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

v 1.3 (updated: November 30, 2021)

*Prepared by Public Consulting Group*

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# I. General Overview

## A. Background

The Quality Improvement Program – New Jersey (QIP-NJ) is a multi-year successor program to the Delivery System Reform Incentive Payment (DSRIP) program. Subject to federal Centers for Medicare and Medicaid Services (CMS) approval, QIP-NJ will be administered by New Jersey Department of Health (DOH, herein referred to as the State), in conjunction with the Department of Human Services (DHS), as a Medicaid pay-for-performance initiative, open to all acute care hospitals (ACHs) statewide. The primary purpose of QIP-NJ is to advance quality improvements in behavioral and maternal health services statewide.

Participating hospitals will earn QIP-NJ incentive payments by satisfying performance targets on State-selected quality measures that demonstrate:

- Improvements in connections to behavioral health services;
- Reductions in potentially preventable utilization for the behavioral health population;
- Improvements in maternal care processes; and
- Reductions in maternal morbidity.

The State has delayed the start date for the QIP-NJ, from July 1, 2020, as originally planned, to July 1, 2021. The State and DHS have received CMS approval for an interim time-limited directed payment, known as the QIP "Bridge" payment. ACHs will receive a per diem add-on payment for Medicaid Managed Care (MMC) hospital inpatient claims during the two periods of: July 1, 2020 – September 30, 2020; and October 1, 2020 – March 31, 2021. For more information, refer to the State's QIP-NJ "Bridge" Payment Memo.

The State convened a Quality Measures Committee (QMC), comprised of experts in the fields of mental health, substance use disorder (SUD), maternal health, and quality measurement, to provide on-going critical input for QIP-NJ. The performance measures proposed by the State and further recommended by the QMC for inclusion in the QIP-NJ are detailed within this "Funding Mechanics Protocol, Performance Measurement Specifications, and Data Submission Guidelines" (Databook) document.

This Databook provides submission guidelines and technical specifications for the eighteen selected quality measures (eleven of which relate to behavioral health populations and nine to maternal health populations, two measures are included across both populations). This Databook also includes program measurement methods for calculation, standardized diagnostic coding, measure reporting requirements, and incentive payment impact weights, among other elements.

Additional documents supporting the Databook, include:

- Addendum A: Value Code Sets by Measure (Value Set Compendium available in Excel)
- Addendum B: Standard Reporting Template
- Addendum C: Standard Reporting Template Guidance
- Addendum D: Databook Change Log

The first three addenda may be found on the QIP-NJ Resources page.

## B. Medicaid Management Information System (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, subject to CMS approval, will calculate claims-based measures on behalf of program participating hospitals.

Primarily, administrative claims data are generated from a wide array of services rendered in professional and institutional settings from various provider types. Subsequently, claims data are submitted and adjudicated within the MMIS. This information is then provided to CMS and retained in the federal Medicaid Statistical Information System (MSIS) data warehouse. Further, the data are copied and transferred for storage to another dedicated repository where it is maintained by a DMAHS vendor.

Individual utilization that may be used to measure quality performance are contained within administrative claims data. Primarily, this data captures the occurrence of a behavioral or maternal health service (or lack thereof). Retrospective claims analysis includes claims from relevant providers seen by the individual, not merely the hospital to whom the individual is attributed (section "Attribution Methodology Overview").

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

Although historically, medical records have been in the form of paper records, through Meaningful Use and other endeavors, many hospitals have shifted towards widespread adoption of 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 individual 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.

In calculating requiring non-claims-based measures, Hospitals may rely on multiple sources for searching and obtaining necessary data aligned with the measure's specifications and calculation methods. This could include both data abstracted from EHR systems as well as paper chart sources.

The State reserves the right to audit individual claims, charts, and EHR data to perform primary source validation to ensure that sampled data have been collected, interpreted, and transmitted correctly.

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

Two instrument-based measures are included in MY1. Each will be used to collect data specific to the behavioral and maternal health populations attributed to a participating hospital. Instrument-based measures are reporting only during MY1. Detail on the mechanics surrounding payment is detailed under section "Payment Arrangement". These two measures and their applicability to the two program populations are as follows:

| Measure # | Measure Name and National Quality Forum (NQF) # | Measure Steward | Impact on Payment |
|---|---|---|---|
| BH10 | 3-Item Care Transitions Measure (CTM-3) - NQF #0228 | University of Colorado Denver Anschutz Medical Campus | Reporting only |
| M8 | 3-Item Care Transitions Measure (CTM-3) – NQF #0228 | University of Colorado Denver Anschutz Medical Campus | Reporting only |
| BH11 | Use of a Standardized Screening Tool for Social Determinants of Health (4 Domains) | NJ DOH | Reporting only |
| M9 | Use of a Standardized Screening Tool for Social Determinants of Health (5 Domains) | NJ DOH | Reporting only |

*Figure 1. Non-claims-based measures: Instrument-based measures*

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

The provided data file format, known as the Standard Reporting Template, and submission instructions for chart / EHR and instrument-based measures are to be used as a guideline for creating standardized "flat file" submissions based on data abstracted from a participating hospital's EHR using the patient attribution rosters. These files must be pipe-delimited ("|") to enable additional delimiter values required in collected data (such as commas and dashes). If a hospital wishes to submit a flat file with alternative delimiters, they should contact the QIP-NJ team to discuss feasibility.

Hospitals must agree to this method of submission, discussed in the Technical Contact Forum series and presented in shared materials on the QIP-NJ Participants and Stakeholders page, and let the State know if a flat file will be used for submission of Baseline data by August 30, 2021.

Should a participating hospital be unable to develop required flat files, data must be entered either manually or via export into the Microsoft Excel template provided.

All collected data will undergo a preliminary validation review prior to importation into a repository where programming scripts will perform further verification processes. A summary report will be generated for

each file identifying any errors or incompleteness requiring additional action. Incentive payments will be contingent upon fully executing all program submission guidelines.

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

| DY | Measurement Period | Submission Deadline[1] | Results and MMIS Patient-Level Report (PLR) Released |
|---|---|---|---|
| Baseline (Y0) | 7/1/2020 – 12/31/2020 | 09/30/2021 | 12/06/2021 |
| MY1 | 7/1/2021 – 12/31/2021 | 07/22/2022 | TBD |

*Figure 1. Reporting schedule for submission of non-claims-based measures*

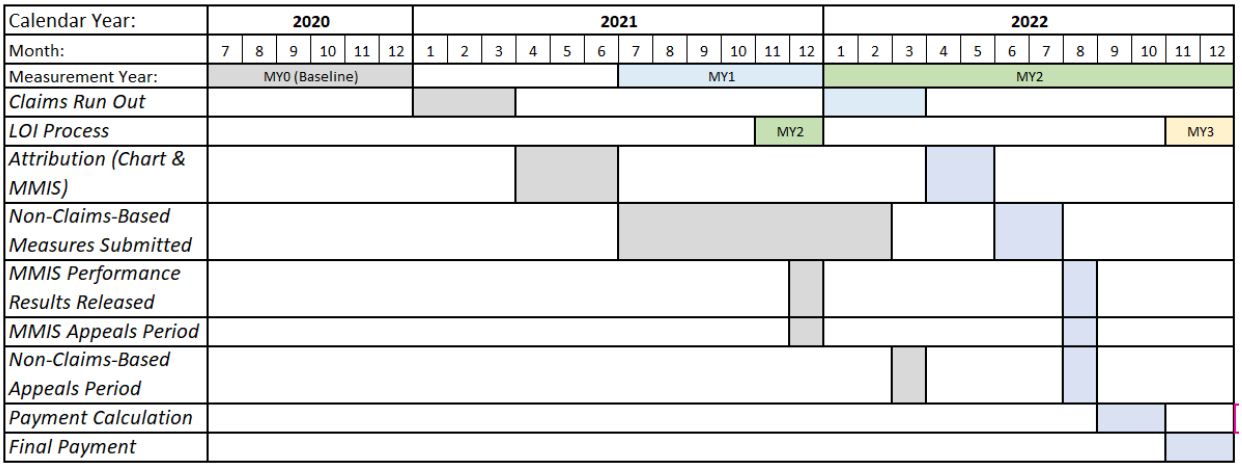


*Figure 2. QIP-NJ MY0-MY2 Timeline*

| Measurement Year (MY) | Dates |
|---|---|
| MY0 (Baseline) | July 1, 2020 – December 31, 2020 |
| MY1 | July 1, 2021 – December 31, 2021 |
| MY2 | January 1, 2022 – December 31, 2022 |
| MY3 | January 1, 2023 – December 31, 2023 |
| MY4 | January 1, 2024 – December 31, 2024 |
| MY5 | January 1, 2025 – December 31, 2025 |

