



**Funding Mechanics Protocol,  
Performance Measurement Specifications, and  
Data Submission Guidelines for  
Quality Improvement Program - New Jersey (QIP-NJ)**

November 2020, v 0.1

*Prepared by Public Consulting Group*

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## Table of Contents

I. General Overview .....	5
A. Background.....	5
B. MMIS Measures – Administrative claims data.....	5
C. Non-claims-based measures: Chart / Electronic Health Records (EHR) measures .....	6
D. Non-claims-based measures: Instrument-based measures .....	6
E. Data submission procedures of non-claims-based measures .....	7
F. Reporting schedule for submission of non-claims-based measures.....	8
G. QIP-NJ Incentive Impact .....	8
H. Small Denominators .....	8
I. Payment Arrangement.....	9
i. Funds Flow .....	10
J. Sampling Methodology.....	10
i. Sample Size Calculation Examples.....	12
K. Measure Stewards and Citations .....	12
i. Measure Steward Specification Version Control.....	13
L. Data Reporting and Calculation Methods .....	14
M. Attribution Methodology Overview.....	14
i. MMIS Measures .....	15
ii. Chart / EHR Measures .....	16
N. Data Specification Conditions.....	17
i. MMIS Represented Data .....	17
ii. Performance Measure Calculation and Reporting Time Periods.....	17
iii. Eligible Population.....	17
iv. Age Criteria.....	17
v. Continuous Eligibility.....	18
vi. Coding Guidance .....	18
vii. Claim Types .....	18
O. MMIS Measure Acknowledgment Process .....	18
P. Specification Sheet Description and Definitions .....	19
II. Measurement Specifications: Behavioral Health Measure Set .....	22
A. Behavioral Health Measures Grid .....	23

Measure BH1: 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization .....	25
Measure BH2: Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge .....	28
Measure BH3: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day) .....	32
Measure BH4: Follow-Up After Emergency Department Visit for Mental Illness (FUM) (30 day) .....	36
Measure BH5: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET – I) .....	40
Measure BH6: Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET – E) .....	45
Measure BH7: Preventative Care and Screening: Screening for Depression and Follow-Up .....	52
Measure BH8: Substance Use Screening and Intervention Composite .....	55
Measure BH9: Timely Transmission of Transition Record (Behavioral Health) .....	61
Measure BH10: 3-Item Care Transitions Measure (CTM-3) .....	64
Measure BH11: Use of a Standardized Screening Tool for Social Determinants of Health .....	68
III. Measurement Specifications: Maternal Health Measure Set .....	71
A. Maternal Health Measures Grid .....	72
Measure M1: Severe Maternal Morbidity (SMM) .....	73
Measure M2: PC-02 Cesarean Birth .....	75
Measure M3: Postpartum Depression Screening (PDS-E) .....	78
Measure M4: Postpartum Care (PPC) .....	81
Measure M5: Treatment of SUD in Pregnant Women (Initiation of Alcohol and Other Drug Treatment) (IET – I) .....	84
Measure M6: Timely Transmission of Transition Record (Maternal Health) .....	89
Measure M7: Treatment of Severe Hypertension .....	92
Measure M8: 3-Item Care Transitions Measure (CTM-3) .....	96
Measure M9: Use of a Standardized Screening Tool for Social Determinants of Health .....	100
Appendix A: Value Code Sets by Measure .....	103
Measure BH1: 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization .....	104
Measure BH2: Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge ....	105
Measure BH3: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) (30 day) .....	106
Measure BH4: Follow-Up After Emergency Department Visit for Mental Illness (FUM) (30 day) .....	107
Measure BH5: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET – I) .....	108
Measure BH6: Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET – E) ....	109

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Measure BH7: Preventative Care and Screening: Screening for Depression and Follow-Up .....	110
Measure BH8: Substance Use Screening and Intervention Composite .....	111
Measure BH9: Timely Transmission of Transition Record (Behavioral Health) .....	112
Measure BH10: 3-Item Care Transitions Measure (CTM-3) .....	113
Measure BH11: Use of a Standardized Screening Tool for Social Determinants of Health .....	114
Measure M1: Severe Maternal Morbidity (SMM).....	115
Measure M2: PC-02 Cesarean Birth .....	116
Measure M3: Postpartum Depression Screening.....	117
Measure M4: Postpartum Care (PPC) .....	118
Measure M5: Treatment of SUD in Pregnant Women (Initiation of Alcohol and Other Drug Treatment) (IET – I) .....	119
Measure M6: Timely Transmission of Transition Record (Maternal Health).....	120
Measure M7: Treatment of Severe Hypertension .....	121
Measure M8: 3-Item Care Transitions Measure (CTM-3).....	122
Measure M9: Use of a Standardized Screening Tool for Social Determinants of Health .....	123

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## I. General Overview

### A. Background

The Quality Improvement Program – New Jersey (QIP-NJ) is the five-year successor program to the Delivery System Reform Incentive Payment (DSRIP) program. The primary purpose of QIP-NJ is to advance quality improvements in acute care hospitals and their Medicaid Managed Care patient population across New Jersey in the domains of Behavioral Health and Maternal Health.

The NJ Department of Health (DOH, herein referred to as the State) convened a Quality Measures Committee (QMC), comprised of experts in the fields of mental health, substance use disorder, maternal health and quality measurement, to provide on-going critical input to this program. The performance measures proposed by the State and further recommended by the QMC for inclusion in the payment arrangement are detailed within this document.

This Funding Mechanics Protocol, Performance Measurement Specifications, and Data Submission Guidelines document (herein referred to as the “Databook”) provides the submission guidelines and specifications for the QIP-NJ clinical performance measure set. This includes the measurement methodologies, standardized diagnostic coding, measure reporting requirements, and incentive payment impact weights, among other elements.

This Databook includes a total of eighteen unique QIP-NJ measures. Of these, nine measures relate specifically to Behavioral Health and seven to Maternal Health; two measures are related to these through using the attributed populations and measurement of other social care factors.

One MMIS measure is repeated within the Behavioral Health and Maternal Health measure set, BH5 – M5: Initiation of alcohol and other drug treatment. Substance use disorder (SUD) profoundly affects the two different populations; hence, this is the reason for inclusion in both domains for QIP-NJ.

In support of QIP-NJ, there are additional documents to support the Databook, including:

- Appendix A: Value Code Sets by Measure (compendium available in Excel)
- Appendix B: Excel templates for chart / EHR and instrument-based measures

These documents may also be found on the QIP-NJ Resources page:

<https://dsrip.nj.gov/Home/Resources>.

### B. MMIS Measures – Administrative claims data

The primary method to compute measure performance is through administrative claims data submitted for payment to the New Jersey Department of Medical Assistance and Human Services (DMAHS). To measure clinical performance across settings of care for the relevant population, the State, with the Centers for Medicare & Medicaid Services (CMS) approval, agree to calculate certain measures on behalf of participating hospitals.

Primarily, administrative claims data are generated from a wide array of services rendered in professional and institutional settings from various providers types. Subsequently, claims data are submitted and adjudicated within the MMIS. This information is then provided to CMS and retained in the federal

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Medicaid Statistical Information System (MSIS) data warehouse. Further, the data are copied and transferred for storage to another dedicated repository where it is transformed by a DMAHS vendor.

Patient utilization that may be used to measure quality performance are contained within administrative claims data. Primarily, this data captures the occurrence of a service (or lack thereof). Retrospective claims analysis includes those from relevant providers seen by the enrollee, not merely the hospital to whom the enrollee is attributed.

Collection of administrative claims data alone, however, may be incomplete for certain performance measures if pertinent clinical information is missing. If the clinical information is not required for processing the service payment, the data may not be submitted on the claim. Additionally, the information may not be captured during the adjudication process. Therefore, collection methods that include both analysis of claims and the review of patient medical charts is valuable in quality measurement and is paramount to realizing the objectives of QIP-NJ.

### C. Non-claims-based measures: Chart / Electronic Health Records (EHR) measures

Although historically, patient medical records have been in the form of paper records, through Meaningful Use and other endeavors, many hospitals have shifted towards widespread adoption of Electronic Health Record (EHR) systems. The evolution of digital quality measurement has afforded more seamless transfer of patient data with added benefits including increased harmonization with industry standards, less subjective interpretation, and minimized human error through automation. Irrespective of the medium and tools used, medical record review and abstraction requires the retrospective collection of information from patient charts.

Hospitals may find that performing queries of their EHR system more efficiently and robustly identifies patients that meet, or do not meet, measure criteria. Depending upon how the given EHR system is setup and governed, however, data elements may not be required for certain fields or modules. Moreover, valuable data may be within an unstructured format (e.g. contained within medical notes). Understandably, this may be challenging to abstract without using advanced programming techniques, such as natural language processing.

Hence, hospitals may rely on multiple sources and methods for searching and obtaining data, including an EHR systems solution in combination with chart review and abstraction. For example, a query may first be run to identify whether patients meet specific measure criteria. Subsequently, a chart audit may be used to further locate additional documented data points not captured within the query as necessary.

Understandably, the process may be resource intensive on several levels. To mitigate this concern and where applicable by measure, statistically valid sampling procedures (section “Sampling Methodology”) to find representative patient cases will be accepted for QIP-NJ.

### D. Non-claims-based measures: Instrument-based measures

Two instrument-based measures are included for QIP-NJ in Year 1. Each will be used to collect data specific to the behavioral health and maternal health populations attributed to a hospital. Per processes described in section “Data Submission of Non-claims-based measures”, data will be validated and summarized.

Measure #	Measure Name and NQF #	Measure Steward	State Baseline	VBP Reporting Years <sup>1</sup>
BH10	3-Item Care Transitions Measure (CTM-3) - NQF #0228	University of Colorado Denver Anschutz Medical Campus	N/A	Reporting only
BH11	Use of a Standardized Screening Tool for Social Determinants of Health (4 Domains)	The State of New Jersey	N/A	Reporting only
M8	3-Item Care Transitions Measure (CTM-3) – NQF #0228	University of Colorado Denver Anschutz Medical Campus	N/A	Reporting only
M9	Use of a Standardized Screening Tool for Social Determinants of Health (5 Domains)	The State of New Jersey	N/A	Reporting only

## E. Data submission procedures of non-claims-based measures

Ensuring that all teams are empowered and supported at every step of data management is critical to QIP-NJ's success. The provided data file format and submission instructions for chart / EHR and instrument-based measures are to be used as a guideline for creating a delimited flat file from the hospital's EHR(s). The requested files will be preferably pipe-delimited, "|", to allow for other delimiter values that may be inherent in collected data such as commas and dashes.

If this method will be employed by the respective hospital's information technology team, engagement of intent to participate at least two months (60 business days) prior to the submission deadline is necessary. This commitment will require the team's attendance at a brief virtual information session, which will include designating a primary point of contact, discussion of procurement of a test file through a secure file transfer process (SFTP), instruction around the validation process, and the resubmission process of rectifying any errors prior to creation of the final production file.

Additionally, there may be supplemental data elements that the team agrees will be pertinent to capture in the file that may need to be mapped to standardized codes from "homegrown" or other non-standard codes. Gathered from each entity, this will be documented and shared with the State and a final decision will be made in advance of procuring the test file. A data dictionary, among other tools and guidance documentation, will be provided for each applicable measure.

If provision of a flat file is not feasible, the data must be entered, either manually or via export, into the Microsoft Excel templates provided. These templates are formatted accordingly and have applicable lookup values (e.g. diagnostic codes) and required formatting per measure. As with the flat file, there may

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<sup>1</sup> See Section "Reporting schedule for submission of non-claims-based measures" for detailed breakdown

be supplemental data elements that the team agrees will be pertinent to capture in the file that may need to be mapped. If desired, technological consulting sessions may be conducted for this method as well along the same timeline as pertaining to the flat files. More information will be forthcoming several months in advance of the submission deadline.

All data collected will undergo a preliminary validation before being imported into a repository where programming scripts will be further executed upon it to verify accuracy. Subsequently, a summary report will be generated for each file reflecting any errors or incomplete sections that must be fixed by the hospital prior to further analysis. Payment is contingent upon fully following and executing all submission guidelines.

Questions regarding the submission process may be forwarded to [QIP-NJ@pcgus.com](mailto:QIP-NJ@pcgus.com).

#### F. Reporting schedule for submission of non-claims-based measures

DY	Submission Type	Measurement Period	Submission Deadline <sup>2</sup>
Baseline (Y0)	Baseline	7/1/2020 – 12/31/2020	08/01/2021
Y1	Full Year Early Submission	7/1/2021 – 9/31/2021	TBD
	Full Year for Payment	7/1/2021 – 12/31/2021	TBD
Y2	Midyear Checkpoint	1/1/2022 – 6/31/2022	TBD
	Full Year for Payment	1/1/2022 – 12/31/2022	TBD
Y3	Midyear Checkpoint	1/1/2023 – 6/30/2023	TBD
	Full Year for Payment	1/1/2023 – 12/31/2023	TBD
Y4	Midyear Checkpoint	1/1/2024 – 6/30/2024	TBD
	Full Year for Payment	1/1/2024 – 12/31/2024	TBD
Y5	Midyear Checkpoint	1/1/2025 – 6/30/2025	TBD
	Full Year for Payment	1/1/2025 – 12/31/2025	TBD

Mid-year submissions are required for the claims-based Behavioral Health measures but will not drive payment.

#### G. QIP-NJ Incentive Impact

The impact weights are included within the Behavioral Health and Maternal Health measures grid. As noted, the instrument-based measures are reporting only during Year 1. Detail on the mechanics surrounding payment are detailed (section “Payment Arrangement”).

#### H. Small Denominators

a. MMIS - Regardless of the volume of patients identified in the denominator, the results will be reported on behalf of the hospital. However, for hospitals with a denominator less than 30, this measure will not be included for payment calculation. Accordingly, the weights of the other measures in this measure set will be adjusted.

b. Chart / EHR measures - If a measure has a denominator that is less than allowed by the applicable sampling table, the entire population is to be reported and sampling will not apply.

<sup>2</sup> Note that these dates are tentative and subject to change prior to the beginning of QIP-NJ  
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## I. Payment Arrangement

The amount of payment to each hospital would be based on two factors:

*For behavioral health:*

- 1) The number of Medicaid Managed Care enrolled individuals with a behavioral health diagnosis who received services from the hospital in the measurement period, and
- 2) Meeting state-set targets on the behavioral health provider performance measures.

*For maternal health:*

- 1) The number of Medicaid Managed Care enrolled individuals who delivered in the hospital during the measurement period, and
- 2) Meeting state-set targets on the maternal health provider performance measures.

To determine each hospital's payment, the State would generate a roster of Medicaid Managed Care enrolled individuals attributed to each hospital in the measurement period.

The State will calculate the proportion of the attributed individuals served by each hospital out of the total attributed individuals served by hospitals eligible for funding. Each hospital would be eligible for this proportional share of funding out of the total pool, if they meet all their measurement targets as described below.

