Letter of Direction #22



Michelle Lujan Grisham, Governor David R. Scrase, M.D., Secretary Nicole Comeaux, J.D., M.P.H, Director

Date:

December 24, 2019

To:

Centennial Care 2.0 Managed Care Organizations

From:

Nicole Comeaux, Director, Medical Assistance Division

Subject:

Tracking Measure Reporting Requirements Repeal & Replace LOD #16

Title:

Tracking Measure Reporting Requirements

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

TM #1 - Fall Risk Management

TM #2 - Diabetes Short-Term Complications Admission Rate

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

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

TM #5 - Immunizations for Adolescents

TM #6 - Long Acting Reversible Contraceptive (LARC)

TM #7 - Smoking Cessation

TM #8 - Ambulatory Care

TM #9 - Annual Dental Visit

TM #10 - Controlling High Blood Pressure

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

For HSD to remain compliant with reporting requirements of the Legislative Finance Committee, in addition to the LOD report specifications listed above, the data for TM #2 Diabetes Short-Term Complications Admission Rate, must also be submitted on a separate reporting template within fifteen (15) calendar days from the end of each reporting period. If the fifteenth (15th) calendar day is not a business day, then the report must be submitted the following business day. The attached template titled MCO.LFCPM Template will be used for this report. The naming convention for this submission is: MCO.LFCPM.QXCYXX.vX. A completed attestation form is required with every submission.

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

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

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

Table 1
Fall Risk Management Codes:

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

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

The following specifications shall be used for reporting TM #3, Screening for Clinical Depression and Follow-Up Plan: The percentage of Medicaid Members age eighteen (18) and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. The MCO must use the CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for the relevant reporting year.

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

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

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

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

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

Table 2

LARC Utilization Codes:

ICD10	CPT	HCPCS	NDC
Z30.430	11981	J7300	52027201
Z30.433	11983	J7301	52027401
Z30.431	58300	J7302	52433001
Z30.49		J7306	50419042101
Z 97.5		J7307	50419042201
T83.6XXA		J7297	5128520401
		J7298	

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

Table 3

Smoking Cessation Product and Service Utilization

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

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

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

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

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

Attachments: LOD #22 Quarterly Reporting Templates MCO.LFCPM Template

LOD #22 Attachment 1 - TM #1 Fall Risk Management

Percentage of Medicaid Members 265 yrs. of age who had a fall or had problems with balance/walking in the past 12 months; who were seen by a practitioner in the past 12 months; and who received fall risk intervention from their current practitioner.

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2019 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 April 2018-March 2019	Q1 April Q2 July Q3 Q4 Jar 2018-March 2018-June Oct 2018- 2019 2019- Dec 2019 2019 Sept 2019 2019	Q3 Oct 2018- Sept 2019	Q4 Jan 2019- Dec 2019
Number of Medicaid Members <a>><a>><a>><a>><a>><a>><a>><a>><a>><a>				
Number of Medicaid Members \geq 65 years of age during the measurement period (past 12 months). (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021	O4 April	03		
Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	2020-March 2020-June 2021 2021		12 P	2021- Dec 2021
Number of Medicaid Members >65 years of age that have a claim with a date of service in the measurement period (past 12 months). Please refer to the				
Crosswalk tab for TM #1 Fall Risk Management ICD 10 and CPT codes. (Numerator)			***************************************	
Number of Medicaid Members ≥ 65 years of age during the measurement period (past 12 months). (Denominator)				
Percentages	#DIV/0!	#DIV/0! #DIV/0! #DIV/0!	#DIV/0!	#DIV/0I

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

by a practitionier in the past 12 months; and who received fall risk intervention from their current practitioner.	men current	practitioner.		
Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period. Q1 April Q2 July O3 2019-March 2019-June 2020 Sept 2020	Q1 April 2019-March 2020	Q1 April Q2 July 2019-March 2019-June (2020 2020 S	Q3 Oct 2019- Sept 2020	Q4 Jan 2020- Dec 2020
Number of Medicaid Members <a><a><a><a><a><a><a><a><a><a><a><a><a><				
Number of Medicaid Members ≥ 65 years of age during the measurement period (past 12 months). (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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