*Figure 3. QIP-NJ MYs*

## G. Small Denominators

Where a hospital does not meet the minimum denominator requirement for a measure, the measure must still be reported (for non-claims-based measures) but will be removed from performance payment

[1] Date changed from 8/1/2021 to 8/2/2021.

consideration for the MY and the subsequent MY. Incentive payments attached to measures that have been removed will be reallocated across remaining measures for that population.

Hospitals must be able to satisfy the denominator reporting requirements of at least one measure per participating population (Behavioral Health or Maternal Health populations) to remain eligible for payments associated with that population. Minimum denominator requirements will vary by measure:

- MMIS - Denominator with fewer than 30 will not be included in payment calculations;
- Chart / EHR - Denominators with fewer than that which is identified by the applicable sampling table (30) will not be included in payment calculations.

## H. Payment Arrangement

### i. Gap-to-Goal Methodology

Participating hospitals are expected to achieve statewide performance benchmarks for each measure by the end of this multi-year program. Individual participating hospital targets, based on the hospital's baseline performance for each measure, will be assigned to hospitals annually using a gap-to-goal methodology. The State will first identify a uniform annual percentage of the gap between the statewide goal and baseline performance that each hospital must achieve on each measure. Full readjustment of annual percentages will occur for hospitals meeting performance targets, while partial readjustment will occur for hospitals failing to meet performance targets.

Payment amounts are be based on two factors:

*Behavioral health:*

1) The number of Medicaid Managed Care (MMC)-enrolled individuals with a principal diagnosis[2] of behavioral health who are attributed to the participating hospital for the measurement period, and;
2) Whether performance targets have been met.

*Maternal health:*

1) The number of MMC-enrolled individuals who delivered in the participating hospital during the measurement period, and;
2) Whether performance targets have been met.

To determine each hospital's payment, the State will annually generate a list of MMC-enrolled individuals attributed to each hospital during the measurement period. The State will then calculate for each hospital, their proportion of attributed patients in comparison to the entire program's eligible patient population. This proportion will determine the eligible share of total program incentive payments for each hospital.

[2] The principal diagnosis, as defined in the National Uniform Claim Committee (NUCC) Official UB-04 Data Specifications Manual, is "the condition established after study to be chiefly responsible for occasioning the admission of the patient for care" and is reported as the principal diagnosis on the claim.

The State shall then review the hospital performance on State-selected metrics across attributed population. For each metric there shall be a hospital-specific target set using the "gap-to-goal" methodology compared to a statewide goal.

All measures within both the behavioral health and maternal health populations are weighted equally. When a hospital meets or exceeds a measure's performance target or the statewide target, the hospital will earn a portion of their total possible funding, as determined by attribution. Funding shall not be awarded when the hospital fails to meet a measure's performance target (inclusive of partial achievement). In addition, should a hospital fail to submit the necessary data to calculate performance on non-claims-based measures, the hospital will forfeit funding across all measures for that population (maternal or behavioral health).

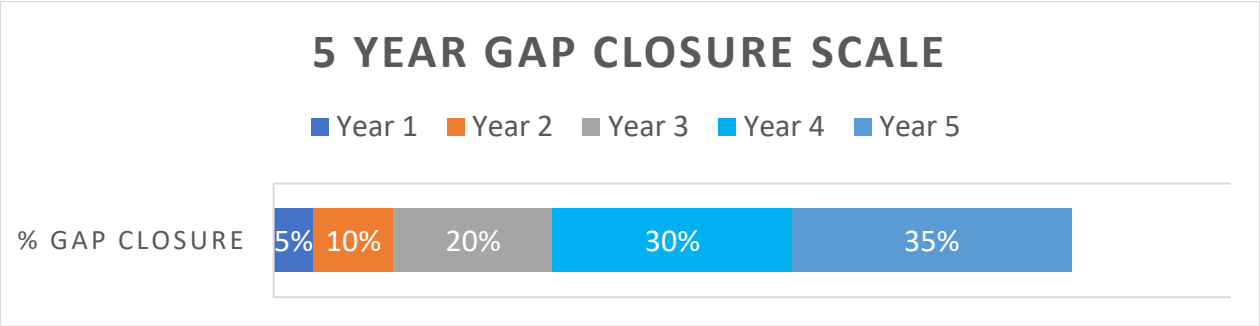


*Figure 3. QIP-NJ Five Year Gap Closure Scale*

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

Any hospital failing to meet a performance target will forfeit the measure's associated funding amount. Hospitals meeting or exceeding performance targets may be eligible to collect some proportion of these undistributed funds. The State shall assign the portion of undistributed funds to be redistributed through each measure. Hospitals meeting or exceeding their individual target on that measure shall receive a share of the unearned funds allocated to that measure, based on their share of attribution for the behavioral health or maternal health population. Should more than 85% of hospitals fail to meet performance targets on any given measure, all unearned funds associate with that measure will not be forfeit but will instead be redistributed across each hospital's remaining measures, within that measure set (maternal or behavioral health).

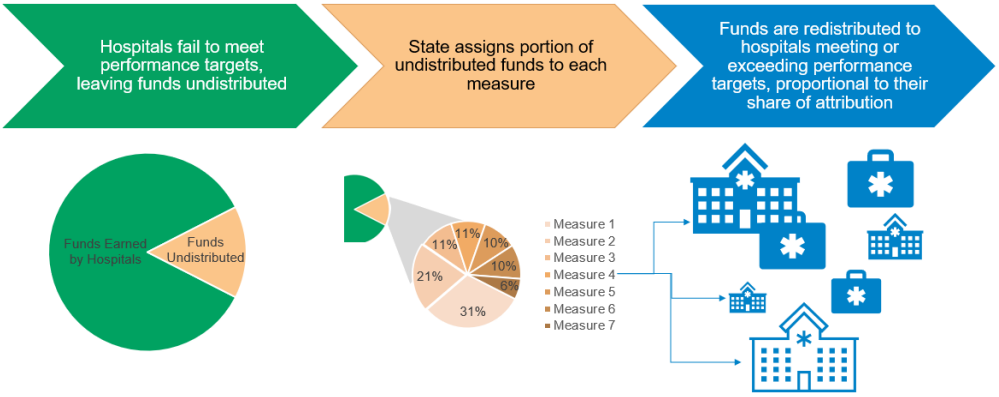


*Figure 4. QIP-NJ Redistribution Methodology*

### ii. Funds Flow

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 MMC-enrolled individuals 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 hospital specific payment amounts into rate cells and federal funding groups under the following categories: Expansion, Title XXI and non-Expansion Title XIX.

The State will provide the full funding for QIP-NJ through financial transactions to the Managed Care Organizations (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 proportionate to the volume of total payments by each MCO to the hospital during the rating period. The MCOs will be required to disburse single annual payments to hospitals in accordance with Managed Care contract conditions.

The State will provide a directed payment schedule to each MCO showing 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.

