age-specific indicators (ages 1 to 3) by dividing the age-specific numerator by the age-specific denominator and multiplying by 100 to get a percentage.

Step 4:

Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

If administrative data are used, the entire eligible population is used for the denominator. If using the hybrid method (administrative plus medical record data sources), a systematic sample can be drawn of 411, with 137 in each age group.

F. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

A sample of 411 will provide sufficient statistical power for states reporting a state-wide developmental screening rate for children ages 1 to 3. With the smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. States will want to use this measure to improve screening rates, age-specific rates may help states to target their efforts. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 may be insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

The eligible population, from which the original sample was drawn, should be stratified by age, and the age-specific sample drawn from within each stratum. To oversample for any age group, the state should return to the original listing of eligible children in that age group, and continue adding children to the sample until the larger sample is complete. However, to maintain consistency of reporting and avoid having to weight the age groups to calculate the total, the state should only include the first 137 children sampled in the age-specific and total rates reported to CMS.

MEASURE FPC-CH: FREQUENCY OF ONGOING PRENATAL CARE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid/CHIP deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:

- <21 percent of expected visits
- 21 percent–40 percent of expected visits
- 41 percent–60 percent of expected visits
- 61 percent–80 percent of expected visits
- ≥81 percent of expected visits

This measure uses the same denominator as the Timeliness of Prenatal Care measure.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Specifications for this measure reference instructions included in Measure PPC-CH (Timeliness of Prenatal Care). Refer to the PPC-CH measure specifications for additional detail.
- States may use vital records as an alternative data source for this measure if they have confidence in the completeness and accuracy of these data. States can use Medicaid administrative data to determine the measure-eligible population (including the requirement of continuous eligibility from 43 days before delivery through 56 days after delivery) and then link the Medicaid records to vital records data to identify the information needed to calculate the numerator, including gestational age at delivery, the number of prenatal care visits, and the timing of these visits in relation to the gestational age. States using vital records should document this data source in the “Additional Notes/Comments on Measure” field in MACPro. States should also provide information about the proportion of measure-eligible enrollees who were identified in Medicaid administrative data but for whom a birth certificate could not be found in vital records data.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for definitions of a PCP and OB/GYN practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	<p>Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting.</p> <p>Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year are counted twice. Women who had multiple live births during one pregnancy are counted once.</p> <p>Follow the steps below to identify the eligible population:</p> <p>Step 1: Identify deliveries. Identify all women with a delivery (<u>Deliveries Value Set</u>) between November 6 of the year prior to the measurement year and November 5 of the measurement year.</p> <p>Step 2: Exclude non-live births (<u>Non-live Births Value Set</u>).</p> <p>Step 3: Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.</p>

C. ADMINISTRATIVE SPECIFICATION**Denominator**

The eligible population.

Numerator

Women who had an unduplicated count of <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent, or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age.

For each delivery, follow the steps below to calculate each woman's ratio of observed-to-expected prenatal care visits.

Step 1

Identify the delivery date using hospital discharge data.

Step 2

Identify the date when the woman enrolled in Medicaid/CHIP and determine the stage of pregnancy at time of enrollment. If the woman has gaps in enrollment during pregnancy, use the last enrollment segment to determine continuous enrollment in Medicaid/CHIP. For

women with a gap in enrollment any time during pregnancy (including a gap in the first trimester), the last enrollment segment is the enrollment start date during the pregnancy that is closest to the delivery date. Use the following approach (or an equivalent method) to calculate the stage of pregnancy at time of enrollment. If gestational age is not available, assume a gestational age of 280 days (40 weeks):

- Convert gestational age into days.
- Subtract gestational age (in days) from the date of delivery (step 1).
- Subtract the date obtained above from the date when the woman enrolled in Medicaid/CHIP to determine the stage of pregnancy at time of enrollment.
- Divide the numbers of days the woman was pregnant at enrollment (step 3) by 30. Round the resulting number according to the .5 rule to a whole number.

For example, delivery date is August 8, 2015; gestational age is 33 weeks; date of enrollment is May 6, 2015. Given these variables, the process is:

- Gestational age in days is 231 days (33 weeks x 7 days/week).
- Date of delivery – gestational age (in days) is December 20, 2014 (August 8, 2015 – 231 days).
- Date when the woman enrolled in Medicaid/CHIP– date obtained in Step 2 is 137 days (May 6, 2015– December 20, 2014).
- Month in which prenatal care began is 4.56 months (137 days/30 days) and then round up to 5 months using the 0.5 rule.
- This woman's stage of pregnancy at time of enrollment is 5 months.

Step 3

Use Table FPC-A to find the number of recommended prenatal visits by gestational age and stage of pregnancy at time of enrollment per the American College of Obstetricians and Gynecologists (ACOG). The chart subtracts the number of missed visits prior to the date the woman enrolled from the number of recommended visits for a given gestational age.

ACOG recommends that women with an uncomplicated pregnancy receive visits every 4 weeks for the first 28 weeks of pregnancy, every 2–3 weeks until 36 weeks of pregnancy, and weekly thereafter. For example, ACOG recommends 14 visits for a 40-week pregnancy. If the woman enrolled during her fourth month (3 missed visits prior to enrollment in Medicaid/CHIP), the expected number of visits is $14 - 3 = 11$.

For deliveries with a gestational age <28 weeks or >43 weeks, calculate the expected number of prenatal care visits using the date when the woman enrolled and ACOG's recommended schedule of visits. For example, if gestational age is 26 weeks and the woman enrolled during her second month of pregnancy, the expected number of prenatal care visits is 5 (6 expected visits [1 visit every 4 weeks or 6 visits in 24 weeks], less 1 visit missed in the first month).

If gestational age is 44 weeks and the woman enrolled during her third month of pregnancy, the expected number of prenatal care visits is 16 (14 expected visits for a 40-week gestation plus 1 visit each additional week [18 total expected prenatal care visits], less 2 visits missed in the first and second months).

Step 4

Identify the number of discrete prenatal care visits the woman received during the course of her pregnancy and while enrolled in Medicaid/CHIP using claims and encounter data.

To identify prenatal visits that occurred during the first trimester, refer to the Timeliness of Prenatal Care (PPC-CH) measure decisions rules for Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester.

To identify prenatal visits that occurred during the second and third trimester, refer to the Timeliness of Prenatal Care (PPC-CH) measure instructions for Identifying Prenatal Care For Women Not Continuously Enrolled During the First Trimester. Visits that occur on the date of delivery and meet the prenatal visit criteria count toward the measure.

All criteria must be met for encounters to be counted as a discrete prenatal care visit. For example, Decision Rules 2 and 3 require multiple components (typically a visit combined with a diagnosis code or another prenatal service such as a lab test or an ultrasound). Ultrasound and lab results alone are not considered a discrete prenatal care visit unless they are combined with other criteria.

Services that occur over multiple visits can be combined to create a discrete prenatal care visit if all services occur within the time frame established in the measure and services are not double counted. States must develop systems to avoid double counting. For example, a code from the Stand Alone Prenatal Visits Value Set on the same date of service as a code from the Prenatal Visits Value Set is interpreted to represent a single visit/encounter and may not be counted twice. If the woman had a gap in enrollment, count only the visits received during the last enrollment segment.

Step 5

Calculate the ratio of observed visits (step 4) to expected visits (step 3).

Step 6

Report each woman in the appropriate category:

- <21 percent
- 21 percent–40 percent
- 41 percent–60 percent
- 61 percent–80 percent
- ≥81 percent of expected visits

D. HYBRID SPECIFICATION

Denominator

A systematic sample of women drawn from the eligible population. If this measure and the Timeliness of Prenatal and Postpartum Care measure are collected, the same systematic sample must be used for both.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

Women who had an unduplicated count of the number of expected visits that was <21 percent, 21 percent–40 percent, 41 percent–60 percent, 61 percent–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. The visits may be identified through either administrative data or medical record review.

The numerator is calculated retroactively from date of delivery or expected date of delivery (EDD).

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Use the medical record documentation requirements in the Timeliness of Prenatal Care measure to identify prenatal visits that occur during the first, second, and third trimesters.

Identify gestational age at birth from the hospital record (e.g., admission write-ups, histories and physicals, discharge summaries, or labor and delivery records) or birth certificate. Gestational age is the number of completed weeks that elapsed between the first day of the last normal menstrual period and the date of delivery. If gestational age is not available, assume a gestational age of 280 days (40 weeks).

Methods recommended to determine gestational age are:

- Physician ascertainment using ultrasound or Dubowitz assessment
- Last menstrual period (LMP) calculation (date of LMP – date of delivery) ÷ 7. If gestational age is recorded or calculated in fractions of a week, round down to the lower whole number.

E. ADDITIONAL NOTES

This measure is based on deliveries. Count women who have multiple deliveries from a single pregnancy once. Include each pregnancy for women who have multiple deliveries from different pregnancies.

When counting prenatal visits, include visits with physician assistants, nurse practitioners, and midwives.

If both Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care are collected using the Hybrid Method, the same sample for collection must be used.

If the Hybrid Method is used, a combination of administrative data and medical record review may not be used to identify prenatal care visits for an individual in the denominator. For example, for one woman, two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) may not be counted, even if each visit shows a different date of service.

Table FPC-A: Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Individual Enrolled in Medicaid/CHIP

Gestational Age in Weeks	Month Individual Enrolled in Medicaid/CHIP								
	0–1st month	2nd month	3rd month	4th month	5th month	6th month	7th month	8th month	9th month
28	6	5	4	3	1	1	-	-	-
29	6	5	4	3	1	1	-	-	-
30	7	6	5	4	2	1	1	-	-
31	7	6	5	4	2	1	1	-	-
32	8	7	6	5	3	2	1	-	-
33	8	7	6	5	3	2	1	-	-
34	9	8	7	6	4	3	2	1	-
35	9	8	7	6	4	3	2	1	-
36	10	9	8	7	5	4	3	1	-
37	11	10	9	8	6	5	4	2	-
38	12	11	10	9	7	6	5	3	-
39	13	12	11	10	8	7	6	4	1
40	14	13	12	11	9	8	7	5	1
41	15	14	13	12	10	9	8	6	2
42	16	15	14	13	11	10	9	7	3
43	17	16	15	14	12	11	10	8	4

Source: Guidelines for Perinatal Care, Fifth Edition. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Refer to Table FPC-A in HEDIS specifications (2016 version).

Note: Dashes indicate no visit is expected.

MEASURE FUH-CH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for children ages 6 to 20 who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported.

- Percentage of discharges for which children received follow-up within 30 days of discharge
- Percentage of discharges for which children received follow-up within 7 days of discharge

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure includes age 6 and older. For reporting of the Child Core Set measure, include children ages 6 to 20 only.
- Follow the detailed specifications to (1) include the appropriate discharge when the patient was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the patient was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than (or equal to) the 7-day follow-up rate.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of a mental health practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, POS and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	6 to 20 years old as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No gaps in enrollment.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).

Event/diagnosis	<p>An acute inpatient discharge with a principal diagnosis of mental illness (<u>Mental Illness Value Set</u>) on or between January 1 and December 1 of the measurement year.</p> <p>To identify acute inpatient discharges:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay to determine whether it falls on or between January 1 and December 1 of the measurement year. <p>Use only facility claims to identify discharges and diagnoses for denominator events (including readmissions or direct transfers). Do not use professional claims. The denominator for this measure is based on discharges, not children. If children have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.</p>
Acute facility readmission or direct transfer	<p>If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal mental health diagnosis (<u>Mental Health Diagnosis Value Set</u>) within the 30-day follow-up period, count only the last discharge. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.</p> <p>To identify readmissions to an acute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stays to determine whether they fall after December 1 of the measurement year. <p>States must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above.</p>
Exclusions	<p>Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.</p> <p>To identify readmissions to a nonacute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (<u>Nonacute Inpatient Stay Value Set</u>) on the claim. 3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period.

Exclusions (continued)	<p>Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the <u>Mental Health Diagnosis Value Set</u>).</p> <p>To identify readmissions to an acute inpatient care setting:</p> <ol style="list-style-type: none"> 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). 2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period. <p>States must identify “transfers” using their own methods and then confirm the acute inpatient care setting using the steps above.</p> <p>These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.</p>
---------------------------	--

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

30 Day Follow-up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.

7 Day Follow-up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations 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 non-behavioral healthcare setting (FUH RevCodes Group 2 Value Set) with a mental health practitioner
- A visit in a non-behavioral 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

The following meets criteria for only the 30-Day Follow-Up indicator:

- Transitional care management services (TCM 14 Day Value Set), where the date of service on the claim is 29 days after the eligible population event/diagnosis date of discharge

Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

D. ADDITIONAL NOTES

There may be 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. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the period specified (e.g., within 30 days after discharge or within 7 days after discharge).

MEASURE HPV-CH: HUMAN PAPILLOMAVIRUS (HPV) VACCINE FOR FEMALE ADOLESCENTS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of female adolescents 13 years old who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- HPV vaccines administered prior to an enrollee's 9th birthday cannot be counted toward the measure numerator.
- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all Medicaid and CHIP-enrolled female adolescents who turned 13 years of age during the measurement year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, any immunizations missing from claims or registry data must be sought from medical records.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, ICD-9, and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Female adolescents who turned 13 years of age during the measurement year.
Continuous enrollment	12 months prior to the enrollee's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid /CHIP enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (i.e., an enrollee whose coverage lapses for 2 months [60 days] is not continuously enrolled).
Anchor date	Enrolled on the enrollee's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

At least three HPV vaccinations (HPV Vaccine Administered Value Set), with different dates of service on or between the enrollee's 9th and 13th birthdays.

Exclusions (optional)

Either of the following meets optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the enrollee's 13th birthday
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011

D. HYBRID SPECIFICATION**Denominator**

A systematic sample drawn from the eligible population. States that use the hybrid method to report the Immunizations for Adolescents (IMA-CH) measure may use the female enrollees from the IMA-CH sample as a start for this measure and may draw enough additional female enrollees from the remaining eligible population of this measure until the full sample size and appropriate oversample is reached.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

At least three HPV vaccinations, with different dates of service, on or between the enrollee's 9th and 13th birthdays.

Administrative Data

Refer to the Administrative Specification above to identify positive numerator hits from the administrative data.

Medical Record Review

For immunization evidence obtained from the medical record, the state may count enrollees where there is evidence that the antigen was rendered from either of the following:

- A note indicating the name of the specific antigen and the date of service, or
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered

Exclusions (optional)

Refer to the Administrative Specification for exclusion criteria. The exclusion must have occurred on or before the enrollee's 13th birthday.

E. ADDITIONAL NOTES

This measure follows the Centers for Disease Control and Prevention (CDC) and Advisory Council on Immunization Practices (ACIP) guidelines for immunizations. HEDIS implements changes to the guidelines (e.g., new vaccine recommendations) after three years to account for the measure's look-back period and to allow the industry time to adapt to the new guidelines.

MEASURE IMA-CH: IMMUNIZATIONS FOR ADOLESCENTS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of adolescents 13 years old 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 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all Medicaid and CHIP-enrolled adolescents who turned 13 years old during the reporting year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, seek any immunizations missing from claims or registry data from medical records.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CPT, ICD-9, and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Adolescents who turn 13 years old during the measurement year.
Continuous enrollment	12 months prior to the adolescent's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the 13th birthday. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the adolescent may not have more than a 1-month gap in coverage (i.e., an adolescent whose coverage lapses for 2 months (60 days) is not continuously enrolled).
Anchor date	Enrolled on the adolescent's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

For meningococcal and Tdap or Td, count only evidence of the antigen or combination vaccine.

Meningococcal: At least one meningococcal conjugate or meningococcal polysaccharide vaccine (Meningococcal Vaccine Administered Value Set), with a date of service on or between the adolescent's 11th and 13th birthdays.

Tdap/Td: Any of the following with a date of service on or between the adolescent's 10th and 13th birthdays meet criteria:

- At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (Tdap Vaccine Administered Value Set)
- At least one tetanus, diphtheria toxoids (Td) vaccine (Td Vaccine Administered Value Set)
- At least one tetanus vaccine (Tetanus Vaccine Administered Value Set) and at least one diphtheria vaccine (Diphtheria Vaccine Administered Value Set) on the same date of service or on different dates of service

Combination 1 (Meningococcal, Tdap/Td): Adolescents who are numerator compliant for both indicators (meningococcal, Tdap/Td).

Exclusion (optional)

Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rate. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data do not indicate that the contraindicated immunization was rendered.

Either of the following meets optional exclusion criteria:

- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Vaccination Value Set) any time on or before the enrollee's 13th birthday
- Anaphylactic reaction to the vaccine or its components (Anaphylactic Reaction Due To Serum Value Set), with a date of service prior to October 1, 2011

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerators

For meningococcal conjugate or polysaccharide and Tdap or Td, count only the evidence of the antigen or combination vaccine.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

For immunization information obtained from the medical record, count adolescents where there is evidence that the antigen was rendered from either of the following:

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered

Exclusion (optional)

Refer to Administrative Specification for exclusion criteria. The exclusion must have occurred by the adolescent's 13th birthday.

E. ADDITIONAL NOTES

NCQA follows the Centers for Disease Control and Prevention (CDC) and Advisory Council on Immunization Practices (ACIP) guidelines for immunizations. HEDIS implements the guidelines (e.g., new vaccine recommendations) after three years to account for the measure's look-back period and to allow the industry time to adapt to the new guidelines.

MEASURE LBW-CH: LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS

Centers for Disease Control and Prevention
(National Center for Health Statistics)

A. DESCRIPTION

Percentage of live births that weighed less than 2,500 grams in the state during the reporting period.

Data Collection Method: State Vital Records

Guidance for Reporting:

- The denominator should include the number of Medicaid and CHIP resident live births in the state for the measurement period regardless of the length of enrollment for women with these births.
- The measurement period for this measure is the calendar year before the Child Core Set reporting year. For example, calendar year 2015 data should be used for the FFY 2016 reporting year.
- Eligibility for this measure is based on deliveries that were covered by Medicaid or CHIP. For the purpose of Child Core Set reporting, states should identify Medicaid/CHIP enrollees based on (1) the primary source of payment for delivery designated on the vital record, or (2) the linkage of vital records and Medicaid/CHIP eligibility data. States that link the vital records to Medicaid/CHIP eligibility data may use either the mother's or infant's record (or a linkage of the two records) to determine eligibility for the denominator. States should document the methodology in the "Additional Notes on Measure" field.

B. ELIGIBLE POPULATION

Deliveries where principal source of payment for delivery is Medicaid or CHIP.

C. ADMINISTRATIVE SPECIFICATION

State vital records

Denominator

Number of resident live births in the state in the reporting period with Medicaid and/or CHIP as the payer source.

Numerator

Number of resident live births less than 2,500 grams with Medicaid and/or CHIP as the payer source.

Units

Report as a percentage.