The state would then review the hospital performance on selected metrics for the attributed population. For each metric there would be a hospital-specific target set using the "gap to goal" methodology and a statewide goal. Performance would be measured for each hospital utilizing MMIS claims data, or hospital reported data.

For each measure on which the hospital meets their individual "gap to goal" target or the statewide target, the hospital would earn a portion of their funding as determined by their attribution. If the hospital fails to meet their "gap to goal" target on any or all measures, their payment would be reduced according to the number of measures for which they did not meet the measure(s) "gap to goal" target(s). In addition, if a hospital fails to submit the necessary data to calculate performance on non-claims-based measures, the hospital will forfeit its opportunity to earn any funding, regardless of measure. Partial funding would not be awarded for partial achievement of the hospital's "gap to goal" target.

In the event a hospital has a denominator too small to be significant on a given measure, the measure would not be considered towards the overall performance of the hospital, and the Target Funding would be spread across the remaining measures. Where the measure requires hospital submission of data, submission would still be required, but with no impact on the performance calculation for incentive funds.

Hospitals meeting or exceeding their individual target may be eligible to receive additional funding from the pool of undistributed funds generated by hospitals that did not meet required performance targets. The State will assign the portion of undistributed funds for each measure. Hospitals meeting or exceeding their individual target on that measure will receive a share of the unearned funds allocated to that measure, based on their share of attribution for the behavioral health and maternal health populations. If on any measure more than 85% of hospitals fail to meet the "gap to goal" target, no redistribution funds

will be tied to that measure for the given measurement year and the funds would be divided across the remaining measures.

#### i. Funds Flow

The State will fund the Quality Improvement Program-New Jersey (QIP-NJ) through a funding pool in the rate certification to be allocated across impacted rate cells after the close of the rating period as described in the 2020-2021 rate development guide.

The State will use MMIS data to determine amounts to be paid to individual hospitals after the close of the rating period based on the volume of Medicaid Managed Care enrollees in the focus populations attributed to the hospital, and the hospital's performance on program measures and any related redistribution earnings.

The State will use the same MMIS data to allocate the hospital specific payment amounts into rate cells and federal funding groups: Expansion, Title XXI and non-Expansion Title XIX.

The State will provide the full funding for the QIP program through financial transactions to the MCOs after the close of the rating period. The Funding will be provided to each MCO based on the allocation of total incentives earned by each hospital across each MCO with which that hospital has a contract. Such allocation will be proportional to the volume of total payments by each MCO to the hospital during the rating period. The MCOs will be required to disburse annual lump sum payments to the hospitals in accordance with the Managed Care contract.

The State will provide a directed payment schedule to each of the MCOs which shows the payments due to each hospital based on the hospital's performance. In following the proportional algorithm mentioned above, there may be occasions in which a hospital will receive the total sum of their earned incentive payment from more than one MCO.

All hospitals will be required to report on non-claims-based measures to receive funding under this program. If a hospital fails to submit the necessary data to the State to support analysis on the non-claims-based measures, the hospital will forfeit its opportunity to earn funds through performance on State calculated claims-based measures under this preprint.

#### J. Sampling Methodology

For several chart / EHR and instrument-based measures, a random sample is permitted for the following six unique measures:

Measure #	Measure Name and NQF #	Measure Steward	Data Source
BH7	Preventative Care and Screening: Screening for Depression and Follow-Up	CMS	Chart/EHR
BH8	Substance Use Screening and Intervention Composite – NQF #2597	ASAM	Chart/EHR

BH9	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR
BH10	3-Item Care Transitions Measure (CTM-3) - NQF #0228	University of Colorado Denver Anschutz Medical Campus	Instrument-Based
BH11	Use of a Standardized Screening Tool for Social Determinants of Health (4 Domains) – N/A	TBD	Instrument-Based
M2	PC-02 Cesarean Birth - NQF #0471	Joint Commission	Chart/EHR
M8	3-Item Care Transitions Measure (CTM-3) – NQF #0228	University of Colorado Denver Anschutz Medical Campus	Instrument-Based
M9	Use of a Standardized Screening Tool for Social Determinants of Health (5 Domains) - N/A	TBD	Instrument-Based

Hospitals choosing to sample for measures must ensure that the initial total patient population and sample size meet the conditions stated. As the case volume and mix will differ with respect to a given hospital, each will be required to summarize the steps taken to ensure that a representative random sample was generated as part of the data submission process.

The initial total patient population is based upon the average monthly volume of patients. The interpretation of what constitutes the initial population, however, differs between the Behavioral Health and the Maternal Health population. For the Behavioral Health population, this is based upon the total unique number of Medicaid Managed Care patients in the attributed population seen for an encounter at the setting appropriate to the measure. For the Maternal Health population, the initial patient population includes the total unique number of Medicaid Managed Care patients admitted to the hospital for inpatient acute care associated with deliveries.

*Table: Sample Size Calculation*

Initial Total Patient Population Size (Denominator)	Calculated Minimum Random Sample Size
>= 501	101
126 – 500	20% of the population
30 – 125	30
< 30	No sampling permitted. 100% of the patient population meeting the measure criteria must be reported.

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#### i. Sample Size Calculation Examples

- A hospital's behavioral health Initial Total Patient eligible for depression screening is 700 patients during the calendar year. Using the above table, 101 patients may be sampled.
- A hospital's maternal health Initial Total Patient eligible for survey is 400 patients during the calendar year. Using the above table,  $400 * (0.20) = 80$  patients may be sampled.
- A hospital's behavioral health Initial Total Patient eligible for depression screening is 43 patients during the calendar year. Using the above table, 30 patients may be sampled.
- A hospital's maternal health Initial Total Patient eligible for survey is 20 patients during the calendar year. Using the above table, 100% of the patient population must be reported; therefore, no sampling is permitted.

#### K. Measure Stewards and Citations

The QIP-NJ performance measures were selected based upon their endorsement by respected national health care and policy bodies as well as their expertise in comparing quality performance. The entity that developed the given specification is referred to as the measure steward and acts as the "owner" of the measure, responsible for any modifications. Respective measure descriptions are made available to the public and include such data elements as the numerator, denominator, and exclusions, among other pertinent items.

National endorsement allows for open replication of the measure for comparative purposes by other health care entities provided that the required citations are met. The measure steward is identified for each measure along with respective hyperlinks under each measure to review detail and change history. Wherever possible, the value sets are noted and are contained in Appendix A.

The measure stewards that are represented within the first year of QIP-NJ and their respective citations include:

1. Alliance for Innovation on Maternal Health (AIM)
  - Measure content sources include the AIM SMM Codes List and literature pertaining to severe hypertension during pregnancy and the postpartum period. AIM has neither reviewed nor approved the modified measure.
2. American Medical Association – Physician Consortium for Performance Improvement (AMA-PCPI)
  - Measure content has been sourced from PCPI®; PCPI® has neither reviewed nor approved the modified measure. Although PCPI® has ceased operations as of July 2020, measurement resources will be housed at the American College of Physicians beginning in November 2020.
3. American Society of Addiction Medicine (ASAM)
  - Measure content has been sourced from ASAM. ASAM has neither reviewed nor approved the modified measure.
4. Centers for Medicare & Medicaid Services (CMS)
  - Measure content has been sourced from CMS. CMS has neither reviewed nor approved the modified measure.
5. The Joint Commission

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- The Specifications Manual for National Inpatient Quality Measures is the collaborative work of the Centers for Medicare & Medicaid Services and The Joint Commission. The Specifications Manual is periodically updated by CMS and The Joint Commission. Users of the Specifications Manual for National Hospital Inpatient Quality Measures must update their software and associated documentation based on the published manual production timelines.
6. National Committee for Quality Assurance (NCQA)
    - Measure content has been sourced from the HEDIS, Volume 2, Technical Specifications for Health Plans by the National Committee for Quality Assurance (NCQA) and modified by QIP-NJ program. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA has neither reviewed nor approved these modified measures.
  7. The State of New Jersey (TBD SDOH tool)
  8. University of Colorado Denver Anschutz Medical Campus
    - Measure content has been sourced from University of Colorado Denver Anschutz Medical Campus; the University has neither reviewed nor approved this modified measure.

#### i. Measure Steward Specification Version Control

Generally, the measure steward's specifications have been adhered to within the Databook. In some instances, however, it has been necessary to adjust the measure stewards' specifications to better align with the goals, and populations (e.g. measurement periods, age requirements) of QIP-NJ.

Where applicable, major deviations from the original specifications are indicated in addition to the reason for the change in the respective section "Measure Specifications". Measure specifications and referenced code sets have been updated to reflect the latest documentation though these may be further updated prior to the start of the respective year of QIP-NJ. Therefore, the accompanying hyperlinks within these respective sections may be used to obtain additional information regarding the original measure specification.

As each measure steward is responsible for the maintenance of the measure(s) they develop, each steward may follow different maintenance schedules. To ensure consistent usage by QIP-NJ providers, the State will evaluate the most recent finalized version made publicly available prior to October 15 of each calendar year.

Following, a determination will be made whether the newest version will be adopted. As necessary, the Databook will be updated, clearly indicating whether the newer or older version is to be followed. When an update from a measure steward would significantly change the results of a measure for which baselines were set, the original version of the measure specification will be maintained for the duration of QIP-NJ.

Especially during the first year of QIP-NJ, continual assessment of hospital data collected and frequent touchpoints with stakeholders, will inform decision-making regarding the measures' status. This includes whether the current measures' specifications, benchmarks, and payment structure require modifications. Additionally, whether measures will be added into (or subtracted from) the two domains will be codified.

The State will set the benchmarks for each hospital after the baseline is calculated for Year 1, or after previous year performance is calculated for subsequent years. The State reserves the right to adjust

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elements of the measurement specifications and the statewide benchmark based on performance prior to the start of the next measurement period.

## L. Data Reporting and Calculation Methods

As discussed in Section “Data Submission Procedures of non-claims-based measures”, QIP-NJ allows for multiple data collection methods to ensure broad and deep performance measurement. This section describes a high-level overview for each calculation methodology as it applies to QIP-NJ and the anticipated collection steps by hospitals. QIP-NJ participating patients will be assigned to a hospital based on an attribution algorithm (Section “Attribution Methodology Overview”).

## M. Attribution Methodology Overview

At the close of each measurement period, the DMAHS vendor will extract claims data for the attributable population, allowing for three months of claims aging.

The DMAHS vendor will conduct attribution using the below protocol:

Attribution for the maternal health population will be determined by the hospital at which the birth occurs.

Attribution of the behavioral health population will be determined as follows:

- For members who have three or more outpatient behavioral health claims during the measurement year, AND two or more outpatient behavioral health claims with a single hospital, the member will be attributed to the hospital with the majority of the member’s outpatient behavioral health claims.
- For members not attributed through the above, who have three or more outpatient physical health claims during the measurement year, AND two or more outpatient physical health claims with a single hospital, the member will be attributed to the hospital with the majority of the member’s outpatient physical health claims.
- For members not attributed through the above, who have three or more emergency department claims during the measurement year, AND two or more emergency department claims with a single hospital, the member will be attributed to the hospital with the majority of the member’s emergency claims.
- For members not attributed through the above, if the member has any inpatient claims (Maternity, Psychiatric or Med/Surgery), the member will be attributed to the hospital with the majority of the member’s inpatient claims.
- If above criteria not met, member will not be attributed.

Where two hospitals have the same volume of claims in any category above, the most recent visit of that type will be used as a tiebreaker.

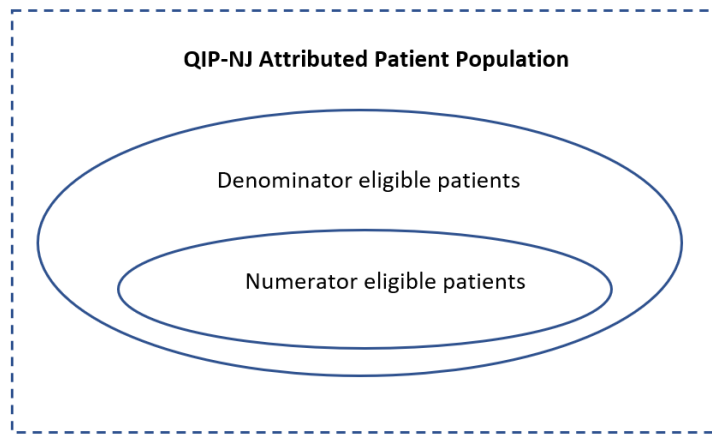
Attribution results will be delivered to the independent assessor (PCG), where the member assignment rosters will be reviewed for:

- Review of aggregate attributable population over projections/baseline
- Growth or loss in volume over baseline for each hospital
- Any change of more than 10% will trigger notice to the State and a data integrity review
- Churn within a hospital’s attributed population (not applicable to baseline)

- This information may be used as a hospital stratification criterion as part of our program evaluation design.

#### i. MMIS Measures

The steps that follow describe the process that the State will take on the behalf of hospitals to calculate measures that utilize MMIS data.



Step 1: The State identifies the hospital-specific attributed patient population.

For each MMIS-calculated measure the first step is to capture the attributed patients for the hospital for which the measure is being run.

Step 2: Of those attributed patients, the State identifies the patients that meet the denominator (D) criteria.

Step 3: Of those denominator patients, the State identifies the patients that meet the numerator (N) criteria.

Step 4: The State computes the result.

$$\text{Result} = \frac{\text{Numerator}}{\text{Denominator}}$$

Performance measures from a variety of care settings are represented within the QIP-NJ measure set. Examples are provided below. The setting of care for each measure is indicated on the QIP-NJ specification sheet.

- Inpatient or Emergency Department Setting – refers to any MMIS measure that only considers care that was provided within the inpatient or emergency department setting. This could be monitoring a single episode of care or comparing care across inpatient or emergency department events.
- Outpatient Setting – refers to any MMIS measure that only considers care that was provided in an outpatient setting (e.g. hospital-based clinic, primary care office, Federally Qualified Health Center)

(FQHC), behavioral health clinic). This could be monitoring care for a single date of service or comparing care across multiple outpatient visits.

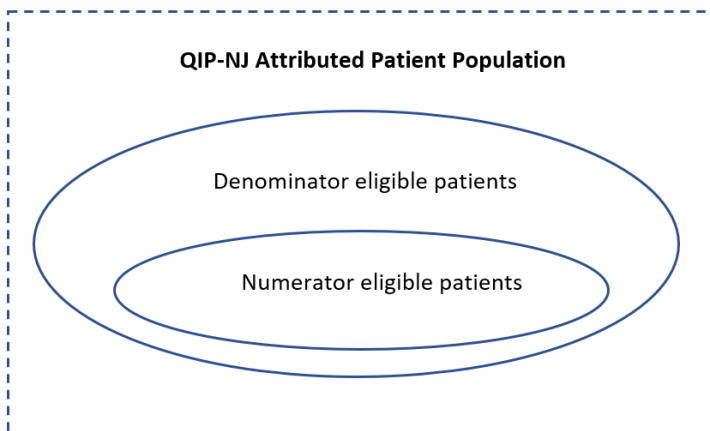
- c. Multi-Setting – refers to any MMIS measure that considers care received in multiple settings of care. This may compare care across multiple service events, or to capture diagnosis and/or procedure codes to reflect patient treatment history. Comparing care across settings can determine if the expected coordination or follow-up care took place between settings.

