

**SUMMARY OF UPDATES TO THE FFY 2014 AND FFY 2015 HEALTH HOME CORE SET MEASURE TECHNICAL SPECIFICATIONS AND RESOURCE MANUALS
AUGUST 2015**

OVERALL CHANGES

FFY 2014 and FFY 2015 reporting

- Updated reporting year, data collection time frame, and HEDIS version

Update	FFY 2014 Reporting	FFY 2015 Reporting
Reporting Year	FFY 2014	FFY 2015
Data collection timeframe	2013	2014
HEDIS Version for HEDIS measures	2014	2015

- Added three new appendices
 - Appendix A: Health Home Core Set Value Set Directory User Manual
 - Appendix B: Guidance for Selecting Sample Sizes for Hybrid Measures
 - Appendix C: Definition of Medicaid/CHIP Core Set Practitioner Types
- Added information on data collection method(s) to all measure specifications.
- HEDIS specifications have all been updated, replacing codes in the specifications with value sets.
- Added guidance to reporting based on TA requests.

I. THE CORE SET OF HEALTH CARE QUALITY MEASURES FOR MEDICAID HEALTH HOME PROGRAMS

FFY 2014 and FFY 2015 reporting

- Updated description of Health Home Core Set Measures to include electronic health records (EHR) as a data source, where appropriate
- Updated description for Screening for Clinical Depression and Follow-Up Plan (CDF) measure:
 - Percentage of Health Home enrollees age 12 and older screened for clinical depression on the date of encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.
- Updated CDF data collection method to hybrid or EHR.
- Updated Plan All-Cause Readmission Rate (PCR) measure description:

- For Health Home enrollees age 18 and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.
- Updated Follow-Up After Hospitalization for Mental Illness (FUH) measure description from “mental health disorders” to “mental illness diagnoses.”
- Updated Controlling High Blood Pressure (CBP) measure data collection method to hybrid or EHR.
- Updated Timely Transmission of Transition Record (CTR) measure description:
 - Percentage of discharges from an inpatient facility to home or any other site of care for which a transition record was transmitted to the facility, Health Home provider or primary physician, or other health care professional designated for follow-up care within 24 hours of discharge, among Health Home enrollees.
- Changed Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) measure to administrative or EHR.
- Updated PQI92 measure name to PQI 92 Prevention Quality Chronic Condition Composite.
- Added section on Health Home Utilization measures.

FFY 2015 reporting only

- Updated description for PCR in the measure table to clarify that acute readmissions must be unplanned.
- Updated description for CBP in the measure table with the following descriptions of measure criteria:
 - Health Home enrollees ages 18 to 59 whose BP was <140/90 mm Hg.
 - Health Home enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg.
 - Health Home enrollees ages 60 to 85 without a diagnosis of diabetes and whose BP was <150/90 mm Hg.

II. DATA COLLECTION AND REPORTING OF THE HEALTH HOME CORE SET

FFY 2014 and FFY 2015 reporting

Data collection and preparation for reporting

- Aligned order of bullets with Adult Core Set Technical Specifications and Resource Manual.
- Added information on value sets used in HEDIS specifications.
- Added language to “Data collection time frames for measures” requesting that states indicate start and end dates for the measurement period using the “Date Range” field in the reporting system.

- Added information about reporting a weighted rate.
- Updated information about aggregating information for each Health Home program.
- Updated information on data sources.
- Included additional sampling guidance.

Reporting and submission

- Removed mention of CARTS, and noted that procedures for using the new web-based reporting tool will be provided at a later date.
- Added guidance that a health home program with an effective date during calendar year 2013 or earlier is eligible to report for FFY 2014.

III. TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME CORE SET MEASURES

Measure ABA: Adult body mass index assessment

Updates for FFY 2014 and FFY 2015

- Updated Guidance for Reporting to exclude reversed claims.
- Removed Guidance for Reporting bullet relevant to FFY 2013.
- Added Anchor Date to Eligible Population section.
- Updated administrative numerator:
- For enrollees younger than 19 years of age on the date of service, BMI percentile (BMI Percentile Value Set) also meets criteria.
- Added sampling guidance:
- 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.
- Updated hybrid numerator medical record guidance:
- Ranges and thresholds do not meet criteria for this indicator. A distinct BMI value or percentile, if applicable, is required for numerator compliance.
- Removed note on look-back period.