MEASURE MMA-CH: MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 5 to 20 who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:

- Percentage of children who remained on an asthma controller medication for at least 50 percent of their treatment period
- Percentage of children who remained on an asthma controller medication for at least 75 percent of their treatment period

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has 5 reportable rates – ages 5 to 11, 12 to 18, 19 to 50, 51 to 64, and a total (ages 5 to 64). For reporting of the Child Core Set measure, include the rates for ages 5 to 11, 12 to 18, and 19 to 20 and a total rate that is the sum of these 3 rates.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

IPSD	Index prescription start date. The earliest prescription dispensing date for any asthma controller medication during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days that an enrollee is covered by at least one asthma controller medication, divided by the number of days in the treatment period.
Oral medication dispensing event	<p>One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events ($100/30 = 3.33$, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is filled.</p> <p>Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days' supply and divide by 30. Use the Drug ID to determine if the prescriptions are the same or different.</p> <p>Examples include:</p> <ul style="list-style-type: none"> • Two prescriptions for different medications dispensed on the same day, each with a 60-day supply, equals four dispensing events (two prescriptions with two dispensing events each)

<p>Oral medication dispensing event (continued)</p>	<ul style="list-style-type: none"> • Two prescriptions for different medications dispensed on the same day, each with a 15-day supply, equals two dispensing events (two prescriptions with one dispensing event each) • Two prescriptions for the same medication dispensed on the same day, each with a 15-day supply, equals one dispensing event (sum the days' supply for a total of 30 days) <p>Two prescriptions for the same medication dispensed on the same day, each with a 60-day supply, equals four dispensing events (sum the days' supply for a total of 120 days)</p>
<p>Inhaler dispensing event</p>	<p>When identifying the eligible population, use the definition below to count inhaler dispensing events.</p> <p>All inhalers (i.e., canisters) of the same medication dispensed on the same day count as one dispensing event. Medications with different Drug IDs dispensed on the same day are counted as different dispensing events. For example, if a child received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events.</p> <p>Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.</p> <p>Use the Drug ID field in the NDC list to determine if the medications are the same or different.</p>
<p>Injection dispensing event</p>	<p>Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a child received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events.</p> <p>Allocate the dispensing events to the appropriate year based on the date when the prescription was filled.</p>
<p>Calculating number of days covered for the numerator</p>	<p>If multiple prescriptions for different medications are dispensed on the same day, calculate number of days covered by a controller medication using the prescriptions with the longest days' supply. For multiple different prescriptions dispensed on different days with overlapping days' supply, count each day within the treatment period only once toward the numerator.</p> <p>If multiple prescriptions for the same medication are dispensed on the same or different day, sum the days' supply and use the total to calculate the number of days covered by a controller medication. For example, three controller prescriptions for the same medication are dispensed on the same day, each with a 30-day supply, sum the days' supply for a total of 90 days covered by a controller.</p> <p>Subtract any day's supply that extends beyond December 31 of the measurement year.</p> <p>Use the Drug ID provided by the NDC to determine if the prescriptions are the same or different.</p>

C. ELIGIBLE POPULATION

Age	<p>5 to 20 years by December 31 of the measurement year. Report three age stratifications and a total rate:</p> <ul style="list-style-type: none"> • 5 to 11 years • 12 to 18 years • 19 to 20 years • Total <p>The total is the sum of the age stratifications.</p>
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage during each year of continuous enrollment year.
Anchor date	December 31 of the measurement year.
Benefits	Medical. Pharmacy during the measurement year.
Event/diagnosis	<p>Follow the steps below to identify the eligible population for the measure.</p> <p>Step 1:</p> <p>Identify enrollees as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.</p> <ul style="list-style-type: none"> • At least one ED visit (<u>ED Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>) • At least one acute inpatient encounter (<u>Acute Inpatient Value Set</u>), with a principal diagnosis of asthma (<u>Asthma Value Set</u>) • At least four outpatient visits (<u>Outpatient Value Set</u>) or observation visits (<u>Observation Value Set</u>) on different dates of service, with any diagnosis of asthma (<u>Asthma Value Set</u>) and at least two asthma medication dispensing events (Table MMA-A). Visit type need not be the same for the four visits. • At least four asthma medication dispensing events (Table MMA-A) <p>Step 2:</p> <p>An enrollee identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (<u>Asthma Value Set</u>), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (i.e., measurement year or the year prior to the measurement year).</p> <p>Step 3: Required Exclusions</p> <p>Exclude enrollees who met any of the following criteria:</p>

Event/diagnosis (continued)	<ul style="list-style-type: none"> • Enrollees who had any diagnosis from any of the following value sets, any time during the enrollee's history through December 31 of the measurement year: <ul style="list-style-type: none"> • <u>Emphysema Value Set</u> • <u>Other Emphysema Value Set</u> • <u>COPD Value Set</u> • <u>Obstructive Chronic Bronchitis Value Set</u> • <u>Chronic Respiratory Conditions Due to Fumes/Vapors Value Set</u> • <u>Cystic Fibrosis Value Set</u> • <u>Acute Respiratory Failure Value Set</u> <p>Enrollees who had no asthma controller medications (Table MMA-B) dispensed during the measurement year.</p>
-----------------------------	---

Table MMA-A. Asthma Medications

Description	Prescriptions
Antiasthmatic combinations	Dyphylline-guaifenesin Guaifenesin-theophylline
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol Fluticasone-salmeterol Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone Budesonide Ciclesonide Flunisolide Fluticasone CFC free Mometasone
Leukotriene modifiers	Montelukast Zafirlukast Zileuton
Mast cell stabilizers	Cromolyn
Methylxanthines	Aminophylline Dyphylline Theophylline
Short-acting, inhaled beta-2 agonists	Albuterol Levalbuterol Pirbuterol

Source: Refer to Table MMA-A in HEDIS specifications (2016 version).

D. ADMINISTRATIVE SPECIFICATION**Denominator**

The eligible population.

Numerator

Medication Compliance 50 Percent: The number of enrollees who achieved a PDC of at least 50% for their asthma controller medications (Table MMA-B) during the measurement year.

Medication Compliance 75 Percent: The number of enrollees who achieved a PDC of at least 75% for their asthma controller medications (Table MMA-B) during the measurement year.

Follow the steps below to identify numerator compliance.

Step 1: Identify the IPSD. The IPSD is the earliest dispensing event for any asthma controller medication (Table MMA-B) during the measurement year.

Step 2: To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3: Count the days covered by at least one prescription for an asthma controller medication (Table MMA-B) during the treatment period. To ensure that a day's supply that extends beyond the measurement year is not counted, subtract any day's supply that extends beyond December 31 of the measurement year.

Step 4: Calculate the enrollee's PDC using the following equation. Round (using the .5 rule) to two decimal places.

$$\frac{\text{Total Days Covered by a Controller Medication in the Treatment Period (step 3)}}{\text{Total Days in Treatment Period (step 2)}}$$

Medication Compliance 50 Percent: Sum the number of enrollees whose PDC is $\geq 50\%$ for their treatment period.

Medication Compliance 75 Percent: Sum the number of enrollees whose PDC is $\geq 75\%$ for their treatment period.

Table MMA-B Asthma Controller Medications

Description	Prescription
Antiasthmatic combinations	Dyphylline-guaifenesin Guaifenesin-theophylline
Antibody inhibitor	Omalizumab
Inhaled steroid combinations	Budesonide-formoterol Fluticasone-salmeterol Mometasone-formoterol
Inhaled corticosteroids	Beclomethasone Budesonide Ciclesonide Flunisolide Fluticasone CFC free Mometasone
Leukotriene modifiers	Montelukast Zafirlukast Zileuton
Mast cell stabilizers	Cromolyn
Methylxanthines	Aminophylline Dyphylline Theophylline

Source: Refer to Table MMA-B in HEDIS specifications (2016 version).

MEASURE PC02-CH: CESAREAN SECTION FOR NULLIPAROUS SINGLETON
VERTEX (NSV)

The Joint Commission

A. DESCRIPTION

Percentage of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.

Data Collection Method: Hybrid

Guidance for Reporting:

- This measure applies to both Medicaid and CHIP enrolled women that meet the measure eligibility criteria.
- Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.
- This measure requires administrative data and medical record review to determine the required data elements for the numerator and denominator. Appendix D provides additional information on data elements for this measure.
- Medical record review or use of vital records is required to determine the denominator for this measure. The Hybrid Specification section includes a link to The Joint Commission sampling guidelines that can ease the burden of the medical record review process.
- Risk adjustment is not specified for reporting this measure at the state level.
- To determine gestational age and parity, it is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix D.
- In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, the measure should be calculated using ICD-10 codes for claims with a date of discharge on or after October 1, 2015. The ICD-10 codes for this measure are available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-child-icd10-codes.zip>.

The following coding systems are used in this measure: ICD-9 and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population of nulliparous patients who delivered a live term singleton newborn in vertex presentation. See specifications related to Medical Record Review below.

The following table provides guidance for the minimum recommended sample size for Medical Record Review.

Eligible Population	Minimum Recommended Sample Size
≥ 1,551	311
391 – 1,550	20% of the Eligible Population (78 – 310)
78 – 390	78
30 – 77	No sampling; 100% of Eligible Population required
<30	Denominator too small to report

Source: Adapted from The Joint Commission, “Quarterly Sampling Examples,” available at <https://manual.jointcommission.org/releases/TJC2015A1/SamplingChapterTJC.html>

Regardless of the selected sample size, The Joint Commission recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on sampling, refer to The Joint Commission’s “Population and Sampling Specifications” guidelines located at <https://manual.jointcommission.org/releases/TJC2015A1/SamplingChapterTJC.html>

Include populations with ICD-9-CM Principal or Other Diagnosis Codes for outcome of delivery as defined in Table PC02-A and with a delivery of a newborn with 37 weeks or more of gestation completed.

Include populations with ICD-9-CM diagnosis codes for pregnancy resulting in a delivery during the hospitalization as defined in Tables PC02-B, PC02-C, PC02-D, and PC02-E.

Medical Record Review

Medical record review is required to collect the following denominator data elements: gestational age and parity. See Appendix D for additional guidance on collecting these data elements.

To determine gestational age and parity, it is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed in Appendix D.

Table PC02-A. ICD-9-CM Diagnosis Code for Outcome of Delivery

ICD-9-CM Code	Description
V27.0	DELIVER-SINGLE LIVEBORN

Table PC02-B. ICD-9-CM Diagnosis Codes to Identify Complications Mainly Related to Pregnancy

ICD-9-CM Code	Description
640.81	HEM EARLY PREG NEC-DELIV
640.91	HEM EARLY PREG-DELIVERED
641.01	PLACENTA PREVIA-DELIVER
641.11	PLACENTA PREV HEM-DELIV
641.21	PREM SEPAR PLACEN-DELIV
641.31	COAG DEF HEMORR-DELIVER
641.81	ANTEPARTUM HEM NEC-DELIV
641.91	ANTEPARTUM HEM NOS-DELIV
642.01	ESSEN HYPERTEN-DELIVERED
642.02	ESSEN HYPERTEN-DEL W P/P
642.11	RENAL HYPERTEN PG-DELIV
642.12	RENAL HYPERTEN-DEL P/P
642.21	OLD HYPERTEN NEC-DELIVER
642.22	OLD HYPERTEN-DELIV W P/P
642.31	TRANS HYPERTEN-DELIVERED
642.32	TRANS HYPERTEN-DEL W P/P
642.41	MILD/NOS PREECLAMP-DELIV
642.42	MILD PREECLAMP-DEL W P/P
642.51	SEVERE PREECLAMP-DELIVER
642.52	SEV PREECLAMP-DEL W P/P
642.61	ECLAMPSIA-DELIVERED
642.62	ECLAMPSIA-DELIV W P/P
642.71	TOX W OLD HYPERTEN-DELIV
642.72	TOX W OLD HYP-DEL W P/P
642.91	HYPERTENS NOS-DELIVERED
642.92	HYPERTENS NOS-DEL W P/P
643.01	MILD HYPEREM GRAV-DELIV
643.11	HYPEREM W METAB DIS-DEL
643.21	LATE VOMIT OF PREG-DELIV
643.81	VOMIT COMPL PREG-DELIVER
643.91	VOMIT OF PREG NOS-DELIV
644.21	EARLY ONSET DELIVERY-DEL
645.11	POST TERM PREG-DEL
645.21	PROLONGED PREG-DEL
646.01	PAPYRACEOUS FETUS-DELIV
646.11	EDEMA IN PREG-DELIVERED
646.12	EDEMA IN PREG-DEL W P/P

ICD-9-CM Code	Description
646.21	RENAL DIS NOS-DELIVERED
646.22	RENAL DIS NOS-DEL W P/P
646.31	RECURNT PREG LOSS-DELIV
646.41	NEURITIS-DELIVERED
646.42	NEURITIS-DELIVERED W P/P
646.51	ASYM BACTERIURIA-DELIVER
646.52	ASY BACTERURIA-DEL W P/P
646.61	GU INFECTION-DELIVERED
646.62	GU INFECTION-DELIV W P/P
646.71	LIVER/BIL TRCT DISR-DEL
646.81	PREG COMPL NEC-DELIVERED
646.82	PREG COMPL NEC-DEL W P/P
646.91	PREG COMPL NOS-DELIVERED
647.01	SYPHILIS-DELIVERED
647.02	SYPHILIS-DELIVERED W P/P
647.11	GONORRHEA-DELIVERED
647.12	GONORRHEA-DELIVER W P/P
647.21	OTHER VD-DELIVERED
647.22	OTHER VD-DELIVERED W P/P
647.31	TUBERCULOSIS-DELIVERED
647.32	TUBERCULOSIS-DELIV W P/P
647.41	MALARIA-DELIVERED
647.42	MALARIA-DELIVERED W P/P
647.51	RUBELLA-DELIVERED
647.52	RUBELLA-DELIVERED W P/P
647.61	OTH VIRAL DIS-DELIVERED
647.62	OTH VIRAL DIS-DEL W P/P
647.81	INFECT DIS NEC-DELIVERED
647.82	INFECT DIS NEC-DEL W P/P
647.91	INFECT NOS-DELIVERED
647.92	INFECT NOS-DELIVER W P/P
648.01	DIABETES-DELIVERED
648.02	DIABETES-DELIVERED W P/P
648.11	THYROID DYSFUNC-DELIVER
648.12	THYROID DYSFUN-DEL W P/P
648.21	ANEMIA-DELIVERED
648.22	ANEMIA-DELIVERED W P/P
648.31	DRUG DEPENDENCE-DELIVER
648.32	DRUG DEPENDEN-DEL W P/P

ICD-9-CM Code	Description
648.41	MENTAL DISORDER-DELIVER
648.42	MENTAL DIS-DELIV W P/P
648.51	CONGEN CV DIS-DELIVERED
648.52	CONGEN CV DIS-DEL W P/P
648.61	CV DIS NEC PREG-DELIVER
648.62	CV DIS NEC-DELIVER W P/P
648.71	BONE DISORDER-DELIVERED
648.72	BONE DISORDER-DEL W P/P
648.81	ABN GLUCOSE TOLER-DELIV
648.82	ABN GLUCOSE-DELIV W P/P
648.91	OTH CURR COND-DELIVERED
648.92	OTH CURR COND-DEL W P/P
649.01	TOBACCO USE DISOR-DELLIV
649.02	TOBACCO USE DIS-DEL-P/P
649.11	OBESITY-DELIVERED
649.12	OBESITY-DELIVERED W P/P
649.21	BARIATRIC SURG STAT-DEL
649.22	BARIATRIC SURG-DEL W P/P
649.31	COAGULATION DEF-DELIV
649.32	COAGULATN DEF-DEL W P/P
649.41	EPILEPSY-DELIVERED
649.42	EPILEPSY-DELIVERED W P/P
649.51	SPOTTING-DELIVERED
649.61	UTERINE SIZE DESCREP-DEL
649.62	UTERINE SIZE-DEL W P/P
649.81	SPON LABR W PLAN C/S-DEL
649.82	LBR W PLAN C/S-DEL W P/P

Table PC02-C. ICD-9-CM Diagnosis Codes to Identify Normal Delivery and Other Indications for Care

ICD-9-CM Code	Description
650	NORMAL DELIVERY
651.01	TWIN PREGNANCY-DELIVERED
651.11	TRIPLET PREGNANCY-DELIV
651.21	QUADRUPLET PREG-DELIVER
651.31	TWINS W FETAL LOSS-DEL
651.41	TRIPLETS W FET LOSS-DEL
651.51	QUADS W FETAL LOSS-DEL
651.61	MULT GES W FET LOSS-DEL
651.71	MULT GEST-FET REDUCT DEL
651.81	MULTI GESTAT NEC-DELIVER
651.91	MULT GESTATION NOS-DELIV
652.01	UNSTABLE LIE-DELIVERED
652.11	CEPHALIC VERS NOS-DELIV
652.21	BREECH PRESENTAT-DELIVER
652.31	TRANSVER/OBLIQ LIE-DELIV
652.41	FACE/BROW PRESENT-DELIV
652.51	HIGH HEAD AT TERM-DELIV
652.61	MULT GEST MALPRES-DELIV
652.71	PROLAPSED ARM-DELIVERED
652.81	MALPOSITION NEC-DELIVER
652.91	MALPOSITION NOS-DELIVER
653.01	PELVIC DEFORM NOS-DELIV
653.11	CONTRACT PELV NOS-DELIV
653.21	INLET CONTRACTION-DELIV
653.31	OUTLET CONTRACTION-DELIV
653.41	FETOPELV DISPROPOR-DELIV
653.51	FETAL DISPROP NOS-DELIV
653.61	HYDROCEPH FETUS-DELIVER
653.71	OTH ABN FET DISPRO-DELIV
653.81	DISPROPORTION NEC-DELIV
653.91	DISPROPORTION NOS-DELIV
654.01	CONGEN ABN UTERUS-DELIV
654.02	CONG ABN UTER-DEL W P/P
654.11	UTERINE TUMOR-DELIVERED
654.12	UTERINE TUMOR-DEL W P/P

ICD-9-CM Code	Description
654.21	PREV C-DELIVERY-DELIVRD
654.31	RETROVERT UTERUS-DELIVER
654.32	RETROVERT UTER-DEL W P/P
654.41	ABN UTERUS NEC-DELIVERED
654.42	ABN UTERUS NEC-DEL W P/P
654.51	CERVICAL INCOMPET-DELIV
654.52	CERV INCOMPET-DEL W P/P
654.61	ABN CERVIX NEC-DELIVERED
654.62	ABN CERVIX NEC-DEL W P/P
654.71	ABNORM VAGINA-DELIVERED
654.72	ABNORM VAGINA-DEL W P/P
654.81	ABNORMAL VULVA-DELIVERED
654.82	ABNORMAL VULVA-DEL W P/P
654.91	ABN PELV ORG NEC-DELIVER
654.92	ABN PELV NEC-DELIV W P/P
655.01	FETAL CNS MALFORM-DELIV
655.11	FETAL CHROMOSO ABN-DELIV
655.21	FAMIL HEREDIT DIS-DELIV
655.31	FET DAMG D/T VIRUS-DELIV
655.41	FET DAMG D/T DIS-DELIVER
655.51	FET DAMAG D/T DRUG-DELIV
655.61	RADIAT FETAL DAMAG-DELIV
655.71	DECREASE FETAL MOVMT DEL
655.81	FETAL ABNORM NEC-DELIVER
655.91	FETAL ABNORM NOS-DELIVER
656.01	FETAL-MATERNAL HEM-DELIV
656.11	RH ISOIMMUNIZAT-DELIVER
656.21	ABO ISOIMMUNIZAT-DELIVER
656.31	FETAL DISTRESS-DELIVERED
656.41	INTRAUTER DEATH-DELIVER
656.51	POOR FETAL GROWTH-DELIV
656.61	EXCESS FETAL GRTH-DELIV
656.71	OTH PLACENT COND-DELIVER
656.81	FET/PLAC PROB NEC-DELIV
656.91	FET/PLAC PROB NOS-DELIV
657.01	POLYHYDRAMNIOS-DELIVERED

ICD-9-CM Code	Description
658.01	OLIGOHYDRAMNIOS-DELIVER
658.11	PREM RUPT MEMBRAN-DELIV
658.21	PROLONG RUPT MEMB-DELIV
658.31	ARTIFIC RUPT MEMBR-DELIV
658.41	AMNIOTIC INFECTION-DELIV
658.81	AMNIOTIC PROB NEC-DELIV
658.91	AMNIOTIC PROB NOS-DELIV
659.01	FAIL MECH INDUCT-DELIVER
659.11	FAIL INDUCTION NOS-DELIV
659.21	PYREXIA IN LABOR-DELIVER
659.31	SEPTICEM IN LABOR-DELIV
659.41	GRAND MULTIPARITY-DELIV
659.51	ELDERLY PRIMIGRAVIDA-DEL
659.61	ELDERLY MULTIGRAVIDA-DEL
659.71	ABN FTL HRT RATE/RHY-DEL
659.81	COMPLIC LABOR NEC-DELIV
659.91	COMPLIC LABOR NOS-DELIV

Table PC02-D. ICD-9-CM Diagnosis Codes to Identify Complications Mainly in the Course of Labor or Delivery

ICD-9-CM Code	Description
660.01	OBSTRUC/FET MALPOS-DELIV
660.11	BONY PELV OBSTRUCT-DELIV
660.21	ABN PELV TIS OBSTR-DELIV
660.31	PERSIST OCCIPTPOST-DELIV
660.41	SHOULDER DYSTOCIA-DELIV
660.51	LOCKED TWINS-DELIVERED
660.61	FAIL TRIAL LAB NOS-DELIV
660.71	FAILED FORCEPS NOS-DELIV
660.81	OBSTRUCT LABOR NEC-DELIV
660.91	OBSTRUCT LABOR NOS-DELIV
661.01	PRIM UTERINE INERT-DELIV
661.11	SEC UTERINE INERT-DELIV
661.21	UTERINE INERT NEC-DELIV
661.31	PRECIPITATE LABOR-DELIV
661.41	UTER DYSTOCIA NOS-DELIV
661.91	ABNORMAL LABOR NOS-DELIV

ICD-9-CM Code	Description
662.01	PROLONG 1ST STAGE-DELIV
662.11	PROLONG LABOR NOS-DELIV
662.21	PROLONG 2ND STAGE-DELIV
662.31	DELAY DEL 2ND TWIN-DELIV
663.01	CORD PROLAPSE-DELIVERED
663.11	CORD AROUND NECK-DELIVER
663.21	CORD COMPRESS NEC-DELIV
663.31	CORD ENTANGLE NEC-DELIV
663.41	SHORT CORD-DELIVERED
663.51	VASA PREVIA-DELIVERED
663.61	VASC LESION CORD-DELIVER
663.81	CORD COMPLICAT NEC-DELIV
663.91	CORD COMPLICAT NOS-DELIV
664.01	DEL W 1 DEG LACERAT-DEL
664.11	DEL W 2 DEG LACERAT-DEL
664.21	DEL W 3 DEG LACERAT-DEL
664.31	DEL W 4 DEG LACERAT-DEL
664.41	OB PERINEAL LAC NOS-DEL
664.51	OB PERINEAL HEMATOMA-DEL
664.81	OB PERINEAL TRAU NEC-DEL
664.91	OB PERINEAL TRAU NOS-DEL
665.01	PRELABOR RUPT UTERUS-DEL
665.11	RUPTURE UTERUS NOS-DELIV
665.22	INVERS UTERUS-DEL W P/P
665.31	LACERAT OF CERVIX-DELIV
665.41	HIGH VAGINAL LACER-DELIV
665.51	OB INJ PELV ORG NEC-DEL
665.61	DAMAGE TO PELVIC JT-DEL
665.71	OB PELVIC HEMATOMA-DELIV
665.72	PELVIC HEMATOM-DEL W PP
665.81	OB TRAUMA NEC-DELIVERED
665.82	OB TRAUMA NEC-DEL W P/P
665.91	OB TRAUMA NOS-DELIVERED
665.92	OB TRAUMA NOS-DEL W P/P
666.02	THRD-STAGE HEM-DEL W P/P
666.12	POSTPA HEM NEC-DEL W P/P