## ii. Chart / EHR Measures

In this section, the steps that follow describe the process that the hospital will take to sample (where applicable), abstract and calculate measures that utilize chart / EHR collected data.

In addition to the steps highlighted below, hospitals will need to complete a supplemental template or provide a flat file containing patient level information including, but not limited to, Medicaid ID, member name, date of birth, inclusion in the numerator and denominator of each measure. Hospitals must also retain copies of any reports that they and their consulting partners generate to calculate chart/EHR measures in case of audit.

The following graphic represents data that is limited to the hospital's data only.



Step 1: The hospital receives the final retrospective attributed patient population list from the State.

Step 2: The hospital runs a query of their EHR system limited to searching for information about the attributed patient population only. This query always first includes looking for the measure-specific denominator (D) criteria as outlined in the QIP-NJ specification sheet and detailed by the measure steward specifications. The result is referred to as the Initial Total Patient.

Step 3: The hospital compares the initial patient total to the sampling tables to determine the number of patient records that must be abstracted (refer to Section “Sampling Methodology” for information).

Step 4: The hospital runs a standard random sampling query to select the specific patient records for abstraction.

Step 5: The hospital staff reviews the sampled patient records to determine if the numerator (N) criteria have been met.



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Step 6: The hospital enters the initial patient total, numerator and denominator values into the template or flat file. Formulas within the workbook will automatically calculate the result.

## N. Data Specification Conditions

### i. MMIS Represented Data

The data that are made available for performance measurement includes paid Medicaid claims, both fee-for-service and managed care encounter claims.

### ii. Performance Measure Calculation and Reporting Time Periods

Hospitals shall adhere to the measurement periods identified in the specifications for each measure. There are several time periods that affect performance measures to be aware of and are defined below. These will be updated for each reporting year (only Y1 are currently displayed).

- a. Look-back Period – Some measures are indexed to a specific date or event (e.g. index date), such as a hospital admission or discharge, where the measure requires that a certain diagnosis be present within a defined prior period to the index event for the patient to be included in the population. This prior period is referred to as the look-back period.
- b. Performance Period –The experience period, otherwise referred to as the measurement period, indicates the specific duration of time in which the dates of service must take place in order to be considered for the measure.
- c. Reporting Period – The time-period for which the measure must be reported. QIP-NJ measures must be reported annually, unless otherwise specified. Each measure specification sheet indicates the reporting period, as well as when the report is due to be reported by, or on the behalf of, the hospital.
- d. Baseline Period – The time-period for which the first measurement will be computed. Future performance will then be compared against the baseline period. Each measure specification sheet indicates the baseline period. For MMIS measures, 2020 data will be utilized to set the measures' QIP-NJ improvement target goal (ITG) in later years. The baseline period for the majority of chart/EHR measures will utilize 2020 abstracted data unless otherwise noted.

### iii. Eligible Population

The eligible population for QIP-NJ includes all Medicaid Managed Care enrolled individuals meeting the population criteria for Maternal and or Behavioral Health. For all measures, the eligible population is assigned to a hospital based on the attribution model discussed in section "Attribution Methodology Overview". The denominator population is identified as a sub-set of these assigned patients based upon meeting each measure's specific denominator criteria. Certain measures have specific requirements surrounding continuous enrollment during the performance period. Continuous enrollment means that members are enrolled in health coverage with minimal gaps to keep them in the respective measurement cohorts.

### iv. Age Criteria

The age criterion is specific to each measure. Generally, adults 18 years and older are indicated, which often have been modified from the original specifications (and noted as such). The age may be calculated as of the last day of the measurement period or the date of the service relative to the member's date of birth, depending on the particulars of the specific measure.

- a. Age Stratifications – Measure results can be categorized into population age ranges to drill down on clinical care outcomes for various age groups. The measure steward’s age stratifications were followed unless the age ranges were considered too narrow or too broad to effectively capture QIP-NJ population health results.
- b. Pay for Performance (P4P) – When there are age stratifications, the age stratification that applies to P4P incentive payments will be the “Total” age group unless otherwise indicated.

#### v. Continuous Eligibility

The duration of time that a patient is eligible for benefits to be included in the measure denominator. The specifications provide the continuous enrollment requirement (if relevant), for each measure.

#### vi. Coding Guidance

- a. Code Specificity – Appendix A has been updated to include Value Sets with the highest degree of specificity and should be utilized when determining measure results. To reduce the size of the Databook, the code tables within the measure specifications have been changed to code ranges where possible or are cited by name only.
- b. Code Table Versions – National codes provided have been updated to the latest versions available. ICD-10 codes have been added alongside ICD-9 codes when provided by the measure steward. For measures that have not been updated, ICD-10 codes were mapped (forward only from ICD 9 to 10) using the AHRQ Map IT 2015 tool: <http://www.qualityindicators.ahrq.gov/resources/Toolkits.aspx>. Therefore, measure stewards that have utilized older versions will reflect updated codes. However, unless accounting for exclusions that may have extensive lookback periods, it is doubtful there will be many ICD-9 code claim submissions (if there is, this should trigger an internal review).
- c. Code Use — Please note that the codes provided in the Databook are for quality analysis purposes only. These codes are published by the respective national measure stewards to determine measure results but may not reflect the care or billing practices of your organization.

#### vii. Claim Types

For both paper and electronic claim formats, the determination of what constitutes a claim is defined by National Billing Committees. Generalized guidelines are required on each claim to identify the type of service or Type of Bill represented by the submitted data. Certain bill types are designated by required data components which are utilized for the adjudication of the submitted claim, while other data components may be provided as a means of additional information only. The data elements required by the New Jersey Medicaid claim processing were identified through billing supplements and training documents located within the NJMMIS website.

### O. MMIS Measure Acknowledgment Process

The MMIS data measure results computed on behalf of the hospitals will be made available to hospitals for viewing based on the reporting periods indicated in the measure specification. The hospitals will be provided the opportunity to view and export the final numerator, denominator, and computed results.

Hospitals are required to provide acknowledgement to the State in accordance with the QIP-NJ MMIS measures timelines that they have received and reviewed their measure numerators, denominators, and

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calculated results. Hospitals will be able to access these files on the QIP-NJ SFTP (<https://sftphealth.pcgus.com/>) with their specific hospital log in. An acknowledgement process will be administered and shared with hospitals once these files are ready for their review.

## P. Specification Sheet Description and Definitions

Each measure specification sheet is divided into four major sections.

1. The opening section provides high level references including the measure title, QIP-NJ number, measure description, data source, National Quality Forum (NQF) number (if applicable), the measure steward and measure steward version (if applicable).
2. The second section is labeled the “Measure Calculation Description.” This section provides the primary information required to calculate the measure including the numerator, denominator, result information and any qualifications to the criteria that provide additional information.
3. The third section is labeled “Measure Collection Description” and provides fields related to the collection process for example the setting of care, reporting parameters and whether sampling, continuous eligibility or risk adjustment applies to the measure. This section will also include the improvement target goal details (not included for Year 1). “Data Elements” flags key variables to note in the collection process.
4. The final section is labeled “QIP-NJ Incentive Impact” and identifies the financial incentive award as either non-payment or pay for performance (P4P).

The following fields, as defined here, are included in the measure specifications sheets. The possible field entries are indicated.

- Measure and designated domain / number – provides the name of the measure, the domain, and the respective measure number.
- Measure Description – provides a short explanation of the purpose of the measure.
- Data Source – indicates the method of the data collection.
  - MMIS
  - Chart/EHR
  - Instrument-based
- NQF# – the National Quality Forum (NQF) is a non-profit organization that endorses and publicly reports health care quality measure specifications. If the NQF has endorsed a measure, the NQF is provided to assist the hospital in determining whether the hospital currently collects and reports the measure for other programs.
- Measure Steward – the measure steward is the entity that developed and maintains the original measure specifications. This information is provided to assist the hospital in determining whether the hospital currently collects and reports the measure for other programs. The measure steward provides the detailed specification information regarding the measure that should be reviewed to support the hospital’s measurement processes.
- Measure Steward Version – through the measure maintenance process, measure specifications are adjusted and refined based on the most currently available clinical and technical information. This results in different specification versions in use for the same measure. To ensure that hospitals can compare the QIP-NJ measure specification to the measure steward’s version, the version number

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is provided. When codes were referenced from multiple versions of the measure, the source for each code type is noted.

- Numerator – defines the specific criteria that identifies the portion of the patient population that meet the specific performance measurement.
- Denominator – defines the general criteria which identifies the patient population eligible for measurement.
- Result – the calculated performance. This can be expressed as either a rate or percentage.
- Percentage – an indicator of healthcare to monitor measure compliance. A percentage measures the number of a certain set of events that are proportional to one another. The numerator and denominator are the same unit of measurement and the numerator is a subset of the denominator.
- Rate – this is a specific kind of ratio, in which two measurements are related to each other but do not utilize the same unit of measurement. The numerator is not a subset of the denominator when a rate is calculated. A rate measures the number of events compared to another unit of measurement, for example the utilization per member months.
- Setting of Care – this field lists where the service(s) was rendered and helps identify which provider type has the information available.
- Inpatient or Emergency Department Setting – this refers to any measure that only considers care that was provided within the inpatient or emergency department setting and is information available to the hospital.
- Outpatient Setting – this refers to any measure that only considers care that was provided in an outpatient setting. This information may be available at the hospital-based clinic if the service is offered.
- Multi-Setting – this refers to any MMIS or EHR measure that considers care that was received across multiple care settings.
- Measure Qualifications – this field allows for additional information to be included in the measure specification. This may include such information as links to the measure steward, references to usage of the measure in other data sets, or it may indicate where the original specification was adjusted to more accurately follow the objectives of the QIP-NJ program (e.g. changes to measure stratifications).
- Measurement Period – this field, otherwise known as the performance period, indicates the specific interval of time that a service must take place within to be considered to meet the measure criteria.
- Calendar year – Annual QIP-NJ measurement will be based on the calendar year as compared to the federal fiscal year or state fiscal year as some measure sets allow.
- Baseline Period – this is the time period for which the first measurement will be reported and subsequent performance measured against. Each measure's data source and experience period will impact the baseline period. The MMIS baseline period will initially be 2020 to set the overall measure improvement target goal (ITG).
- Claim Type(s) – the claim type represents required data components utilized for the adjudication of a claim for payment. The New Jersey claim type values that were used for programming the MMIS measures are identified for each MMIS measure.
- Continuous Eligibility – this field indicates whether continuous eligibility applies to the measure. If it does not, N/A will be marked.

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- Risk Adjustment – this field indicates whether risk adjustment applies to the measure. If it does not, NA will be marked.
  - Sampling – this field indicates whether sampling applies to the measure. If it does not, NA will be marked.
  - Continuous Eligibility/ Risk Adjustment/ Sampling Methodology – this field provides instructions if any of these elements apply to the measure.
  - Data Elements – The Data Elements section of some of the chart-based measures is designed to be a starting point for data collection from the medical chart and/or EHR. As it may not be inclusive of every item needed to report the measure accurately and completely, a thorough study of the measure’s numerator and denominator, inclusion and exclusion criteria and collection procedures will be required to determine all of the data elements needed from the medical chart or the EHR.

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## II. Measurement Specifications: Behavioral Health Measure Set

## A. Behavioral Health Measures Grid

Measure #	Measure Name and NQF #	Measure Steward	Data Source	State Baseline	VBP Reporting Years	Measure Weight
BH1	30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization- NQF #2860	CMS	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	11.11%
BH2	Follow-Up After Hospitalization for Mental Illness –30-days Post Discharge- NQF #0576	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	11.11%
BH3	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day) – NQF #3488	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	11.11%
BH4	Follow-Up After Emergency Department Visit for Mental Illness (30 day)– NQF #3489	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	11.11%
BH5	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment – NQF #0004	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	11.11%
BH6	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - NQF #0004	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	11.11%
BH7	Preventative Care and Screening: Screening for Depression and Follow-Up – N/A	CMS	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Pay-for-performance in all years (1-5)	11.11%

BH8	Substance Use Screening and Intervention Composite – NQF #2597	ASAM	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Pay-for-performance in all years (1-5)	11.11%
BH9	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Pay-for-performance in all years (1-5)	11.11%



## Measure BH1: 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization

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### Measure Description:

This measure calculates an unplanned, 30-day readmission rate for adult patients 18 years and older with a principal discharge diagnosis of a psychiatric disorder within a twelve-month period.

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### Data Source:

**MMIS**

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### NQF #:

**Based on 2860**

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### Measure Steward:

**Centers for Medicare & Medicaid Services (CMS)**

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### Measure Steward Version:

**June 12, 2019**

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### Statewide Target:

**25%**

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### **Numerator:**

A readmission is defined as any unplanned admission to an inpatient facility (IPF) or an acute care hospital (ACH). It must occur within 3 to 30 days after the index discharge date from the eligible index admission date that had the principal discharge diagnosis of a psychiatric disorder (Table BH01\_00). Subsequent admissions on Days 0, 1, and 2 are not counted as readmissions due to transfers/interrupted stay policy.

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### **Denominator:**

Of the hospital's attributed behavioral health population, individuals discharged from an inpatient admission with a principal diagnosis of a psychiatric disorder.

*Note: The Clinical Classifications Software (CCS) has been developed by the Agency for Healthcare Research and Quality (AHRQ) to identify populations for procedure-specific studies. A crosswalk to ICD-10-CM codes is available in the accompanying VSD Appendix.*

This process defines planned readmissions from the CMS 30-day HWR Measure Planned Readmission Algorithm, version 4.0 ([https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/Hospital-Wide-All-Cause-Readmission-Updates.zip/Version6.0 Readmission Hospital-Wide Measure Updates Report 3-28-2017.pdf](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/Hospital-Wide-All-Cause-Readmission-Updates.zip/Version6.0%20Readmission%20Hospital-Wide%20Measure%20Updates%20Report%203-28-2017.pdf)). The implemented algorithm distinguishes two approaches that are used to identify planned readmissions.

For purposes of streamlining this measure, however, only "unplanned" readmissions (as observed counts) are factored into calculating the readmission rate. "Planned" (Tables BH01\_01, BH01\_02) and "potentially planned" (Table BH01\_03) readmissions are considered "exclusions". Therefore, to determine an unplanned readmission, the diagnosis or procedure must not specifically be listed within procedures or diagnoses listed within the tables.