TM #1 Fall Risk Management Analysis	gement Analysis	through
Reporting Period		
MCO Name		
Report Run Date		
1. Identify any changes from the previous	0	
reporting period, as well as trends		
identified over time.		
2. Explanation of changes (positive or	2	
negative).		
3. Discuss action plans implemented for		
performance improvement activities	-	
addressing any negative changes.		
4. Provide additional information		
pertinent to the reporting period.		
5. Was there a 5% or more shift in the		
data provided compared to the previous		
quarter? If so, what was the cause?	-	
6. Please provide the name and title of		
the individual who populated the data		
provided.		
7. Please provide the name and title of		
the individual who validated the data		
provided.		
8. Was there a quality check completed	-	
before being submitted? If so, please	5)	
provide the name and title of the		
individual who completed it.		

LOD #22 Attachment 1 - TM #2 - Diabetes Short-Term Complications Admission Rate

Number of inpatient hospital admissions for diabetes short-term onths for Medicaid enrollees age 18-64.

2019				
Please Note: Data cannot be refreshed beyond the two (2) quarters of the Q1 Jan Q2 calendar year which precede the reporting period. Q2 March Jan	Q1 Jan - March	une	Q3 Q4 Jan - Sept Dec	Q4 Jan Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-				
term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for				
members 18-64. Please refer to CMS Core Set of Adult Health Care Quality				
Measures for Medicaid Technical Specifications and Resource Manual for				
relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 18-64 during the				
measurement period. Please feren to CMS core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for				
relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/OI	#DIV/01	#DIV/0!	i0/AIG#

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

#DIV/0!	#DIV/0!	#DIV/0! #DIV/0!	#DIV/0!	Rate per 100,000 member months
				relevant reporting year. (Denominator)
				Measures for Medicaid Technical Specifications and Resource Manual for
		1000		measurement period. Please refer to CMS Core Set of Adult Health Care Quality
				Number of months of Medicaid enrollment for enrollees age 18-64 during the
				relevant reporting year. (Numerator)
				Measures for Medicaid Technical Specifications and Resource Manual for
		1,700		members 18-64. Please refer to CMS Core Set of Adult Health Care Quality
				term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for
				All inpatient hospital admissions with ICD-10 principal diagnosis code for short-
Dec	Jan - Sept	Jan - June	March	calendar year which precede the reporting period.
Q4 Jan	Q3	02	Q1 Jan Q2	Please Note: Data cannot be refreshed beyond the two (2) quarters of the
				2021

2022		Check Property.	THE SWINS	Second Second
Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar Q1 Jan Q2	Q1 Jan	02	Q3	Q4 Jar
year which precede the reporting period.	March	Jan - June	Jan - Sept Dec	Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term				
complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 18-				
64. Please refer to CMS Core Set of Adult Health Care Quality Measures for				
Medicaid Technical Specifications and Resource Manual for relevant reporting year.				
(Numerator)				
Number of months of Medicaid enrollment for enrollees age 18-64 during the				State of the state
measurement period. Please refer to CMS Core Set of Adult Health Care Quality				
Measures for Medicaid Technical Specifications and Resource Manual for relevant				
reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0! #DIV/0! #DIV/0! #DIV/0!	#DIV/0!	i0/NId#

enrollees age 65 and older.

Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for Medicaid er	ons per 100	,000 enroll	ee months	for Medic
2019				
Please Note: Data cannot be refreshed beyond the two (2) quarters of the Q1 Jan	Q1 Jan-	22	Q 3	Q4 Jan
calendar year which precede the reporting period.	March	Jan - June Jan - Sept	Jan - Sept	Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-				
term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for				
members 65 and older. Please refer to CMS Core Set of Adult Health Care				
Quality Measures for Medicaid Technical Specifications and Resource Manual				
for relevant reporting year. (Numerator)				
Number of months of Medicaid enrollment for enrollees age 65 and older during				
the measurement period. Please refer to CMS Core Set of Adult Health Care				
Quality Measures for Medicaid Technical Specifications and Resource Manual				
for relevant reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0! #DIV/0! #DIV/0! #DIV/0!	#DIV/0!