Updates for FFY 2015 only

- Updated allowable gap language.
 - Added hybrid numerator medical record language:
 - Documentation of >99% or <1% meet criteria because a distinct BMI percentile is evident (i.e., 100% or 0%).
 - Updated Additional Notes language:
 - Clarified that “Notation of weight only” is not numerator compliant.
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Measure CDF: Screening for clinical depression and follow-up plan

Updates for FFY 2014 and FFY 2015

- Updated Guidance for Reporting:
 - Modified bullet: This measure uses administrative data and medical record review to calculate the denominator exclusions for the measure. States may also choose to use medical record review to identify numerator cases. States should indicate deviations from the measure specifications if they choose to use the hybrid method to identify numerator cases.
 - Added bullet: This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from CMS. States should describe their sampling methodology in the “Additional Notes/Comments” field.
 - Modified bullet: The date of encounter and screening must occur on the same date of service; if a patient has more than one encounter during the measurement year, the patient should be counted in the numerator and denominator only once based on the most recent encounter.
 - Updated screening definition.
 - Added language to the definition of Standardized Tool: The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
 - Removed CPT codes 90801, 90802, 90804, 90805, 90806, 90807, 90808, and 90809 from Table CDF-A.
 - Modified numerator:
 - Modified text: Patients screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen using one of the codes in Table CDF-B.
 - Deleted: Reporting this code will meet numerator criteria when calculating performance.
 - Added Table CDF-C. Codes to Identify Exclusions.
 - Changed E-Measure Specifications Exclusions section to refer to the Hybrid Specifications for exclusion criteria, as opposed to the Administrative Specification.
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Updates for FFY 2015 only

- None
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Measure PCR: Plan all-cause readmission rate

Updates for FFY 2014 and FFY 2015

- Updated Guidance for Reporting:
- Modified bullet: Include all paid claims only.
- Modified bullet: This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. Therefore, CMS suggests that states report unadjusted rates for this measure (columns 1, 2, and 3 in Tables PCR-A and PCR-B) until a standardized risk adjustor is made available.
- Deleted the “Reporting: Risk Adjustment” section.
- Added the “Reporting: Readmission Rate” section:
- This measure requires risk adjustment. However, there are no standardized risk adjustment tables for Medicaid. CMS suggests that states report unadjusted rates (columns 1, 2, and 3 in Tables PCR-A and PCR-B) for this measure until a standardized risk adjustor is made available. Note: Medicaid-specific risk adjustment tables are required to calculate columns 4, 5, and 6 in Tables PCR-A and PCR-B.

Updates for FFY 2015 only

- Updated measure description:
 - For Health Home enrollees 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days. Data are reported in the following three categories:
 - Count of Index Hospital Stays (IHS) (denominator)
 - Count of 30-Day Readmissions (numerator)
 - Readmission Rate
 - Added new definition for Planned Hospital Stay:
 - A hospital stay is considered planned if it meets criteria as described in step 5 (required exclusions) of the Eligible Population.
 - Updated administrative denominator steps language.
 - Updated reporting language for denominator, numerator, and readmission rate.
 - Updated Tables PCR-A and PCR-B, removing separate rows for male and female.
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Measure FUH: Follow-Up After Hospitalization for Mental Illness

Updates for FFY 2014 and FFY 2015

- Updated description to replace “mental health disorders” with “mental illness diagnoses.”
- Updated Guidance for Reporting:
 - To exclude reversed claims.
 - To add bullets:
 - 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.
 - Deleted definition for “mental health practitioner” and moved to Appendix C.
 - Updated numerator visit types that meet criteria for a follow-up visit.