### **Exclusions:**

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The denominator excludes admissions for patients:

- “Planned” and “potentially planned” readmission diagnoses and procedures as well as readmission for acute or complication of care associated with the discharge diagnosis (Table BH01\_04) \*
- Discharged against medical advice (AMA)
- With unreliable data (e.g. has a death date but also admissions afterwards)
- Missing age or gender
- With a subsequent admission on day of discharge and following 2 days (transfers/interrupted stay period)

\*A readmission includes procedures or diagnoses that are always “planned”, such as:

- Transplant surgery,
- Maintenance chemotherapy/radiotherapy/immunotherapy,
- Rehabilitation, and
- Forceps delivery (Tables BH01\_01, BH01\_02).

A readmission includes procedures that are potentially planned, e.g., colorectal resection or aortic resection (Table BH01\_03). The procedures are considered planned if they do not coincide with a principal discharge diagnosis of a psychiatric illness or complication that might necessitate the procedure (Table BH01\_04).

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**Result:**

The result is expressed as a rate.

**Improvement Direction:**

Lower

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**Measure Qualifications:**

**Data Elements:**

- Index admission date
- Principal discharge diagnosis
- Discharge disposition status
- Readmission date
- Readmission diagnosis(es) / procedure(s)

**Measure Deviations from Original Specifications:**

- The target population was changed to Medicaid
- Dementia / Alzheimer’s disease is not included as a principal psychiatric discharge diagnosis
- The measure is not risk-adjusted based upon demographic data (e.g. gender, age) and principal diagnoses; rather, readmission rate is based upon historical claims that are categorized as unplanned
- The numerator and denominator originally stated as “a readmission within 30 days”; this was changed to exclude readmissions on days 0 through 2

- The performance period used to identify cases in the denominator is 24 months; this is shortened in the revision to accommodate QIP-NJ's timeline
- Data from 12 months prior to the start of the performance period through the performance

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- [https://www.qualityreportingcenter.com/globalassets/ipf-tools-andresources/ipf\\_cy2017\\_ipfqr\\_cbms\\_20171206\\_vfinal508.pdf](https://www.qualityreportingcenter.com/globalassets/ipf-tools-andresources/ipf_cy2017_ipfqr_cbms_20171206_vfinal508.pdf)
- <http://www.qualityforum.org/QPS/2860>

Measure Collection Description			
<u>Setting of Care:</u> <b>Inpatient</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021– December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 –December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>	
<u>Claim Type(s):</u>  <b>01, 14</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	
		<u>Sampling:</u> <b>No</b>	
<u>Continuous Eligibility / Sampling Methodology:</u> <b>The patient must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. No sampling permitted.</b>			

## Measure BH2: Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge

### Measure Description:

The percentage of discharges for patients 18 years of age and older who were hospitalized for treatment of selected mental health disorders or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge.

### Data Source:

**MMIS**

### NQF #:

**Based on 0576**

### Measure Steward:

**NCQA**

### Measure Steward Version:

**HEDIS® MY 2020 & MY 2021**

### Statewide Target:

**75%**

### Measure Calculation Description

#### **Numerator:**

Patients who received a follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occurred on the date of discharge.

Any one of the following meets the criteria for a follow up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.
- An outpatient visit (BH Outpatient Value Set) with a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider.
- An observation visit (Observation Value Set) with a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
- A telephone visit (Telephone Visits Value Set) with a mental health provider.

#### **Denominator:**

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Of the hospital's attributed population, those patients discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental illness diagnosis or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between July 1 and December 1 of the measurement year with continuous enrollment through 30 days post discharge.

To identify acute inpatient discharges:

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

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between July 1 and December 1 of the measurement year.

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Identify the admission date for the stay.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
- If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.
- If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.
- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  - Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
  - 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. The age will be calculated based on the patient's age as of the date of discharge.

#### **Exclusions:**

The following are exclusions from the denominator:

- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
- Exclude both the original and the readmission/direct transfer discharge if the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim).

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- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
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**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

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**Measure Qualifications:****Major Changes HEDIS MY 2020 and MY 2021:**

- Replaced “mental health practitioner” with “mental health provider.”
- Added to the numerator: Behavioral Healthcare Setting Value Set, Telephone Visits Value Set.
- Deleted from the numerator: Mental Health Practitioner Value Set, which removed the mental health provider requirement for follow-up visits for intensive outpatient encounters, partial hospitalizations, community mental health centers and electroconvulsive therapy settings.

**Data Elements:**

- Index admission date
- Principal discharge diagnosis
- Discharge disposition status
- Follow up visit category
- Follow up visit date
- Readmission date (if applicable)

Two age stratifications and total rate are to be reported. The total is the sum of the age stratifications.

- 18–64 years.
  - 65 years and older
  - Total
- 

**Measure Deviations from Original Specifications:**

- Although the original specification includes two rates (one for 7 day and 30 day follow-up), only the latter is considered for payment
- The performance period has been shortened to between July 1 and December 31 to align with the QIP-NJ reporting timeline

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after the ED visit).

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>
- <http://www.qualityforum.org/QPS/0576>

Measure Collection Description			
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>	
<u>Claim Type(s):</u>  <b>01, 02, 03, 04, 06, 14, 15, 18, 19</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>
Continuous Eligibility / Sampling Methodology: <b>The patient must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. No sampling permitted.</b>			

## Measure BH3: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) (30 day)

### Measure Description:

The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of alcohol or other drug dependence within 30-days of discharge (31 total days).

### Data Source:

**MMIS**

### NQF #:

**Based on 3488**

### Measure Steward:

**NCQA**

### Measure Steward Version:

**HEDIS® 2020 & MY 2021**

### Statewide Target:

**25%**

### Measure Calculation Description

#### **Numerator:**

An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence (AOD Abuse and Dependence Value Set) within 30 days (31 total days) after emergency department discharge.

A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- OUD Weekly Non-Drug Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- OUD Monthly Office Based Treatment Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- OUD Weekly Drug Treatment Service Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).



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- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

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**Denominator:**

An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between July 1 and December 1 of the measurement year where the member was 18 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between July 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

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

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

**Exclusions:**

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of alcohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.
- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility (Inpatient Stay Value Set) within the 30-day follow-up period, regardless of primary diagnosis for the admission.
- These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

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**Result:**

Percentage

**Improvement Direction:**

Higher

**Measure Qualifications:**

**Major Changes HEDIS MY 2020 and MY 2021:**

- Added to the numerator and denominator: OUD Monthly Office Based Treatment Value Set, OUD Weekly Non-Drug Service Value Set, OUD Weekly Drug Treatment Service Value Set.

**Data Elements:**

- Attributed to the BH population
- Index admission date
- Principal discharge diagnosis
- Discharge disposition status
- Follow up visit category
- Follow up visit date

**Measure Deviations from Original Specifications:**

- Two rates, one for 30 day and 7 day, are traditionally reported; only the 30 day is required.


The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>
- <http://www.qualityforum.org/QPS/3488>

Measure Collection Description			
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>	
<u>Claim Type(s):</u> <b>01, 02, 03, 04, 06, 14, 15, 18, 19</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>

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Continuous Eligibility / Sampling Methodology: The patient must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. No sampling permitted.



## Measure BH4: Follow-Up After Emergency Department Visit for Mental Illness (FUM) (30 day)

### Measure Description:

The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or intentional self-harm during the measurement year and who had a follow-up visit for mental illness 30-days of discharge (31 total days).

### Data Source:

**MMIS**

### NQF #:

**Based on 3489**

### Measure Steward:

**NCQA**

### Measure Steward Version:

**HEDIS® MY 2020 & MY 2021**

### Statewide Benchmark:

**75%**

### Measure Calculation Description

#### **Numerator:**

An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a principle diagnosis of alcohol or other drug abuse or dependence within 30 days after emergency department discharge (31 total days inclusive).

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

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**Denominator:**

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Patients who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence on or between July 1 and December 1 of the measurement year.

An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between July 1 and December 1 of the measurement year where the member was 18 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between July 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on July 1, include the July 1 visit and do not include ED visits that occur on or between July 2 and July 31; then, if applicable, include the next ED visit that occurs on or after August 1. Identify visits chronologically, including only one per 31-day period.

Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

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

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

**Exclusions:**

The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of alcohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.
- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission. These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

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**Result:**

Percentage

**Improvement Direction:**

Higher

#### Measure Qualifications:

#### Major Changes HEDIS MY 2020 and MY 2021:

- Added telephone visits, e-visits and virtual check-ins to the numerator.

#### Data Elements:

- Principal discharge diagnosis
- Discharge date
- Discharge disposition status
- Follow up visit category
- Follow up visit date
- Readmission date (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>
- <http://www.qualityforum.org/QPS/3489>

Measure Collection Description			
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>	
<u>Claim Type(s):</u>  <b>01, 02, 03, 04, 06, 14, 15, 18, 19</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>
<u>Continuous Eligibility / Sampling Methodology:</u> <b>The patient must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Following, December 1 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. No sampling permitted.</b>			

## Measure BH5: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET – I)

### Measure Description:

The percentage of patients 18 years or older with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

### Data Source:

**MMIS**

### NQF #:

**Based on 0004**

### Measure Steward:

**NCQA**

### Measure Steward Version:

**HEDIS® MY 2020 & MY 2021**

### Statewide Benchmark:

**50%**

### Measure Calculation Description

#### **Numerator:**

Patients who have Initiation of AOD treatment within 14 days of the Index Episode (IESD).

- If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.
- If the Index Episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the member is compliant.
- If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:
  - An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    - Identify the admission date for the stay.
  - IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.



- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non-Drug Service Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set).
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.
- If a member is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.
- Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

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#### **Denominator:**

Members with a new episode of AOD abuse or dependence during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator.

**Step 1:** Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:
  1. IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

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2. IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  3. IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  4. OUD Weekly Non-Drug Service Value Set with Opioid Abuse and Dependence Value Set.
  5. OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set.
  6. OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set.
- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the discharge date for the stay.
  - A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - An opioid treatment service (OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

**Step 2:** Select the Index Episode and stratify based on age and AOD diagnosis cohort.

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- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
  - If the member has a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
  - If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.

If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

**Step 3:** Test for Negative Diagnosis History. Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

**Step 4:** Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

**Exclusions:**

The following are exclusions from the denominator:

- Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

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**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

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**Measure Qualifications:**

### Major Changes HEDIS MY 2020 and MY 2021:

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the Definitions section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

### Data Elements:

- Attributed to the BH population
- Index episode
- Admission date
- Follow up visit category
- Follow up visit date

The measure steward age stratifies the results by 13-17, 18+ and a Total. Only the age stratification that includes all ages (Total) will be used for QIP-NJ. In 2018 the measure steward began stratifying by AOD diagnosis cohort, alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence and total. Payment will not be impacted by performance across these stratifications for Y1.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>
- <http://www.qualityforum.org/QPS/0004>

Measure Collection Description			
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>	
<u>Claim Type(s):</u>  <b>01, 03, 04, 14, 15, 18, 19</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>
<b>Continuous Eligibility / Sampling Methodology: Patients must be continuously enrolled without any gaps 60 days (2 months) before the Index Episode Start Date (IESD) through 48 days after the IESD. Following, November 13 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. No sampling permitted.</b>			

## Measure BH6: Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET – E)

### Measure Description:

The percentage of patients 18 years and older who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

### Data Source:

MMIS

### NQF #:

Based on 0004

### Measure Steward:

NCQA

### Measure Steward Version:

HEDIS® MY 2020 & MY 2021

### Statewide Benchmark:

20%

### Measure Calculation Description

#### Numerator:

Patients who have Engagement of AOD treatment after the initiation encounter within 34 days (total of 34 days) of the index event (IESD).

**Step 1** Identify all members compliant for the Initiation of AOD Treatment numerator.

*For members who initiated treatment via an inpatient admission, the 34-day period for engagement begins the day after discharge.*

**Step 2** Identify members who had an opioid treatment service that bills monthly (ODU Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (ODU Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

For these members, if the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), the member is numerator compliant for Engagement of AOD Treatment.

**Step 3** Identify members whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set).

These members are numerator compliant if they have two or more engagement events, where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

**Step 4** Identify the remaining members whose initiation of AOD treatment was *not* a medication treatment event (members not identified in step 3).

These members are numerator compliant if they meet *either* of the following:

- At least one engagement medication treatment event.
- At least two engagement visits.

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

**Engagement visits** Any of the following beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set **with** IET POS Group 1 Value Set **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set **with** IET POS Group 2 Value Set **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An e-visit or virtual check-in (Online Assessments Value Set) **with** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (ODU Weekly Non Drug Service Value Set).

**Engagement medication treatment events** Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was *a diagnosis of alcohol abuse or dependence* (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was *a diagnosis of opioid abuse or dependence* (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

*If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total column is not the sum of the Diagnosis columns.*

#### **Alcohol Use Disorder Treatment Medications**

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

#### **Opioid Use Disorder Treatment Medications**

Description	Prescription
Antagonist	• Naltrexone (oral and injectable)
Partial agonist	• Buprenorphine (sublingual tablet, injection, implant) • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

- For members in the “other drug abuse or dependence” cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.
- Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than treatment for an opioid use disorder; therefore, they are not included in the medication lists. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.

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### **Denominator:**

Members with a new episode of AOD abuse or dependence during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator.

**Step 1:** Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:
  - IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - OUD Weekly Non Drug Service Value Set with Opioid Abuse and Dependence Value Set.
  - OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set.
  - OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set.
- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:



1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

**Step 2:** Select the Index Episode and stratify based on age and AOD diagnosis cohort.

- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
- If the member has a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
- If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.
- If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

**Step 3:** Test for Negative Diagnosis History. Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

**Step 4:** Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

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**Exclusions:**

The following are exclusions from the denominator:

- Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

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**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

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**Measure Qualifications:****Major Changes HEDIS MY 2020 and MY 2021:**

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the Definitions section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

**Data Elements:**

- Attributed to the BH population
- Index episode
- Admission date
- Follow up visit category
- Follow up visit date

The measure steward age stratifies the results by 13-17 (N/A), 18+ and a Total. Only the age stratification that includes all ages (Total) will be used for QIP-NJ. In 2018 the measure steward began stratifying by AOD diagnosis cohort, alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence and total. Payment will not be impacted by performance across these stratifications for Y1.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>
- <http://www.qualityforum.org/QPS/0004>

Measure Collection Description			
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>	
<u>Claim Type(s):</u>  <b>01, 03, 04, 14, 15, 18, 19</b>	<b>01 – Inpatient Hospital</b> <b>02 – Long Term Care</b> <b>03 – Outpatient Hospital</b> <b>04 – Physician</b> <b>05 – Chiropractor</b> <b>06 – Home Health</b> <b>07 – Transportation</b> <b>08 – Vision</b>	<b>09 – Supplies, DME</b> <b>10 – Podiatry</b> <b>11 – Dental</b> <b>12 – Pharmacy</b> <b>13 – EPDST/Healthstart</b> <b>14 – Institutional Crossover</b> <b>15 – Professional Crossover</b>	<b>16 – Lab</b> <b>17 – Prosthetic and Orthotics</b> <b>18 – Independent Clinic</b> <b>19 – Psychologists</b> <b>21 – Optometrists</b> <b>22 – Mid Level Practitioner</b> <b>23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>
<u>Continuous Eligibility / Sampling Methodology:</u> <b>Patients must be continuously enrolled without any gaps 60 days (2 months) prior to the IESD through 47 days after the IESD (108 total days). Following, November 14 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. No sampling permitted.</b>			

## Measure BH7: Preventative Care and Screening: Screening for Depression and Follow-Up

### Measure Description:

Percentage of patients aged 18 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool and if positive, a follow-up plan is documented on the date of the eligible encounter.