2020				
Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar Q1 Jan Q2 year which precede the reporting period. March Jan Jun Jun Jun Jun Jun Jun Jun Jun Jun Ju	21 Jan- March	March Jan June Jan Sept	Q3 Jan - Sept	Q4 Jan Dec
All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term				
complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 65				
Medicaid Technical Specifications and Resource Manual for relevant reporting year.			10.00	
(Numerator)				
Number of months of Medicaid enrollment for enrollees age 65 and older during the				
measurement period. Please refer to CMS Core Set of Adult Health Care Quality				
Measures for Medicaid Technical Specifications and Resource Manual for relevant				
reporting year. (Denominator)				
Rate per 100,000 member months	#DIV/0!	#DIV/0!	#DIV/0!	i0/NId#

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

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

All inpatient hospital admissions with ICD-10 principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, coma) for members 65 and older. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)

Number of months of Medicaid enrollment for enrollees age 65 and older during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)

2

Q2

Q3 Jan - Sept

Q4 Dec Jan

March Jan

Rate per 100,000 member months

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

Reporting Period	through
MCO Name	
Report Run Date	

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

LOD #22 Attachment 1 - TM #3 - Screening for Clinical Depression and Follow-Up Plan

ed depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

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

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

				reporting year. (Denominator)
				Measures for Medicaid Technical Specifications and Resource Manual for relevant
				the measurement year. Please refer to CMS Core Set of Adult Health Care Quality
				Number of Medicaid Members 18-64 years of age with an outpatient visit during
				year. (Numerator)
				Medicaid Technical Specifications and Resource Manual for relevant reporting
				screen. Please refer to CMS Core Set of Adult Health Care Quality Measures for
	3732			tool AND, if positive, a follow-up plan is documented on the date of the positive
				measurement year that are screened for clinical depression using a standardized
				Number of Medicaid Members 18-64 years of age with an outpatient visit in the
Dec	- Sept	Jan - June	March	calendar year which precede the reporting period.
Jan Q4 Jan	Q3 Jan	Q2 Q3	Q1 Jan -	Please Note: Data cannot be refreshed beyond the two (2) quarters of the
				2022

			Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)					Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)
			Number of Medicald Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numeration)					Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, it positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant responding year. (Numerator)
Q3 - Sept	Q2 Jan - June	Q1 Jan - March	2022 Please Note. Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q4 Jan Dec	Q3 Jan Q4 -Sept	Q2 Jan - June	Q1 Jan - March	2021 Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.
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			Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)					Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)
		9	Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)					Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized tool AND, it positive, a follow-up plan is documented on the date of the positive screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Numerator)
Q3 - Sep	Q2 Jan - June	Q1 Jan- March	Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Jan Q4 Jan -	Q3 Jan - Sept	Q2 Jan - June	Q1 Jan - March	Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.
reen.	positive sc	ne date of the	Percentage of Medicaid enrollees age 65 and older screened for clinical depression on the date of the encounter using an ago-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.	n age-appropriate	nter using a	of the encou	n on the date	Percentage of Medicaid enrollees age 65 and older screened for clinical depressi

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

#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	Percentages
				Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting year. (Denominator)
				Number of Medicaid Members 65 and older with an outpatient visit during the measurement period. Please refer to CMS Core Set of Adult Health Care Quality
				year. (Numerator)
				screening. Please refer to CMS Core Set of Adult Health Care Quality Measures for Medicaid Technical Specifications and Resource Manual for relevant reporting
				tool AND, if positive, a follow-up plan is documented on the date of the positive
				Number of Medicaid Members 65 and older with an outpatient visit in the measurement year that are screened for clinical depression using a standardized
Dec	- Sept	Jan - June	March	calendar year which precede the reporting period.
Jan Q4 Jan	Q3 Jan	02	Q1 Jan	beyond the two (2) quarters of the
				2022

Percentages

#DIV/0! #DIV/0! #DIV/0! #DIV/0!