Updates for FFY 2015 only

- Updated language for acute facility readmission or direct transfer section and exclusions section, which were previously included in event/diagnosis section.
 - Modified language from “encounter” to “visit.”
 - Updated Additional Notes section language.
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Measure CBP: Controlling High Blood Pressure

Updates for FFY 2014 and FFY 2015

- Updated denominator:
 - Deleted “telephone call record” as a document where the diagnosis of hypertension can be recorded from the denominator
 - Added sampling guidance:
 - 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.
 - Updated medical record specification step 2:
 - Added: The enrollee is not compliant if the BP reading is $\geq 140/90$ or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing).
 - Updated medical record specification exclusions language:
 - Exclude from the eligible population all Health Home enrollees who had a nonacute inpatient stay (**Nonacute Care Value Set**) during the measurement year. Include only encounters that indicate the enrollee had a nonacute inpatient stay (do not include outpatient encounters that occurred at a nonacute inpatient facility).
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Updates for FFY 2015 only

- Updated measure description:
- Percentage of Health Home enrollees ages 18 to 85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year based on the following criteria:
- Health Home enrollees ages 18 to 59 whose BP was <140/90 mm Hg.
- Health Home enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Health Home enrollees ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg.
- A single rate is reported and is the sum of all three groups.
- Updated Guidance for Reporting:
- Added new guidance to the first bullet: The numerator for Health Home enrollees ages 18 to 64 will include enrollees ages 18 to 59 who meet the first criterion added to enrollees ages 60 to 64 who meet the second or third criteria. The rate for Health Home enrollees ages 65 to 85 will include all enrollees in that age group who meet the second or third criteria: diagnosis of diabetes with BP < 140/90 mm Hg or no diagnosis of diabetes with BP of <150/90 mm Hg.
- Updated adequate control definition:
- Adequate control is defined as meeting any of the following criteria:
- Health Home enrollees ages 18 to 59 whose BP was <140/90 mm Hg.
- Health Home enrollees ages 60 to 85 with a diagnosis of diabetes whose BP was <140/90 mm Hg.
- Health Home enrollees ages 60 to 85 without a diagnosis of diabetes whose BP was <150/90 mm Hg.
- Updated event/diagnosis language to include the following: In order to increase the specificity of the eligible population, only CPT codes are used to identify outpatient visits.
- Added “Diabetes Flag for the Numerator” to eligible population table.
- Added Table CBP-A: Prescriptions to Identify Health Home Enrollees With Diabetes and added Canagliflozin-metformin and Empagliflozin prescriptions based on current NDC list.
- Updated denominator language clarifying how to confirm the diagnosis of hypertension.
- Updated Identifying the Medical Record language.
- Updated numerator language specifying adequate control of BP by age and diabetes status.
- Updated numerator medical record specification steps to determine representative BP, and added Step 3 guidance for reporting a single rate.
- Updated exclusions language.

Measure CTR: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Updates for FFY 2014 and FFY 2015

- Updated measure description:
- The percentage of Health Home enrollees of all ages discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility, Health Home provider or primary physician or other health care professional designated for follow-up care within 24 hours of discharge, among Health Home enrollees of all ages.
- Updated Guidance for Reporting with the following:
 - This measure may be calculated using sampling, but measure-specific guidelines on sampling are not available from AMA/PCPI. States should describe sampling methodology in the “Additional Notes/Comments” field.
 - All applicable discharges for qualifying enrollees should be included, even if the same enrollee had multiple discharges during the reporting period.
 - The measure assesses whether a transition record including a standard set of data elements was sent to the facility, Health Home provider or primary care physician, or other health care professional, but it is not necessary to capture the information recorded in these data elements.
 - Corrected specification type to hybrid.
 - Clarified guidance for exclusions due to enrollee death.

Updates for FFY 2015 only

- None

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

Updates for FFY 2014 and FFY 2015

- Updated Guidance for Reporting:
- Added bullet: Two rates are reported: initiation of AOD treatment and engagement of AOD treatment.
- Updated bullet: Include all paid, suspended, pending, and denied claims.
- Updated numerator for Rate 1: If the IESD and the initiation visit occur on the same day, they must be with different providers in order to count.
- Added eligible value set code combinations to numerator for Rate 1 and Rate 2.
- Updated numerator for Rate 2 with the following:
- 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 required time frame for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