ICD-9-CM Code	Description
666.22	DELAY P/P HEM-DEL W P/P
666.32	P/P COAG DEF-DEL W P/P
667.02	RETND PLAC NOS-DEL W P/P
667.12	RET PROD CONC-DEL W P/P
668.01	PULM COMPL IN DEL-DELIV
668.02	PULM COMPLIC-DEL W P/P
668.11	HEART COMPL IN DEL-DELIV
668.12	HEART COMPL-DEL W P/P
668.21	CNS COMPL LAB/DEL-DELIV
668.22	CNS COMPLIC-DEL W P/P
668.81	ANESTH COMPL NEC-DELIVER
668.82	ANESTH COMPL NEC-DEL P/P
668.91	ANESTH COMPL NOS-DELIVER
668.92	ANESTH COMPL NOS-DEL P/P
669.01	MATERNAL DISTRESS-DELIV
669.02	MATERN DISTRES-DEL W P/P
669.11	OBSTETRIC SHOCK-DELIVER
669.12	OBSTET SHOCK-DELIV W P/P
669.21	MATERN HYPOTEN SYN-DELIV
669.22	MATERN HYPOTEN-DEL W P/P
669.32	AC REN FAIL-DELIV W P/P
669.41	OTH OB COMPL-DELIVERED
669.42	OTH OB COMPL-DELIV W P/P
669.51	FORCEP DELIV NOS-DELIVER
669.61	BREECH EXTR NOS-DELIVER
669.71	CESAREAN DELIVERY NOS
669.81	COMP LAB/DELIV NEC-DELIV
669.82	COMPL DEL NEC-DEL W P/P
669.91	COMP LAB/DELIV NOS-DELIV
669.92	COMPL DEL NOS-DEL W P/P

Table PC02-E. ICD-9-CM Diagnosis Codes to Identify Complications of the Puerperium

ICD-9-CM Code	Description
670.02	MAJOR PUERP INF-DEL P/P
670.12	PUERP ENDOMET DEL W P/P
670.22	PUERPRL Septicemias or Bacteremias-DEL W P/P
670.32	PRP SPTC THRMB-DEL W P/P

ICD-9-CM Code	Description
670.82	MAJ PRP INF NEC-DL W P/P
671.01	VARICOSE VEIN LEG-DELIV
671.02	VARIC VEIN LEG-DEL W P/P
671.11	VARICOSE VULVA-DELIVERED
671.12	VARICOSE VULVA-DEL W P/P
671.21	THROMBOPHLEBITIS-DELIVER
671.22	THROMBOPHLEB-DELIV W P/P
671.31	DEEP THROM ANTEPAR-DELIV
671.42	THROMB POSTPAR-DEL W P/P
671.51	THROMBOSIS NEC-DELIVERED
671.52	THROMB NEC-DELIV W P/P
671.81	VENOUS COMPL NEC-DELIVER
671.82	VEN COMP NEC-DELIV W P/P
671.91	VENOUS COMPL NOS-DELIVER
671.92	VEN COMP NOS-DELIV W P/P
672.02	PUERP PYREXIA-DEL W P/P
673.01	OB AIR EMBOLISM-DELIVER
673.02	OB AIR EMBOL-DELIV W P/P
673.11	AMNIOTIC EMBOLISM-DELIV
673.12	AMNIOT EMBOL-DELIV W P/P
673.21	PULM EMBOL NOS-DELIVERED
673.22	PULM EMBOL NOS-DEL W P/P
673.31	OB PYEMIC EMBOL-DELIVER
673.32	OB PYEM EMBOL-DEL W P/P
673.81	PULMON EMBOL NEC-DELIVER
673.82	PULM EMBOL NEC-DEL W P/P
674.01	PUERP CEREBVAS DIS-DELIV
674.02	CEREBVAS DIS-DELIV W P/P
674.12	DISRUPT C-SECT-DEL W P/P
674.22	DISRUPT PERIN-DEL W P/P
674.32	OB SURG COMPL-DEL W P/P
674.42	PLACENT POLYP-DEL W P/P
674.82	PUERP COMP NEC-DEL W P/P
674.92	PUERP COMP NOS-DEL W P/P
675.01	INFECT NIPPLE-DELIVERED
675.02	INFECT NIPPLE-DEL W P/P

ICD-9-CM Code	Description
675.11	BREAST ABSCESS-DELIVERED
675.12	BREAST ABSCESS-DEL W P/P
675.21	MASTITIS-DELIVERED
675.22	MASTITIS-DELIV W P/P
675.81	BREAST INFECT NEC-DELIV
675.82	BREAST INF NEC-DEL W P/P
675.91	BREAST INFECT NOS-DELIV
675.92	BREAST INF NOS-DEL W P/P
676.01	RETRACTED NIPPLE-DELIVER
676.02	RETRACT NIPPLE-DEL W P/P
676.11	CRACKED NIPPLE-DELIVERED
676.12	CRACKED NIPPLE-DEL W P/P
676.21	BREAST ENGORGE-DELIVERED
676.22	BREAST ENGORGE-DEL W P/P
676.31	BREAST DIS NEC-DELIVERED
676.32	BREAST DIS NEC-DEL W P/P
676.41	LACTATION FAIL-DELIVERED
676.42	LACTATION FAIL-DEL W P/P
676.51	SUPPR LACTATION-DELIVER
676.52	SUPPR LACTAT-DEL W P/P
676.61	GALACTORRHEA-DELIVERED
676.62	GALACTORRHEA-DEL W P/P
676.81	LACTATION DIS NEC-DELIV
676.82	LACTAT DIS NEC-DEL W P/P
676.91	LACTATION DIS NOS-DELIV
676.92	LACTAT DIS NOS-DEL W P/P

Numerator

Patients with cesarean sections. Include patients with ICD-9-CM Principal or Other Procedure Codes for Cesarean section as defined in Table PC02-F.

Table PC02-F. ICD-9-CM Procedure Codes to Identify Cesarean Section

ICD-9-CM Code	Description
74.0	CLASSICAL C-SECTION
74.1	LOW CERVICAL C-SECTION
74.2	EXTRAPERITONEAL C-SECTION
74.4	CESAREAN SECTION NEC
74.99	CESAREAN SECTION NOS

Exclusions

Principal or Other Diagnosis Codes for contraindications to vaginal delivery as defined in Table PC02-G.

- Less than 8 years of age
- Greater than or equal to 65 years of age
- Length of stay >120 days
- Enrolled in clinical trials (See Appendix D for guidance)
- Gestational age < 37 weeks

Medical record review is required to collect the following exclusion data elements: admission date, birthdate, clinical trial, and discharge date. See Appendix D for additional guidance on collecting these data elements.

Table PC02-G. ICD-9-CM Diagnosis Codes for Contradictions to Vaginal Delivery

ICD-9-CM Code	Description
644.21	EARLY ONSET DELIVERY-DEL
651.01	TWIN PREGNANCY-DELIVERED
651.11	TRIPLET PREGNANCY-DELIV
651.21	QUADRUPLET PREG-DELIVER
651.31	TWINS W FETAL LOSS-DEL
651.41	TRIPLETS W FET LOSS-DEL
651.51	QUADS W FETAL LOSS-DEL
651.61	MULT GES W FET LOSS-DEL
651.81	MULTI GESTAT NEC-DELIVER
651.91	MULT GESTATION NOS-DELIV
652.21	BREECH PERSENTAT-DELIVER
652.31	TRANSVER/OBLIQ LIE-DELIV
652.41	FACE/BROW PRESENT DELIV
652.61	MULT GEST MALPRE-DELIV
652.81	MALPOSITION NEC-DELIVER
654.21	PREV C-SECT NOS-DELIVER
656.41	INTRAUTER DEATH-DELIVER
660.51	LOCKED TWINS-DELIVERED
662.31	DELAY DEL 2ND TWIN-DELIV
669.61	BREECH EXTR NOS-DELIVER
761.5	MULT PREGNANCY AFF NB
V27.1	DELIVER-SINGLE STILLBORN
V27.2	DELIVER-TWINS, BOTH LIVE
V27.3	DEL-TWINS, 1 NB, 1 SB
V27.4	DELIVER-TWINS, BOTH SB
V27.5	DEL-MULT BIRTH, ALL LIVE
V27.6	DEL-MULT BRTH, SOME LIVE
V27.7	DEL-MULT BIRTH, ALL SB

MEASURE PDENT-CH: PERCENTAGE OF ELIGIBLES WHO RECEIVED
PREVENTIVE DENTAL SERVICES

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of individuals ages 1 to 20 who are enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.

Data Collection Method: Administrative (Form CMS-416)

Guidance for Reporting:

- CMS will calculate this measure for states based on data submitted as part of the EPSDT report (CMS-416). States are not asked, and will not be able to provide data for this measure in MACPro.
- The denominator for this measure includes only individuals enrolled in a Medicaid program or a CHIP Medicaid expansion program for at least 90 continuous days and eligible for EPSDT services.
- States with a separate CHIP program should report dental data in Section III G of the CHIP Annual Report Template System (CARTS) report.
- Instructions for the CMS-416, including for the dental lines of the report, are available at <https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf>.
- Include all paid, unpaid, and denied claims.

The following coding systems are used in this measure: CDT, CPT, and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Unduplicated	An individual may only be counted once.
--------------	---

C. ELIGIBLE POPULATION

Age	Individuals ages 1 to 20.
Continuous enrollment	Eligible for EPSDT services for at least 90 continuous days.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The total unduplicated number of individuals ages 1 to 20 who have been continuously enrolled in Medicaid or CHIP Medicaid Expansion programs for at least 90 days and are eligible to receive EPSDT services.

Version of Specification: CMS 2016

The dental procedure codes, nomenclatures and descriptors above have been obtained from Current Dental Terminology (including procedure codes, nomenclatures, descriptors and other data contained therein) ("CDT")
CDT IS COPYRIGHT © 2013 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

Numerator

The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 (or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

The numerator should be inclusive of services reimbursed directly by the state under fee-for-service, managed care, prospective payment, or any other payment arrangements, or through any other health or dental plans that contract with the state to provide services to Medicaid or CHIP Medicaid expansion enrollees, based on an unduplicated paid, unpaid, or denied claim.

Exclusions

Do not include in this count the following groups of individuals:

- Medically needy individuals ages 1 to 20 if your state does not provide EPSDT services for the medically needy population
- Individuals eligible for Medicaid only under a §1115 waiver as part of an expanded population for which the full complement of EPSDT services is not available
- Undocumented aliens who are eligible only for emergency Medicaid services
- Children in separate state CHIP programs
- Groups of individuals ages 1 to 20 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services)

MEASURE PPC-CH: TIMELINESS OF PRENATAL CARE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of Medicaid/CHIP deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that had a prenatal care visit in the first trimester or within 42 days of enrollment in Medicaid/CHIP.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- References to postpartum visits in the original HEDIS specifications have been removed because they are not relevant to reporting of the Child Core Set, which only focuses on the timeliness of prenatal care.
- If both Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care are collected using the Hybrid Method, the same sample for collection must be used.
- If the Hybrid Method is used, a combination of administrative data and medical record review may not be used to identify prenatal care visits for an individual in the denominator. For example, for one woman, two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) may not be counted, even if each visit shows a different date of service.
- States may use vital records as an alternative data source for this measure if they have confidence in the completeness and accuracy of these data. States can use Medicaid administrative data to determine the measure-eligible population (including the requirement of continuous eligibility from 43 days before delivery through 56 days after delivery) and then link the Medicaid records to vital records data to identify the information needed to calculate the numerator, including gestational age at delivery, the number of prenatal care visits, and the timing of these visits in relation to the gestational age. States using vital records should document this data source in the "Additional Notes/Comments on Measure" field in MACPro. States should also provide information about the proportion of measure-eligible enrollees who were identified in Medicaid administrative data but for whom a birth certificate could not be found in vital records data.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for definitions of a PCP and OB/GYN practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, LOINC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.

Benefit	Medical.
Event/ diagnosis	<p>Delivered a live birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. Include women who delivered in any setting.</p> <p>Multiple births. Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.</p> <p>Follow the steps below to identify the eligible population, which is the denominator for the rate:</p> <p>Step 1 Identify deliveries. Identify all women with a delivery (<u>Deliveries Value Set</u>) between November 6 of the year prior to the measurement year and November 5 of the measurement year.</p> <p>Step 2 Exclude non-live births (<u>Non-live Births Value Set</u>).</p> <p>Step 3 Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery and 56 days after delivery, with no gaps.</p>

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

Timeliness of Prenatal Care

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in Medicaid/CHIP and the gaps in enrollment during the pregnancy.

Include only visits that occur while the woman was enrolled.

Follow the steps below to identify the numerator.

Step 1

Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women, proceed to step 2.

For women not enrolled on or before 280 days prior to delivery (or EDD), who were therefore pregnant at the time of enrollment, proceed to step 3.

Step 2

Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176–280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester.

For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.

Step 3

Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).

For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4.

For women whose last enrollment started less than 219 days before delivery, proceed to step 5.

Step 4

Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester and find a visit between the last enrollment start date and 176 days before delivery.

Step 5

Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester and find a visit within 42 days after enrollment.

Decision Rules for Identifying Prenatal Care For Women Continuously Enrolled During the First Trimester

Decision Rule 1

Either of the following during the first trimester, where the practitioner type is an OB/GYN practitioner or other prenatal care practitioner or PCP meets criteria:

- A bundled service (Prenatal Bundled Services Value Set) where the state can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated)
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set)

Decision Rule 2

Any of the following during the first trimester, where the practitioner type for the prenatal visit is an OB/GYN practitioner or other prenatal care practitioner, meet criteria:

- A prenatal visit (Prenatal Visits Value Set) with an obstetric panel (Obstetric Panel Value Set)
- A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set)
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set)
- A prenatal visit (Prenatal Visits Value Set) with all of the following:
 - Toxoplasma (Toxoplasma Antibody Value Set)
 - Rubella (Rubella Antibody Value Set)
 - Cytomegalovirus (Cytomegalovirus Antibody Value Set)
 - Herpes simplex (Herpes Simplex Antibody Value Set)

- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO (ABO Value Set)
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and Rh (Rh Value Set)
- A prenatal visit (Prenatal Visits Value Set) with rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set)

Decision Rule 3

Any of the following during the first trimester, where the practitioner type is a PCP, meet criteria:

- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an obstetric panel (Obstetric Panel Value Set)
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set)
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and all of the following:
 - Toxoplasma (Toxoplasma Antibody Value Set)
 - Rubella (Rubella Antibody Value Set)
 - Cytomegalovirus (Cytomegalovirus Antibody Value Set)
 - Herpes simplex (Herpes Simplex Antibody Value Set)
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO (ABO Value Set)
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and Rh (Rh Value Set)
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set) and rubella (Rubella Antibody Value Set) and ABO/Rh (ABO and Rh Value Set)
- A prenatal visit (Prenatal Visits Value Set) with any state-defined code for LMP or EDD with an obstetrical history
- A prenatal visit (Prenatal Visits Value Set) with any state-defined code for LMP or EDD with risk assessment and counseling/education

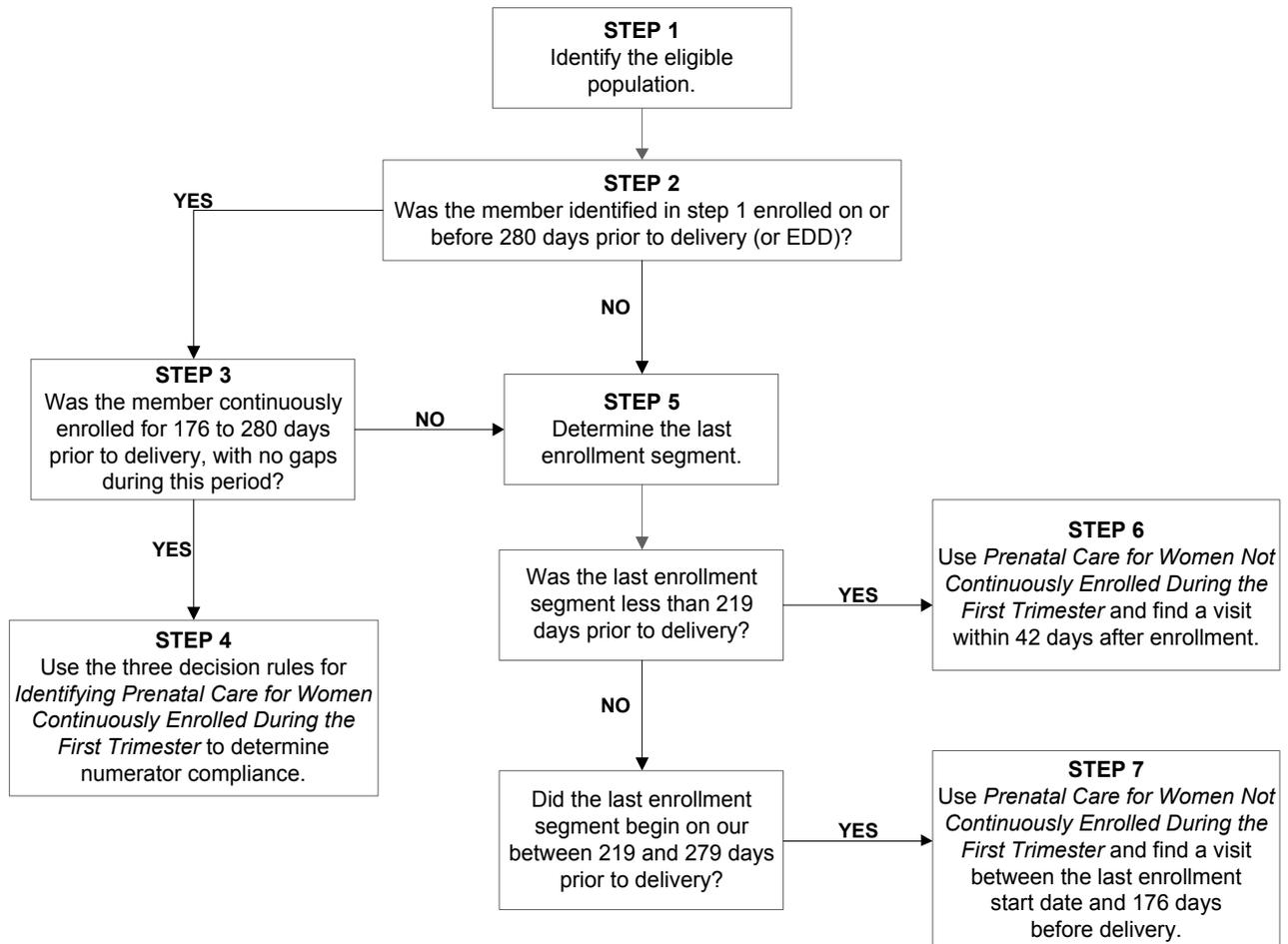
Note: For Decision Rule 3 criteria that require a prenatal visit code (Prenatal Visits Value Set) and a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.

Decision Rules for Identifying Prenatal Care For Women Not Continuously Enrolled During the First Trimester

Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:

- A bundled service (Prenatal Bundled Services Value Set) where the state can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated.)
- A visit for prenatal care (Stand Alone Prenatal Visits Value Set)
- A prenatal visit (Prenatal Visits Value Set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound Value Set)
- A prenatal visit (Prenatal Visits Value Set) with a principal pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set)

Note: For criteria that require a prenatal visit code (Prenatal Visits Value Set) and a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set), codes must be on the same claim.



D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

A prenatal visit in the first trimester or within 42 days of enrollment, depending on the date of enrollment in Medicaid/CHIP and gaps in enrollment during the pregnancy. Include only visits that occurred while the woman was enrolled.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Prenatal care visit to an OB/GYN practitioner or other prenatal care practitioner or PCP. For visits to a PCP a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:

- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
 - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing), or
 - TORCH antibody panel alone, or
 - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
 - Echography of a pregnant uterus
 - Documentation of LMP or EDD in conjunction with either of the following:
 - Prenatal risk assessment and counseling/education
 - Complete obstetrical history

Note: For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN practitioner or other PCP with a principal diagnosis of pregnancy. Refer to Appendix C for definitions of a PCP and OB/GYN practitioner.