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

Reporting Period	through
MCO Name	
Report Run Date	

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

TRACKING MEASURE #4

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

DESCRIPTION

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

- 1. The percentage of discharges for members ages 6-17 (as of the day of discharge) which the member received follow-up within 7 days of discharge.
- 2. The percentage of discharges for members 18 and older (as of the day of discharge) which the member received follow-up within 7 days of discharge

ELIGIBLE POPULATION

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

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

Event/Diagnosis

Age

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

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

To identify acute inpatient discharges:

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

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

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

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

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

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

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

1. Identify the admission date for the stay

Exclusions

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

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

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

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

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

Denominators

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

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

Numerators

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

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

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

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

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

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

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

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

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

FOSTER CARE, CHILD, NON-THERAPEUTIC, PER DIEM	FOSTER	H0041
ORAL MED ADM DIRECT OBSERVE	ORAL MI	H0033
ALCOHOL AND/OR DRUG SERVICES; METHADONE	АLСОНО	H0020
ALCOHOL AND/OR DRUG SERVICES	ALCOHO	H0019
BEHAVIORAL HEALTH; SHORT-TERM RESIDENTIAL (NON-HOSPITAL RESIDENTIAL TREATMENT PROGRAM)	BEHAVIC	H0018
ALCOHOL AND/OR DRUG SERVICES; INTENSIVE	ALCOHO	H0015
ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE	АLСОНО	H0010
ALCOHOL AND/OR DRUG ASSESSMENT	АLСОНО	H0001
SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT	SMOKIN	G0436
DRUG SCREEN MULTI DRUG CLASS	DRUG SC	G0434
UNLISTED EVALUATION AND MANAGEMENT SERVICE	UNLISTE	99499
PROLONGED SERVICE OFFICE	PROLON	99355
PROLONGED SERVICE OFFICE	PROLON	99354
UNLISTED SPECIAL SERVICE OR REPORT	UNLISTE	99199
ASSESS HLTH/BEHAVE SUBSEQ	ASSESS H	96151
ASSESS HLTH/BEHAVE INIT	ASSESS H	96150
NEUROPSYCH TST ADMIN W/COMP	NEUROP	96120
NEUROPSYCH TESTING BY TEC	NEUROP	96119
NEUROPSYCH TST BY PSYCH/PHYS	NEUROP	96118
NEUROBEHAVIORAL STATUS EXAM	NEUROB	96116
DEVELOPMENTAL TEST EXTEND	DEVELOF	96111
DEVELOPMENTAL SCREEN W/SCORE	DEVELOR	96110
ASSESSMENT OF APHASIA (INCLUDES ASSESSME	ASSESSN	96105
PSYCHO TESTING ADMIN BY COMP	PSYCHO:	96103
PSYCHO TESTING BY TECHNICIAN	PSYCHO	96102
PSYCHO TESTING BY PSYCH/PHYS	PSYCHO	96101
UNLISTED PSYCHIATRIC SERVICE OR PROCEDUR	UNLISTE	90899
PREPARATION OF REPORT	PREPAR.	90889
NARCOSYNTHESIS FOR PSYCHIATRIC DIAGNOSTIC AND THERAPEUTIC PURPOSES	NARCOS'	90865
PHARMACOLOGIC MGMT W/PSYTX	PHARMA	90863
PHARMACOLOGIC MANAGEMENT, INCLUDING PRESCRIPTION, USE, AND REVIEW OF MEDICATION	PHARMA	90862
FAMILY PSYCHOTHERAPY (WITHOUT THE PATIEN	FAMILY F	90846
INDIVIDUAL PSYCHOTHERAPY, INTERACTIVE, USING PLAY EQUIPMENT, PHYSICAL DEVICES	INDIVIDU	90814
INDIVIDUAL PSYCHOTHERAPY, INSIGHT ORIENTED, BEHAVIOR MODIFYING 75 TO 80	INDIVIDU	80806

T1502	T1024	T1023	T1007	S9482	S9453	S9446	S9075	S5145	\$5110	Q3014	Н2036	H2034	Н2033	H2032	H2030	H2023
MEDICATION ADMIN VISIT	EVALUATION AND TREATMENT BY AN INTEGRATED, SPECIALTY TEAM	PROGRAM INTAKE ASSESSMENT	TREATMENT PLAN DEVELOPMENT	FAMILY STABILIZATION 15 MIN	SMOKING CESSATION CLASSES, NON-PHYSICIAN PROVIDER, PER SESSION	PT EDUCATION NOC GROUP	SMOKING CESSATION TREATMENT	FOSTER CARE THERAPEUTIC, PER DIEM	DAY CARE SERVICES, ADULT, PER 15 MINUTES	TELEHEALTH FACILITY FEE	ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM	ALCOHOL AND/OR DRUG ABUSE HALFWAY HOUSE SERVICES, PER DIEM	MULTISYSTEMIC THERAPY FOR JUVENILES, PER	ACTIVITY THERAPY, PER 15 MINUTES	MENTAL HEALTH CLUBHOUSE SERVICES, PER 15	SUPPORTED EMPLOY, PER 15 MIN