Updates for FFY 2015 only

- Updated measure description:
- Percentage of Health Home enrollees age 13 and older with a new episode of alcohol or other drug (AOD) dependence who received the following:
- Initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.
- Initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
- Updated Event/diagnosis section to clarify “New episode of AOD during the Intake Period.”
- Modified language from “encounter” to “visit.”
- Added language to numerator for Rate 1 and Rate 2 to clarify that an inpatient admission in combination with a diagnosis of AOD meets criteria when identifying initiation and engagement.
- Moved paragraph regarding methods of billing to Additional Notes section and modified notes:
- The unit of service must have occurred during the required time frame for the rate (e.g., within 14 days of the IESD or within 30 days after the date of the initiation encounter).

Measure PQI92: Prevention Quality Chronic Composite

Updates for FFY 2014 and FFY 2015

- Updated measure title to Prevention Quality Chronic Composite.
- Updated measure description:
 - The number of hospital admissions for ambulatory care sensitive chronic conditions per 100,000 enrollee months for Health Home enrollees age 18 and older. This measure includes adult hospital admissions for diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.
- Updated Guidance for Reporting:
 - Added bullet: States should report this measure as a rate per 100,000 enrollee months as opposed to per 100,000 Health Home enrollees.
 - Added description for two-step process for determining whether enrollees should be counted in the measure.
 - Added bullet: This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers shown in Table PQI92.B may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
 - Removed bullet: Age is based on the date of admission (hospital setting) or date of service (outpatient setting).
 - Updated age in Eligible Population section: Age 18 and older as of the 15th or 30th of the month (or the 28th of the month in February). Date for counting member months must be consistent across the reporting period.

Updates for FFY 2015 only

- None

IV. TECHNICAL SPECIFICATIONS FOR THE HEATH HOME UTILIZATION MEASURES

- Updated measure description for Nursing Facility Utilization (NFU) measure.

Measure AMB: Ambulatory Care-Emergency Department Visits

Updates for FFY 2014 and FFY 2015

- Removed following bullet in Guidance for Reporting as these stratifications will not be requested:
- Report age-stratified rates in total and separately by enrollee type:
- Total Medicaid
- Medicaid/Medicare Dual-Eligible
- Medicaid—Disabled
- Medicaid—Other Low Income
- Individuals may be counted in more than one category. Health Home enrollees who have a restricted benefit package are not reported separately, but are included in the Total Medicaid population; therefore, the sum of the Medicaid/Medicare Dual-Eligible, Medicaid-Disabled, and Medicaid-Other Low Income may not equal the Total Medicaid.
- Clarified measures uses administrative specification.
- Modified administrative denominator specifications:
- Modified language to clarify denominator is number of enrollee months.
- Modified administrative numerator specifications:
- Added: 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.
- Added: Matching enrollment with utilization: Run enrollment reports used for enrollee month calculations to determine utilization rates within 30 days of the claims reports and for the same time period.

Updates for FFY 2015 only

- None

Measure IU: Inpatient Utilization

Updates for FFY 2014 and FFY 2015

- Removed following bullet in Guidance for Reporting as these stratifications will not be requested:
- Report age-stratified rates in total and separately by enrollee type:
- Total Medicaid
- Medicaid/Medicare Dual-Eligible
- Medicaid—Disabled
- Medicaid—Other Low Income
- Individuals may be counted in more than one category. Health Home enrollees who have a restricted benefit package are not reported separately, but are included in the Total Medicaid population; therefore, the sum of the Medicaid/Medicare Dual-Eligible, Medicaid-Disabled, and Medicaid-Other Low Income may not equal the Total Medicaid.
- Specified measure is administrative specification.
- Clarified which steps are for calculating denominator and numerator.
- Modified administrative denominator specifications:
- Modified language to clarify denominator is number of enrollee months.
- Modified administrative numerator specifications:
- Removed the guidelines and formulas to report inpatient discharges and step 2 and formulated into steps 1 through 8.
- Made step 3, step 9.
- Made step 4, step 10.
- Made Table IU.C, IU.A and Table IU.D, IU.B.

Updates for FFY 2015 only

- None

Measure NFU: Nursing Facility Utilization

- No changes.