### Data Source:

**Chart/HER**

### NQF #:

**Based on 0418**

### Measure Steward:

**CMS**

### Measure Steward Version:

**Feb 10, 2020**

### Statewide Benchmark:

**80%**

### Measure Calculation Description

#### **Numerator:**

Patients screened for depression (Table BH07\_01) on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool (Table BH07\_03) and, if positive, a follow-up plan is documented on the date of the eligible encounter.

#### **Approved depression screening tools:**

1. Beck Depression Inventory (BDI or BDI-II)
2. Clinically Useful Depression Outcome Scale (CUDOS)
3. Depression Scale (DEPS)
4. Hamilton Rating Scale for Depression (HAM-D)
5. Major Depression Inventory (MDI)
6. Patient Health Questionnaire (PHQ-9) and
7. PROMIS Depression Total Score (T Score)
8. Zung Self-Rating Depression Scale

*Other tools may be used only with the explicit pre-approval of NJ DOH*

**Follow-Up Plan** - Documented follow-up for a positive depression screening must include one or more of the following:

1. Additional evaluation for depression
2. Suicide Risk Assessment
3. Referral to practitioner who is qualified to diagnose and treat depression
4. Pharmacological interventions
5. Other interventions or follow-up for the diagnosis or treatment of depression

#### **Denominator:**

All patients aged 18 years and older at the beginning of the measurement period with at least one eligible encounter (Table BH07\_00) the measurement period.

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**Exclusions:**

The following are exclusions and exceptions from the denominator:

- A patient is not eligible if one or more of the following conditions (Table BH07\_02) are documented during the encounter during the measurement period:
- Patient has an active diagnosis of a disorder prior to any encounter during the measurement period

**Denominator Exceptions**

Patients with a Documented Reason for not Screening for Depression:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

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**Result:**

Percentage

**Improvement Direction:**

Higher

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**Measure Qualifications:****Data Elements**

- Screening (index) date
- Follow up date (if applicable)
- Screening tool used
- Screening tool result
- Follow up plan
- Exclusionary diagnosis or other reason (if applicable)

**Measure Deviations from Original Specifications:**

- The list of CPT codes in BH07\_00 has been shortened
- One HCPCS code from BH07\_01 has been removed
- The exclusions table (BH07\_02) has been merged from three tables into one table
- A table of LOINC codes for screening tools (BH07\_03) has been added to capture the screening tool

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ff-2020-hh-core-set-manual.pdf>
- <http://www.qualityforum.org/QPS/0418>

Measure Collection Description		
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>	<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>
<b>Continuous Eligibility / Sampling Methodology: The patient must be continuously enrolled in Medicaid for at least 90 days during the measurement year during which an outpatient visit occurred (Table BH07_00). Following, October 2 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. Sampling is permitted for this measure.</b>		

#### Data File Layout and Submission Requirements:

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple screening events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

Variable Description	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Index Date	10 Characters	YYYY/MM/DD Format
Follow Up Date	10 Characters	YYYY/MM/DD Format
Exclusionary Diagnosis	7 Characters	
CPT Code	5 Characters	
HCPCS Code	5 Characters	
LOINC Code	5 Characters	
Screening Tool Used	2 Characters	00 = Refused Further Intervention 01 = Beck Depression Inventory (BDI or BDI-II)

		02 = Center for Epidemiologic Studies Depression Scale (CES-D) 03 = Clinically Useful Depression Outcome Scale (CUDOS) 04 = Depression Scale (DEPS) 05 = Duke Anxiety-Depression Scale (DADS) 06 = Hamilton Rating Scale for Depression (HAM-D) 07 = Major Depression Inventory (MDI) 08 = Patient Health Questionnaire (PHQ-9) 09 = PROMIS Depression Total Score (T Score) 10 = Quick Inventory of Depressive Symptomatology Self-Report (QID-SR) 11 = Zung Self-Rating Depression Scale
Result of Screening	2 Characters	00 = Refused Screening 01 = Positive result 02 = Negative result 03 = Indeterminate
Screening Score	3 Characters	
Follow Up Plan	1 Character	0 = Refused Further Intervention 1 = Additional evaluation for depression 2 = Suicide Risk Assessment 3 = Referral to practitioner who is qualified to diagnose and treat depression 4 = Pharmacological interventions 5 = Other interventions or follow-up for the diagnosis or treatment of depression
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

## Measure BH8: Substance Use Screening and Intervention Composite

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Measure Description:

Percentage of patients aged 18 years and older who received a substance use screening at least once within the last 24 months AND who received an intervention for all positive screening results.

Data Source:

**Chart/EHR**

NQF #:

**Based on 2597**

Measure Steward:

**American Society of Addiction Medicine (ASAM)**

Measure Steward Version:

**Mar 06, 2015**

Statewide Target:

**80%**

### Measure Calculation Description

**Numerator:**

Patients who received the following substance use screenings (a valid LOINC code from BH08: Screening Tools & SBIRT) at least once within the last 24 months AND who received an intervention for all positive screening results (a valid CPT or HCPCS code from BH08: Health Visits):

Tobacco use component

Patients who were screened for tobacco use at least once within the last 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Unhealthy alcohol use component

Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

Drug use component (nonmedical prescription drug use and illicit drug use)

Patients who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 24 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user

Acceptable screening tools are listed below by individual component and inclusive of the three components (if applicable):

Tobacco use component:

1. Fagerstrom Test for Nicotine Dependence (FND)

Unhealthy alcohol use component:

1. CAGE Questionnaire for Detecting Alcoholism
2. The Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

Drug use component:

1. CAGE-AID Substance Abuse Screening Tool
2. DAST-10 Prescription and Illicit Drug Use Screening



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Inclusive (tobacco use, unhealthy alcohol use and drug use):

1. NIDA Quick Screen
2. NIDA Drug Use Screening Tool (NMASSIST)

*Other tools may be used only with the explicit pre-approval of NJ DOH*

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**Denominator:**

All patients who were seen twice for any visits (a valid CPT or HCPCS code from the value sets including Assessment, Evaluation, and Cessation) or who had at least one preventive care visit (a valid CPT or HCPCS code from the value sets including Office Visit, Preventive Care Services, or Annual Wellness) during the 12-month measurement period

**Exclusions:**

Denominator exceptions include:

- Documentation of medical reason(s) for not screening for tobacco use,
- Unhealthy alcohol use, or
- Nonmedical prescription drug/illicit drug use (e.g., limited life expectancy or other medical reason)

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**Result:**

Percentage

**Improvement Direction:**

Higher

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**Measure Qualifications:**

**Data Elements:**

- Screening date
- Screening tool used
- Screening tool result
- Follow up plan
- Exclusionary diagnosis or other reason (if applicable)

**Measure Deviations from Original Specifications:**

- The recommended list of valid screening tools has been augmented

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/2597>

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**Measure Collection Description**

<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 –December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>	
<u>Continuous Eligibility Period:</u> <b>Yes</b>	<u>Risk Adjustment:</u> <b>No</b>		<u>Sampling:</u> <b>No</b>
<u>Continuous Eligibility / Sampling Methodology:</u> <b>The patient must be continuously enrolled from the date of discharge through 30 days after discharge without a gap in coverage to be eligible. Sampling is not permitted.</b>			

#### Data File Layout and Submission Requirements:

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple screening events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

Variable	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Index Date	10 Characters	YYYY/MM/DD Format
Follow Up Date	10 Characters	YYYY/MM/DD Format
Exclusionary Diagnosis	7 Characters	
CPT Code	5 Characters	
HCPCS Code	5 Characters	
LOINC Code	5 Characters	
Screening Tool Used for Tobacco	2 Characters	00 = Refused Screening 01 = Fagerstrom Test for Nicotine Dependence (FND)

Result of Screening for Tobacco	3 Character	Score between 0 - 100
Follow Up Plan for Tobacco	1 Character	00 = Refused Further Intervention 01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other
Screening Tool Used for Alcohol	2 Characters	00 = Refused Screening 01 = CAGE Questionnaire for Detecting Alcoholism 02 = The Alcohol Use Disorders Identification Test-Concise (AUDIT-C)
Result of Screening for Alcohol	3 Character	Score between 0 - 100
Follow Up Plan for Alcohol	1 Character	00 = Refused Further Intervention 01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other
Screening Tool for Drug		00 = Refused Further Intervention 01 = CAGE-AID Substance Abuse Screening Tool 02 = DAST-10 Prescription and Illicit Drug Use Screening
Result of Screening for Drug	3 Character	Score between 0 - 100
Follow Up Plan for Drug		00 = Refused Further Intervention 01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other
Screening Tool for Inclusive		00 = Refused Further Intervention 01 = NIDA Quick Screen 02 = NIDA Drug Use Screening Tool (NMASSIST) 03 = Tobacco, Alcohol, Prescription Medication and other Substance Use (TAPS) 04 = Two-Item Conjoint Screen (TICS) for Alcohol and Other Drug Problems
Result of Screening Inclusive	3 Character	Score between 0 - 100
Follow Up Plan for Inclusive		00 = Refused Further Intervention

		01 = Screening, brief intervention, and referral to treatment (SBIRT) 02 = Other
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

DRAFT

## Measure BH9: Timely Transmission of Transition Record (Behavioral Health)

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### Measure Description:

Percentage of patients, 18 years and older, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

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### Data Source:

**Chart/EHR**

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### NQF #:

**Based on 0648**

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### Measure Steward:

**AMA-PCPI**

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### Measure Steward Version:

**2009**

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### Statewide Benchmark:

**80%**

### Measure Calculation Description

#### **Numerator:**

Patients with a behavioral health diagnosis (Table BH09\_00) for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up care within 24 hours of discharge.

**Transition record** - A core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.

**Transmitted** – The transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

**Primary physician or other health care professional designated for follow-up care** - May be a designated primary care physician (PCP), medical specialist, or other physician or health care professional

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#### **Denominator:**

Of the attributed population, patients 18 years and older discharged from an inpatient facility (e.g. hospital inpatient) to home/self-care or any other site of care with an AOD Diagnosis. See Table BH09M06\_01 for codes to identify patients discharged from an inpatient facility.

#### **Exclusions:**

- Patients who expired. (BH09M06\_02)
- Patients who left against medical advice or discontinued care. (BH09M06\_02)

**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

**Measure Qualifications:****Data Elements:**

- Diagnosis of Care (Working Diagnosis) (Table BH09\_00)
- Bill Type Code
- Revenue Code
- Patient Discharge Status Code
- Discharge Date
- Patient Discharge Summary Transmission Date

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/0648>

Measure Collection Description		
<u>Setting of Care:</u> <b>Inpatient or Emergency Department</b>		<u>Reporting Period:</u> <b>Annual</b>
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>11.11%</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>	<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>

Continuous Eligibility / Sampling Methodology: **Sampling is permitted for this measure.**

**Data File Layout and Submission Requirements:**

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple screening events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

Variable Description	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	

Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Discharge Date	10 Characters	YYYY/MM/DD Format
Transmission Date	10 Characters	YYYY/MM/DD Format
Discharge Diagnosis	7 Characters	
Bill Code	4 Characters	
Revenue Code	4 Characters	
Patient Discharge Status Code	2 Characters	
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

## Measure BH10: 3-Item Care Transitions Measure (CTM-3)

### Measure Description:

The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among patients 18 years and older from general acute care hospitals within the past 30 days.

### Data Source:

**Instrument-Based**

### NQF #:

**Based on 0228**

### Measure Steward:

**University of Colorado Denver Anschutz Medical Campus**

### Measure Steward Version:

**12/16/2019**

### Statewide Benchmark:

**N/A**

### Measure Calculation Description

#### **Numerator:**

The numerator is the hospital level sum of CTM-3 scores for all eligible sampled patients.

The items and response options are as follows:

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
  - ☐ Strongly Disagree
  - ☐ Disagree
  - ☐ Agree
  - ☐ Strongly Agree
  - ☐ Don't Know/Don't Remember/Not Applicable
2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
  - ☐ Strongly Disagree
  - ☐ Disagree
  - ☐ Agree
  - ☐ Strongly Agree
  - ☐ Don't Know/Don't Remember/Not Applicable
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.
  - ☐ Strongly Disagree
  - ☐ Disagree
  - ☐ Agree



- ☐ Strongly Agree
- ☐ Don't Know/Don't Remember/Not Applicable

#### Denominator:

Of the attributed behavioral health population, the number of eligible sampled adult patients discharged from a general acute care hospital.

#### Exclusions:

- Patients under age 18,
- Patients who died in the hospital, and
- Patients who did not stay at least one night in the hospital

#### Result:

The result is expressed as a percentage.

#### Improvement Direction:

Higher

#### Measure Qualifications:

#### Data Elements:

- Survey date
- Survey tool result
- Follow up plan
- Exclusionary diagnosis or other reason (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/0228>

Measure Collection Description		
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>None</b>
<u>Payment Method:</u> <b>NA</b>		<u>Measure Weight:</u> <b>NA</b>
<u>Continuous Eligibility Period:</u> NA	<u>Risk Adjustment:</u> No	<u>Sampling:</u> Yes

Continuous Eligibility / Sampling Methodology: **Sampling is permitted for this measure.**

## Survey Administration

- Survey should be administered between 48 hours and 30 days post discharge, regardless of mode of administration.
- No proxies are permitted to respond on behalf of patients. Someone other than the person who received care is permitted to read the questions to the respondent and/or record the responses.
- May be administered as a stand-alone instrument or combined with other hospital-specific questions.
- Data collection shall be closed out no later than 4 weeks following start of data collection for that respondent.
- Mode of delivery:
  1. Mail-only – includes CTM-3 only or combined with other hospital-specific questions. With cover letter that may be tailored but must include language indicating the purpose of the survey, explanation that participation is voluntary, and statement that the individual's health benefits will not be affected by participation.
  2. Telephone-only – Standardized script should be used, interviewers administering the surveys must be trained, and must attempt to contact respondent at least five times unless respondent refuses to complete the survey.
  3. Mixed mode of mail and telephone – Specifications for mail-only and telephone-only apply, except second mailing is not required and only non-respondents shall be contacted by telephone at least five times as per telephone only mode.