LOD #22 Attachment 1 - TM #4 - Follow-up after Hospitalization for Mental Illness

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

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

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

quarterly data of CY19.	2					}	
WEBSUTE	רודי לד	2h-t0 /1/2	CITA AT-AS	רווס מז-ה	רוזאלדו	20-70-67.13	the th
Measures	Numerator Denominator Pe	Numerator Denominator Percentage	tage Numerator Denominator Percenta	ge Numerator Denominator Perce	ntage Numerator Denominator Percenta	e Numerator Denominator Percenta	e Numerator Denomina
NOT HEDIS MEASURE: Follow-Up after release from inpatient psychiatric hospitalization stays of four or more days.					_		
7- Day follow-up after release from							
inpatient psychiatirc hospitalization stays of four or more days for Mental Illness-							
within 7 days (6-17)							
7- Day follow-up after release from			_				
inpatient psychiatirc hospitalization stays of four or more days for Mental Illness-					8		
within 7 days (18+)							

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

Reporting Period	through
MCO Name	
Report Run Date	

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

LOD #22 Attachment 1 - TM #5 - Immunizations for Adolescents (IMA)

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

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

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

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

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

TM #5 - Immunizations for Adolescents

Reporting Period	through
MCO Name	
Report Run Date	

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

LOD #22 Attachment 1 - TM #6 - Long Acting Reversible Contraceptive (LARC)

Utilization of Long Acting Reversible Contraceptives (LARCs)

2019				
Please Note: Data cannot be refreshed beyond the two (2) quarters Q1	Jan	Q2	၀္သ	Q4 Jan
of the calendar year which precede the reporting period.	- March	- March Jan - June Jan - Sept - Dec	Jan - Sept	- Dec
Number of LARCs utilized in female Medicaid Members, 15 - 19			i.	
years of age. Please refer to Crosswalk tab for TM 6 Utilization of				
Long Acting Reversible Contraceptive utilization codes.		s		9

၀ွ	Q4 Jan
- March Jan - June Jan - Sept - Dec	- Dec
۵	Q3

2020				
Done Note: Data compatible refreshed beyond the tro (2) quarters	2	3	23	2
of the calendar year which precede the reporting period.	- March	- March Jan - June	Jan - Sept - Dec	- Dec
Number of LARCs utilized in female Medicaid Members, 15 - 19				
years of age. Please refer to Crosswalk tab for TM 6 Utilization of				
Long Acting Reversible Contraceptive utilization codes.				

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

LOD #22 Attachment 1 - TM #6 - Long Acting Reversible Contraceptive (LARC)

Utilization of Long Acting Reversible Contraceptives (LARCs)

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

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

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

LOD #22 Attachment 1 TM #7- Smoking Cessation

Utilization of smoking and tobacco cessation products and counseling services.

		•		
2019				
Please Note: Data cannot be refreshed beyond the two (2) quarters of Q1 the calendar year which precede the reporting period.	Q1 Jan . March	Q1 Jan Q2 March Jan - June	Q3 Jan - Sept	Q4 Jan -
1. Total number of unduplicated members receiving smoking and				
tobacco cessation products/services (Nicotine replacement,				
Counseling Services, Quit Line and Medications). Please refer to the				
2 Total manches of mile for modifier and table				
ביו טנמו וומוווסבו טו מווונס וטו סוווטאוווצ מוומ נטטמכנט נפששמוטוו				
products/services (NRT etc.) Please refer to the Crosswalk tab for TM7				
Smoking Cessation utilization codes.				
3. Total dollar amount for smoking and tobacco cessation				
products/services (NRT etc.) Please refer to the Crosswalk tab for TM7				
Smoking Cessation utilization codes.				