E. ADDITIONAL NOTES

When counting prenatal visits, include visits with physician assistants, nurse practitioners, and midwives.

For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the state has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.

Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.

For women whose last enrollment segment started on or between 219 and 279 days before delivery, the state has sufficient opportunity to provide prenatal care by the end of the first trimester.

For women whose last enrollment segment started less than 219 days before delivery, the state has sufficient opportunity to provide prenatal care within 42 days after enrollment.

Services that occur over multiple visits count toward this measure as long as all services are within the time frame established in the measure. Ultrasound and lab results alone should not be considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.

The state must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple estimated dates of delivery (EDD) are documented, the state must define a method to determine which EDD to use, and use that date consistently. The LMP may not be used to determine the first trimester.

A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate. A colposcopy alone is not numerator compliant.

The intent is that a visit is with a PCP or OB/GYN practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.

The intent of the measure is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

MEASURE SEAL-CH: DENTAL SEALANTS FOR 6–9 YEAR OLD CHILDREN AT ELEVATED CARIES RISK

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled children ages 6 to 9 at elevated risk of dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth within the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- There are five primary differences between the SEAL Child Core Set measure and the dental sealant measure included in the Form CMS-416: (1) the SEAL measure is reported for children ages 6 to 9, only, while the Form CMS-416 measure is reported for children ages 6 to 9 and 10 to 14; (2) the SEAL measure denominator includes children at elevated risk of dental caries (i.e., “moderate” or “high” risk), while the Form CMS-416 measure does not require assessment of risk for dental caries; (3) the SEAL measure has a continuous enrollment criterion of 180 days, while the Form CMS-416 measure has a continuous enrollment criterion of 90 days; (4) the SEAL measure counts sealants on first permanent molars only, while the Form CMS-416 measure counts sealants on all permanent molars; and (5) the measurement period for the Child Core Set measure is the calendar year, while the Form CMS-416 measure is calculated for the federal fiscal year.
- Elevated risk can be assessed using one of two methods (1) identify enrollees with ‘moderate’ or ‘high’ risk during the measurement year using CDT codes D0602 or D0603 or (2) identify enrollees with at least one CDT service code from Table SEAL.A. States may use a three-year lookback period for these codes if data are available or else may use one year of data for the measurement year.
- Children enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for the measure.
- A technical assistance brief on calculating the dental sealant measure is available at <https://www.medicaid.gov/medicaid/benefits/downloads/sealant-measure-brief.pdf>.
- Sample SAS Code for programming the dental sealant measure and an accompanying Guide to Data Elements are available on request through the TA mailbox at MACQualityTA@cms.hhs.gov.
- Include all paid, suspended, pending, and denied claims.

The following coding systems are used in this measure: CDT and NUCC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children ages 6 to 9 at the last day of the measurement year.
Continuous enrollment	Child must be continuously enrolled for at least 180 days.
Allowable gap	None.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	At “elevated” risk for dental caries (i.e., “moderate” or “high” risk).

C. ADMINISTRATIVE SPECIFICATION**Denominator**

The unduplicated number of eligible children ages 6 to 9 at “elevated” risk for dental caries (i.e., “moderate” or “high” risk).

“Elevated” risk is determined as follows:

- The enrollee has a visit with a CDT code = (D0602 or D0603 in the measurement year, OR
- The enrollee has a SERVICE Code among those in Table SEAL-A in the measurement year, OR
- The enrollee has a SERVICE Code among those in Table SEAL-A in any of the three years prior to the measurement year. (Note: the enrollee does not need to be enrolled in Medicaid/CHIP in any of the prior three years for the denominator enrollment criteria; this is a “look back” for enrollees who do have claims experience in any of the prior three years.)

Table SEAL-A. CDT Codes to Identify “Elevated Risk”

D2140	D2394	D2630	D2720	D2791	D3110
D2150	D2410	D2642	D2721	D2792	D3120
D2160	D2420	D2643	D2722	D2794	D3220
D2161	D2430	D2644	D2740	D2799	D3221
D2330	D2510	D2650	D2750	D2930	D3222
D2331	D2520	D2651	D2751	D2931	D3230
D2332	D2530	D2652	D2752	D2932	D3240
D2335	D2542	D2662	D2780	D2933	D3310
D2390	D2543	D2663	D2781	D2934	D3320
D2391	D2544	D2664	D2782	D2940	D3330
D2392	D2610	D2710	D2783	D2941	
D2393	D2620	D2712	D2790	D2950	

Version of Specification: ADA-DQA 2016

2016 American Dental Association on behalf of the Dental Quality Alliance (DQA) ©. All rights reserved. Use by individuals or other entities for purposes consistent with the DQA’s mission and that is not for commercial or other direct revenue-generating purposes is permitted without charge.

Numerator

The unduplicated number of eligible children ages 6 to 9 at “elevated” risk for dental caries (i.e., “moderate” or “high” risk) who received a sealant on a permanent first molar tooth as a dental service.

Step 1

Check if enrollee received a sealant as a dental service.

- If [SERVICE CODE] = D1351 AND
- If [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table SEAL-B below, then proceed to the next step.⁵
- If both of these criteria are not met, then the service is not counted as a “dental service.” The enrollee is counted in the denominator but is not counted in the numerator.

Note: In this step, all claims with missing or invalid SERVICE Code, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table SEAL-B will not be counted in the numerator.

Step 2

For those who received a sealant as a dental service (determined in Step 1), check if the sealant was placed on a permanent first molar.

- If [TOOTH-NUMBER] = 3, 14, 19 or 30, then count in numerator.
- If not, then service was not provided for the permanent first molar. The enrollee is counted in the denominator but is not counted in the numerator.

Table SEAL-B. NUCC maintained Provider Taxonomy Codes classified as “Dental Service”*

122300000X	1223P0106X	1223X0008X	125Q00000
1223D0001X	1223P0221X	1223X0400X	261QF0400X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X
1223E0200X	1223P0700X	125J00000X	
1223G0001X	1223S0112X	125K00000X	

* Services provided by County Health Department dental clinics may also be included as “dental” services.

+ Only dental hygienists who provide services under the supervision of a dentist should be classified as “dental” services. Services provided by independently practicing dental hygienists should be classified as “oral health” services and are not applicable for this measure.

⁵Identifying “dental” services: Programs and plans that do not use standard NUCC maintained provider Taxonomy Codes should use valid mapping to identify providers whose services will be categorized as “dental” services. In the case of stand-alone dental plans that reimburse ONLY for services rendered by or under the supervision of the dentist, states should consider all claims as “dental” services.

D. ADDITIONAL NOTES

More information on the rationale for and implementation of the measure is provided in the DQA Measures User Guide, available at

http://www.ada.org/en/~/media/ADA/Science%20and%20Research/Files/DQA_2016_User_Guide.

Reliability of the measure score depends on the quality of the data used to calculate the measure. The percentage of missing and invalid data for these data elements must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, records with missing or invalid SERVICE CODE will be counted in the denominator but not in the numerator. These records are assumed to not have had a visit. In this case, a low quality data set will result in a low utilization score.

Measure Limitations Due to Limitations of Administrative Data

This measure will not delineate those whose teeth have not erupted, those who have already received sealants in prior years, and those with decayed/filled teeth not candidates for sealants. However, this measure is designed to identify the prevalence of sealant placement on a permanent first molar tooth during the reporting year for children ages 6 to 9 years at elevated risk for caries; this measure is not designed to provide the absolute percentage of children who have ever had a sealant on a permanent first molar. As such, this prevalence-based measure is intended to be used for monitoring trends in sealant placement over time, variations in sealant placement between reporting entities, and disparities in sealant placement.

Some codes (i.e., a few endodontic codes) included to identify children at elevated risk may also be reported for instances such as trauma and may contribute to slight overestimation of children at “elevated” risk.

Since “elevated risk” determination requires an evaluation (to record CDT risk code) or a treatment visit (to record a treatment code), children who are enrolled but do not have a visit in the reporting year or a treatment visit in any of the prior three years will not have sufficient information to be included in the measure. While this is a limitation, the intent of this process measure is to seek to understand whether children who can be positively identified as being at elevated risk receive the recommended preventive services.

MEASURE SRA-CH: CHILD AND ADOLESCENT MAJOR DEPRESSIVE DISORDER (MDD): SUICIDE RISK ASSESSMENT

American Medical Association – Physician Consortium for Performance Improvement® (AMA-PCPI)

A. DESCRIPTION

Percentage of patient visits for enrollees ages 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.

Data Collection Method: Electronic Health Records

Guidance for Reporting:

- This measure is specified for calculation using electronic health records.
- This measure is based on the percentage of patient visits rather than enrollees.
- More information about this measure is available in the eCQM Library (CMS 177v3), available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/eCQM_Library.html. More information about CMS177v3 is available in the Electronic Clinical Quality Improvement Resource Center (eCQI Resource Center) at <https://ecqi.healthit.gov>.
- Value sets for this measure are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC), located at <https://vsac.nlm.nih.gov>. Access to the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a UMLS license at <https://uts.nlm.nih.gov/license.html>. When searching for value sets for the SRA measure, states should use the measure's associated eMeasure number (CMS177v3) or NQF number (1365). For reporting on 2015 data, use the version of the value sets associated with the 07-01-2014 release.
- Refer to Appendix E for eMeasure flow for this measure.

The following coding systems are used in this measure: CDCREC, CPT, ICD-9, ICD-10, LOINC, SNOMED and SOP. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. E-MEASURE SPECIFICATIONS

Denominator

All patient visits for those enrollees ages 6 through 17 years with a diagnosis of major depressive disorder.

Denominator Logic

- **Initial Patient Population =**
 - AND: "Patient Characteristic Birthdate: birth date" >= 6 year(s) starts before start of "Measurement Period"
 - AND: "Patient Characteristic Birthdate: birth date" < 17 year(s) starts before start of "Measurement Period"
 - AND: Count >= 2 of:
 - OR: "Encounter, Performed: Office Visit"
 - OR: "Encounter, Performed: Outpatient Consultation"
 - OR: "Encounter, Performed: Patient Provider Interaction"
 - OR: "Encounter, Performed: Psych Visit - Diagnostic Evaluation"
 - OR: "Encounter, Performed: Psych Visit - Family Psychotherapy"
 - OR: "Encounter, Performed: Psychoanalysis"
 - OR: "Encounter, Performed: Group Psychotherapy"
 - OR: "Encounter, Performed: Psych Visit - Psychotherapy"
 - during "Measurement Period"
 - AND:
 - OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation"
 - AND: "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation"
 - OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psych Visit - Family Psychotherapy"
 - AND: "Occurrence A of Encounter, Performed: Psych Visit - Family Psychotherapy" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Psych Visit - Family Psychotherapy"
 - OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Face-to-Face Interaction"
 - AND: "Occurrence A of Encounter, Performed: Face-to-Face Interaction" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Face-to-Face Interaction"

- OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Group Psychotherapy"
 - AND: "Occurrence A of Encounter, Performed: Group Psychotherapy" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Group Psychotherapy"
- OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Outpatient Consultation"
 - AND: "Occurrence A of Encounter, Performed: Outpatient Consultation" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Outpatient Consultation"
- OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Office Visit"
 - AND: "Occurrence A of Encounter, Performed: Office Visit" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Office Visit"
- OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psychoanalysis"
 - AND: "Occurrence A of Encounter, Performed: Psychoanalysis" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Psychoanalysis"
- OR:
 - AND: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" starts before or during "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"
 - AND: "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy" during "Measurement Period"
 - AND NOT: "Occurrence A of Diagnosis, Active: Major Depressive Disorder-Active" ends before start of "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"
- **Denominator =**
 - AND: "Initial Patient Population"

Denominator Exclusions

None.

Numerator

Patient visits with an assessment for suicide risk.

Numerator Definition

The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. Suicide risk assessment can include specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (e.g., positive reasons for living, strong social support); and identification of any family history of suicide or mental illness. Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicide Severity Rating Scale can also be used.

Numerator Guidance

A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period.

This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. A minimum of two encounters are required during the measurement period for a patient to be included in this measure to establish that the eligible professional has an existing relationship with the patient; if the patient is only seen once by the eligible professional, the patient is not included in the measure. Once it has been established that the patient has been seen at least twice by the eligible professional, every visit for major depressive disorder should be counted as a measurable episode for the measure calculation. For example, at every visit for MDD, the patient should have a suicide risk assessment.

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment" included in the numerator logic below.

Numerator Logic

- AND: "Intervention, Performed: Suicide Risk Assessment" during
 - OR: "Occurrence A of Encounter, Performed: Office Visit"
 - OR: "Occurrence A of Encounter, Performed: Outpatient Consultation"
 - OR: "Occurrence A of Encounter, Performed: Face-to-Face Interaction"
 - OR: "Occurrence A of Encounter, Performed: Psych Visit - Diagnostic Evaluation"
 - OR: "Occurrence A of Encounter, Performed: Psych Visit - Psychotherapy"
 - OR: "Occurrence A of Encounter, Performed: Psych Visit - Family Psychotherapy"
 - OR: "Occurrence A of Encounter, Performed: Psychoanalysis"
 - OR: "Occurrence A of Encounter, Performed: Group Psychotherapy"

C. ADDITIONAL NOTES

Data Criteria - Quality Data Model (QDM) Data Elements

Available in the SRA Value Set

"Diagnosis, Active: Major Depressive Disorder-Active" using "Major Depressive Disorder-Active Grouping Value Set (2.16.840.1.113883.3.526.3.1491)"

"Encounter, Performed: Face-to-Face Interaction" using "Face-to-Face Interaction Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1048)"

"Encounter, Performed: Group Psychotherapy" using "Group Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1187)"

"Encounter, Performed: Office Visit" using "Office Visit Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1001)"

"Encounter, Performed: Outpatient Consultation" using "Outpatient Consultation Grouping Value Set (2.16.840.1.113883.3.464.1003.101.12.1008)"

"Encounter, Performed: Patient Provider Interaction" using "Patient Provider Interaction Grouping Value Set (2.16.840.1.113883.3.526.3.1012)"

"Encounter, Performed: Psych Visit - Diagnostic Evaluation" using "Psych Visit - Diagnostic Evaluation Grouping Value Set (2.16.840.1.113883.3.526.3.1492)"

"Encounter, Performed: Psych Visit - Family Psychotherapy" using "Psych Visit - Family Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1018)"

"Encounter, Performed: Psych Visit - Psychotherapy" using "Psych Visit - Psychotherapy Grouping Value Set (2.16.840.1.113883.3.526.3.1496)"

"Encounter, Performed: Psychoanalysis" using "Psychoanalysis Grouping Value Set (2.16.840.1.113883.3.526.3.1141)"

"Intervention, Performed: Suicide Risk Assessment" using "Suicide Risk Assessment Grouping Value Set (2.16.840.1.113883.3.526.3.1484)"

"Patient Characteristic Birthdate: birth date" using "birth date LOINC Value Set (2.16.840.1.113883.3.560.100.4)"

Reporting Stratification

None.

Supplemental Data Elements

"Patient Characteristic Ethnicity: Ethnicity" using "Ethnicity CDC Value Set (2.16.840.1.114222.4.11.837)"

"Patient Characteristic Payer: Payer" using "Payer Source of Payment Typology Value Set (2.16.840.1.114222.4.11.3591)"

"Patient Characteristic Race: Race" using "Race CDC Value Set (2.16.840.1.114222.4.11.836)"

"Patient Characteristic Sex: ONC Administrative Sex" using "ONC Administrative Sex Administrative Sex Value Set (2.16.840.1.113762.1.4.1)"

MEASURE W15-CH: WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children who turned 15 months old during the measurement year and who had the following number of well-child visits with a primary care practitioner (PCP) during their first 15 months of life:

- No well-child visits
- One well-child visit
- Two well-child visits
- Three well-child visits
- Four well-child visits
- Five well-child visits
- Six or more well-child visits

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Children should be listed in the numerator for their highest number of visits only. Thus if a child has 5 visits, include the child only in the 5-visit numerator. The sum of all rates should equal 100 percent.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of a PCP.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	15 months old during the measurement year.
Continuous enrollment	31 days to 15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2014, and turns 15 months old on April 9, 2015.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Day the child turns 15 months old.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerators

Seven separate numerators are calculated, corresponding to the number of children who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits (Well-Care Value Set), on different dates of service, with a PCP during their first 15 months of life.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

Seven separate numerators are calculated, corresponding to the number of children who received 0, 1, 2, 3, 4, 5, 6 or more complete well-child visits, on different dates of service, with a PCP during their first 15 months of life.

The well-child visit must occur with a PCP.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from administrative data.

Medical Record Review

Documentation from the medical record must include a note indicating a visit with a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance

Do not include services rendered during an inpatient or emergency department (ED) visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

E. ADDITIONAL NOTES

This measure is based on the CMS and American Academy of Pediatrics guidelines for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at <http://www.aap.org> and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at <http://www.Brightfutures.org> for more information about well-child visits.

MEASURE W34-CH: WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 3 to 6 who had one or more well-child visits with a primary care practitioner (PCP) during the measurement year.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for the definition of a PCP.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, and ICD-10. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	3 to 6 years old as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

At least one well-child visit (Well-Care Value Set) with a PCP during the measurement year.

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

At least one well-child visit with a PCP during the measurement year. The PCP does not have to be the practitioner assigned to the child.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Documentation must include a note indicating a visit to a PCP, the date when the well-child visit occurred and evidence of all of the following:

- A health history
- A physical developmental history
- A mental developmental history
- A physical exam
- Health education/anticipatory guidance

Do not include services rendered during an inpatient or ED visit.

Preventive services may be rendered on visits other than well-child visits. Well-child preventive services count toward the measure, regardless of the primary intent of the visit, but services that are specific to an acute or chronic condition do not count toward the measure.

Visits to school-based clinics with practitioners whom the state would consider PCPs may be counted if documentation of a well-child exam is available in the medical record or administrative system in the time frame specified by the measure. The PCP does not have to be assigned to the child.

The state may count services that occur over multiple visits, as long as all services occur in the time frame specified by the measure.

E. ADDITIONAL NOTES

This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. Refer to the American Academy of Pediatrics Guidelines for Health Supervision at <http://www.aap.org> and Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents (published by the National Center for Education in Maternal and Child Health) at <http://www.Brightfutures.org> for more information about well-child visits.

**MEASURE WCC-CH: WEIGHT ASSESSMENT AND COUNSELING FOR
NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS:
BODY MASS INDEX ASSESSMENT FOR CHILDREN/ADOLESCENTS**

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrical/ gynecological (OB/GYN) practitioner and who had evidence of body mass index (BMI) percentile documentation during the measurement year.

Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- Only the BMI percentile component is included in the Child Core Set measure; the physical activity/nutrition counseling measure components are not included in the measure.
- The eligible population (denominator) for this measure includes children ages 3 to 17 who have an outpatient visit and meet the continuous enrollment criteria.
- A BMI percentile is included in the numerator count if the specified documentation is present, regardless of the primary intent of the visit. A BMI without a percentile is not acceptable for inclusion in the numerator count.
- For states reporting a Child Core Set measure that is also an Electronic Health Record (EHR) Medicaid Incentive Program measure, please indicate whether any information was extracted from electronic health records. Please report this information in the “Additional Notes/Comments on Measure” field.
- The height, weight, and BMI must be from the same data source.
- The height and weight measurement should be taken during the measurement year.
- If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year or year prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix C for definitions of a PCP and OB/GYN practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-9, ICD-10, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

BMI	Body mass index. A statistical measure of the weight of a person scaled according to height.
BMI percentile	The percentile ranking based on the CDC’s BMI-for-age growth charts, which indicates the relative position of the patient’s BMI number among others of the same gender and age.

C. ELIGIBLE POPULATION

Age	3 to 17 years old as of December 31 of the measurement year. Report two age stratifications and a total for each of the three indicators: <ul style="list-style-type: none"> • 3 to 11 years • 12 to 17 years • Total The total is the sum of the age stratifications.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid/CHIP enrollee for whom enrollment is verified monthly, the child may not have more than a 1-month gap in coverage (i.e., a child whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	An outpatient visit (<u>Outpatient Value Set</u>) with a PCP or an OB/GYN during the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population.

Numerator

BMI percentile (BMI Percentile Value Set) during the measurement year.

Exclusions (optional)

Enrollees who have a diagnosis of pregnancy (Pregnancy Value Set) during the measurement year.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population for the Total age band (Ages 3 to 17). The Total sample is stratified by age to report rates for ages 3 to 11 and ages 12 to 17.

Use a sample size of 411, unless special circumstances apply. States may reduce the sample size using information from the current year’s administrative rate or the prior year’s audited, hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, Refer to Appendix B, Guidance for Selecting Sample Sizes for Hybrid Measures.

Numerator

BMI percentile during the measurement year as identified by administrative data or medical record review.