## Data Submission Requirements

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple survey events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

## Data File Format Instructions

Variable Description	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format

Exclusion Reason	2 Character	01 = Patients under age 18, 02 = Patients who died in the hospital, 03 = Patients who did not stay at least one night in the hospital
Stand-Alone/ Combined	1 Character	1 = Stand-Alone 2 = Combined
Delivery Method	1 Character	1 = Mail-only 2 = Telephone-only 3 = Mixed mode of mail and telephone
Survey Date Completed	10 Characters	YYYY/MM/DD Format
Question 1 Response	1 Character	1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree
Question 2 Response	1 Character	1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree
Question 3 Response	1 Character	1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree 5 = I was not given any medication when I left the hospital
Total Score	2 Characters	
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

## Measure BH11: Use of a Standardized Screening Tool for Social Determinants of Health

---

### Measure Description:

For the BH population served, the percent of individuals who have received a screening using a validated tool including SDOH domains identified by the State.

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### Data Source:

**Instrument-Based**

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### NQF #:

**N/A**

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### Measure Steward:

**The State of New Jersey**

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### Measure Steward Version:

**TBD**

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### Statewide Benchmark:

**N/A**

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### Measure Calculation Description

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#### **Numerator:**

Of the attributed population with Behavioral Health needs attributed to the facility, those that received a screening using a validated tool including SDOH domains identified by the State of New Jersey.

Domains required by the State (4):

1. Housing
2. Food Security
3. Transportation
4. Social Supports

Validated screening tools:

1. American Academy of Family Physicians (AAFP): Social Determinants of Health
2. PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

*Other tools may be used only with the explicit pre-approval of NJ DOH*

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#### **Denominator:**

The population with Behavioral Health needs attributed to the facility.

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#### **Result:**

The result is expressed as a percentage.

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#### **Improvement Direction:**

Higher

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#### **Measure Qualifications:**

##### **Data Elements:**

- Survey date

November 2020, Version 0.1

Prepared by Public Consulting Group

- Survey tool
- Survey tool result
- Exclusionary diagnosis or other reason (if applicable)

Measure Collection Description		
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>None</b>
<u>Payment Method:</u> <b>NA</b>		<u>Measure Weight:</u> <b>NA</b>
<u>Continuous Eligibility Period:</u> NA	<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>

Continuous Eligibility / Sampling Methodology: **Sampling is permitted for this measure.**

#### Data Submission Requirements:

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple survey events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

#### Data File Format Instructions

Variable Description	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Survey Date Completed	10 Characters	YYYY/MM/DD Format
Exclusions	1 Character	0 = No Exclusion/Survey Complete 1 = Patient Declined 2 = Screening Incomplete
SDOH Screening Tool	2 Character	01 = American Academy of Family Physicians (AAFP): Social Determinants of Health 02 = Health Leads (Creative Commons)

		03 = PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Domain 1 (Housing) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 1 (Housing) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Domain 2 (Food Security) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 2 (Food Security) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Domain 3 (Transportation) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 3 (Transportation) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Domain 4 (Social Supports) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 4 (Social Supports) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

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### III. Measurement Specifications: Maternal Health Measure Set

DRAFT

## A. Maternal Health Measures Grid

Measure #	Measure Name and NQF #	Measure Steward	Data Source	State Baseline	VBP Reporting Years	Measure Weight
M1	Severe Maternal Morbidity (SMM)	CDC	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	16.67%
M2	PC-02 Cesarean Birth - NQF #0471	Joint Commission	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) hospital reported data	Pay-for-performance in all years (1-5)	16.67%
M3	Postpartum Depression Screening	NCQA	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) hospital reported data	Pay-for-performance in all years (1-5)	16.67%
M4	Postpartum Care - NQF #1517	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	16.67%
M5	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment in Pregnant Women -NQF #0004	NCQA	MMIS	"Year 0" (7/1/2020-12/31/2020) claims data	Pay-for-performance in all years (1-5)	16.67%
M6	Timely Transmission of the Transition Record- NQF #0648	AMA-PCPI	Chart/EHR	"Year 0" (7/1/2020-12/31/2020) Hospital reported data	Pay-for-performance in all years (1-5)	16.67%
M7	Treatment of Severe Hypertension	Alliance for Innovation on Maternal Health (AIM)	Chart/EHR	Y1: 7/1/2021-12/31/2021 Hospital reported data	Reporting only in Y1, Pay-for-performance in Y2-5	16.67%



## Measure M1: Severe Maternal Morbidity (SMM)

### Measure Description:

For the Maternal Health population served, the percentage of births resulting in Severe Maternal Morbidities as defined by the CDC.

<u>Data Source:</u> <b>MMIS</b>	<u>NQF #:</u> <b>N/A</b>
<u>Measure Steward:</u> <b>CDC</b>	<u>Measure Steward Version:</u> <b>N/A</b>
<u>Statewide Benchmark:</u> <b>25.2%</b>	

### Measure Calculation Description

#### **Numerator:**

The number of women with severe maternal morbidities aged 18 to 55 years of age identified in the diagnosis and procedure code sets identified by CDC (Table MH01\_00).

To identify delivery hospitalizations with SMM, CDC uses administrative hospital discharge data and International Classification of Diseases (ICD) diagnosis and procedure codes. The updated list of 21 indicators and corresponding ICD codes used to identify delivery hospitalizations with SMM for both ICD-9 and ICD-10 may be used to track SMM when using administrative hospital discharge data.

For all pregnancy related codes O00-O9A:

1. Are only applicable to maternity patients aged 18 – 55 years inclusive
2. Use a code under Z3A (e.g. Z3A.20 - Z3A.42) to document the exact week during the pregnancy
3. Due to rare prevalence, the following indicators may be combined for reporting purposes:
  - Acute myocardial infarction and aneurysm,
  - Cardiac arrest/ventricular fibrillation and conversion of cardiac rhythm, and
  - Temporary tracheostomy and ventilation.

#### **Denominator:**

All women with a delivery (Table MH01\_01) at the acute care hospital during the measurement year.

#### **Exclusions:**

The following are exclusions (Table MH01\_02) from the denominator:

- Length of stay shorter than the 90<sup>th</sup> percentile as reported on the NJDOH Report Card
- Ectopic pregnancies
- Abnormal products of conception, and
- Miscarriages

#### **Result:**

Percentage

**Improvement Direction:**

Lower

**Measure Qualifications:**

**Data Elements:**

- SMM Indicator
- Birth Admission Code / Discharge Diagnosis

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm>

Measure Collection Description			
<u>Setting of Care:</u> <b>Site of Birth Admission</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>16.66%</b>	
<u>Claim Type(s):</u>  <b>01</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>No</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>

Continuous Eligibility / Sampling Methodology: **No sampling permitted.**



## Measure M2: PC-02 Cesarean Birth

---

### Measure Description:

This measure assesses the rate of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth.

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### Data Source:

**Chart/EHR**

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### NQF #:

**Based on 0471**

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### Measure Steward:

**The Joint Commission**

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### Measure Steward Version:

**Jan 09, 2019**

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### Statewide Benchmark:

**23.6%**

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## Measure Calculation Description

### **Numerator**

Patients with cesarean deliveries, having an ICD-10-PCS Principal or Other Procedure Code for a Cesarean delivery (Table MH02\_00)

### **Denominator**

Of the New Jersey Low Income attributed population, nulliparous patients who deliver a live term singleton newborn in vertex presentation (Table MH02\_01) with  $\geq 37$  and  $< 42$  weeks of gestation (Table MH02\_02) completed.

### **Exclusions:**

Patients with:

- An ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for Multiple Gestations and Other Presentations *or*
- Gestational age  $< 37$  or  $> 42$  weeks or unable to determine (UTD) (Table MH02\_03)

Additional exclusion criteria:

- Less than 18 years of age
- Greater than or equal to 55 years of age and
- Length of Stay  $> 120$  days
- Patients enrolled in clinical trials

---

### **Result:**

The result is expressed as a percentage.

### **Improvement Direction:**

Lower

## Measure Qualifications:

### Data Elements:

- Cesarean delivery
- Delivery in vertex presentation
- Delivery time in weeks

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/0471>
- <https://manual.jointcommission.org/releases/TJC2019A/MIF0167.html>

Measure Collection Description			
<u>Setting of Care:</u> <b>Site of Birth Admission</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>16.66%</b>	
<u>Claim Type(s):</u>  <b>01</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>No</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>

Continuous Eligibility / Sampling Methodology: **Sampling is permitted for this measure.**

### Data Submission Guidelines:

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

### Data File Format Instructions

Variable Description	Variable Length	Variable Values / Format
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Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Date of Delivery	10 Characters	YYYY/MM/DD Format
Diagnosis 1	7 Characters	
Diagnosis 2	7 Characters	
Diagnosis 3	7 Characters	
Diagnosis 4	7 Characters	
Diagnosis 5	7 Characters	
Procedure 1	7 Characters	
Procedure 2	7 Characters	
Nulliparous Y/N	1 Character	0 = U 1 = Y 2 = N
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

## Measure M3: Postpartum Depression Screening (PDS-E)

### Measure Description:

The percentage of women who had a screening for maternal depression at least once between after birth and prior to discharge.

### Data Source:

Chart / EHR

### NQF #:

Based on 1401

### Measure Steward:

NCQA

### Measure Steward Version:

HEDIS® MY 2020 & MY 2021 (ECDS)

### Statewide Benchmark:

90%

### Measure Calculation Description

#### **Numerator:**

Women who had a documented result of a maternal depression screening using a standardized instrument (LOINC code) at least once before discharge from a birth admission.

#### **Denominator:**

All live births of women in the defined QIP-NJ Maternal Health Population who delivered (Deliveries Value Set) at the hospital in the measurement year (initial population minus Exclusions).

#### **Exclusions:**

Women who:

- Were transferred to another facility before or after delivery,
- Who expired prior to discharge,
- Delivered in hospice or used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set)

#### **Result:**

The result is expressed as a percentage.

#### **Improvement Direction:**

Lower

#### **Measure Qualifications:**

#### **Major Changes HEDIS MY 2020 and MY 2021:**

N/A

#### **Data Elements:**

- Delivery
- Depression screen with standardized validation tool

### Measure Deviations from Original Specifications:

- Modified from inpatient maternal screening at time of birth and prior to discharge; originally, from outpatient place of service that occurs 7 to 84 days of delivery or within child's first 6 months of life
- Modified to only include one rate to report "Depression Screening"; original has two rates that includes "Follow-Up on Positive Screen"

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/1401>

Measure Collection Description			
<u>Setting of Care:</u> <b>Inpatient</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>16.66%</b>	
<u>Claim Type(s):</u>  <b>01</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>No</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>
<u>Continuous Eligibility / Sampling Methodology:</u> <b>Continuous enrollment 43 days prior to delivery through 60 days after delivery. Following, September 8 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. Sampling is permitted for this measure.</b>			

### Data Submission Requirements

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

## Data File Format Instructions

Variable Description	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Admission Date	10 Characters	YYYY/MM/DD Format
Survey Date	10 Characters	YYYY/MM/DD Format
Discharge Date	10 Characters	YYYY/MM/DD Format
Exclusion Reason	2 Character	00 = No exclusion 01 = Patient expired 02 = Patient transferred prior to delivery 03 = Other (describe after last column)
Instrument Type	2 Character	
Screening Result	2 Character	
Screening Test Outcome	2 Character	00 = Refused Screening 01 = Positive result 02 = Negative result 03 = Indeterminate



## Measure M4: Postpartum Care (PPC)

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### Measure Description:

The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

---

### Data Source:

**MMIS**

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### NQF #:

**Based on 1517**

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### Measure Steward:

**NCQA**

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### Measure Steward Version:

**HEDIS® MY 2020 & MY 2021**

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### Statewide Benchmark:

**75%**

## Measure Calculation Description

### **Numerator:**

Women who had a postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Visits Value Set).
- Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the organization can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

---

### **Denominator:**

Delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include women who delivered in any setting except hospice.

Multiple births. Women who had two separate deliveries (different dates of service) between of the measurement year count twice. Women who had multiple live births during one pregnancy count once.

**Step 1:** Identify deliveries. Identify all women with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year.

Note: The intent is to identify the date of delivery (the date of the “procedure”). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge.

**Step 2:** Exclude non-live births (Non-live Births Value Set).

---

**Step 3:** Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery through 60 days after delivery, with no gaps.

**Exclusions:**

- Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set)
- Hospice delivery setting
- Exclude non-live births (Non-live Births Value Set)

---

**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

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**Measure Qualifications:**

**Major Changes HEDIS MY 2020 and MY 2021:**

- Revised the definition of last enrollment segment.
- Clarified that visits that occur prior to the enrollment start date (during the pregnancy) meet criteria.
- Added telephone visits (Telephone Visits Value Set) e-visits and virtual check-ins (Online Assessments Value Set) - clarified in the Notes that services provided via telephone, e-visit or virtual check-in are eligible for use in reporting both rates.

**Data Elements:**

- Index date
- Follow up visit

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/1517>

Measure Collection Description			
<u>Setting of Care:</u> <b>Outpatient</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>16.66%</b>	
<u>Claim Type(s):</u>  <b>04, 14, 15, 19, 23</b>	<b>01 – Inpatient Hospital</b> <b>02 – Long Term Care</b> <b>03 – Outpatient Hospital</b> <b>04 – Physician</b> <b>05 – Chiropractor</b> <b>06 – Home Health</b> <b>07 – Transportation</b> <b>08 – Vision</b>	<b>09 – Supplies, DME</b> <b>10 – Podiatry</b> <b>11 – Dental</b> <b>12 – Pharmacy</b> <b>13 – EPDST/Healthstart</b> <b>14 – Institutional Crossover</b> <b>15 – Professional Crossover</b>	<b>16 – Lab</b> <b>17 – Prosthetic and Orthotics</b> <b>18 – Independent Clinic</b> <b>19 – Psychologists</b> <b>21 – Optometrists</b> <b>22 – Mid Level Practitioner</b> <b>23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>
<u>Continuous Eligibility / Sampling Methodology:</u> <b>Continuous enrollment 43 days prior to delivery through 60 days after delivery. Following, October 8 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. Sampling is permitted for this measure.</b>			

## Measure M5: Treatment of SUD in Pregnant Women (Initiation of Alcohol and Other Drug Treatment) (IET – I)

### Measure Description:

The percentage of pregnant women with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

### Data Source:

**MMIS**

### NQF #:

**Based on 0004**

### Measure Steward:

**NCQA**

### Measure Steward Version:

**HEDIS® MY 2020 & MY 2021**

### Statewide Benchmark:

**55%**

### Measure Calculation Description

#### **Numerator:**

Patients who have Initiation of AOD treatment within 14 days of the Index Episode (IESD).

- If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.
- If the Index Episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the member is compliant.
- If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:
  - An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    - Identify the admission date for the stay.
  - IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non-Drug Service Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set).
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).
- For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.
- If a member is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The "Total" column is not the sum of the diagnosis columns.
- Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

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### **Denominator:**

Members with a new episode of AOD abuse or dependence during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator.