## I. Sampling Methodology

Sampling is permitted when calculating the following measures:

| Measure # | Measure Name and NQF # | Measure Steward | Data Source |
|---|---|---|---|
| BH7 | Preventative Care and Screening: Screening for Depression and Follow-Up – NQF #0418 | 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) | NJ DOH | Instrument-Based |
| M2 | PC-02 Cesarean Birth - NQF #0471 | Joint Commission | Chart/EHR |
| M3 | Measure M3: Postpartum Depression Screening – NQF #1401 | NCQA | Chart/EHR |
| M6 | Timely Transmission of the Transition Record- NQF #0648 | AMA-PCPI | Chart/EHR |
| M7 | Treatment of Severe Hypertension | Alliance for Innovation on Maternal Health (AIM) | 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) | NJ DOH | Instrument-Based |

*Figure 5. Chart/EHR Measures Eligible for Sampling*

Sampling may be permitted based upon of the volume of attributed individuals. For behavioral health measurement, this is determined by the total number of individuals in the attributed population with an encounter in an appropriate setting during the MY. For maternal health measurement, sampling is determined by the total number of attributed individuals admitted to the hospital for labor and delivery during the MY.

The sampling methodology used for QIP-NJ should follow:

Administrative pull → initial patient population (IPP) → # of resultant individuals in IPP used to determine sample size → randomize order of individuals on IPP list & pull sample → complete chart abstraction for selected sample → finalize metrics numerator and denominator.

If a hospital cannot eliminate exclusions and denominator non-compliant individuals prior to abstraction, they may use the initial patient population; however, they will need to backfill after abstraction to ensure there is a minimum denominator of 30.

| **Attributed Individuals Population Size (Denominator)** | **Calculated Minimum Random Sample Size** |
|---|---|
| >= 501 | 101 |
| 150 – 500 | 20% of the population |
| 30 – 149 | 30 |
| < 30 | No sampling permitted. 100% of the attributed individuals meeting the measure criteria must be reported. |

*Figure 6. Sample Size Calculation*

Sample Size Calculation Examples:

- A hospital has 700 behavioral health attributed individuals eligible for depression screening in MY1. Using the above table, 101 attributed individuals may be sampled.
- A hospital's maternal health total attributed individuals is 400. Using the above table, 400 * (0.20) = 80 attributed individuals may be sampled.
- A hospital has 43 behavioral health attributed individuals eligible for depression screening during the MY. Using the above table, 30 attributed individuals may be sampled.
- A hospital has 20 maternal health attributed individuals eligible for survey during the MY Using the above table, 100% of the attributed individuals must be reported; therefore, no sampling is permitted.

Hospitals choosing to report the results of the above measures based on a sampling methodology as opposed to reporting on all patients must ensure that all sampling conditions associated with that measure have been met. Each measure reported through a sample must include a description of steps taken to validate that sampling requirement have been met.

When a sample is taken for a measure and exclusions force that population below the 30- patient denominator requirement, the process for backfilling patients is as follows:
• Step 1: Identify the eligible population from the attribution roster and remove all required exclusions based upon the respective measure specifications. All required exclusions must be removed from the final eligible population.
• Step 2: Search chart/EHR systems to identify numerator events for all members in the eligible population.
• Step 3: If applicable, for members for whom non-claims-based data do not show a positive numerator event (numerator compliance), search non-claims-based data for an exclusion to the service/procedure being measured.
Step 4: Exclude from the eligible population, members from step 3 for whom system data identified an exclusion to the service or procedure being measured.

## J. Measure Stewards and Citations

QIP-NJ performance measures were selected based in part, upon their endorsement by industry leading standards organizations. Each entity that develops a given measure is referred to as that measure's steward and as such is responsible for updating the measures specifications. Measure specifications that are made available to the public typically include descriptions of inclusionary and exclusionary conditions related to measure numerators and denominators. Prevailing debate related to the applicability of a particular measure or its limitations or advantages when compared to other similar measures are also frequently included in measure specifications. The measure steward is identified for each state-selected quality 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.

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 (SHTN) 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 AMA-PCPI®; PCPI® has neither reviewed nor approved the modified measure. Although AMA-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. CMS
    - Measure content has been sourced from CMS. CMS has neither reviewed nor approved the modified measure.
5. The Joint Commission
    - The Specifications Manual for National Inpatient Quality Measures is the collaborative work of the CMS 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 Healthcare Effectiveness Data and Information Set (HEDIS), Volume 2, Technical Specifications for Health Plans by NCQA and modified by QIP-NJ. HEDIS® is a registered trademark of the NCQA. NCQA has neither reviewed nor approved these modified measures.
7. NJ DOH
    - NJ DOH is working to compile a list of appropriate screening tools for Social Determinants of Health (SDOH). If a tool is not listed in the measure specification for BH11 / M9, hospitals must submit their tool to QIP-NJ@pcgus.com for approval and to map the domains for data collection.
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, measure specifications as maintained by stewards have been adhered to within the Databook. In some instances, however, it is necessary to adjust measure specifications to better align with the goals, and populations (e.g., measurement periods, age requirements, state billing guidelines) of QIP-NJ.

Where applicable, material deviations from measure steward specifications have been indicated along with the reason underlying the change. Measure specifications and referenced code sets have been

updated to reflect current recommendations though these may be further updated prior to the start each program year.

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. As necessary, the Databook will be updated in a way which indicates whether a newer or older version is to be followed and what additional changes may be relevant to the QIP-NJ program. The State reserves the right to adjust elements of the measurement specifications and the statewide benchmark based on performance prior to the start of the next measurement period.

Especially during the first year of QIP-NJ, continual assessment of hospital data collected and frequent touchpoints and collaboration with stakeholders to help inform decision-making regarding the measures' status, which may include but not be limited to determining whether the current measures' specifications, benchmarks, and payment structure require modifications and, whether measures will be added into (and/or subtracted from) the two domains.

## K. Attribution Methodology Overview

At the close of each measurement period and its necessary claims runout period, DOH will extract claims data related to the attributed populations. Attribution rosters will then be developed using the following process:

Maternal Health: Attribution for the maternal health population will be determined by the following criteria:

- The hospital at which a birth occurs,
- The admission date for that birth, and
- MMC[3] enrollment as of December 31st of the applicable measurement year.

This allows for an individual giving birth prior to enrollment in MMC to be attributed so long as they are enrolled by the close of the MY and the birth is documented on a Medicaid paid claim.

Behavioral Health:

The following steps apply to the BH attribution process:

Step 1 - an individual must meet the diagnosis and utilization-based eligibility criteria to be deemed attributable. The primary diagnosis[4] may be from any provider, at any point in the measurement period, not just the provider visit(s) that lead(s) to their attribution at a specific hospital.

[3] The five health plans that currently participate in NJ FamilyCare program: Aetna, AMERIGROUP NJ, Horizon NJ Health, UnitedHealthcare NJ, and WellCare. If an individual is enrolled in either the HMO or D-SNP of any of these five health plans, they are considered eligible. These plans may be the primary or secondary payers for the enrolled beneficiary. Individuals enrolled in PACE, Medicare Advantage, and other commercial insurance plans are not eligible for QIP-NJ (refer to 2021 NJMMIS Quick Guide, section "21. HMO/D-SNP/PACE Plan Names" (031099).
[4] The BH primary diagnoses are catalogued in the Value Set Compendium (VSC), tab "BH09_00"; the M primary diagnoses are catalogued in tab "M06_00". The UB revenue codes are catalogued in tab "App_Revenue" starting in v1.2 of the VSC.

Step 2 – using the BH attribution hierarchy, the individual is assigned to the hospital most likely to impact their quality of BH care, regardless of the diagnoses on the claims at that facility.

To this end, an outpatient Obstetrical claim could attribute an individual under the "outpatient physical health" level of the hierarchy, even if the primary diagnosis on the claim is pregnancy-related, so long as the individual was not already attributed at the level above it on the hierarchy.