Administrative Data

Refer to Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Documentation must include height, weight and BMI percentile during the measurement year. The height, weight and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile
- BMI percentile plotted on age-growth chart

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

Ranges and thresholds do not meet criteria. A distinct BMI percentile or value, if applicable, is required for numerator compliance. Documentation of >99 percent or <1 percent meet criteria because a distinct BMI percentile is evident (i.e., 100 percent or 0 percent).

Exclusions (optional)

Refer to the Administrative Specification for exclusion criteria. Exclusionary evidence in the medical record must include a note indicating a diagnosis of pregnancy. The diagnosis must have occurred during the measurement year.

F. ADDITIONAL NOTES

Records that do not include documentation of BMI percentile or that include notation of BMI value only, or height and weight only do not count as numerator compliant.

Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit.

This page left blank for double-sided copying.

Appendix A
Child Core Set
HEDIS® Value Set Directory
User Manual

This page left blank for double-sided copying.

A. WHAT IS THE VALUE SET DIRECTORY?

Measure specifications for HEDIS® measures in the Child Core Set reference value sets. A “value set” is the complete set of codes used to identify a service or condition included in a measure. The Value Set Directory (VSD) includes all value sets and codes needed to report HEDIS Child Core Set measures. This appendix describes how to use value sets in calculating HEDIS measures in the Child Core Set.

B. STRUCTURE OF THE VALUE SET DIRECTORY

The VSD (Excel workbook) contains the following spreadsheets:

- Child Measures to Value Sets
- Child Value Sets to Codes
- Summary of Changes – Codes
- Summary of Changes – Value Sets

The columns in the value sets are based on those included in the National Library of Medicine Value Set Authority Center (VSAC) standardized value set file. Not all columns will be needed for Child Core Set reporting, depending on how the state’s information systems are organized. All columns have been included in the value set to preserve consistency with the national standard.

C. WHAT’S NEW IN THE VALUE SET DIRECTORY?

- ICD-10-CM and ICD-10-PCS codes are included in the value sets and are not listed individually in the *Summary of Changes – Codes* spreadsheet.
- Other specific code and value set changes are included in the Summary of Changes spreadsheets, as described in this manual.

D. CHILD MEASURES TO VALUE SETS

The Child Measures to Value Sets spreadsheet lists value sets by measure and includes the elements in Table A.1.

Table A.1. Child Measure to Value Sets

Element Name	Element Description
Measure ID	The abbreviation for the measure.
Measure Name	The measure name.
Value Set Name	The value set name.
Value Set OID	Unique identifier for the value set.

Use the Child Measures to Value Sets spreadsheet to identify all value sets used for a particular measure or to identify all measures that use a specific value set. For example, setting the Measure ID filter to “WCC-CH” demonstrates that the BMI Assessment for Children/Adolescents measure uses the following value sets:

Measure ID	Measure Name	Value Set Name	Value Set OID
WCC-CH	BMI Assessment for Children/Adolescents	BMI Percentile	2.16.840.1.113883.3.464.1004.1038
WCC-CH	BMI Assessment for Children/Adolescents	Outpatient	2.16.840.1.113883.3.464.1004.1202
WCC-CH	BMI Assessment for Children/Adolescents	Pregnancy	2.16.840.1.113883.3.464.1004.1219

Setting the Value Set Name filter to “Well-Care” identifies the three measures that use the value set:

Measure ID	Measure Name	Value Set Name	Value Set OID
AWC-CH	Adolescent Well-Care Visits	Well-Care	2.16.840.1.113883.3.464.1004.1262
W15-CH	Well-Child Visits in the First 15 Months of Life	Well-Care	2.16.840.1.113883.3.464.1004.1262
W34-CH	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Well-Care	2.16.840.1.113883.3.464.1004.1262

E. CHILD VALUE SETS TO CODES

The Child Value Sets to Codes spreadsheet lists the codes included in each value set and includes the elements in Table A.2.

Table A.2. Child Value Sets to Codes

Element Name	Element Description
Value Set Name	The value set name.
Value Set OID	Unique identifier for the value set.
Value Set Version	The version date for the value set directory (2015-11-13 for federal fiscal year 2016 reporting).
Code	The code.
Definition	The code definition. Note: The definition is not included for Uniform Bill, ¹ CPT, ² or the American Dental Association’s Code on Dental Procedures and Nomenclature (CDT) codes due to licensing restrictions.

Element Name	Element Description
Code System	The code system for the code. Code systems are labeled as: CPT Current Procedural Terminology HCPCS Healthcare Common Procedure Coding System Level II ICD9CM International Classification of Diseases, 9th Revision, Clinical Modification (Diagnosis codes) ICD9PCS International Classification of Diseases, 9th Revision, Clinical Modification (Procedure codes) ICD10CM International Classification of Diseases, 10th Revision, Clinical Modification (Diagnosis codes) ICD10PCS International Classification of Diseases, 10th Revision, Procedure Coding System (Procedure codes) LOINC ³ Logical Observation Identifiers Names and Codes POS CMS Place of Service UBREV Uniform Bill (Revenue codes) UBTOB Uniform Bill (Type of Bill codes)
Code System OID	Unique identifier for the code system.
Code System Version	Code system version tracking number.

¹Uniform Bill Codes (“UB Codes”) are protected under federal copyright laws and are owned by the American Hospital Association (AHA). The UB Codes in the HEDIS specifications are included with the permission of the AHA. The UB Codes contained in the HEDIS specifications may be used by health plans and other health care delivery organizations for the purpose of calculating and reporting HEDIS results or using HEDIS measure results for their internal quality improvement purposes. All other uses of the UB Codes require a license from the AHA. Software vendors and all others desiring to use the UB Codes in a commercial product to generate HEDIS results, or for any other use, must obtain a commercial use license directly from the AHA. To inquire about licensing, please contact ub04@healthforum.com.

²CPT codes copyright 2015 American Medical Association. All rights reserved. CPT is a trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

³LOINC® is a registered trademark of the Regenstrief Institute.

Use the Child Value Sets to Codes spreadsheet to identify all codes in a value set or to identify all value sets that use a particular code. For example, setting the Value Set Name filter to “Vaccine Causing Adverse Effect,” which is referenced in the Childhood Immunization Status measure (Measure CIS-CH) demonstrates that the following codes are included in the value set:

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.46 4.1004.1259	2015-11-13	T50.A15A	[T50.A15A] Adverse effect of pertussis vaccine, including combinations with a pertussis component, initial encounter	ICD10CM	2.16.840.1.1 13883.6.90	2014.0.0.13AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.46 4.1004.1259	2015-11-13	T50.A15D	[T50.A15D] Adverse effect of pertussis vaccine, including combinations with a pertussis component, subsequent encounter	ICD10CM	2.16.840.1.1 13883.6.90	2014.0.0.13AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.46 4.1004.1259	2015-11-13	T50.A15S	[T50.A15S] Adverse effect of pertussis vaccine, including combinations with a pertussis component, sequela	ICD10CM	2.16.840.1.1 13883.6.90	2014.0.0.13AA
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.46 4.1004.1259	2015-11-13	E948.4	Tetanus vaccine causing adverse effects in therapeutic use	ICD9CM	2.16.840.1.1 13883.6.103	2.16.840.1.113883. 3.464.1004.1259
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.46 4.1004.1259	2015-11-13	E948.5	Diphtheria vaccine causing adverse effects in therapeutic use	ICD9CM	2.16.840.1.1 13883.6.103	2.16.840.1.113883. 3.464.1004.1259
Vaccine Causing Adverse Effect	2.16.840.1.113883.3.46 4.1004.1259	2015-11-13	E948.6	Pertussis vaccine, including combinations with a pertussis component, causing adverse effects in therapeutic use	ICD9CM	2.16.840.1.1 13883.6.103	2.16.840.1.113883. 3.464.1004.1259

Setting the Code filter to “296.20” demonstrates that the code is included in the following value sets:

Value Set Name	Value Set OID	Value Set Version	Code	Definition	Code System	Code System OID	Code System Version
Chronic Conditions	2.16.840.1.113883.3.4 64.1004.1062	2015-11-13	296. 20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113 883.6.103	2014.1.13AA
Mental and Behavioral Disorders	2.16.840.1.113883.3.4 64.1004.1300	2015-11-13	296. 20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113 883.6.103	2014.1.13AA
Mental Health Diagnosis	2.16.840.1.113883.3.4 64.1004.1178	2015-11-13	296. 20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113 883.6.103	2014.1.13AA
Mental Illness	2.16.840.1.113883.3.4 64.1004.1179	2015-11-13	296. 20	Major depressive affective disorder, single episode, unspecified	ICD9CM	2.16.840.1.113 883.6.103	2014.1.13AA

F. SUMMARY OF CHANGES – CODES

The Summary of Changes – Codes spreadsheet lists code changes in FFY 2016 by value set and includes the elements in Table A.3.

Table A.3. Summary of Changes – Codes

Element Name	Element Description
Value Set	The name of the value set affected by the change.
Change	The change (Added; Deleted).
Code System	The code system for the code.
Code	The code.
Revised	The date the revision occurred.

Use the Summary of Changes – Codes spreadsheet to identify codes added to or deleted from a concept. For example, setting the Value Set Name filter to “Influenza Vaccine Administered” demonstrates one added code.

Value Set	Change	Code System	Code
Influenza Vaccine Administered	Added	CPT	90630

Codes for value sets that are new to the 2016 Child Core Set and value sets that are new to a specific measures are not listed individually in the Summary of Changes – Codes spreadsheet.

Codes for value sets that have been deleted from the 2016 Child Core Set or from a specific measure are not listed individually in the Summary of Changes – Codes spreadsheet.

New and deleted value sets are listed in the Summary of Changes – Value Sets spreadsheet.

G. SUMMARY OF CHANGES – VALUE SETS

The Summary of Changes – Value Sets spreadsheet lists changes in FFY 2016 by value sets and includes the elements in Table A. 4.

Table A.4. Summary of Changes – Value Sets

Element Name	Element Description
Child Core Set 2015	The name of the value set in the FFY 2015 manual (value sets that did not exist are labeled NA).
Change	The change (Added; Deleted; Revised).
Child Core Set 2016	The name of the value set in the FFY 2016 manual or the affected measures (for deleted value sets).

Use the Summary of Changes – Value Sets spreadsheet to identify revised, added, or deleted value sets. For example:

- The Acute Inpatient Value Set was added to the Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication measure.
- The BMI Value Set was deleted from the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents Body Mass Index Assessment for Children/Adolescents measure.

This page left blank for double-sided copying.

Appendix B
Guidance for Selecting
Sample Sizes for HEDIS® Hybrid Measures

This page left blank for double-sided copying.

This appendix provides additional information on when it may be feasible to use a sample size of less than 411 when the hybrid method is used. The sample size is based on the current year's administrative rate or the prior year's reported rate. The guidance in the table below is designed to minimize the burden of medical record review, while providing an adequate sample size for calculating the measure. More information on the use of the hybrid method for Child Core Set Reporting is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/hybrid-brief.pdf>.

Table B.1. Determining Sample Sizes for Hybrid Measures When Data Are Available from the Current Year's Administrative Rate or the Prior Year's Reported Rate

Current Year's Administrative Rate or the Prior Year's Reported Rate	Minimum Sample Size
≤50%	411
51%	411
52%	410
53%	410
54%	409
55%	407
56%	405
57%	403
58%	401
59%	398
60%	395
61%	392
62%	388
63%	384
64%	380
65%	376
66%	371
67%	366
68%	360
69%	354
70%	348
71%	342
72%	335
73%	328
74%	321
75%	313

Current Year's Administrative Rate or the Prior Year's Reported Rate	Minimum Sample Size
76%	305
77%	296
78%	288
79%	279
80%	270
81%	260
82%	250
83%	240
84%	229
85%	219
86%	207
87%	196
88%	184
89%	172
90%	159
91%	147
92%	134
93%	120
94%	106
≥95%	100

Note: Truncate the decimal portion of the rate to obtain a whole number.

Appendix C
Definition of Medicaid/CHIP Core Set
Practitioner Types

This page left blank for double-sided copying.

PRACTITIONER TYPE	DEFINITION
Mental Health Practitioner	<p>A practitioner who provides mental health services and meets any of the following criteria:</p> <ul style="list-style-type: none"> • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC)

PRACTITIONER TYPE	DEFINITION
Obstetrical/Gynecological (OB/GYN) and Other Prenatal Care Practitioner	<p data-bbox="573 254 695 281">Includes:</p> <ul data-bbox="573 296 1427 604" style="list-style-type: none"><li data-bbox="573 296 1427 499">• Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology<li data-bbox="573 506 1427 604">• Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)
Primary Care Practitioner (PCP)	<ul data-bbox="573 625 1427 758" style="list-style-type: none"><li data-bbox="573 625 1427 688">• A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services.<li data-bbox="573 695 1427 758">• Licensed practical nurses and registered nurses are not considered PCPs
Prescribing Practitioner	<p data-bbox="573 787 1427 877">A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications.</p>

Appendix D
Additional Information on Data Elements for
Measure PC02: Cesarean Section for
Nulliparous Singleton Vertex

This page left blank for double-sided copying.

This appendix provides additional information on the data elements required to calculate the rates for PC-02: Cesarean Section using medical record review. For the purposes of state reporting, it is acceptable to use vital records data if available to collect gestational age and parity. Table D.1 lists the data elements required for the denominator.

Table D.1: Denominator Data Elements Requiring Medical Record Review

Data element	Admission Date
Definition	The month, day, and year of admission to acute inpatient care.
Suggested data collection question	What is the date the patient was admitted to acute inpatient care?
Allowable values	MM = Month (01-12) DD = Day (01-31) YYYY = Year (20XX)
Notes for abstraction	<p>The intent of this data element is to determine the date that the patient was actually admitted to acute inpatient care. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the admission date is correct. If the abstractor determines through chart review that the date is incorrect, for purposes of abstraction, she/he should correct and override the downloaded value.</p> <p>If using claim information, the ‘Statement Covers Period’ is not synonymous with the ‘Admission Date’ and should not be used to abstract this data element. These are two distinctly different identifiers:</p> <ul style="list-style-type: none"> • The Admission Date is purely the date the patient was admitted as an inpatient to the facility. • The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included in a particular claim. The “From” Date is the earliest date of service on the claim. <p>For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.</p> <p>Example:</p> <p>Medical record documentation reflects that the patient was admitted to observation on 04-05-2015. On 04-06-2015 the physician writes an order to admit to acute inpatient effective 04-05-2015. The Admission Date would be abstracted as 04-06-2015; the date the determination was made to admit to acute inpatient care and the order was written.</p>

Data element	Admission Date
Notes for abstraction (continued)	<p>The admission date should not be abstracted from the earliest admission order without regard to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, the date should not be used.</p> <p>Example:</p> <p>Preoperative Orders are dated as 04-05-2015 with an order to admit to Inpatient. Postoperative Orders, dated 05-01-2015, state to admit to acute inpatient. All other documentation supports that the patient presented to the hospital for surgery on 05-01-2015. The admission date would be abstracted as 05-01-2015.</p> <p>If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.</p> <p>For newborns that are born within this hospital, the admission date is the date the baby was born.</p>
Only allowable data sources	<p>Physician orders Face sheet UB-04</p> <p>Note: The physician order is the priority data source for this data element. If there is not a physician order in the medical record, use the other “only allowable sources” to determine the Admission Date.</p>
Excluded data sources	UB-04, “From” and “Through” dates

Data element	Birth Date
Definition	<p>The month, day, and year the patient was born.</p> <p>Note: Patient’s age (in years) is calculated by Admission Date minus Birth date. The algorithm to calculate age must use the month and day portion of admission date and birth date to yield the most accurate age.</p>
Suggested data collection question	What is the patient’s date of birth?
Allowable values	<p>MM = Month (01-12) DD = Day (01-31) YYYY = Year (1880-Current Year)</p>
Notes for abstraction	<p>Because this data element is critical in determining the population for all measures, the abstractor should NOT assume that the claim information for the birth date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birth date through chart review, she/he should default to the date of birth on the claim information.</p>

Data element	Birth Date
Suggested data sources	Emergency department record Face sheet Registration form UB-04

Data element	Clinical Trial
Definition	Documentation that during this hospital stay, the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied.
Suggested data collection question	During this hospital stay, was the patient enrolled in a clinical trial in which patients with the same condition as the measure being studied?
Allowable values	Y (Yes): There is documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied. N (No): There is no documentation that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied, or unable to determine from medical record documentation.
Notes for abstraction	<p>To select "Yes" to this data element, BOTH of the following must be true:</p> <ol style="list-style-type: none"> 1. There must be a signed consent form for clinical trial. For the purposes of abstraction, a clinical trial is defined as an experimental study in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received. Treatments/interventions most often include use of drugs, surgical procedures, and devices. Often a control group is used to compare with the treatment/intervention. Allocation of different interventions to participants is usually randomized. 2. There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with the same condition as the measure being studied. Patients may either be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continue active participation in that clinical trial during this hospital stay. <p>Only capture patients enrolled in clinical trials studying pregnant patients or newborns. For Perinatal Care measures ONLY, it is appropriate to default the data element to "No" unless a diagnosis code for clinical trial is present. If this code is present, or the state knows via some other electronic method that the patient is participating in a clinical trial, default the data element to "Yes". Abstractors may change the defaulted value of "No" based on hospital participation in a clinical trial.</p>

Data element	Clinical Trial
Notes for Abstraction (continued)	<p>In the following situations, select "No":</p> <ol style="list-style-type: none"> 1. There is a signed patient consent form for an observational study only. Observational studies are non-experimental and involve no intervention (e.g., registries). Individuals are observed (perhaps with lab draws, interviews, etc.), data are collected, and outcomes are tracked by investigators. Although observational studies may include the assessment of the effects of an intervention, the study participants are not allocated into intervention or control groups. 2. It is not clear whether the study described in the signed patient consent form is experimental or observational. <p>It is not clear which study population the clinical trial is enrolling. Assumptions should not be made if it is not specified.</p>
Only allowable data sources	Signed consent form for clinical trial.

Data element	Discharge Date
definition	The month, day, and year the patient was discharged from acute care, left against medical advice, or died during this stay.
Suggested data Collection Question	What is the date the patient was discharged from acute care, left against medical advice (AMA), or died?
Allowable values	MM = Month (01-12) DD = Day (01-31) YYYY = Year (2001-Current Year)
Notes for abstraction	Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the claim information for the discharge date is correct. If the abstractor determines through chart review that the date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the discharge date on the claim information.
Suggested data sources	<p>Face sheet</p> <p>Progress notes</p> <p>Physician orders</p> <p>Discharge summary</p> <p>Nursing discharge notes</p> <p>Transfer note</p> <p>UB-04</p>

Data element	Gestational Age
Definition	The weeks of gestation completed at the time of delivery. Gestational age is defined as the number of weeks that have elapsed between the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery, irrespective of whether the gestation results in a live birth or a fetal death.
Suggested data collection question	How many weeks of gestation were completed at the time of delivery?
Allowable values	1-50 UTD=Unable to Determine
Notes for abstraction	<p>Gestational age should be rounded off to the nearest completed week, not the following week. For example, an infant born on the 5th day of the 36th week (35 weeks and 5/7 days) is at a gestational age of 35 weeks, not 36 weeks.</p> <p>The delivery or operating room record should be reviewed first for gestational age. If gestational age is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note, and discharge summary until a positive finding for gestational age is found. In cases where there is conflicting data, the gestational age found in the first document according to the order listed above should be used. The phrase "estimated gestational age" is an acceptable descriptor for gestational age.</p> <p>If the patient has not received prenatal care, and the gestational age is unknown, select allowable value UTD.</p> <p>When the admission date is different from the delivery date, use documentation of the gestational age completed closest to the delivery date.</p> <p>Gestational age should be documented by the clinician as a numeric value between 1 and 50. The clinician, not the abstractor, should perform the calculation to determine gestational age based on the first day of the last normal menstrual period (not presumed time of conception) and the date of delivery.</p> <p>If the gestational age entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.</p> <p>Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA), or registered nurse (RN).</p>

Data element	Gestational Age
Only allowable data sources <u>in order of preference</u>	<p>Delivery room record</p> <p>Operating room record</p> <p>History and physical</p> <p>Prenatal forms</p> <p>Admission clinician progress notes</p> <p>Discharge summary</p> <p>Vital Statistics</p> <p>Note: It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed above.</p>

Data element	Parity
Definition	The number of deliveries the patient experienced prior to current hospitalization.
Suggested data collection question	How many deliveries did the patient experience prior to current hospitalization?
Allowable values	0-50 UTD=Unable to Determine
Notes for abstraction	<p>The delivery or operating room record should be reviewed first for parity. If parity is not recorded in the delivery or operating room record, then continue to review the data sources in the following order: history and physical, prenatal forms, clinician admission progress note and discharge summary until a positive finding for parity is found. In cases where there is conflicting data, parity found in the first document according to the order listed above should be used.</p> <p>If parity entered by the clinician in the first document listed above is obviously incorrect (in error) but it is a valid number and the correct number can be supported with other documentation in the other acceptable data sources in the medical record, the correct number may be entered.</p> <p>If parity is not documented and GTPAL terminology is documented where G= Gravida, T= Term, P= Preterm, A= Abortions and L= Living, all previous term and preterm deliveries prior to this hospitalization should be added together to determine parity.</p> <p>If parity is not documented and gravidity is documented as one, parity should be considered zero.</p> <p>The previous delivery of twins or any multiple gestation is considered one parous event.</p>

Data element	Parity
Notes for abstraction (continued)	<p>Documentation in the acceptable data sources may be written by the following clinicians: physician, certified nurse midwife (CNM), advanced practice nurse/physician assistant (APN/PA) or registered nurse (RN).</p> <p>It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed below.</p> <p>If the number for parity documented in the EHR includes the delivery for the current hospitalization, parity should be answered as one number less than the number documented.</p> <p>If primagravida is documented, select zero for parity.</p>
Only allowable data sources <u>in order of preference</u>	<p>Delivery room record</p> <p>Operating room record</p> <p>History and physical</p> <p>Prenatal forms</p> <p>Admission clinician progress note</p> <p>Discharge summary</p> <p>Note: It is acceptable to use data derived from vital records reports received from state or local departments of public health if they are available and are directly derived from the medical record with a process in place to confirm their accuracy. If this is the case, these may be used in lieu of the acceptable data sources listed above.</p>

This page left blank for double-sided copying.