**Step 1:** Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- OUD Weekly Non-Drug Service Value Set with Opioid Abuse and Dependence Value Set.
- OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set.
- OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set.
- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

**Step 2:** Select the Index Episode and stratify based on age and AOD diagnosis cohort.

- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
- If the member has a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
- If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.

If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

**Step 3:** Test for Negative Diagnosis History. Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

**Step 4:** Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

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**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

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**Measure Qualifications:**

**Major Changes HEDIS MY 2020 and MY 2021:**

- Clarified the Episode Date when detoxification occurs during an acute inpatient stay.
- Updated the step 3 instructions for ED and observation visits that result in an inpatient stay, to make them consistent with instructions in the Definitions section.
- Added value sets for opioid treatment services that are billed weekly or monthly to the denominator and numerators.
- Updated the continuous enrollment period.

**Data Elements:**

- Attributed to the MH population
- Index episode
- Admission date
- Follow up visit category
- Follow up visit date

Only the age stratification that includes all ages (Total) will be used for QIP-NJ. In 2018 the measure steward began stratifying by AOD diagnosis cohort, alcohol abuse or dependence, opioid abuse or dependence, other drug abuse or dependence and total.

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>
- <http://www.qualityforum.org/QPS/0004>

Measure Collection Description			
<u>Setting of Care:</u> <b>Multi-setting</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>16.6%</b>	
<u>Claim Type(s):</u>  <b>01, 03, 04, 14, 15, 18, 19</b>	<b>01 – Inpatient Hospital 02 – Long Term Care 03 – Outpatient Hospital 04 – Physician 05 – Chiropractor 06 – Home Health 07 – Transportation 08 – Vision</b>	<b>09 – Supplies, DME 10 – Podiatry 11 – Dental 12 – Pharmacy 13 – EPDST/Healthstart 14 – Institutional Crossover 15 – Professional Crossover</b>	<b>16 – Lab 17 – Prosthetic and Orthotics 18 – Independent Clinic 19 – Psychologists 21 – Optometrists 22 – Mid Level Practitioner 23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>Yes</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>
<b>Continuous Eligibility/ Risk Adjustment/ Sampling Methodology: Patients must be continuously enrolled without any gaps 60 days (2 months) before the Index Episode Start Date (IESD) through 48 days after the IESD. Following, November 14 is the last day in the calendar year that a member is eligible for consideration into this measurement cohort. No sampling permitted.</b>			



## Measure M6: Timely Transmission of Transition Record (Maternal Health)

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### Measure Description:

Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

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### Data Source:

Chart/EHR

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### NQF #:

Based on 0648

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### Measure Steward:

AMA-PCPI

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### Measure Steward Version:

2009

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### Statewide Benchmark:

80%

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### Measure Calculation Description

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#### **Numerator:**

Patients who had a birth admission discharge for whom a transition record was transmitted to the facility or primary care physician or other health care professional designated for follow-up care within 24 hours of discharge.

**Transition record** - a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.

**Transmitted** - transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).

**Primary physician or other health care professional designated for follow-up care** - may be a designated primary care physician (PCP), medical specialist, or other physician or health care professional

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#### **Denominator:**

Of the attributed population, patients 18 years and older discharged from an inpatient facility (i.e. hospital inpatient) to home/self-care or any other site of care with an AOD Diagnosis. See Table BH09M06\_01 for codes to identify patients discharged from an inpatient facility.

#### **Exclusions:**

- Patients who expired. (Table BH09M06\_02)
- Patients who left against medical advice or discontinued care. (Table BH09M06\_02)

**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

**Measure Qualifications:****Data Elements:**

- Diagnosis of Care (birth admission)
- Bill Type Code
- Revenue Code
- Patient Discharge Status Code
- Discharge Date
- Patient Discharge Summary Transmission Date
- Race
- Ethnicity

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/0648>

Measure Collection Description		
<u>Setting of Care:</u> <b>Inpatient or Emergency Department</b>	<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>	<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>	<u>Measure Weight:</u> <b>11.11%</b>	
<u>Continuous Eligibility Period:</u> <b>Yes</b>	<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>
<u>Continuous Eligibility / Sampling Methodology:</u> <b>Sampling is permitted for this measure.</b>		

**Data Submission Requirements:**

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

## Data File Format Instructions

Variable Length	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Discharge Date	10 Characters	YYYY/MM/DD Format
Transmission Date	10 Characters	YYYY/MM/DD Format
Discharge Diagnosis	7 Characters	
Bill Code	4 Characters	
Revenue Code	4 Characters	
Patient Discharge Status Code	2 Characters	
Race	2 Characters	00 = Not Reported 01 = White (Caucasian) 02 = Black / African American 03 = American Indian or Alaska Native 04 = Asian 05 = Native Hawaiian and Pacific Islander 06 = Other Race
Ethnicity	2 Characters	00 = Not Reported 01 = Hispanic or Latino 02 = Not Hispanic or Latino

## Measure M7: Treatment of Severe Hypertension

### Measure Description:

The percentage of pregnant or postpartum women aged 18 to 55 years old with a severe hypertensive episode that is treated within one hour by a recommended first-line agent.

### Data Source:

Chart/EHR

### NQF #:

N/A

### Measure Steward:

Alliance for Innovation on Maternal Health (AIM)

### Measure Steward Version:

N/A

### Statewide Benchmark:

80%

### Measure Calculation Description

#### **Numerator:**

The number of women with persistent (two or more episodes within fifteen minutes) of new-onset severe hypertension who were treated within one hour with a first-line agent, including:

- IV Labetalol,
- IV Hydralazine, or
- PO Nifedipine

Severe hypertension (SHTN) may be reflected in either the systolic or diastolic blood pressure:

- A systolic blood pressure  $\geq 160$  mm Hg or
- A diastolic blood pressure  $\geq 110$  mm Hg reading

Readings are taken at greater than 15-minute intervals and no more than 4 hours apart (until BP stabilizes within a normal range).

First-line agents (Table MH07\_00) must be dispensed within one hour of the second reading of SHTN. IV Labetalol and IV hydralazine are the preferred first-line agents although oral nifedipine (a calcium channel blocker) is favored if intravenous therapy is unavailable. Second-line interventions such as anesthesia and magnesium sulfate are rarely used and therefore, not recommended, respectively.

#### **Denominator:**

Women with persistent (twice within 15 minutes) new-onset Severe HTN (Systolic:  $>160$  or Diastolic:  $>110$ ).

Patients of greater than or equal to 20 weeks gestation through 7 days postpartum with:

- An ICD-10-CM Principal Diagnosis or Other Diagnosis Code for Pre-existing or Gestational Hypertension, Eclampsia/Pre-eclampsia (Table MH07\_01) or

And

- Two or more readings of severe hypertension (SHTN) defined as
  - A systolic blood pressure  $\geq 160$  mm Hg or

- A diastolic blood pressure  $\geq 110$  mm Hg reading

That are taken between at least 15 minutes and no more than 4 hours apart

For this measure, records are at the procedure level, not the individual level. For an individual to be included in the denominator she must have at least 2 BP readings, but the hospital may report up to 5 BP readings.

Include all member BP readings. BP entries 3-5 may be “9” filled if there are no additional readings. Records without date and time of service as formatted for BP readings and medication administration will not be included in the calculation.

#### Exclusion:

- Women with an exacerbation of chronic hypertension.
- Any SHTN instances that occur:
  - Prior to 20 weeks of pregnancy or
  - After 7 days postpartum
- An ICD-10-CM Principal Diagnosis or Other Diagnosis Code for Gestational Edema or Unspecified Maternal Hypertension (Table MH07\_02)

#### Measure Qualifications:

#### Data Elements:

- The maternal medical record will be used to validate diagnosis and treatment.

Measure Collection Description			
<u>Setting of Care:</u> <b>Inpatient or Emergency Department</b>		<u>Reporting Period:</u> <b>Annual</b>	
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>		<u>Baseline Period:</u> <b>July 1, 2020 – December 31, 2020</b>	
<u>Payment Method:</u> <b>P4P</b>		<u>Measure Weight:</u> <b>16.6%</b>	
<u>Claim Type(s):</u> <b>01</b>	<b>01 – Inpatient Hospital</b> <b>02 – Long Term Care</b> <b>03 – Outpatient Hospital</b> <b>04 – Physician</b> <b>05 – Chiropractor</b> <b>06 – Home Health</b> <b>07 – Transportation</b> <b>08 – Vision</b>	<b>09 – Supplies, DME</b> <b>10 – Podiatry</b> <b>11 – Dental</b> <b>12 – Pharmacy</b> <b>13 – EPDST/Healthstart</b> <b>14 – Institutional Crossover</b> <b>15 – Professional Crossover</b>	<b>16 – Lab</b> <b>17 – Prosthetic and Orthotics</b> <b>18 – Independent Clinic</b> <b>19 – Psychologists</b> <b>21 – Optometrists</b> <b>22 – Mid Level Practitioner</b> <b>23 – Hearing Aid</b>
<u>Continuous Eligibility Period:</u> <b>No</b>		<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>No</b>

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology: **No sampling permitted.**

## Data Submission Requirements

As this measure examines multiple instances of blood pressure readings per member, the second of which may be followed by a first-line agent treatment, it is important to provide *time of each separate procedure in addition to the date*.

An example scenario is that a member presents with an SMM episode and has three separate blood pressure readings occurring, the second followed by treatment with a first-line agent.

Member 0000012 is seen in the emergency room on 4/1/2020 at 02:00:

- Diagnosis is “Eclampsia, severe” (ICD-10 CM: O14.13)
- Blood pressure reading is 160/110

Member 0000012 has follow-up on 4/1/2020 at 02:30:

- Blood pressure reading is 160/110

Member 0000012 has Labetalol (NDC: 101350641) administered on 4/1/2020 at 02:45

Member 0000012 has follow-up on 4/1/2020 at 03:00:

- Blood pressure reading is 130/80

As Member 0000012 has improved vital signs, no additional drug is administered

## Data File Format Instructions

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

Variable Length	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Admission Date/Time	18 Characters	YYYY-MM-DD hh:mm:ss
Diagnosis 1	7 Characters	
Diagnosis 2	7 Characters	

Diagnosis 3	7 Characters	
Service Date and Time BP1	18 Characters	YYYY-MM-DD hh:mm:ss
BP Reading 1: Systolic	3 Characters	
BP Reading 1: Diastolic	3 Characters	
Service Date and Time BP2	18 Characters	YYYY-MM-DD hh:mm:ss
BP Reading 2: Systolic	3 Characters	
BP Reading 2: Diastolic	3 Characters	
Service Date and Time BP3	18 Characters	YYYY-MM-DD hh:mm:ss; 99999999 99:99 if no additional reading
BP Reading 3: Systolic	3 Characters	
BP Reading 3: Diastolic	3 Characters	
Service Date and Time BP4	18 Characters	YYYY-MM-DD hh:mm:ss; 99999999 99:99 if no additional reading
BP Reading 4: Systolic	3 Characters	
BP Reading 4: Diastolic	3 Characters	
Service Date and Time BP5	18 Characters	YYYY-MM-DD hh:mm:ss; 99999999 99:99 if no additional reading
BP Reading 5: Systolic	3 Characters	
BP Reading 5: Diastolic	3 Characters	
RX Date and Time	18 Characters	YYYY-MM-DD hh:mm:ss
RX NDC	9 Characters	No dashes
RX Route	1 Character	1= Intravenous 2= Oral 3= Other
Non Firstline Agent Administered	1 Character	1 = Yes 2 = No

## Measure M8: 3-Item Care Transitions Measure (CTM-3)

### Measure Description:

The CTM-3 is a hospital level measure of performance that reports the average patient reported quality of preparation for self-care response among patients aged 18 years and older adult patients discharged from general acute care hospitals within the past 30 days.

### Data Source:

**Instrument Based Data**

### NQF #:

**Based on 0228**

### Measure Steward:

**University of Colorado Denver Anschutz Medical Campus**

### Measure Steward Version:

**12/16/2019**

### Statewide Benchmark:

**N/A**

### Measure Calculation Description

#### **Numerator:**

The numerator is the hospital level sum of CTM-3 scores for all eligible sampled patients.

The items and response options are as follows:

1. The hospital staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left the hospital.
  - ☐ Strongly Disagree
  - ☐ Disagree
  - ☐ Agree
  - ☐ Strongly Agree
  - ☐ Don't Know/Don't Remember/Not Applicable
2. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
  - ☐ Strongly Disagree
  - ☐ Disagree
  - ☐ Agree
  - ☐ Strongly Agree
  - ☐ Don't Know/Don't Remember/Not Applicable
3. When I left the hospital, I clearly understood the purpose for taking each of my medications.
  - ☐ Strongly Disagree
  - ☐ Disagree
  - ☐ Agree
  - ☐ Strongly Agree
  - ☐ Don't Know/Don't Remember/Not Applicable



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**Denominator:**

Of the attributed maternal health population, the number of eligible sampled adult patients discharged from a general acute care hospital.

**Exclusions:**

- Patients who died in the hospital
- Patients who did not stay at least one night in the hospital

**Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

**Measure Qualifications:****Data Elements:**

- Survey date
- Survey tool result
- Follow up plan
- Exclusionary diagnosis or other reason (if applicable)

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- <http://www.qualityforum.org/QPS/0228>

Measure Collection Description	
<u>Setting of Care:</u> <b>TBD</b>	<u>Reporting Period:</u> <b>Annual</b>
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>	<u>Baseline Period:</u> <b>None</b>
<u>Payment Method:</u> <b>N/A</b>	<u>Measure Weight:</u> <b>N/A</b>
<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>

Sampling or Risk Adjustment Methodology: **Sampling is permitted for this measure.**

**Survey Administration**

- Survey should be administered between 48 hours and 30 days post discharge, regardless of mode of administration.

- No proxies are permitted to respond on behalf of patients. Someone other than the person who received care is permitted to read the questions to the respondent and/or record the responses.
- May be administered as a stand-alone instrument or combined with other hospital-specific questions.
- Data collection shall be closed out no later than 4 weeks following start of data collection for that respondent.
- Mode of delivery:
  1. Mail-only – includes CTM-3 only or combined with other hospital-specific questions. With cover letter that may be tailored but must include language indicating the purpose of the survey, explanation that participation is voluntary, and statement that the individual's health benefits will not be affected by participation.
  2. Telephone-only – Standardized script should be used, interviewers administering the surveys must be trained, and must attempt to contact respondent at least five times unless respondent refuses to complete the survey.
  3. Mixed mode of mail and telephone – Specifications for mail-only and telephone-only apply, except second mailing is not required and only non-respondents shall be contacted by telephone at least five times as per telephone only mode.