Please Note: Data cannot be refreshed beyond the two (2) quarters of Q1 the calendar wear which precede the reporting period	Q1 Jan-	Q2 Q3	Q3	Q4 Jan
 Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement. 				
Counseling Services, Quit Line and Medications). Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				
2. Total number of units for smoking and tobacco cessation				
products/services (NRT etc.) Please refer to the Crosswalk tab for TM7				
Smoking Cessation utilization codes.				
3. Total dollar amount for smoking and tobacco cessation				0
products/services (NRT etc.) Please refer to the Crosswalk tab for TM7				
Smoking Cessation utilization codes.				

2020				
Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan- March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan . Dec
Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling)				
Services, Quit Line and Medications). Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.				
2. Total number of units for smoking and tobacco cessation				
products/services (NRT etc.) Please refer to the Crosswalk tab for TM7				
Smoking Cessation utilization codes.				
3. Total dollar amount for smoking and tobacco cessation				
products/services (NRT etc.) Please refer to the Crosswalk tab for TM7				
Smoking Cessation utilization codes.				

the calendar year which precede the reporting period. March Jan-June Jan-Sept Dec
Total number of unduplicated members receiving smoking and tobacco cessation products/services (Nicotine replacement, Counseling Services, Quit Line and Medications). Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.
2.Total number of units for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.
3.Total dollar amount for smoking and tobacco cessation products/services (NRT etc.) Please refer to the Crosswalk tab for TM7 Smoking Cessation utilization codes.

LOD #22 Attachment 1 TM #7- Smoking Cessation

access. Provide details on the tobacco cessation services and products offered. Indicate if the service or product listed below is provided along with requirements and limitations, length of coverage, frequency and barriers to

arress.					
			MCO Name:		
Service	Requirements	Limitations	Length of Coverage	Frequency	Barriers to Access
Nicotine Gum					
Nicotine Patch					
Nicotine Nasal					
Nicotine Inhaler					
Nicotine Lozenge					
Chantix					
Zyban (Wellbutrin, Bupropion)					
Wellbutrin (Zyban, Bupropion)					
Bupropion SR (Zyban, Wellbutrin)		,			2
Face-to-face counseling					
Group counseling					
Proactive telephone counseling					
Smokeless Tobacco Coverage (chewing tobacco, snuff)					

TM #7- Smoking Cessation

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

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

Utilization of ambulatory care for Outpatient Visits.

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

PCUC	March Comment		Steer Constitution (St.)	STATISTICS AND ADDRESS OF THE PARTY OF THE P
Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the reporting period.	Q1 Jan - March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan
Number of ambulatory out patient visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				8
Rate per 1,000 member months	#DIV/0!	#DIV/0! #DIV/0!	#DIV/0! #DIV/0!	#DIV/0!

(2) quarters of the calendar year which precede the reporting period. Number of ambulatory out patient visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator) Total member months of the measurement year. Please	Q1 Jan - March	Q2 Jan - June	Jan:
Number of ambulatory out patient visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)			
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)			
	#DIV/01		#DI

Utilization of ambulatory care for ED Visits.				
2019				
Please Note: Data cannot be refreshed beyond the two (2) quarters of the calendar year which precede the		J _{an} 22	Q ₃	Q4 Jan
reporting period.	- March	Jan - June	Jan - Sept	- Dec
Number of ED visits during the measurement period.				
Please refer to relevant reporting year HEDIS Technical				
Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please				
refer to relevant reporting year HEDIS Technical				
Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0! #DIV/0! #DIV/0! #DIV/0!	#DIV/0!	#DIV/0!

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

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

#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	Rate per 1,000 member months
				Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)
				Number of ED visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)
Q4 Jar	Q3 Jan - Sept	Q2 Jan - June	Q1 Jan - March	efreshed beyond the two year which precede the eriod.
discontinue de la constitución d				2020