Appendix E
e-Measure Flow for Reporting the Suicide
Risk Assessment (SRA) Measure

This page left blank for double-sided copying.

Refer to the specific section of the SRA specifications to identify the Quality Data Model (QDM) data elements and associated value sets for use in reporting this measure.

1. Start Initial Patient Population
2. Check Patient Characteristic Birthdate:
 - a. If QDM data element, BIRTH DATE, is greater than or equal to 6 years of age AND less than 17 years of age before the start of the measurement period equals No, do not include in Initial Patient Population. Stop Processing.
 - b. If QDM data element, BIRTH DATE, is greater than or equal to 6 years of age AND less than 17 years of age before the start of the measurement period, equals Yes, continue processing and proceed to check Encounter Performed.
3. Check Encounter Performed: Total number of encounters must be greater than or equal to 2:
 - a. If QDM data element, OFFICE VISIT, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check for another Encounter Performed until total number of encounters are greater than or equal to 2.
 - b. If QDM data element, OFFICE VISIT, during the measurement period equals No, proceed to check next Encounter Performed.
 - c. If QDM data element, OUTPATIENT CONSULTATION, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check for another Encounter Performed until total number of encounters are greater than or equal to 2.
 - d. If QDM data element, OUTPATIENT CONSULTATION, during the measurement period equals No, proceed to check next Encounter Performed.
 - e. If QDM data element, PATIENT PROVIDER INTERACTION, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check for another Encounter Performed until total number of encounters are greater than or equal to 2.
 - f. If QDM data element, PATIENT PROVIDER INTERACTION, during the measurement period equals No, proceed to check next Encounter Performed.
 - g. If QDM data element, PSYCH VISIT – DIAGNOSTIC EVALUATION, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check for another Encounter Performed until total number of encounters are greater than or equal to 2.
 - h. If QDM data element, PSYCH VISIT – DIAGNOSTIC EVALUATION, during the measurement period equals No, proceed to check next Encounter Performed.
 - i. If QDM data element, PSYCH VISIT – FAMILY PSYCHOTHERAPY, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check for another Encounter Performed until total number of encounters are greater than or equal to 2.
 - j. If QDM data element, PSYCH VISIT – FAMILY PSYCHOTHERAPY, during the measurement period equals No, proceed to check next Encounter Performed.

- k. If QDM data element, PSYCHOANALYSIS, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check for another Encounter Performed until total number of encounters are greater than or equal to 2.
 - l. If QDM data element, PSYCHOANALYSIS, during the measurement period equals No, proceed to check next Encounter Performed.
 - m. If QDM data element, GROUP PSYCHOTHERAPY, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check for another Encounter Performed until total number of encounters are greater than or equal to 2.
 - n. If QDM data element, GROUP PSYCHOTHERAPY, during the measurement period equals No, do not include in the Initial Patient Population and proceed to check next Encounter Performed.
 - o. If QDM data element, PSYCH VISIT - PSYCHOTHERAPY, during the measurement period equals Yes, include in the Initial Patient Population and proceed to check Diagnosis Active if total number of encounters are greater than or equal to 2.
 - p. If QDM data element, PSYCH VISIT - PSYCHOTHERAPY, during the measurement period equals No, do not include in the Initial Patient Population. Stop Processing.
4. Check Diagnosis Active:
- a. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – DIAGNOSTIC EVALUATION, during measurement period equals Yes include in Initial Patient Population and continue on to the Denominator.
 - b. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – DIAGNOSTIC EVALUATION, during measurement period equals No proceed to check next Diagnosis Active.
 - c. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – FAMILY PSYCHOTHERAPY, during measurement period equals Yes include in Initial Patient Population and continue on to the Denominator.
 - d. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – FAMILY PSYCHOTHERAPY, during measurement period equals No, proceed to check next Diagnosis Active.
 - e. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, FACE-TO-FACE INTERACTION, during measurement period equals Yes, include in Initial Patient Population and continue on to the Denominator.
 - f. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, FACE-TO-FACE INTERACTION, during measurement period equals No, proceed to check next Diagnosis Active.
 - g. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, GROUP PSYCHOTHERAPY, during measurement

period equals Yes, include in Initial Patient Population and continue on to the Denominator.

- h. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, GROUP PSYCHOTHERAPY, during measurement period equals No, proceed to check next Diagnosis Active.
 - i. If Occurrence A of QDM data element, MAJOR DEPRESSIVE - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, OUTPATIENT CONSULTATION, during measurement period equals Yes, include in Initial Patient Population and continue on to the Denominator.
 - j. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, OUTPATIENT CONSULTATION, during measurement period equals No, proceed to check next Diagnosis Active.
 - k. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, OFFICE VISIT, during measurement period equals Yes, include in Initial Patient Population and continue on to the Denominator.
 - l. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, OFFICE VISIT, during measurement period equals No, proceed to check next Diagnosis Active.
 - m. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCHOANALYSIS, during measurement period equals Yes, include in Initial Patient Population and continue on to the Denominator.
 - n. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCHOANALYSIS, during measurement period equals No, proceed to check next Diagnosis active.
 - o. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE, starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – PSYCHOTHERAPY, during measurement period equals Yes, include in Initial Patient Population and continue on to the Denominator.
 - p. If Occurrence A of QDM data element, MAJOR DEPRESSIVE DISORDER - ACTIVE starts before or during but does not end before the start of Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – PSYCHOTHERAPY, during measurement period equals No, do not include in the Initial Patient Population. Stop Processing.
5. Start Denominator
 - a. Denominator equals the Initial Patient Population. Denominator is represented by the letter B in the sample calculation listed at the end of this document. Letter B equals 10 patients in the sample calculation.
 6. Start Numerator
 7. Check Intervention Performed:

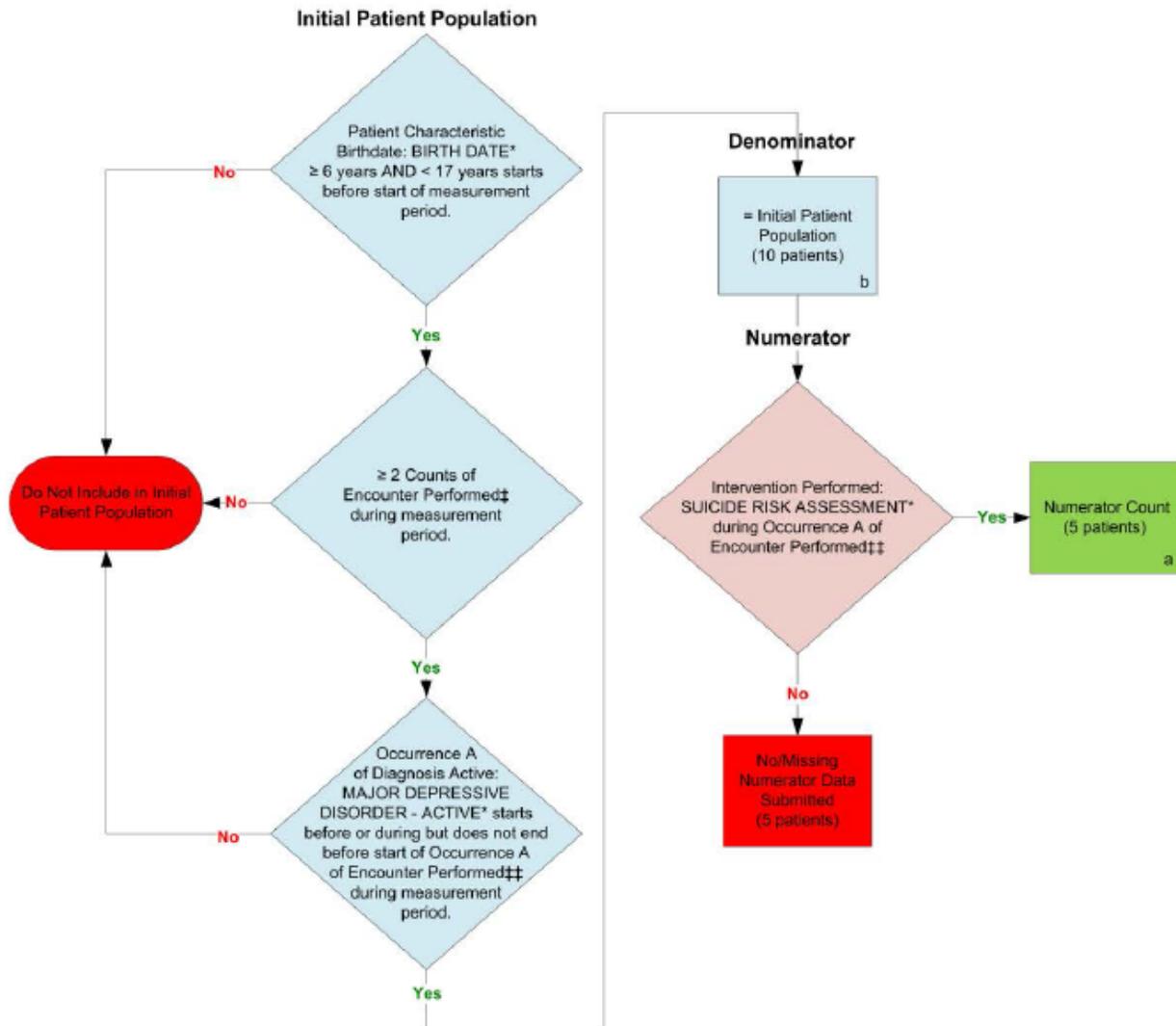
- a. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – DIAGNOSTIC EVALUATION equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- b. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – DIAGNOSTIC EVALUATION equals No, proceed to check next Intervention Performed.
- c. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – FAMILY PSYCHOTHERAPY equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- d. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCH VISIT – FAMILY PSYCHOTHERAPY equals No, proceed to check next Intervention Performed.
- e. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, FACE-TO-FACE INTERACTION equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- f. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, FACE-TO-FACE INTERACTION equals No, proceed to check next Intervention Performed.
- g. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, GROUP PSYCHOTHERAPY equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- h. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, GROUP PSYCHOTHERAPY equals No, proceed to check next Intervention Performed.
- i. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, OUTPATIENT CONSULTATION equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- j. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, OUTPATIENT CONSULTATION equals No, proceed to check next Intervention Performed.
- k. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, OFFICE VISIT equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- l. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, OFFICE VISIT equals No, proceed to check next Intervention Performed.

- m. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCHOANALYSIS equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- n. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCHOANALYSIS equals No, proceed to check next Intervention Performed.
- o. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCH VISIT - PSYCHOTHERAPY equals Yes, include in the Numerator count. The Numerator is represented by the letter A in the sample calculation listed at the end of this document. Letter A equals 5 patients in the sample calculation.
- p. If Occurrence A of QDM data element SUICIDE RISK ASSESSMENT during Occurrence A of Encounter Performed QDM data element, PSYCH VISIT - PSYCHOTHERAPY equals No, include in the No/Missing Numerator Data Submitted count and stop processing.

Sample Calculation

Performance Rate = Numerator (a=5 patients) ÷ Denominator (b=10 patients) – Denominator Exclusions (N/A) – Denominator Exceptions (N/A) = 50.00%

2014 eCQM Flow
 Measure Identifier: CMS177v3
 NQF 1365: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment



*Please refer to the specific section of the eCQM to identify the QDM data elements and associated value sets for use in reporting this eCQM.
 ‡ Appropriate encounters include; Office Visit, Outpatient Consultation, Patient Provider Interaction, Psych Visit – Diagnostic Evaluation, Psych Visit – Family Psychotherapy, Psychoanalysis, Group Psychotherapy, and Psych Visit – Psychotherapy.
 ‡‡ Appropriate encounters include; Psych Visit – Diagnostic Evaluation, Psych Visit – Family Psychotherapy, Face-to-Face Interaction, Group Psychotherapy, Outpatient Consultation, Office Visit, Psychoanalysis, and Psych Visit – Psychotherapy.

SAMPLE CALCULATION:

Performance Rate =

$$\frac{\text{Numerator (a=5 patients)}}{\text{Denominator (b=10 patients) – Denominator Exclusions (N/A) – Denominator Exceptions (N/A)}} = 50.00\%$$

Appendix F
Secondary Bloodstream Infection (BSI)
Guide for CLABSI Measure

This page left blank for double-sided copying.

This appendix* provides new guidance on determining if the bloodstream infection is related to infection at another site and therefore secondary and not a laboratory confirmed bloodstream infection (LCBI).

The purpose of using the CDC/National Healthcare Safety Network (NHSN) infection criteria is to identify and consistently categorize infections that are healthcare-associated into major and specific infection sites or types. LCBI criteria include the caveat that the organism(s) cultured from the blood cannot be related to infection at another site (i.e., must be a primary bloodstream infection [BSI]). One must be sure that there is no other CDC-defined primary site of infection that may have seeded the bloodstream secondarily; otherwise the bloodstream infection may be misclassified as a primary BSI and erroneously associated with the use of a central line, i.e., called a CLABSI. For locations performing in-plan ventilator-associated events (VAE) surveillance, refer to [Figure 4](#) in this appendix, as well as the VAE chapter of the Patient Safety Component manual for specific guidance on assigning a secondary BSI to a VAE. The Patient Safety Component Manual is available at http://www.cdc.gov/nhsn/pdfs/pscmanual/pscmanual_current.pdf

For purposes of National Healthcare Safety Network, in order for a bloodstream infection to be determined to be secondary to a primary infection site, (i.e., related to an infection at another site, such that the primary site of infection may have seeded the bloodstream secondarily), the patient must meet all three criteria below:

1. Meet one of the NHSN site specific definitions (CDC/NHSN Surveillance Definitions for Specific Types of Infections), and
2. Have a positive blood culture within the Secondary BSI Attribution Period, and
3. Meet requirements in Secondary BSI Scenarios 1 or 2 below.

Note:

Since necrotizing enterocolitis (NEC) criteria include neither a site specific culture nor a positive blood culture, an exception for assigning a BSI secondary to NEC is provided.

A BSI is considered secondary to NEC if the patient meets one of the two NEC criteria AND a positive blood culture(s) collected during the secondary BSI attribution period is positive for an LCBI pathogen or the same common commensal is cultured from two or more blood cultures drawn on separate occasions collected on the same or consecutive days.

* This material in this appendix comes from "Appendix 1: Secondary Bloodstream Infection (BSI) Guide" of the NHSN Patient Safety Component Manual (January 2015).

Secondary BSI Scenarios

Below are two potential scenarios with guidance on how to distinguish between the primary or secondary nature of a BSI. The definition of “matching organisms,” and important notes and reporting instructions are also provided. See Figure G.1: Secondary BSI Guide for an algorithmic display of the following instructions.

Scenario 1: Blood and site-specific specimen cultures match for at least one organism: In a patient suspected of having an infection, if blood and a site-specific specimen are collected for culture and both are positive for at least one matching organism, AND if the site-specific culture is an element used to meet the infection site criterion, the BSI is considered secondary to that site-specific infection.

- a. **Example:** Patient meets hospital acquired infection (HAI) criteria for a symptomatic urinary tract infection (SUTI) (suprapubic tenderness and $>10^5$ CFU/ml of *E. coli*) and blood culture collected during the secondary BSI attribution period is positive for *E. coli*. This is an HAI SUTI with a secondary BSI and the reported organism is *E. coli*.
- b. **Example:** Patient meets HAI criteria for a symptomatic urinary tract infection (suprapubic tenderness and $>10^5$ CFU/ml of *E. coli*) and blood culture collected during the SUTI secondary BSI attribution period grows *E. coli* and *P. aeruginosa*. This is an HAI SUTI with a secondary BSI and the reported organisms are *E. coli* and *P. aeruginosa*, since both site and blood culture are positive for at least one matching pathogen.
- c. **Example:** Patient meets HAI criteria for a symptomatic urinary tract infection (suprapubic tenderness and $>10^5$ CFU/ml of *E. coli*) and blood culture collected during the SUTI secondary BSI attribution period is positive for *E. coli* and *S. epidermidis*. This is an HAI SUTI with a secondary BSI and the reported organism is only *E. coli*, since the single common commensal *S. epidermidis* positive blood culture by itself does not meet BSI criteria.

Scenario 2: Blood and site-specific specimen cultures do not match. There are two scenarios that can occur when a patient suspected of having an infection has blood and a site-specific specimen cultured but the organisms do not match.

- a. If the blood isolate is an element used to meet the site-specific criterion, then the BSI is considered secondary to that site-specific infection. (See Table F.2 for a list of infection criteria that include positive blood culture as an element.)
 - i. **Example:** Postoperative patient becomes febrile and complains of nausea and abdominal pain. Blood and an aseptically-obtained T-tube drainage specimen are collected for culture. A CT scan done that day shows fluid collection suggestive of infection. Culture results show *Escherichia coli* from the T-tube drainage specimen but the blood grows *Bacteroides fragilis*. Because the patient meets IAB criteria during the infection window period, by positive site-specific culture (IAB criterion 3a) and by positive blood culture as an element of a different criterion of the same infection site (IAB 3b), the blood is considered a secondary BSI to an IAB and both organisms would be listed as the IAB infection pathogens. No primary BSI would be reported.
 - ii. **Example:** Patient is febrile, has a new onset of cough and has positive chest radiographs indicating the presence of an infiltrate. Blood and bronchoalveolar lavage (BAL) cultures are collected. Culture results show *Klebsiella pneumoniae* $> 10^4$ cfu/ml from the BAL and *Pseudomonas aeruginosa* from the blood. Because the patient can meet PNU2 definition by using the positive blood culture as one of the elements of the infection criterion (i.e. infiltrate on chest x-rays, fever, new onset of cough and positive blood culture), the blood is considered a secondary BSI to a PNEU. No primary BSI would be reported.

- b. If the site-specific culture is an element used to meet the infection site criterion and the blood isolate is not, then the BSI is considered a primary infection.
 - i. **Example:** Postoperative patient has an intraabdominal abscess (IAB) noted during reoperation and purulent material is obtained at that time which grows *Escherichia coli*. The patient spikes a fever two days later and blood culture shows *Bacteroides fragilis*. Because the organisms from the site and blood cultures do not match, and no site-specific criterion that includes positive blood culture as an element is met, both a site-specific infection (GI-IAB criteria 1 and 2) and a primary BSI would be reported.
 - ii. **Example:** Unconscious ICU patient with a Foley catheter and central line for past four days spikes a fever; blood, urine and sputum specimens are collected for culture. The urine culture grows >100,000 CFU/ml of *Escherichia coli*, blood culture grows *Enterococcus faecium*, and sputum shows oral flora only. Because the organisms from the urine and blood cultures do not match, and a UTI criterion that includes positive blood culture as an element is not met, both a SUTI (SUTI criterion 1a) and a primary BSI would be reported. This infection does not meet the ABUTI criterion since that requires at least one matching organism in urine and blood in an asymptomatic patient.

Table F.1: Site-specific criteria that require blood cultures

Organisms cultured from blood as an element		Organisms cultured from blood <u>with</u> imaging test evidence of infection	
Site	Element	Site	Element
Burn Infection	1	Osteomyelitis	3a
Joint or bursa infection	3c	Disc Space Infection	3a
Meningitis or ventriculitis	2c & 3c	Gastrointestinal tract infection	2c
Other infection of the male or female reproductive tract	3a	Gastrointestinal tract infection	3b
Clinically defined pneumonia	Lab finding	Spinal abscess without meningitis	3a
Clinically defined pneumonia	Lab finding	Urinary system infection	3b & 4b
Omphalitis	1b	Endocarditis	4a, 4b, 5a & 5b (specific organisms) 6e & 7e plus other criteria as listed

Note: Table F.2 refers to the Patient Safety Component manual available at http://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf.