The hierarchy for BH is as follows:

- For individuals who have three or more outpatient behavioral health claims during the MY, AND two or more outpatient behavioral health claims with a single hospital, the individual will be attributed to the hospital at which the plurality of the individual's outpatient behavioral health claims have been submitted.
- For individuals not attributed through the above step, who have three or more outpatient physical health claims during the MY, AND two or more outpatient physical health claims with a single hospital, the individual will be attributed to the hospital at which the plurality of the individual's outpatient physical health claims have been submitted.
- For individuals not attributed through any of the aforementioned steps, who have three or more emergency department claims during the MY, AND two or more emergency department claims with a single hospital, the individual will be attributed to the hospital at which the plurality of the individual's emergency claims have been submitted.
- For individuals not attributed through any prior step, if the individual has any inpatient claims (Maternity, Psych or Med/Surg), the individual will be attributed to the hospital at which the plurality of the individual's inpatient claims has been submitted.
- If none of the above criteria are met, the individual will not be attributed to any participating hospital.

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.

As part of the Program Evaluation design for QIP-NJ, attribution results will be reviewed annually for:

- Aggregate attributable population over projections/baseline; and
- Growth or loss in volume over baseline for each hospital, where changes over 10% will trigger a data integrity review.

### i. MMIS Measures

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

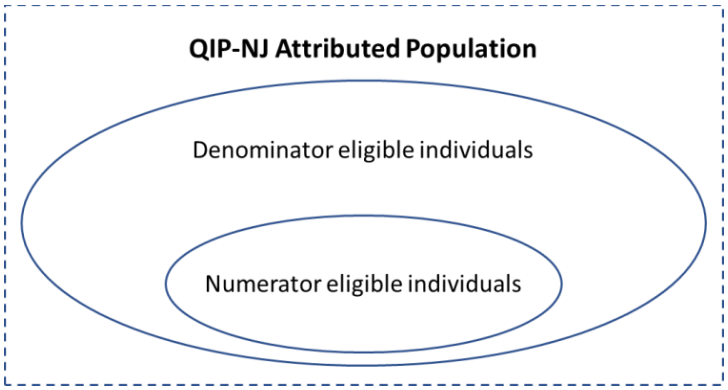


*Figure 7. QIP-NJ Attributed Population for MMIS measures*

Step 1: The State identifies the hospital-specific attributed population for each MMIS-calculated measure.

Step 2: Of those attributed individuals, the State identifies individuals satisfying denominator (D) inclusion criteria.

Step 3: Of denominator eligible individuals, the State identifies individuals that meet numerator (N) inclusion 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. The setting of care for each measure is indicated in the Measure Specification Description and Definitions.

a. Inpatient or ED Setting – refers to any MMIS measure that only considers care provided within inpatient or ED settings. This could be monitoring a single episode of care or comparing care across inpatient or ED events[5].
b. 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, etc.). 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 (such as follow-up after inpatient hospitalization with an outpatient service), or to capture diagnosis and/or procedure codes to reflect an individual's treatment history in multiple eligible settings (screening events taking place in both outpatient and ED setting).

[5] For further insight into place of service definitions, refer to the value code set associated with each specific measure.

## ii. Chart / EHR Measures

The steps that follow describe the process that participating hospitals will take to abstract and calculate measures that require chart or EHR-collected data. In addition to the steps highlighted below, hospitals will need to complete the Standard Reporting Template containing individual level information including, but not limited to, Medicaid ID, patient name, date of birth, and inclusion in the numerator and/or denominator of each measure. Hospitals must retain copies of any reports that pertain to steps taken to calculate chart/EHR measures in case of audit.

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

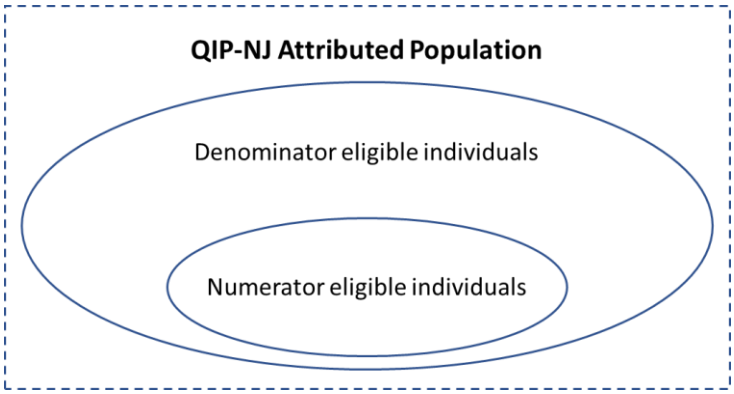


*Figure 8. QIP-NJ Attributed Population for Chart/EHR measures*

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 individuals only. This query always first includes looking for the measure-specific denominator eligibility criteria as outlined in measure specification and detailed by measure steward specifications.

For measures not using a sampling methodology:

> Step 3: The hospital reviews patient records to determine if numerator (N) compliance criteria have been met.

For measures using a sampling methodology:

> 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 reviews the sampled patient records to determine if numerator compliance criteria have been met.

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

## L. Data Specification Conditions

### i. MMIS Represented Data

The data made available for QIP-NJ performance measurement on state-selected quality measures is inclusive of paid claims for both Medicaid fee-for-service and managed care encounters.

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

Hospitals shall adhere to the measurement time periods identified in the specifications for each QIP-NJ state-selected quality measure. Several time periods affect performance measures, each of which will be updated for each applicable reporting year (MY1 has been included below for illustrative purposes):

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 individual to be included in the population. This prior period is referred to as the look-back period.
b. Performance Period – Indicates the specific duration of time in which the dates of service must take place to be considered to meet measure criteria. This may be differ from the MY. As an example, for measures where follow up must occur within 30 days, the last date of the performance period where the index visit may occur is December 1st, not December 31st which is the last day of the MY.
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 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 indicates the baseline period. For MMIS measures, 2020 data will be utilized to set the measures' QIP-NJ targets in later years. The baseline period for the majority of chart/EHR measures will utilize 2020 abstracted data unless otherwise noted.

### iii. Eligible Population

Eligible populations for QIP-NJ includes all MMC 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 program's attribution model (section "Attribution Methodology Overview"). The denominator is identified as a subset of these assigned individuals based upon meeting each measure's specific eligibility criteria. Certain measures have specific requirements surrounding continuous enrollment during the performance period. Continuous enrollment means that individuals are enrolled in health coverage with minimal gaps to keep them in the attributable population for maternal and/or behavioral health.

### iv. Age Criteria

The age criterion is specific to each measure. For all behavioral health measures, the minimum age is 18. There are no such minimum criteria for maternal health. Measure specifications should always be consulted for specific age-related criteria. Age may be calculated as of the last day of the measurement period or the date of the service relative to the individual's date of birth, depending on the specific measure criteria, unless otherwise specified.

Measure results can be categorized into population age ranges to enable disaggregated reviews of clinical care outcomes for various age groups. Measure steward age stratifications were followed unless age ranges were considered too narrow or too broad to effectively address QIP-NJ priority population health improvement goals. When present, the age stratification that applies to P4P incentive payments will be the "Total" age group unless otherwise indicated.