2022				
efreshed beyond the two /ear which precede the eriod.	Q1 Jan - March	Q2 Jan - June	Q3 Jan - Sept	Q4 - Dec
Number of ED visits during the measurement period. Please refer to relevant reporting year HEDIS Technical Specifications for health plans. (Numerator)				
Total member months of the measurement year. Please refer to relevant reporting year HEDIS Technical Specifications For Health Plans. (Denominator)				
Rate per 1,000 member months	#DIV/0!	#DIV/0! #DIV/0! #DIV/0! #DIV/	#DIV/0!	#DIV/
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1	No.
	IM #8 - Ambulatory
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TM #8 - Ambulatory Care	
Reporting Period	through
MCO Name	
Report Run Date	
1. Identify any changes from the previous	
reporting period, as well as trends	
identified over time.	
2. Explanation of changes (positive or	
negative).	
3. Discuss action plans implemented for	
performance improvement activities	5
addressing any negative changes.	
4. Provide additional information	
pertinent to the reporting period.	2
5. Was there a 5% or more shift in the	

8. Was there a quality check completed

the individual who validated the data 7. Please provide the name and title of

provided.

provide the name and title of the before being submitted? If so, please

individual who completed it.

6. Please provide the name and title of

the individual who populated the data

provided.

quarter? If so, what was the cause? data provided compared to the previous

LOD #22 Attachment 1 - TM #9 - Annual Dental Visit (ADV)

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

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

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

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

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

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

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

LOD #22 Attachment 1 - TM #10 - Controlling High Blood Pressure (CBP)

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

	•			
2019				
Please Note: Data cannot be refreshed beyond the two				
(2) quarters of the calendar year which precede the	Q1 Jan	Q2	Ωဒ	Q4 Jan
reporting period.	- March	Jan - June	Jan - Sept	- Dec
The member is numerator compliant if the BP is				
<140/90 mm Hg. The member is not compliant if the				
BP is ≥140/90 mm Hg, if there is no BP reading during				
the measurement year or if the reading is incomplete				
(e.g., the systolic or diastolic level is missing). If there				
are multiple BPs on the same date of service, use the				
lowest systolic and lowest diastolic BP on that date as				
the representative BP. Please refer to relevant				
reporting year HEDIS Technical Specifications for				
health plans. (Numerator)				
Medicaid Members who had at least two visits on				
different dates of service with a diagnosis of				
hypertension during the measurement year or the year				
prior to the measurement year (count services that				
occur over both years). Please refer to relevant			1	
reporting year HEDIS Technical Specifications For				
Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

are was adequately collin offed (- 1 + 0/30) dailing the illeastrement year.	Casalonici	it your.		
2020				
Please Note: Data cannot be refreshed beyond the two				
(2) quarters of the calendar year which precede the	Q1 Jan	Q2	బ్	Q4 Jan
reporting period.	- March	Jan - June	Jan - Sept	- Dec
The member is numerator compliant if the BP is				
<140/90 mm Hg. The member is not compliant if the				
BP is ≥140/90 mm Hg, if there is no BP reading during				
the measurement year or if the reading is incomplete				
(e.g., the systolic or diastolic level is missing). If there				
are multiple BPs on the same date of service, use the				
lowest systolic and lowest diastolic BP on that date as				
the representative BP. Please refer to relevant				
reporting year HEDIS Technical Specifications for				
health plans. (Numerator)				
Medicaid Members who had at least two visits on				1
different dates of service with a diagnosis of				
hypertension during the measurement year or the year				
prior to the measurement year (count services that				
occur over both years). Please refer to relevant				
reporting year HEDIS Technical Specifications For				
Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

2021 Please Note: Data cannot be refreshed beyond the two				
	Q1 Jan - March	Q2 Jan - June	Q3 Jan - Sept	Q4 Jan - Dec
The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the				
BP is ≥140/90 mm Hg, if there is no BP reading during				
the measurement year or if the reading is incomplete				
(e.g., the systolic or diastolic level is missing). If there				
lowest systolic and lowest diastolic BP on that date as				
the representative BP. Please refer to relevant				
reporting year HEDIS Technical Specifications for				
health plans. (Numerator)				
Medicaid Members who had at least two visits on				
different dates of service with a diagnosis of				
hypertension during the measurement year or the year				
prior to the measurement year (count services that				
occur over both years). Please refer to relevant				
reporting year HEDIS Technical Specifications For				
Health Plans. (Denominator)				
Percentages	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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

TM #10 - Controlling High Blood Pressure

Reporting Period	through
MCO Name	
Report Run Date	

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