A **matching organism** is defined as one of the following:

1. If genus and species are identified in both cultures, they must be the same.
 - a. **Example:** A blood culture reported as *Enterobacter cloacae* and an intraabdominal specimen of *Enterobacter cloacae* are matching organisms.
 - b. **Example:** A blood culture reported as *Enterobacter cloacae* and an intraabdominal specimen of *Enterobacter aerogenes* are NOT matching organisms as the species are different.

2. If the organism is less definitively identified in one culture than the other, the identifications must be complementary.
 - a. **Example:** A surgical wound growing *Pseudomonas* spp. and a blood culture growing *Pseudomonas aeruginosa* are considered a match at the genus level and therefore the BSI is reported as secondary to the SSI.
 - b. **Example:** A blood culture reported as *Candida albicans* and a culture from a decubitus reported as yeast are considered to have matching organisms because the organisms are complementary, i.e. *Candida* is a type of yeast.

Notes:

1. Antibiograms of the blood and potential primary site isolates do not have to match.
2. If the blood isolate by itself does not meet BSI criteria (e.g., only one positive blood culture of a common commensal), then that isolate may not be used to indicate the presence of a secondary BSI (see [scenario1c](#)).

Reporting Instructions:

- For reporting secondary BSI for possible ventilator-associated pneumonia (PVAP), [Chapter 10](#) of the Patient Safety Component manual available at http://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf.
- Do not report secondary bloodstream infection for vascular (VASC) infections, Ventilator-Associated Conditions (VAC), or Infection-related Ventilator-Associated Complications (IVAC), pneumonia 1 (PNEU 1).

Pathogen Assignment

Pathogens cultured from secondary BSIs, should be added to those pathogens reported for the primary infection type. The Secondary BSI data collection field should be checked yes.

A secondary BSI pathogen may be assigned to two different primary site infections (e.g., UTI and an IAB infection). Two primary site infections have been identified and a blood culture is collected within both the SUTI and the IAB secondary BSI attribution period. The blood culture pathogen matches both primary site infection pathogens. Therefore, the pathogen is reported for both primary sites as a secondary bloodstream infection.

Example 1: Pathogen Assignment

Hospital Day	BSI	RIT	Infection Window Period	Infection Window Period	BSI
1					
2					
3					
4		1	Urine culture: >100,000 cfu/ml <i>K. pneumoniae</i>		
5		2	Fever > 38.0 C		
6		3			
7		4			
8		5		Fever >38.0 C, Abdominal pain	
9		6		CT Scan : Abdominal abscess	
10		7	Blood culture: <i>K. pneumoniae</i>	Blood culture: <i>K. pneumoniae</i>	
11		8			
12		9			
13		10			
14		11			
15		12			
16		13			
17		14			
18					
19					
20					
21					
22					
23					
			SUTI & Secondary BSI Date of Event = 4 Pathogen: <i>K. pneumoniae</i>	IAB & Secondary BSI Date of Event = 8 Pathogen: <i>K. pneumoniae</i>	

Infection Window Period
(First positive diagnostic test, 3 days before and 3 days after)

Repeat Infection Timeframe (RIT)
(date of event = day 1)

Secondary BSI Attribution Period (Infection Window Period + RIT)

Date of Event (DOE)
(Date the first element occurs for the first time within the infection window period)

Pathogens excluded from specific infection definitions (e.g., yeast in UTI, or Enterococcus spp. for PNEU) are also excluded as pathogens for BSIs secondary to that type of infection (i.e., they cannot be added on to one of these infections as a pathogen). The excluded organism must be accounted for as either 1) a primary bloodstream infection (BSI/CLABSI) or, 2) a secondary bloodstream infection attributed to another primary infection (e.g., IAB, SINU). A blood culture with yeast and *E. faecalis* is collected during the SUTI RIT. A BSI secondary to SUTI is identified. *E. faecalis* is already documented as a pathogen, but the yeast will not be reported as a secondary BSI pathogen, because yeasts are excluded as organisms in the UTI definition. Because no other primary source of infection for which the yeast BSI can be assigned as secondary is found, a primary BSI with yeast is identified.

Example 2: Pathogen Assignment

Hospital Day	BSI	RIT	Infection Window Period	Infection Window Period	RIT
1					
2					
3		1	Dysuria		
4		2	Urine culture: > 100,000 cfu/ml <i>E. faecalis</i>		
5		3			
6		4			
7		5			
8		6			
9		7			
10		8			
11		9	Blood culture: <i>E. faecalis</i> / Yeast	Blood culture: <i>E. faecalis</i> / Yeast	1
12		10			2
13		11			3
14		12			4
15		13			5
16		14			6
17					7
18					8
19					9
20					10
21					11
22					12
23					13
24					14
25					
			UTI & Secondary BSI Date of Event = 3 Pathogen: <i>E. faecalis</i>	Primary BSI Date of Event = 11 Pathogen: Yeast	

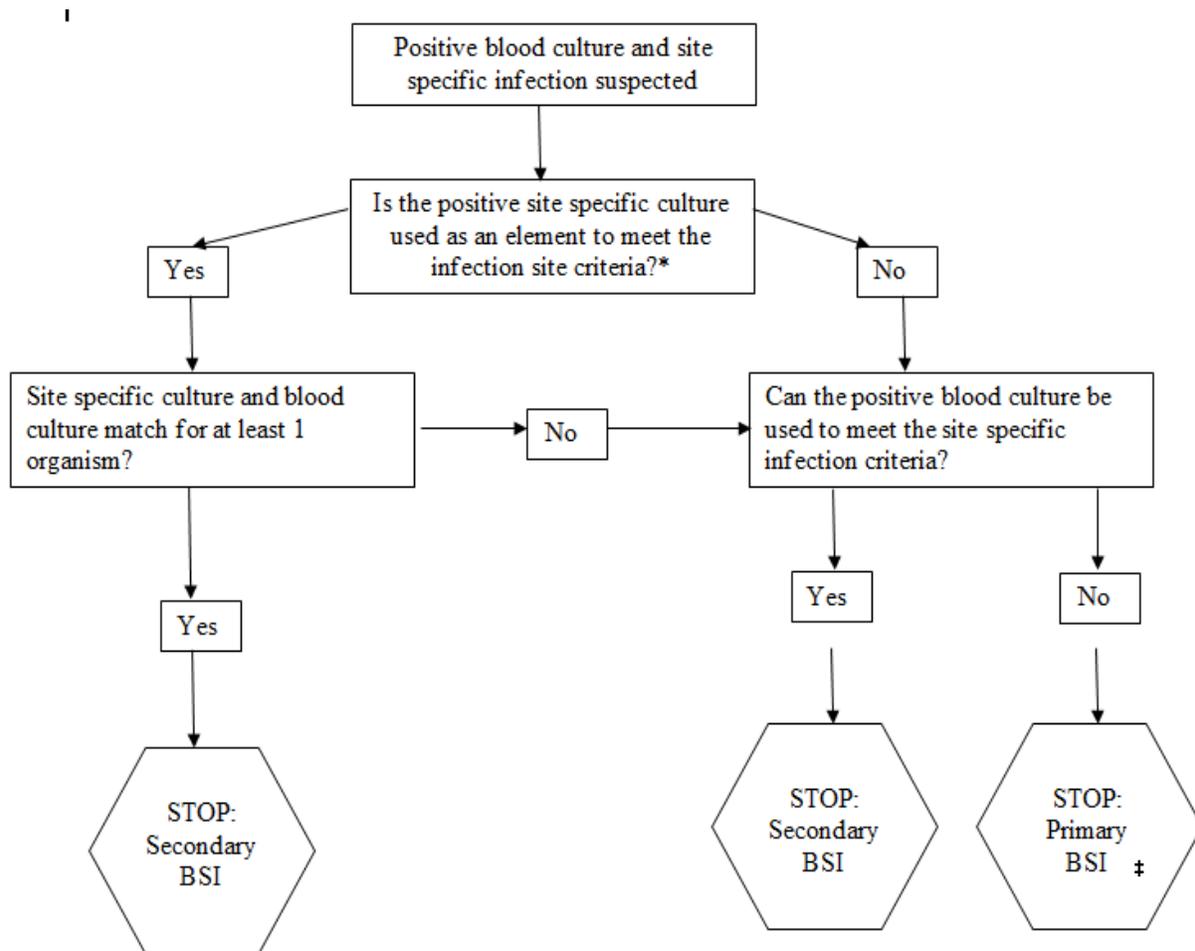
Infection Window Period
(First positive diagnostic test, 3 days before and 3 days after)

Repeat Infection Timeframe (RIT)
(date of event = day 1)

Secondary BSI Attribution Period
(Infection Window Period + RIT)

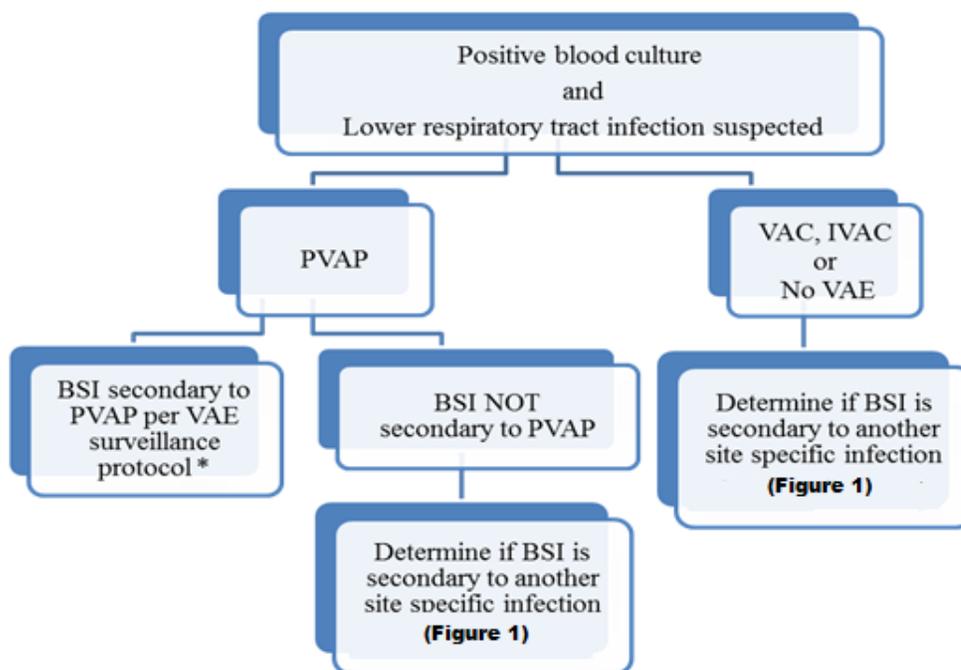
Date of Event (DOE)
(Date the first element occurs for the first time within the infection window period)

Figure 1: Secondary BSI Guide for eligible organisms*
(Not applicable to Ventilator-associated Events [VAE], see Figure 2.)



*If an organism is excluded as a causative agent for a site specific infection (i.e. yeast in UTI), the blood cannot be considered secondary to that site.

‡**Exception:** Since necrotizing enterocolitis (NEC) criteria include neither a site specific culture nor a positive blood culture, an exception for assigning a BSI secondary to NEC is provided. A BSI is considered secondary to NEC if the patient meets one of the 2 NEC criteria AND a positive blood culture(s) collected during the secondary BSI attribution period is positive for an LCBI pathogen or the same common commensal is cultured from 2 or more blood cultures drawn on separate occasions collected on the same or consecutive days.

Figure 2: VAE Guidance for Secondary BSI Determination

*Secondary BSIs may be reported for possible VAP (PVAP) events, provided that at least one organism isolated from the blood culture matches an organism isolated from an appropriate respiratory tract specimen (including respiratory secretions, pleural fluid and lung tissue). The respiratory tract specimen must have been collected on or after the 3rd day of mechanical ventilation and within 2 calendar days before or after the day of onset of worsening oxygenation to be considered as a criterion for meeting the PVAP definitions. In addition, the positive blood culture must have been collected during the 14-day event period, where day 1 is the day of onset of worsening oxygenation.

- In cases where PVAP is met with only the histopathology criterion and no culture is performed, and there is also a positive blood culture, a secondary BSI to VAE is not reported.
- In cases where a culture of respiratory secretions, pleural fluid or lung tissue is performed and does not grow an organism that matches an organism isolated from blood, a secondary BSI to VAE is not reported.

Note: Candida species or yeast not otherwise specified, coagulase-negative Staphylococcus species, and Enterococcus species cultured from blood cannot be deemed secondary to a PVAP, unless the organism was also cultured from pleural fluid or lung tissue.

This page left blank for double-sided copying.

Appendix G
CAHPS® Health Plan Survey 5.0H
Child Questionnaire
(With CCC Supplemental Items)

This page left blank for double-sided copying.

CAHPS® 5.0H, Child Questionnaire (With CCC Supplemental Items)

SURVEY INSTRUCTIONS

Note: The questionnaire is worded for the Medicaid product line. If administering to a commercial product line, replace “6” with “12” in all references to “last 6 months.”

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

Yes → If Yes, Go to Question 1

No

{This box should be placed on the Cover Page}

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call
{SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. Our records show that your child is now in {INSERT HEALTH PLAN NAME}. Is that right?
 Yes →If Yes, Go to Question 3
 No
2. What is the name of your child's health plan? (please print)

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do not include care your child got when he or she stayed overnight in a hospital. Do not include the times your child went for dental care visits.

3. In the last 6 months, did your child have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?
 Yes
 No →If No, Go to Question 5
4. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?
 Never
 Sometimes
 Usually
 Always
5. In the last 6 months, did you make any appointments for a check-up or routine care for your child at a doctor's office or clinic?
 Yes
 No →If No, Go to Question 7
6. In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?
 Never
 Sometimes
 Usually
 Always

7. In the last 6 months, not counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?
- None → If None, Go to Question 16
 - 1 time
 - 2
 - 3
 - 4
 - 5 to 9
 - 10 or more times
8. In the last 6 months, did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?
- Yes
 - No
9. In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?
- Never
 - Sometimes
 - Usually
 - Always
10. In the last 6 months, did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?
- Yes
 - No → If No, Go to Question 14
11. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?
- Yes
 - No
12. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?
- Yes
 - No

13. When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?
- Yes
 No
14. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?
- 0 Worst health care possible
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 Best health care possible
15. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?
- Never
 Sometimes
 Usually
 Always
16. Is your child now enrolled in any kind of school or daycare?
- Yes
 No → If No, Go to Question 19
17. In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?
- Yes
 No → If No, Go to Question 19
18. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?
- Yes
 No

SPECIALIZED SERVICES

19. Special medical equipment or devices include a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment. In the last 6 months, did you get or try to get any special medical equipment or devices for your child?
- Yes
 No → If No, Go to Question 22
20. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?
- Never
 Sometimes
 Usually
 Always
21. Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?
- Yes
 No
22. In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?
- Yes
 No → If No, Go to Question 25
23. In the last 6 months, how often was it easy to get this therapy for your child?
- Never
 Sometimes
 Usually
 Always
24. Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?
- Yes
 No
25. In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?
- Yes
 No → If No, Go to Question 28
26. In the last 6 months, how often was it easy to get this treatment or counseling for your child?
- Never
 Sometimes
 Usually
 Always
27. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?
- Yes
 No

28. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?

Yes

No → If No, Go to Question 30

29. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

Yes

No

YOUR CHILD'S PERSONAL DOCTOR

30. A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

Yes

No → If No, Go to Question 45

31. In the last 6 months, how many times did your child visit his or her personal doctor for care?

None → If None, Go to Question 41

1 time

2

3

4

5 to 9

10 or more times

32. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?

Never

Sometimes

Usually

Always

33. In the last 6 months, how often did your child's personal doctor listen carefully to you?

Never

Sometimes

Usually

Always

34. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
35. Is your child able to talk with doctors about his or her health care?
- 1 Yes
 - 2 No → If No, Go to Question 37
36. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
37. In the last 6 months, how often did your child's personal doctor spend enough time with your child?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
38. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?
- 1 Yes
 - 2 No
39. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?
- 1 Yes
 - 2 No → If No, Go to Question 41
40. In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
41. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?
- 00 0 Worst personal doctor possible
 - 01 1
 - 02 2
 - 03 3
 - 04 4
 - 05 5
 - 06 6
 - 07 7
 - 08 8
 - 09 9
 - 10 10 Best personal doctor possible

42. Does your child have any medical, behavioral, or other health conditions that have lasted for more than 3 months?

- Yes
- No → If No, Go to Question 45

43. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

- Yes
- No

44. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?

- Yes
- No

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, do not include dental visits or care your child got when he or she stayed overnight in a hospital.

45. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments for your child to see a specialist?

- Yes
- No → If No, Go to Question 49

46. In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?

- Never
- Sometimes
- Usually
- Always

47. How many specialists has your child seen in the last 6 months?

- None → If None, Go to Question 49
- 1 specialist
- 2
- 3
- 4
- 5 or more specialists

48. We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

- 0 Worst specialist possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best specialist possible

YOUR CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

49. In the last 6 months, did you get information or help from customer service at your child's health plan?
- Yes
 - No → If No, Go to Question 52
50. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?
- Never
 - Sometimes
 - Usually
 - Always
51. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?
- Never
 - Sometimes
 - Usually
 - Always
52. In the last 6 months, did your child's health plan give you any forms to fill out?
- Yes
 - No → If No, Go to Question 54

53. In the last 6 months, how often were the forms from your child's health plan easy to fill out?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always

54. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?

- 00 0 Worst health plan possible
- 01 1
- 02 2
- 03 3
- 04 4
- 05 5
- 06 6
- 07 7
- 08 8
- 09 9
- 10 10 Best health plan possible

PRESCRIPTION MEDICINES

55. In the last 6 months, did you get or refill any prescription medicines for your child?

- 1 Yes
- 2 No → If No, Go to Question 58

56. In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?

- 1 Never
- 2 Sometimes
- 3 Usually
- 4 Always

57. Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

- 1 Yes
- 2 No

ABOUT YOUR CHILD AND YOU

58. In general, how would you rate your child's overall health?

- 1 Excellent
- 2 Very Good
- 3 Good
- 4 Fair
- 5 Poor

59. In general, how would you rate your child's overall mental or emotional health?

- 1 Excellent
- 2 Very Good
- 3 Good
- 4 Fair
- 5 Poor

60. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?

- 1 Yes
- 2 No → If No, Go to Question 63

61. Is this because of any medical, behavioral, or other health condition?

- 1 Yes
- 2 No → If No, Go to Question 63

62. Is this a condition that has lasted or is expected to last for at least 12 months?

- 1 Yes
- 2 No

63. Does your child need or use more medical care, more mental health services, or more educational services than is usual for most children of the same age?

- 1 Yes
- 2 No → If No, Go to Question 66

64. Is this because of any medical, behavioral, or other health condition?

- 1 Yes
- 2 No → If No, Go to Question 66

65. Is this a condition that has lasted or is expected to last for at least 12 months?

- 1 Yes
- 2 No

66. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

- 1 Yes
- 2 No → If No, Go to Question 69

67. Is this because of any medical, behavioral, or other health condition?

- 1 Yes
- 2 No → If No, Go to Question 69

68. Is this a condition that has lasted or is expected to last for at least 12 months?

- 1 Yes
- 2 No

69. Does your child need or get special therapy such as physical, occupational, or speech therapy?
- Yes
- No → If No, Go to Question 72
70. Is this because of any medical, behavioral, or other health condition?
- Yes
- No → If No, Go to Question 72
71. Is this a condition that has lasted or is expected to last for at least 12 months?
- Yes
- No
72. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?
- Yes
- No → If No, Go to Question 74
73. Has this problem lasted or is it expected to last for at least 12 months?
- Yes
- No
74. What is your child's age?
- Less than 1 year old
- _____ YEARS OLD (write in)
75. Is your child male or female?
- Male
- Female
76. Is your child of Hispanic or Latino origin or descent?
- Yes, Hispanic or Latino
- No, not Hispanic or Latino
77. What is your child's race? Mark one or more.
- White
- Black or African American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- Other
78. What is your age?
- Under 18
- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older
79. Are you male or female?
- Male
- Female

80. What is the highest grade or level of school that you have completed?
- 1 8th grade or less
 - 2 Some high school, but did not graduate
 - 3 High school graduate or GED
 - 4 Some college or 2-year degree
 - 5 4-year college graduate
 - 6 More than 4-year college degree
81. How are you related to the child?
- 1 Mother or father
 - 2 Grandparent
 - 3 Aunt or uncle
 - 4 Older brother or sister
 - 5 Other relative
 - 6 Legal guardian
 - 7 Someone else

82. Did someone help you complete this survey?
- 1 Yes → If yes, go to question 83
 - 2 No → Thank you. Please return the completed survey in the postage-paid envelope.
83. How did that person help you?
Mark one or more.
- a Read the question to me
 - b Wrote down the answer I gave
 - c Answered the questions for me
 - d Translated the questions into my language
 - e Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope.