### v. Coding Guidance

a. Code Specificity – Appendix A has been updated to include Value Sets with the highest degree of specificity and should be used when calculating measure results. Within 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, International Classification of Diseases (ICD)-10- Clinical Modification (CM) codes. For measures that have not been updated, ICD-10-CM codes were mapped (forward only from ICD- 9-CM to ICD- 10-CM) using the Agency for Healthcare Research and Quality (AHRQ) Map IT 2015 tool: http://www.qualityindicators.ahrq.gov/resources/Toolkits.aspx. Therefore, measure stewards that continue to use older versions will have been updated to reflect updated code sets. Although some exclusionary conditions require extensive lookback periods, inclusion of ICD-9-CM coded claim submissions is unlikely.
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 and/or billing practices of your organization.
d. The State is responsible for overseeing the proper calculation of measures for the program. Hospitals are responsible for submitting claims in accordance with NUBC / NUCC guidance and must submit non-claims-based data in accordance with the specifications for QIP-NJ. This includes but is not limited to:
    1. Code sets associated with institutional and professional billing (denoted as UB-04 and CMS-1500, respectively and borne out of primary reimbursement methodologies that are inpatient prospective payment and physician-fee-for-service) which may include:
        i. Type of bill
        ii. Place of service
        iii. Diagnostics
        iv. Procedures: (including ICD-10-PCS, UB Revenue codes, Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS Level II), modifiers)
        v. Provider type/taxonomy

2. Code sets that represent elements of an episode of care not traditionally reimbursed, including Logical Observation Identifiers Names and Codes (LOINC), among others.[6]

e. The State will not allow for modifications to measure specifications where hospital billing or clinical practices do not align with the way performance is measured under QIP-NJ.

### vi. 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 NJ Medicaid claim processing were identified through billing supplements and training documents located within the NJ MMIS website.

## M. MMIS Measure Acknowledgment Process

MMIS data measure results will be made available to hospitals for viewing and export for all applicable reporting periods. Participating hospitals are required to provide an acknowledgement to the State that they have received and reviewed measure numerators, denominators, and calculated results. Results files will be made available through the program's secure file transfer protocol (SFTP) (https://sftphealth.pcgus.com/) and accessed through each hospital's username and password authentication.

## N. Measure Specification 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, NQF number (if applicable), the measure steward and measure steward version (if applicable).
2. The second section includes the "Measure Calculation Description." This section provides information required to calculate the measure including its numerator, denominator, result information and any qualifications to the criteria that provide additional information.
3. The third section included the "Measure Collection Description" and provides fields related to the collection process. For example: the setting of care, reporting parameters or whether sampling, continuous eligibility or risk adjustment applies to the measure. This section also includes improvement target goal details (not included for Year 1) and identifies the financial incentive award as either non-payment or P4PThe "Data Elements" section flags key variables to note in the collection process.

[6] This is not an exhaustive listing of coding; consult the value sets per measure for further guidance.

# 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 | 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 | 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 | 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 | 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 | 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 | 11.11% |
| BH7 | Preventative Care and Screening: Screening for Depression and | CMS | Chart/EHR | "Year 0" (7/1/2020-12/31/2020) Hospital | Pay-for-performance in all years | 11.11% |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Follow-Up – NQF #0418 | | | reported data | | |
| 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 | 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 | 11.11% |
| BH10 | 3-Item Care Transitions Measure (CTM-3) | University of Colorado Denver Anschutz Medical Campus | N/A | "Year 0" (7/1/2020-12/31/2020) Hospital reported data | Reporting only | 0% |
| BH11 | Use of a Standardized Screening Tool for Social Determinants of Health | NJ DOH | N/A | "Year 0" (7/1/2020-12/31/2020) Hospital reported data | Reporting only | 0% |

*Figure 9. Behavioral Health Measures Grid*

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

| Measure Description: |
|---|
| This measure calculates an unplanned, 30-day readmission rate for adults 18 to 64 years of age with a principal discharge diagnosis of a psychiatric disorder within a twelve-month period. |

| Data Source: | NQF #: |
|---|---|
| **MMIS** | **Based on 2860** |
| Measure Steward: | Measure Steward Version: |
| **CMS** | **June 12, 2019** |

| Statewide Target: |
|---|
| **25%** |

**Numerator:**
A readmission is defined as any "unplanned" admission to an ACH. Hence, the numerator is defined by filtering out "always planned" and "potentially planned" diagnoses and procedures. 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.

Excludes:

- "Always planned" (Tables BH01_01, BH01_02), and "potentially planned" (Tables BH01_03) readmission diagnoses and procedures. 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).
- A subsequent admission on day of discharge and following 2 days (days 0, 1 and 2) due to transfers/interrupted stay period.

**Denominator:**
Of the hospital's attributed behavioral health population, eligible index admissions with a principal diagnosis of a psychiatric disorder (Table BH01_00).

This process defines planned readmissions based on criteria from the CMS 30-day Hospital-Wide All-Cause Readmission (HWR) Measure Planned Readmission Algorithm, version 4.0.[7] 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. "Always planned" (Tables BH01_01, BH01_02) and

[7] 2020 HWR Readmission Measure Updates and Specifications Report

"potentially planned" (Tables 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**:
The denominator excludes admissions for individuals:

- "Always planned" (Tables BH01_01, BH01_02), and "potentially planned" (Tables BH01_03) readmission diagnoses and procedures. 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).
- Discharged against medical advice (AMA)
- With unreliable data (e.g., has a death date but also admissions afterwards)
- Missing age or gender

---

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Lower

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**Data Elements**:
- Attributed to the BH population
- 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 from Medicare FFS
- 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 diagnosis
- 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

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
- http://www.qualityforum.org/QPS/2860

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

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

| Measure Description: |
|---|
| The percentage of discharges for individuals 18 to 64 years of age 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: | NQF #: |
|---|---|
| **MMIS** | **Based on 0576** |
| Measure Steward: | Measure Steward Version: |
| **NCQA** | **HEDIS® MY 2020 & MY 2021**<br>**June 28, 2017** |
| Statewide Target: | |
| **75%** | |

## Measure Calculation Description

**Numerator:**

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

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

- For services provided by a hospital, individuals must have received a qualifying mental health follow up service (Table BH02_Nondx: Mental Health Follow-Up Revenue Value Set)
- For services provided in the community in the following settings (Table BH02_POS: NJ Place of Service Value Set):
    - Doctors Office (1)
    - Patient's Home (2)
    - Clinic (8); or
    - Other (9)

  Individuals must have received a qualifying mental health follow up service (Table BH02_Nondx: Mental Health Follow-Up CPT/HCPCS Value Set).

**Denominator:**

Of the hospital's attributed population, those individuals discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental illness or intentional self-harm diagnosis (Table BH02_DetailOID: Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge) on or between July 1 and December 1 of the MY 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 individuals. If individuals have more than one discharge, include all discharges on or between July 1 and December 1 of the MY.

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 MY.
- 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 (Follow-up After Hospitalization for Mental Illness (FUH) – 30 Days After Discharge), 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.

**Exclusions**:

- 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 MY.
- 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).
- 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.
- Exclude individuals receiving Adult Mental Health Rehabilitation (AMHR) within the same calendar month or calendar month subsequent to the index admission (Table BH02_AMHR: Adult Mental Health Rehabilitation (AMHR) Value Set).
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).
- Exclude individuals under age 18 or over age 64 at time of initial admission.

**Result:**

The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Limited to individuals aged 18 -64.
- Deleted from the numerator: Mental Health Practitioner Value Set, which removed the mental health provider requirement for follow-up visits; mental health services are identified using the Mental Health Fee-for-Service Program Provider Manual (Version 4.8.2, January 2021).
- Deleted values sets: Ambulatory Surgical Center POS, Behavioral Healthcare Setting, BH Outpatient, Community Mental Health Center POS, Electroconvulsive Therapy, Observation, Outpatient POS, Partial Hospitalization or Intensive Outpatient, Partial Hospitalization POS.
- Two rates, one for 30 day and 7 day, are traditionally reported; only the 30 day is required. The performance period has been shortened to between July 1 and December 31 to align with the QIP-NJ reporting timeline.