### Data Submission Requirements

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple survey events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

### Data File Format Instructions

Variable Description	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format
Exclusion Reason	2 Character	01 = Patients under age 18, 02 = Patients who died in the hospital, 03 = Patients who did not stay at least one night in the hospital

Stand-Alone/ Combined	1 Character	1 = Stand-Alone 2 = Combined
Delivery Method	1 Character	1 = Mail-only 2 = Telephone-only 3 = Mixed mode of mail and Telephone
Survey Date Completed	10 Characters	YYYY/MM/DD Format
Question 1 Response	1 Character	1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree
Question 2 Response	1 Character	1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree
Question 3 Response	1 Character	1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree 5 = I was not given any medication when I left the hospital
Total Score	2 Characters	
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

## Measure M9: Use of a Standardized Screening Tool for Social Determinants of Health

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### **Measure Description:**

Of women who delivered at the hospital during the measurement period, the percent of individuals who have received a screening using a validated tool including the 5 SDOH domains identified by the State: Housing, Food Security, Transportation, Social Supports, and Domestic Violence

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### **Data Source:**

**Instrument Based**

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### **NQF #:**

**N/A**

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### **Measure Steward:**

**The State of New Jersey**

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### **Measure Steward Version:**

**TBD**

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### **Statewide Benchmark:**

**N/A**

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## Measure Calculation Description

### **Numerator**

Of the women who delivered at the hospital during the measurement period, those that received a screening using a validated tool including SDOH domains identified by the State: Housing, Food Security, Transportation, Social Supports, and Domestic Violence.

### **Denominator**

Women who delivered at the hospital during the measurement period.

Domains required by the State:

- Housing
- Food Security
- Transportation
- Social Supports
- Domestic Violence Status

Validated screening tools:

1. American Academy of Family Physicians (AAFP): Social Determinants of Health
2. NJ Perinatal Risk Assessment (PRA)

*Other tools may be used only with the explicit pre-approval of NJ DOH*

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### **Denominator:**

The Maternal Health population attributed to the facility.

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### **Result:**

The result is expressed as a percentage.

**Improvement Direction:**

Higher

**Measure Qualifications:****Data Elements:**

The following link(s) may be used to obtain additional information regarding the original measure specification. This is provided without assurances:

- N/A

Measure Collection Description	
<u>Setting of Care:</u> <b>Multi-setting</b>	<u>Reporting Period:</u> <b>Annual</b>
<u>Performance Period:</u> <b>July 1, 2021 – December 31, 2021</b>	<u>Baseline Period:</u> <b>None</b>
<u>Payment Method:</u> <b>N/A</b>	<u>Measure Weight:</u> <b>N/A</b>
<u>Risk Adjustment:</u> <b>No</b>	<u>Sampling:</u> <b>Yes</b>

Sampling Methodology: **Sampling is permitted for this measure.**

**Data Submission Requirements**

1. All data must be submitted for performance eligible individuals only
2. Enter all relevant data, including multiple screening events, per eligible member
3. Any individuals who have become ineligible (e.g. no longer enrolled in MMC) should be removed from all results
4. Any additional information may be added after the final column in the submission file if prior consultation and explicit consent has been provided

Variable Description	Variable Length	Variable Values / Format
Medicaid Billing Provider ID	7 Characters	
Medicaid Beneficiary ID	12 Characters	
Measurement Year (MY)	1 Character	Numerical digit 1-5
Member DOB	10 Characters	YYYY/MM/DD Format

Survey Date Completed	10 Characters	YYYY/MM/DD Format
Exclusions	1 Character	0 = No Exclusion/Survey Complete 1 = Patient Declined 2 = Screening Incomplete
SDOH Screening Tool	2 Character	01 = American Academy of Family Physicians (AAFP): Social Determinants of Health 02 = Health Leads (Creative Commons) 03 = PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Domain 1 (Housing) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 1 (Housing) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Domain 2 (Food Security) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 2 (Food Security) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Domain 3 (Transportation) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 3 (Transportation) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Domain 4 (Social Supports) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 4 (Social Supports) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Domain 5 (Domestic Violence) Response	1 Character	0 = No Response 1 = At Risk 2 = Not at Risk
Domain 5 (Domestic Violence) Intervention	1 Character	0= N/A 1= Referral Made 2= No Action Taken
Population Sampled	1 Character	1 = Y 2 = N
Sample Population	4 Characters	

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## Appendix A: Value Code Sets by Measure

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Measure BH1: 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization

Table Name	Table Description
Table BH01_00	AHRQ Modified CCS Psychiatric Principal Discharge Diagnosis categories
Table BH01_01	AHRQ Modified CCS Procedure categories that are always planned
Table BH01_02	AHRQ Modified CCS Diagnosis categories that are always planned
Table BH01_03	AHRQ Modified CCS Diagnosis categories that are potentially planned
Table BH01_04	AHRQ Modified CCS Diagnosis categories that are considered planned if not coinciding with principle discharge diagnosis or complication



## Measure BH2: Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge

Value Set Name	Value Set OID
Ambulatory Surgical Center POS	2.16.840.1.113883.3.464.1004.1480
Behavioral Healthcare Setting	2.16.840.1.113883.3.464.1004.2214
BH Outpatient	2.16.840.1.113883.3.464.1004.1481
Community Mental Health Center POS	2.16.840.1.113883.3.464.1004.1484
Electroconvulsive Therapy	2.16.840.1.113883.3.464.1004.1294
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Intentional Self-Harm	2.16.840.1.113883.3.464.1004.1468
Mental Health Diagnosis	2.16.840.1.113883.3.464.1004.1178
Mental Illness	2.16.840.1.113883.3.464.1004.1179
Nonacute Inpatient Stay	2.16.840.1.113883.3.464.1004.1398
Observation	2.16.840.1.113883.3.464.1004.1191
Outpatient POS	2.16.840.1.113883.3.464.1004.1443
Partial Hospitalization or Intensive Outpatient	2.16.840.1.113883.3.464.1004.1492
Partial Hospitalization POS	2.16.840.1.113883.3.464.1004.1491
Telehealth POS	2.16.840.1.113883.3.464.1004.1460
Telephone Visits	2.16.840.1.113883.3.464.1004.1246
Transitional Care Management Services	2.16.840.1.113883.3.464.1004.1462
Visit Setting Unspecified	2.16.840.1.113883.3.464.1004.1493

Measure BH3: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) (30 day)

Value Set Name	Value Set OID
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013
ED	2.16.840.1.113883.3.464.1004.1086
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
ODD Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220
ODD Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221
ODD Weekly Non Drug Service	2.16.840.1.113883.3.464.1004.2222
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

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Measure BH4: Follow-Up After Emergency Department Visit for Mental Illness (FUM) (30 day)

Value Set Name	Value Set OID
Ambulatory Surgical Center POS	2.16.840.1.113883.3.464.1004.1480
BH Outpatient	2.16.840.1.113883.3.464.1004.1481
Community Mental Health Center POS	2.16.840.1.113883.3.464.1004.1484
ED	2.16.840.1.113883.3.464.1004.1086
Electroconvulsive Therapy	2.16.840.1.113883.3.464.1004.1294
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Intentional Self-Harm	2.16.840.1.113883.3.464.1004.1468
Mental Health Diagnosis	2.16.840.1.113883.3.464.1004.1178
Mental Illness	2.16.840.1.113883.3.464.1004.1179
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Outpatient POS	2.16.840.1.113883.3.464.1004.1443
Partial Hospitalization or Intensive Outpatient	2.16.840.1.113883.3.464.1004.1492
Partial Hospitalization POS	2.16.840.1.113883.3.464.1004.1491
Telehealth POS	2.16.840.1.113883.3.464.1004.1460
Telephone Visits	2.16.840.1.113883.3.464.1004.1246
Visit Setting Unspecified	2.16.840.1.113883.3.464.1004.1493

## Measure BH5: Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET – I)

Value Set Name	Value Set OID
Alcohol Abuse and Dependence	2.16.840.1.113883.3.464.1004.1424
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013
AOD Medication Treatment	2.16.840.1.113883.3.464.1004.2017
Detoxification	2.16.840.1.113883.3.464.1004.1076
ED	2.16.840.1.113883.3.464.1004.1086
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Opioid Abuse and Dependence	2.16.840.1.113883.3.464.1004.1425
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426
ODU Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220
ODU Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221
ODU Weekly Non Drug Service	2.16.840.1.113883.3.464.1004.2222
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

## Measure BH6: Engagement in Alcohol and Other Drug Abuse or Dependence Treatment (IET – E)

Value Set Name	Value Set OID
Alcohol Abuse and Dependence	2.16.840.1.113883.3.464.1004.1424
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013
AOD Medication Treatment	2.16.840.1.113883.3.464.1004.2017
Detoxification	2.16.840.1.113883.3.464.1004.1076
ED	2.16.840.1.113883.3.464.1004.1086
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Opioid Abuse and Dependence	2.16.840.1.113883.3.464.1004.1425
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426
ODU Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220
ODU Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221
ODU Weekly Non Drug Service	2.16.840.1.113883.3.464.1004.2222
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

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## Measure BH7: Preventative Care and Screening: Screening for Depression and Follow-Up

Table Name	Table Description
Table BH07_00	Codes to Identify Outpatient Visits
Table BH07_01	Codes to Document Depression Screen
Table BH07_02	Codes for Exclusionary Diagnoses
Table BH07_03	Codes for Validated Screen Tools

## Measure BH8: Substance Use Screening and Intervention Composite

### BH08 Value Set: Health Visits

Value Set Name	Value Set OID
Office Visit	2.16.840.1.113883.3.464.1003.101.11.1005
Preventive Care Services-Initial Office Visit, 18 and Up	2.16.840.1.113883.3.464.1003.101.11.1115
Preventive Care Services - Established Office Visit, 18 and Up	2.16.840.1.113883.3.464.1003.101.11.1125
Preventive Care Services-Individual Counseling	2.16.840.1.113883.3.464.1003.101.11.1130
Preventive Care Services - Group Counseling	2.16.840.1.113883.3.464.1003.101.11.1135
Preventive Care Services - Other	2.16.840.1.113883.3.464.1003.101.11.1150
Health & Behavioral Assessment - Individual	2.16.840.1.113883.3.526.2.1060
Occupational Therapy Evaluation	2.16.840.1.113883.3.526.2.1063
Psychoanalysis	2.16.840.1.113883.3.526.2.1243
Health and Behavioral Assessment - Initial	2.16.840.1.113883.3.526.2.1324
Annual Wellness Visit	2.16.840.1.113883.3.526.2.1363
Psych Visit - Diagnostic Evaluation	2.16.840.1.113883.3.526.2.1923
Psych Visit - Psychotherapy	2.16.840.1.113883.3.526.2.1927

### BH08 Value Set: Screening Tools & SBIRT

Value Set Name	Value Set OID
Tobacco Use Screening	2.16.840.1.113883.3.526.2.1372
AUDIT Alcohol Screening	2.16.840.1.113883.3.526.2.1919
AUDIT-C Alcohol Screening	2.16.840.1.113883.3.526.2.1929
Single Question Alcohol Screening	2.16.840.1.113883.3.526.2.1930
DAST Prescription and Illicit Drug Use Screening	2.16.840.1.113883.3.526.2.1932
DAST-10 Prescription and Illicit Drug Use Screening	2.16.840.1.113883.3.526.2.1933
Single Question Prescription and Illicit Drug Use Screening	2.16.840.1.113883.3.526.2.1934
Tobacco Use Cessation Counseling	2.16.840.1.113883.3.526.2.424

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## Measure BH9: Timely Transmission of Transition Record (Behavioral Health)

Table Name	Table Description
Table BH09_00	Codes to Identify a Behavioral Health Diagnosis
Table BH09M06_01	Codes to Identify Patients Discharged from Inpatient Facility
Table BH09M06_02	Codes to Identify Discharge Exclusions



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Measure BH10: 3-Item Care Transitions Measure (CTM-3)  
(TBD)

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Measure BH11: Use of a Standardized Screening Tool for Social Determinants of Health  
(TBD)

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## Measure M1: Severe Maternal Morbidity (SMM)

Table Name	Table Description
Table MH01_00	Severe Maternal Morbidity Indicators and Corresponding ICD Codes
Table MH01_01	Birth Admission Codes
Table MH01_02	Diagnoses for Exclusion

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## Measure M2: PC-02 Cesarean Birth

Table Name	Table Description
Table MH02_00	Diagnosis Codes to Identify Outcome of Delivery
Table MH02_01	Procedure Codes to Identify Delivery Procedure
Table MH02_02	Codes to Identify Gestational Weeks Completed
Table MH02_03	Codes to Identify Multiple Gestations and Other Presentations

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### Measure M3: Postpartum Depression Screening

Value Set Name	Value Set OID
Deliveries	2.16.840.1.113883.3.464.1004.1072
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762

#### Measure M4: Postpartum Care (PPC)

Value Set Name	Value Set OID
Acute Inpatient	2.16.840.1.113883.3.464.1004.1810
Acute Inpatient POS	2.16.840.1.113883.3.464.1004.1027
Cervical Cytology Lab Test	2.16.840.1.113883.3.464.1004.1525
Cervical Cytology Result or Finding	2.16.840.1.113883.3.464.1004.1524
Deliveries	2.16.840.1.113883.3.464.1004.1072
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Non-live Births	2.16.840.1.113883.3.464.1004.1187
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Postpartum Bundled Services	2.16.840.1.113883.3.464.1004.1217
Postpartum Visits	2.16.840.1.113883.3.464.1004.1218
Pregnancy Diagnosis	2.16.840.1.113883.3.464.1004.1220
Prenatal Bundled Services	2.16.840.1.113883.3.464.1004.1223
Prenatal Visits	2.16.840.1.113883.3.464.1004.1225
Stand Alone Prenatal Visits	2.16.840.1.113883.3.464.1004.1240
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

Measure M5: Treatment of SUD in Pregnant Women (Initiation of Alcohol and Other Drug Treatment) (IET – I)

Value Set Name	Value Set OID
Alcohol Abuse and Dependence	2.16.840.1.113883.3.464.1004.1424
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013
AOD Medication Treatment	2.16.840.1.113883.3.464.1004.2017
Detoxification	2.16.840.1.113883.3.464.1004.1076
ED	2.16.840.1.113883.3.464.1004.1086
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Opioid Abuse and Dependence	2.16.840.1.113883.3.464.1004.1425
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426
ODU Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220
ODU Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221
ODU Weekly Non Drug Service	2.16.840.1.113883.3.464.1004.2222
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

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## Measure M6: Timely Transmission of Transition Record (Maternal Health)

Table Name	Table Description
Table BH09M06_01	Codes to Identify Patients Discharged from Inpatient Facility
Table BH09M06_02	Codes to Identify Discharge Exclusions

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## Measure M7: Treatment of Severe Hypertension

Table Name	Table Description
Table MH07_00	Recommended First-line Drug Therapies
Table MH07_01	Pre-existing or Gestational Hypertension, Eclampsia/Pre-eclampsia Codes
Table MH07_02	Gestational Edema and Unspecified Hypertension Codes

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Measure M8: 3-Item Care Transitions Measure (CTM-3)  
(TBD)

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Measure M9: Use of a Standardized Screening Tool for Social Determinants of Health  
(TBD)

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