This page left blank for double-sided copying.

Appendix H
CAHPS® Health Plan Survey 5.0H
Child Questionnaire

This page left blank for double-sided copying.

CAHPS® 5.0H, Child Questionnaire (Without CCC Supplemental Items)

SURVEY INSTRUCTIONS

Note: The questionnaire is worded for the Medicaid product line. If administering to a commercial product line, replace “6” with “12” in all references of “last 6 months.”

- Answer each question by marking the box to the left of your answer.
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:
 - Yes → If Yes, Go to Question 1
 - No

{This box should be placed on the Cover Page}

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call
{SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. Our records show that your child is now in {INSERT HEALTH PLAN NAME}. Is that right?
 - Yes → If yes, go to question 3
 - No
2. What is the name of your child's health plan? (please print)

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care. Do not include care your child got when he or she stayed overnight in a hospital. Do not include the times your child went for dental care visits.

3. In the last 6 months, did your child have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?
 - Yes
 - No → If No, Go to Question 5
4. In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?
 - Never
 - Sometimes
 - Usually
 - Always
5. In the last 6 months, did you make any appointments for a check-up or routine care for your child at a doctor's office or clinic?
 - Yes
 - No → If No, Go to Question 7

6. In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?
- ₁ Never
 - ₂ Sometimes
 - ₃ Usually
 - ₄ Always
7. In the last 6 months, not counting the times your child went to an emergency room, how many times did he or she go to a doctor's office or clinic to get health care?
- ₀ None → If None, Go to Question 15
 - ₁ 1 time
 - ₂ 2
 - ₃ 3
 - ₄ 4
 - ₅ 5 to 9
 - ₆ 10 or more times
8. In the last 6 months, did you and your child's doctor or other health provider talk about specific things you could do to prevent illness in your child?
- ₁ Yes
 - ₂ No
9. In the last 6 months, did you and your child's doctor or other health provider talk about starting or stopping a prescription medicine for your child?
- ₁ Yes
 - ₂ No → If No, Go to Question 13
10. Did you and a doctor or other health provider talk about the reasons you might want your child to take a medicine?
- ₁ Yes
 - ₂ No
11. Did you and a doctor or other health provider talk about the reasons you might not want your child to take a medicine?
- ₁ Yes
 - ₂ No
12. When you talked about your child starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for your child?
- ₁ Yes
 - ₂ No

13. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months?

- 0 Worst health care possible
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Best health care possible

14. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?

- Never
- Sometimes
- Usually
- Always

YOUR CHILD'S PERSONAL DOCTOR

15. A personal doctor is the one your child would see if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

- Yes
- No → If No, Go to Question 27

16. In the last 6 months, how many times did your child visit his or her personal doctor for care?

- None → If None, Go to Question 26
- 1 time
- 2
- 3
- 4
- 5 to 9
- 10 or more times

17. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?

- Never
- Sometimes
- Usually
- Always

18. In the last 6 months, how often did your child's personal doctor listen carefully to you?

- Never
- Sometimes
- Usually
- Always

19. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
20. Is your child able to talk with doctors about his or her health care?
- 1 Yes
 - 2 No → If No, Go to Question 22
21. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
22. In the last 6 months, how often did your child's personal doctor spend enough time with your child?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
23. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?
- 1 Yes
 - 2 No
24. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?
- 1 Yes
 - 2 No → If No, Go to Question 26
25. In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?
- 1 Never
 - 2 Sometimes
 - 3 Usually
 - 4 Always
26. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?
- 00 0 Worst personal doctor possible
 - 01 1
 - 02 2
 - 03 3
 - 04 4
 - 05 5
 - 06 6
 - 07 7
 - 08 8
 - 09 9
 - 10 10 Best personal doctor possible

**GETTING HEALTH CARE
FROM SPECIALISTS**

When you answer the next questions, do not include dental visits or care your child got when he or she stayed overnight in a hospital.

27. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments for your child to see a specialist?

- 1 Yes
 2 No → If No, Go to Question 31

28. In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?

- 1 Never
 2 Sometimes
 3 Usually
 4 Always

29. How many specialists has your child seen in the last 6 months?

- 0 None → If None, Go to Question 31
 1 1 specialist
 2 2
 3 3
 4 4
 5 5 or more specialists

30. We want to know your rating of the specialist your child saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

- 00 0 Worst specialist possible
 01 1
 02 2
 03 3
 04 4
 05 5
 06 6
 07 7
 08 8
 09 9
 10 10 Best specialist possible

YOUR CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

31. In the last 6 months, did you get information or help from customer service at your child's health plan?

Yes
 No →If No, Go to Question 34

32. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?

Never
 Sometimes
 Usually
 Always

33. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?

Never
 Sometimes
 Usually
 Always

34. In the last 6 months, did your child's health plan give you any forms to fill out?

Yes
 No →If No, Go to Question 36

35. In the last 6 months, how often were the forms from your child's health plan easy to fill out?

Never
 Sometimes
 Usually
 Always

36. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?

0 Worst health plan possible
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 Best health plan possible

ABOUT YOUR CHILD AND YOU

37. In general, how would you rate your child's overall health?
- 1 Excellent
 - 2 Very Good
 - 3 Good
 - 4 Fair
 - 5 Poor
38. In general, how would you rate your child's overall mental or emotional health?
- 1 Excellent
 - 2 Very Good
 - 3 Good
 - 4 Fair
 - 5 Poor
39. What is your child's age?
- 00 Less than 1 year old
_____ YEARS OLD (write in)
40. Is your child male or female?
- 1 Male
 - 2 Female
41. Is your child of Hispanic or Latino origin or descent?
- 1 Yes, Hispanic or Latino
 - 2 No, not Hispanic or Latino
42. What is your child's race? Mark one or more.
- a White
 - b Black or African American
 - c Asian
 - d Native Hawaiian or other Pacific Islander
 - e American Indian or Alaska Native
 - f Other
43. What is your age?
- 0 Under 18
 - 1 18 to 24
 - 2 25 to 34
 - 3 35 to 44
 - 4 45 to 54
 - 5 55 to 64
 - 6 65 to 74
 - 7 75 or older
44. Are you male or female?
- 1 Male
 - 2 Female
45. What is the highest grade or level of school that you have completed?
- 1 8th grade or less
 - 2 Some high school, but did not graduate
 - 3 High school graduate or GED
 - 4 Some college or 2-year degree
 - 5 4-year college graduate
 - 6 More than 4-year college degree

46. How are you related to the child?

- 1 Mother or father
- 2 Grandparent
- 3 Aunt or uncle
- 4 Older brother or sister
- 5 Other relative
- 6 Legal guardian
- 7 Someone else

47. Did someone help you complete this survey?

- 1 Yes → If yes, go to question 48
- 2 No → Thank you. Please return the completed survey in the postage-paid envelope.

48. How did that person help you?

Mark one or more.

- a Read the question to me
- b Wrote down the answer I gave
- c Answered the questions for me
- d Translated the questions into my language
- e Helped in some other way

THANK YOU

Please return the completed survey in the postage-paid envelope.

This page left blank for double-sided copying.

Appendix I
Guidance for Conducting the Child
Consumer Assessment of Healthcare
Providers and Systems (CAHPS®) Health
Plan Survey 5.0H (Medicaid)

This page left blank for double-sided copying.

Assessing patient experiences with health care is an important dimension of the quality of care. The Child Core Set includes a measure of experiences with health care based on the CAHPS® Survey.⁶ This appendix provides additional guidance to states in carrying out CAHPS data collection, including information on the version of CAHPS used for Child Core Set reporting, contracting with a survey vendor, instructions on how to identify children with chronic conditions, guidance for generating a sample frame, and conducting the survey using standard protocols.

A. VERSION OF CAHPS FOR CHILD CORE SET REPORTING

CAHPS is a family of surveys designed to assess consumer experiences with care. Different versions of the survey are available for use among various populations, payers, and settings. The version of the CAHPS Survey specified in the Child Core Set is the CAHPS Health Plan Survey 5.0H, Child Questionnaire, with the Children with Chronic Conditions (CCC) Supplemental Items. The core child questionnaire captures families' overall experiences with their children's health care. The CCC Supplemental items focus on components of care essential for the successful treatment, management, and support of children with chronic conditions. Inclusion of the CCC Supplemental Items is encouraged by the Centers for Medicare & Medicaid Services (CMS), but the decision to do so is up to each state. Appendix G and Appendix H contain the survey instruments.

States and health plans that collect the CAHPS 5.0H Survey with CCC Supplemental Items produce two separate sets of results: one for the general child population and one for the population of children with chronic conditions. For each population, results include the same ratings, composites, and individual question summary rates as those reported for the CAHPS Health Plan Survey 5.0H, Child Questionnaire. In addition, five CCC-specific results are calculated for each population: (1) access to specialized services, (2) family-centered care: personal doctor who knows child, (3) coordination of care for children with chronic conditions, (4) access to prescription medicines, and (5) family-centered care: getting needed information. CCC results for the general population are provided so that survey sponsors can compare the experiences of the general child population and children with chronic conditions population.

B. CONTRACTING WITH A SURVEY VENDOR

To adhere to CAHPS 5.0H measure specifications, states must create a sample frame and contract with a National Committee for Quality Assurance (NCQA) certified HEDIS 2016 survey vendor that will administer the survey according to HEDIS protocols. The survey vendor draws the actual samples and fields the survey.

NCQA maintains a list of survey vendors that have been trained and certified by NCQA to administer the CAHPS 5.0H survey. Each survey vendor is assigned a maximum capacity of samples. The capacity reflects the firm's and NCQA's projection of resources available to be dedicated to administer the survey. A current listing of NCQA-certified HEDIS 2016 survey vendors is available at

http://www.ncqa.org/Portals/0/HEDISQM/Programs/SVC/2016_HEDIS_CAHPS-Vendor_Web_List.pdf.

C. IDENTIFYING THE SUPPLEMENTAL SAMPLE OF CHILDREN WITH CHRONIC CONDITIONS

To identify children with chronic conditions, states should search claims and encounter data for the measurement year and the year prior to the measurement year to assign a prescreen status

⁶CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

code to each child in the CAHPS survey sample frame data file. The prescreen status code identifies children who are more likely to have a chronic condition. The prescreen status codes are defined as follows:

1 = No claims or encounters during the measurement year or the year prior to the measurement year that meet the criteria listed for prescreen status code 2.

2 = The child has claims or encounters during the measurement year or the year prior to the measurement year that indicate the child is likely to have a chronic condition. Any of the following meet criteria.

- At least one outpatient visit (Outpatient Value Set), observation visit (Observation Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set), acute inpatient encounter (Acute Inpatient Value Set; Newborn/Pediatric Acute Inpatient Value Set), or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year with a diagnosis code from the Chronic Conditions Value Set. The diagnosis does not have to be the principal diagnosis.
- At least one psychiatry visit (Psychiatry Value Set) with a diagnosis code from the Chronic Conditions Value Set and a place of service code from one of the following:
 - BH Acute Inpatient POS Value Set.
 - BH Nonacute Inpatient POS Value Set.
 - BH ED POS Value Set.
 - BH Outpatient/PH/IOP POS Value Set.
- At least two outpatient visits (Outpatient Value Set) or observation visits (Observation Value Set) on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis. The visit codes need not be from the same value set (for example, one visit with a code from the Outpatient Value Set and another visit with a code from the Observation Value Set qualifies).
 - Conduct Disorder Value Set.
 - Emotional Disturbance Value Set.
 - Hyperkinetic Syndrome Value Set.
 - Asthma Value Set.
 - Failure to Thrive Value Set.
- At least two psychiatry visits (Psychiatry Value Set) on different dates of service during the measurement year or the year prior to the measurement year with an outpatient place of service code (BH Outpatient/PH/IOP POS Value Set) and a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis.
 - Conduct Disorder Value Set.
 - Emotional Disturbance Value Set.
 - Hyperkinetic Syndrome Value Set.

- Asthma Value Set.
- Failure to Thrive Value Set.
- At least one acute inpatient encounter (Acute Inpatient Value Set; Newborn/Pediatric Acute Inpatient Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set) or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year with a diagnosis code from any of the value sets listed below. The diagnosis does not have to be the principal diagnosis.
 - Conduct Disorder Value Set.
 - Emotional Disturbance Value Set.
 - Hyperkinetic Syndrome Value Set.
 - Asthma Value Set.
 - Failure to Thrive Value Set.
- At least one psychiatry visit (Psychiatry Value Set) with a diagnosis code (the diagnosis does not have to be the principal diagnosis) and a place of service code from the lists below.

Diagnosis Code Value Sets	Place of Service Code Value Sets
<ul style="list-style-type: none"> • <u>Conduct Disorder Value Set.</u> • <u>Emotional Disturbance Value Set.</u> • <u>Hyperkinetic Syndrome Value Set.</u> • <u>Asthma Value Set.</u> • <u>Failure to Thrive Value Set.</u> 	<ul style="list-style-type: none"> • <u>BH Acute Inpatient POS Value Set.</u> • <u>BH Nonacute Inpatient POS Value Set.</u> • <u>BH ED POS Value Set.</u>

D. GENERATING A SAMPLE FRAME

States are responsible for generating a complete, accurate, and valid sample frame data file that is representative of the entire eligible population (Table I.1). If states choose to have their sample frame validated, they should arrange for an auditor to verify the integrity of the sample frame before the survey vendor draws the sample and administers the survey.

Table I.1. Eligible Population for Child CAHPS 5.0H (Medicaid)

Ages	Age 17 and younger as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	For a Medicaid enrollee in a state where enrollment is verified monthly, the child may not have more than a one-month gap in coverage (the child must be enrolled for five of the last six months of the measurement year). For a Medicaid enrollee in a state where enrollment is verified daily, the child may have no more than one gap in enrollment of up to 45 days during the last six months of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Source: HEDIS 2016 Volume 3: Specifications for Survey Measures
<http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx>.

To enable the survey vendor to generate the systematic sample, states must generate a sample frame data file for each survey to be fielded. States are strongly encouraged to generate sample frames after eliminating disenrolled and deceased enrollees and updating eligibility files with address and telephone number corrections. When sampling, keep the following in mind:

- If a state collects CAHPS data for both its Medicaid and CHIP programs, states must generate separate sample frames for children in CHIP and Medicaid to meet CHIPRA requirements.⁷
- If each managed care plan carries out its own CAHPS survey, a separate sample frame must be generated for each plan.
- If a state has children enrolled in multiple delivery systems (managed care, primary care case management, and/or fee for service), the sample frame(s) should be representative of all children covered by the entire program. A state may generate one statewide sample frame that includes children in all delivery systems or separate sample frames for each delivery system. The sample frame(s) should represent all children that meet the eligibility criteria specified in Table I.1.

E. DRAWING THE SAMPLE

The survey vendor is responsible for drawing the survey samples from the sample frame generated by the state. For each survey administered, the survey vendor draws a systematic sample of 1,650 children from the general child population and then, if the state has decided to collect the additional items, draws the CCC supplemental sample. The survey vendor selects 1,840 children for the CCC supplemental sample from the set of enrollees with a prescreen status code of 2 who were not already selected for the general child population sample. The survey vendor combines the general child population sample (n=1,650) and the CCC supplemental sample (n=1,840) for survey administration and submission of survey results.

Deduplication

To reduce respondent burden, the survey vendor should deduplicate samples so that only one child per household is included in the sample.

Oversampling

A state should instruct its survey vendor to oversample if it has a prior history of low survey response rates, if it anticipates that a significant number of addresses or telephone numbers in the enrollment files are inaccurate, if it cannot eliminate disenrolled children from eligibility files, or if it does not expect to achieve a denominator of 100 for most survey calculations. The required sample sizes are based on the average number of complete and valid surveys obtained by health plans during prior years; therefore, using the required sample size for a given survey does not guarantee that a state will achieve the goal of 411 completed surveys or the required denominator of 100 complete responses for each survey result. The state should work

⁷ The CAHPS CHIPRA requirement applies to all Title XXI (CHIP) programs. States must submit data that are representative of all children covered by their entire Title XXI program (CHIP Medicaid Expansion, Separate CHIP Program, or Combination CHIP Program) beginning in 2013. If a state chooses to collect CAHPS data for children in both Medicaid and CHIP, the state must separately sample children enrolled in the Title XIX (Medicaid) and Title XXI (CHIP) programs and must separate data for children enrolled in Medicaid and CHIP when submitting data to CMS to fulfill the CHIPRA requirement.

with its survey vendor to determine the number of complete and valid surveys it can expect to obtain without oversampling based on prior experience.

If its prior response rates or the number of completed surveys is expected to fall below the 411 completed surveys required, the survey vendor should oversample to achieve the goal of 411 completed surveys. For example, if the vendor increases the sample by 5 percent, the final sample size would be 1,733. If the vendor increases the sample by 20 percent, the final sample size would be 1,980. Table I.2 displays final sample sizes at various oversampling rates. The survey vendor will work with the state to determine an appropriate sampling strategy. For a detailed discussion of oversampling, see “HEDIS 2016 Volume 3: Specifications for Survey Measures,” Appendix 7, “General Recommendations for Oversampling Survey Measures.”

Table I.2. Oversampling Rates and Final Sample Sizes for the CAHPS 5.0H Child Survey

Sample	Required Sample Size	Oversampling Rate and Final Sample Size					
		5%	10%	15%	20%	25%	30%
CAHPS 5.0H General Child Population Sample	1,650	1,733	1,815	1,898	1,980	2,063	2,145
CCC Supplemental Sample	1,840	1,932	2,024	2,116	2,208	2,300	2,392
Total Sample Size	3,490	3,665	3,839	4,014	4,188	4,363	4,537

Source: Tables CCC-5 in “HEDIS 2016 Volume 3: Specifications for Survey Measures”

F. SURVEY ADMINISTRATION

The sampling and data collection procedures that the survey vendors have been trained and certified to carry out promote both the standardized administration of the survey instruments by different survey vendors and the comparability of resulting data. For results to comply with CAHPS 5.0H survey specifications, the state’s survey vendor must follow one of the standard CAHPS 5.0H survey protocols. The state will have to work with its survey vendor to select one of two standard options for administering CAHPS 5.0H surveys:

1. The mail-only methodology, a five-wave mail protocol with three questionnaire mailings and two reminder postcards (81 days)
2. The mixed methodology, a four-wave mail protocol (two questionnaires and two reminder postcards) with telephone follow-up of a minimum of three and a maximum of six telephone attempts (70 days)

The basic tasks and time frames for the two protocol options are detailed in Tables I.3 and I.4. Regardless of the approach selected, the survey vendor is expected to maximize the final survey response rate and to pursue contacts with potential respondents until completing the selected data collection protocol. Achieving the targeted number of completed surveys does not justify ceasing the survey protocol.

Neither the state nor the survey vendor may offer incentives of any kind for completion of the survey. Either a parent or caretaker who is familiar with the child’s health care may complete the child survey. The vendor is expected to maintain the confidentiality of systematically sampled children.

Table I.3. Survey Vendor Tasks and Time Frames for the Mail-Only Methodology

Vendor Tasks	Time Frame (Days)
Send first questionnaire and cover letter to the surveyed child's family	0
Send a postcard reminder to nonrespondents 4–10 days after mailing the first questionnaire	4–10
Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire	35
Send a second postcard reminder to nonrespondents 4–10 days after mailing the second questionnaire	39–45
Send a third questionnaire and third cover letter to nonrespondents approximately 25 days after mailing the second questionnaire	60
Allow at least 21 days for the respondent to return the third questionnaire	81

Source: HEDIS 2016 Volume 3: Specifications for Survey Measures.

Table I.4. Survey Vendor Tasks and Time Frames for the Mixed Methodology

Vendor Tasks	Time Frame (Days)
Send first questionnaire and cover letter to the surveyed child's family	0
Send a postcard reminder to nonrespondents 4–10 days after mailing the first questionnaire	4–10
Send a second questionnaire and second cover letter to nonrespondents approximately 35 days after mailing the first questionnaire	35
Send a second postcard reminder to nonrespondents 4–10 days after mailing the second questionnaire	39–45
Initiate computer-assisted telephone interviews (CATI) for nonrespondents approximately 21 days after mailing the second questionnaire	56
Initiate systematic contact for all nonrespondents so that at least 3 telephone calls (and no more than 6 telephone calls) are attempted at different times of the day, on different days of the week, and in different weeks	56–70
Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all nonrespondents) approximately 14 days after initiation	70

Source: HEDIS 2016 Volume 3: Specifications for Survey Measures.

G. FOR FURTHER INFORMATION

Information about the CAHPS family of surveys and the CAHPS Database is available at <http://www.cahps.ahrq.gov/>.

Information about the NCQA's HEDIS Survey Vendor Certification program can be found at <http://www.ncqa.org/HEDISQualityMeasurement/CertifiedSurveyVendorsAuditorsSoftwareVendors/HEDISSurveyVendorCertification/CAHPS50HSurvey.aspx>.

Information on "HEDIS 2016 Volume 3: Specifications for Survey Measures" is available at <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures/HEDIS2016.aspx>.