**Data Elements:**

- Attributed to the BH population
- Place of Service (020300 2021 NJMMIS Quick Guide)
- Mental Health Outpatient Billing (Revenue, CPT, HCPCS) Code
- Index admission date
- Principal discharge diagnosis
- 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/0576

| Measure Collection Description | | | |
|---|---|---|---|
| Setting of Care:<br>**Multi-setting (see claim types below)** | | Reporting Period:<br>**Annual** | |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**11.11%** | |
| Claim Type(s):<br><br>**01, 03, 04, 06, 14, 15, 18, 19, 22** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **Yes** | Risk Adjustment: **No** | Sampling: **No** | |
| Continuous Eligibility / Sampling Methodology: **The individual 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 an individual is eligible for consideration into this measurement cohort. No sampling is permitted.** | | | |

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

| Measure Description: |
|---|
| The percentage of discharges for individuals 18 to 64 years of age who had a visit to the ED with a principal diagnosis of alcohol or other drug dependence (AOD) during the MY AND who had a AOD use treatment follow-up visit with any provider within 30-days of discharge (31 total days). |

| Data Source: | NQF #: |
|---|---|
| **MMIS** | **Based on 3488** |
| Measure Steward: | Measure Steward Version: |
| **NCQA** | **HEDIS® 2020 & MY 2021**<br>**October 4, 2019** |
| Statewide Target: | |
| **25%** | |

## Measure Calculation Description

**Numerator:**
An AOD use treatment follow-up visit (AOD Treatment Service Follow-up CPT/HCPCS Value Set) with any provider, within 30 days (31 total days) after emergency department discharge with a principal diagnosis of AOD. Include visits that occur on the date of the ED visit. Claims must have the appropriate modifiers to indicate substance use treatment services, as identified in the AOD Treatment Value Set.

Any one of the following meets the criteria for an AOD follow-up visit:

- For services provided in the community in the following settings (NJ Place of Service Value Set):
  - Outpatient Hospital (7)

  Individuals must have received a qualifying AOD follow up service (AOD Treatment Service Follow-up CPT/HCPCS Value Set)
- For services provided in the community in the following settings (NJ Place of Service Value Set):
  - Doctors Office (1)
  - Patient's Home (2)
  - Clinic (8); or
  - Other (9)

Individuals must have received a qualifying AOD follow up service (AOD Treatment Service Follow-up CPT/HCPCS Value Set).

**Denominator:**
An ED visit (BH03_DetailOID->ED Value Set) with a principal diagnosis of AOD abuse or dependence (BH03_DetailOID-> AOD Abuse and Dependence Value Set) on or between July 1 and December 1 of the MY where the individual was 18 years of age through 64 years of age on the date of the visit.

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

If an individual has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an individual 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.

**Exclusions**:

- Exclude if the index admission results in an observation (Observation Value Set).
- Exclude ED visits that result in an inpatient stay (Inpatient Stay Value Set) and ED visits followed by an admission to an acute or nonacute inpatient care setting (Nonacute Inpatient Stay Value Set) 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: Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).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.
- Exclude 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 individual 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 principal 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.
- Exclude if individual used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

**Result:**
Percentage

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Limited to individuals aged 18-64.

- Deleted values sets: IET Stand Alone Visits, OUD Weekly Non-Drug Service, OUD Monthly Office Based Treatment, IET Visits Group 1 and Group 2, Telephone Visits, Online Assessments.
- Added in an AOD Treatment Service Follow-up CPT/HCPCS Value Set based on NJ MMIS billing codes.
- Two rates, one for 30 day and 7 day, are traditionally reported; only the 30 day is required.
- The performance period has been shortened to between July 1 and December 31 to align with the QIP-NJ reporting timeline.

**Data Elements:**

- Attributed to the BH population
- Place of Service (020300 2021 NJMMIS Quick Guide)
- AOD Treatment Service Follow-up CPT/HCPCS Value Set
- Index admission date
- Principal discharge diagnosis
- Discharge disposition status
- Follow up visit billing (Revenue, CPT, HCPCS) code
- Follow up visit date

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 | | | |
|---|---|---|---|
| Setting of Care:<br>**Multi-setting (see claim types below)** | | Reporting Period:<br>**Annual** | |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**11.11%** | |
| Claim Type(s):<br>**03, 04, 06, 14, 15, 18, 19, 22** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **Yes** | Risk Adjustment: **No** | Sampling: **No** | |
| Continuous Eligibility / Sampling Methodology: **The individual 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 an individual is eligible for consideration into this measurement cohort. No sampling permitted.** | | | |

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

| Measure Description: |
|---|
| The percentage of discharges for individuals 18 to 64 years of age who had a visit to the emergency department with a principal diagnosis of mental health or intentional self-harm during the MY and who had a follow-up visit for mental illness within 30-days of discharge (31 total days). |

| Data Source: | NQF #: |
|---|---|
| **MMIS** | **Based on 3489** |
| Measure Steward: | Measure Steward Version: |
| **NCQA** | **HEDIS® MY 2020 & MY 2021**<br>**October 24, 2019** |
| Statewide Benchmark: | |
| **75%** | |

## Measure Calculation Description

**Numerator:**
Individuals who received a mental health follow-up visit within 30 days after ED visit (31 total days). Includes visits that occur on the date of the ED visit.

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

- For services provided by a hospital, individuals must have received a qualifying mental health follow up service (Table BH04_Nondx: Mental Health Follow-Up Revenue Value Set)
- For services provided in the community in the following settings (Table BH04_POS: NJ Place of Service Value Set):
    - Doctors Office (1)
    - Patient's Home (2)
    - Clinic (8); or
    - Other (9)

  Individuals must have received a qualifying mental health follow up service (Table BH04_Nondx: Mental Health Follow-Up CPT/HCPCS Value Set).

**Denominator:**
Individuals who were treated and discharged from an ED with a principal diagnosis of mental health or intentional self-harm on or between July 1 and December 1 of the MY.

An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Mental Health Diagnosis; Intentional Self-Harm Value Set) on or between July 1 and December 1 of the MY where the individual was 18 years of age through 64 years of age on the date of the visit.

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

If an individual has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an individual 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.

**Exclusions**:

- 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.

- 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 principal 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.

- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).
- Exclude individuals receiving Adult Mental Health Rehabilitation (AMHR) within the same calendar month or calendar month subsequent to the index admission (Table BH04_AMHR: Adult Mental Health Rehabilitation (AMHR) Value Set).

**Result:**
Percentage

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

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

- Measure description for individuals 6 years of age and older; only individuals 18 years of age and older are included for QIP-NJ.
- Deleted from the numerator: Mental Health Practitioner Value Set, which removed the mental health provider requirement for follow-up visits; mental health services are identified using the Mental Health Fee-for-Service Program Provider Manual (Version 4.8.2, January 2021). Two rates, one for 30 day and 7 day, are traditionally reported; only the 30 day is required.

The performance period has been shortened to between July 1 and December 31 to align with the QIP-NJ reporting timeline.

**Data Elements:**

- Attributed to the BH population
- Principal discharge diagnosis
- Discharge date
- Discharge disposition status
- Follow up visit billing (Revenue, CPT, HCPCS) code
- 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 | | | |
|---|---|---|---|
| Setting of Care:<br>**Multi-setting (see claim types below)** | | Reporting Period:<br>**Annual** | |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**11.11%** | |
| Claim Type(s):<br>**03, 04, 06, 14, 15, 18, 19, 22** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **Yes** | Risk Adjustment: **No** | Sampling: **No** | |
| Continuous Eligibility / Sampling Methodology: **Individuals 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 an individual is eligible for consideration into this measurement cohort. No sampling permitted.** | | | |

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

Measure Description:
The percentage of individuals 18 to 64 years of age 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:<br>**MMIS** | NQF #:<br>**Based on 0004** |
|---|---|
| Measure Steward:<br>**NCQA** | Measure Steward Version:<br>**HEDIS® MY 2020 & MY 2021**<br>**June 10, 2019** |
| Statewide Benchmark:<br>**50%** | |

## Measure Calculation Description

**Definitions:**

| | |
|---|---|
| Intake Period | July 1–November 13 of the MY. The Intake Period is used to capture new episodes of AOD abuse and dependence. |
| Index Episode | The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.<br>*For ED or observation visits that result in an inpatient stay*, the inpatient discharge is the index episode. |
| Date of service for services billed weekly or monthly | For an opioid treatment service that bills monthly or weekly (Table BH0506M05_IET_DetailOID: IET Master Table > OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events). |
| IESD | Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.<br>*For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay),* the IESD is the date of service.<br>*For an inpatient stay or for detoxification that occurred during an inpatient stay,* the IESD is the date of discharge.<br>*For detoxification* (other than detoxification that occurred during an inpatient stay), the IESD is the date of service. |

| | |
|---|---|
| | *For ED or observation visits that result in an inpatient stay,* the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).<br>*For direct transfers*, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort). |
| Negative Diagnosis History | A period of 60 days (2 months) before the IESD when the individual had no claims/encounters with a diagnosis of AOD abuse or dependence.<br>*For an inpatient stay,* use the admission date to determine the Negative Diagnosis History.<br>*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.<br>*For direct transfers,* use the first admission to determine the Negative Diagnosis History. |
| Direct transfer | A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:<br>An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.<br>An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.<br>An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.<br>Use the following method to identify admissions to and discharges from inpatient settings.<br>1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).<br>2. Identify the admission and discharge dates for the stay. |

**Numerator:**
Individuals who have initiation of AOD treatment within 14 days of the Index Episode (IESD).

- If the IESD 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 individual is compliant.
- If the IESD 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 individual is compliant.
- If the IESD was not an inpatient discharge, the individual 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 IESD 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 IESD 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 IESD 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 an individual is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the individual only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.

- Exclude the individual 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 MY.

**Denominator:**
Individuals 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 individuals 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.
    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 individuals with more than one episode of AOD abuse or dependence, use the first episode.

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

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

The total is not a sum of the diagnosis cohorts. Count individuals 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 individual with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

**Step 3:** Test for Negative Diagnosis History. Exclude individuals 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. Individuals 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**:

- Exclude individuals 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.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- 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.
- Limited measure to individuals aged 18-64.
- 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 MY1.

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

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

| Measure Description: |
|---|
| The percentage of individuals 18 to 64 years of age who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit. |

| Data Source: | NQF #: |
|---|---|
| **MMIS** | **Based on 0004** |
| Measure Steward: | Measure Steward Version: |
| **NCQA** | **HEDIS® MY 2020 & MY 2021**<br>**June 10, 2019** |
| Statewide Benchmark: | |
| **20%** | |

## Measure Calculation Description

**Numerator:**

Individuals 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 individuals compliant for the Initiation of AOD Treatment numerator.

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

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

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

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

These individuals 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 (OUD 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 individual is compliant for multiple cohorts,* only count the individual once for the Total Engagement numerator. The Total column is not the sum of the Diagnosis columns.

***Alcohol Use Disorder Treatment Medications List***

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

***Opioid Use Disorder Treatment Medications List***

| Description | Prescription |
|---|---|
| Antagonist | • Naltrexone (oral and injectable) |
| Partial agonist | • Buprenorphine (sublingual tablet, injection, implant) |

| | |
|---|---|
| | • Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film) |

- For individuals 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.

**Denominator:**
Individuals 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 IESD. Identify all individuals 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 individuals with more than one episode of AOD abuse or dependence, use the first episode.

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

The total is not a sum of the diagnosis cohorts. Count individuals 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 individual with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

**Step 3:** Test for Negative Diagnosis History. Exclude individuals 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. Individuals 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**:

- Exclude individuals 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.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- 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.
- Limited the age range of the measure to 18-64 years of age.
- 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 MY1.

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

# Measure BH7: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (PDS)

| Measure Description: |
|---|
| Percentage of individuals 18 to 64 years of age 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: | NQF #: |
|---|---|
| **Chart/EHR** | **Based on 0418** |
| Measure Steward: | Measure Steward Version: |
| **CMS** | **September 21, 2020** |
| Statewide Benchmark: | |
| **80%** | |

## Measure Calculation Description

**Numerator:**
Individuals who received a hospital outpatient or ED visit screen for depression (Table BH07_01: Codes to Document Depression Screen) on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool (as indicated by Logical Observation Identifiers Names and Codes (LOINC), if available, Table BH07_03, and tool score, or medical notes that clearly reflect the tool name and tool score that may be entered into the Standard Reporting Template) and, if positive, a follow-up plan is documented on the date of the eligible encounter, at least once during the measurement period.[8] If an individual has multiple screenings during the measurement year, a follow up must be documented following a positive screen on at least one of those encounters to be considered numerator compliant.

Any one of the following meets the criteria for an encounter:

- Revenue or CPT code (Table BH07_00: ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set *)

**Approved depression screening tools**:
1A. Beck Depression Inventory (BDI)
1B. Beck Depression Inventory (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-2)

[8] Individuals seen multiple times during the measurement period for an eligible encounter need not be screened more than once, unless clinically indicated.

7. Patient Health Questionnaire (PHQ-9*)
8. PROMIS Depression Total Score (T Score)
9. Zung Self-Rating Depression Scale
10. Other
11. Columbia Suicide Severity Screen (C-SSRS)

*The PHQ-2 should be used as a "first-step" approach; if the individual screens positive, they should be further evaluated with the PHQ-9.

*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 individuals 18 through 64 years of age at the beginning of the measurement period with at least one eligible outpatient or ED encounter (BH07_00) during the measurement period.

**Exclusions:**

- An individual is not eligible if one or more of the following diagnoses (Table BH07_02a) are documented in the 12 months prior to the measurement period,
- Individual is in hospice (Table BH07_02b), or
- Individuals who are receiving Adult Mental Health Rehabilitation (AMHR) within the same calendar month or calendar month subsequent to the index admission (Table BH07_02c).

***Exceptions***[9]*:*
Individuals with a documented reason for not screening for depression:

- Individual refuses to participate (G8433, Screening for depression not completed, documented reason); examples may include:
    - Individual is in an emergent situation where time is of the essence and to delay treatment would jeopardize the individual's health status,

[9] Denominator exceptions are conditions that remove a patient from the denominator only if the numerator criteria are not met (depression screening not completed, reason documented, e.g., medical reason for not performing a screening). Patients meeting the denominator exception criteria should still be reported. They allow for the adjustment of the final calculated score for hospitals exhibiting higher risk populations and are only used in proportional eMeasures. Clinical codes representing what constitute an exception will be evaluated following submission of Baseline data and will be made available for MY1.

- The individual'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.

**Result:**
Percentage

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Setting has been expanded to both the ED and hospital outpatient setting
- Age is modified from 12 years and older to 18 years and older
- The list of CPT codes and HCPCS codes from BH07_00 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; If LOINC is not captured in the EHR, the Standard Reporting Template has lookup options for the tool name
- Continuous eligibility requirements have been removed for this measure

**Data Elements**

- Attributed to the BH population
- Screening (index) date
- Encounter date
- Screening tool used
- Screening tool result
- Follow up plan documented
- 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:

- https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/ffy-2020-hh-core-set-manual.pd_2.pdf
- http://www.qualityforum.org/QPS/0418

## Measure Collection Description

| Setting of Care:<br>**ED or Outpatient** | | Reporting Period:<br>**Annual** |
|---|---|---|
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**11.11%** |
| Continuous Eligibility Period: No | Risk Adjustment: **No** | Sampling: **Yes** |

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

**Data File Layout and Submission Requirements:**

1. All data must be submitted for performance eligible individuals, in accordance with the sampling methodology
2. Enter all relevant data, including multiple screening events, per eligible individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements.

# Measure BH8: Substance Use Screening and Intervention Composite

| Measure Description: | |
|---|---|
| Percentage of individuals 18 to 64 years of age who received a substance use screening at least once within the last 12 months AND who received an intervention for all positive screening results. | |
| Data Source:<br>**Chart/EHR** | NQF #:<br>**Based on 2597** |
| Measure Steward:<br>**ASAM** | Measure Steward Version:<br>**March 06, 2015** |
| Statewide Target:<br>**80%** | |

## Measure Calculation Description

**Numerator:**
Individuals 18 to 64 years of age who received the following substance use screenings (a valid HCPCS, CPT, UBREV or LOINC code from Table BH08_00) at least once within the last 12 months in the ED or outpatient setting AND who received at least one intervention for all positive screening results (a valid CPT, Revenue, HCPCS, or LOINC code from BH08_00: Health Visits & Screening Tools & SBIRT *):

Tobacco use component
Individuals who were screened for tobacco use at least once within the last 12 months AND who received tobacco cessation intervention if identified as a tobacco user

Unhealthy alcohol use component
Individuals who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 12 months AND who received brief counseling if identified as an unhealthy alcohol user

Drug use component (nonmedical prescription drug use and illicit drug use)
Individuals who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 12 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 (AUDIT)
3. 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

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

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

Note: The inclusive screening tool encompasses all four components. If the individual screens positively on the NIDA Quick Screen, the NMASSIST should be administered as a follow-up tool.

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

**Denominator:**
All individuals 18 through 64 years of age at the beginning of the measurement period with at least one eligible outpatient or ED encounter (BH08_00) during the measurement period.

**Exclusions:**

- Documentation of medical reason(s) for not screening (Table BH08_01: Medical Reasons for Not Screening)
- Use of opioids for chronic pain management (Medical notation that a pain contract agreement exists in the patient record; further detail may be accessed at: https://njafp.org/new-prescribing-law/)
- Limited life expectancy or hospice (Table BH08_01: Codes for Hospice)
- ED visits that result in an observation stay (Table BH08_01: Additional CPT Codes (Observation))

**Result:**
Percentage

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Setting has been expanded to both the ED and hospital outpatient setting
- Visits determined by multiple codes, including revenue and HCPCS codes – addition of value set "Mental Health Follow-Up Revenue Value Set"
- Time period for tool administration has been modified from 24 months to 12 months
- The recommended list of valid screening tools has been augmented
- Continuous eligibility requirements have been removed for this measure

**Data Elements:**

- Attributed to the BH population
- Screening date
- Screening tool(s) used
- Screening tool(s) 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/2597

| Measure Collection Description | | |
|---|---|---|
| Setting of Care:<br>**Outpatient and ED** | | Reporting Period:<br>**Annual** |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**11.11%** |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **Yes** |

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

**Data File Layout and Submission Requirements:**

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidelines.
2. Hospitals should submit as much relevant data as possible, however, to reduce administrative burden, hospitals can choose to report only the ED visit that resulted in the administration of the tool for the 3 components when there are multiple ED visits logged.
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements.

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

| Measure Description: |
|---|
| Percentage of individuals 18 to 64 years of age discharged from an inpatient facility to home or other specified site of care for whom a transition record was transmitted to the facility, primary care physician, or other health care professional designated for follow-up care within 24 hours of discharge. |

| Data Source: | NQF #: |
|---|---|
| **Chart/EHR** | **Based on 0648** |
| Measure Steward: | Measure Steward Version: |
| **AMA-PCPI** | **June 28, 2017** |

Statewide Benchmark:
**80%**

## Measure Calculation Description

**Numerator:**
Individuals with a principal behavioral health or AOD diagnosis (Table BH09_00) for whom a transition record was transmitted to the facility/physician/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.

**Denominator:**
Of the attributed behavioral health population, individuals 18 years and older discharged from an inpatient facility (Table BH09M06_01a) to home/self-care or any other designated site of care (Table BH09M06_01b) with a principal mental health or AOD diagnosis (Table BH09_00).

**Exclusions**:
- Individuals who expired, left against medical advice, or discontinued care (BH09M06_02).

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Added principal behavioral health diagnosis requirement.

**Data Elements**:
- Attributed to the BH population
- Diagnosis of Care (Working Diagnosis) (Table BH09_00)
- Bill Type 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 | | |
|---|---|---|
| Setting of Care:<br>**Inpatient** | | Reporting Period:<br>**Annual** |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**11.11%** |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **Yes** |
| Continuous Eligibility / Sampling Methodology: **Sampling is permitted.** | | |

**Data File Layout and Submission Requirements:**

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidelines
2. Enter all relevant data, per eligible individual
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
5. Please refer to the “Standard Reporting Template” for more detail on submission requirements

# 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 individuals 18 to 64 years of age from ACHs within the past 30 days. | |
| Data Source:<br>**Instrument-Based** | NQF #:<br>**Based on 0228** |
| Measure Steward:<br>**University of Colorado Denver Anschutz Medical Campus** | Measure Steward Version:<br>**December 16, 2019** |
| Statewide Benchmark:<br>**N/A** | |

## Measure Calculation Description

**Numerator:**
The numerator is the hospital level sum of the CTM-3 scores for all eligible sampled individuals. Hospitals may submit results from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and/or Experience of Care and Health Outcomes (ECHO) surveys in lieu of administering an independent survey.

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

☐ I was not given any medication when I left the hospital

There are 4 response options for Q1 and Q2: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4

There are 5 response options for Q3: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, I was not given any medication when I left the hospital = 5.

Therefore, the range of total raw score per individual is 3 to 13.

ECHO responses for questions 12, 18 and 22, respectively:

1. In the last 12 months, how often did the people you went to for counseling or treatment explain things in a way you could understand?

   ☐ Never

   ☐ Sometimes

   ☐ Usually

   ☐ Always

2. In the last 12 months, how often were you involved as much as you wanted in your counseling or treatment?

   ☐ Never

   ☐ Sometimes

   ☐ Usually

   ☐ Always

3. In the last 12 months, were you given as much information as you wanted about what you could do to manage your condition?

   ☐ Yes

   ☐ No

There are four response options for questions 12 and 18. Never = 1, Sometimes = 2, Usually = 3 and Always = 4.

There are two response options for question 22. Yes = 1 and No = 0.

Therefore the range of score will be 2-9, with a score of 9 being the most positive response.

**Denominator:**
Of the attributed behavioral health population, the number of eligible sampled adults discharged from an ACH.

**Exclusions:**

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

**Result:**
The result is expressed as an average score.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Permit the submission of data from HCAHPS and ECHO surveys in addition to independent survey design.

**Data Elements:**

- Attributed to the BH population
- 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

| Setting of Care:<br>**Inpatient** | | Reporting Period:<br>**Annual** |
|---|---|---|
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 – December 31, 2020** |
| Payment Method:<br>**NA** | | Measure Weight:<br>**NA** |
| Continuous Eligibility Period: NA | Risk Adjustment: **No** | Sampling: **Yes** |

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

## 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.
    4. Electronic – Submission of data is allowed if secure transmission protocols exist and if data may be appropriately mapped into respective answers.

    Note: any inquiries about the mode of delivery for the survey should be directed to QIP-NJ@pcgus.com.

Where CTM-3 questions or survey guidance differ from CMS guidance for HCAHPS (i.e. timeframe for closing out data collection), hospitals submitting HCAHPS results should defer to CMS guidance.

## Data Submission Requirements

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidance

2. Enter all relevant data, including multiple survey events, per eligible individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

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

| Measure Description: |
|---|
| For the BH population served, the percent of individuals 18 to 64 years of age who have received a screening using a validated tool including SDOH domains identified by the State. |

| Data Source: | NQF #: |
|---|---|
| **Instrument-Based** | **N/A** |
| Measure Steward: | Measure Steward Version: |
| **NJ DOH** | **July 1, 2021** |

Statewide Benchmark:
**N/A**

## Measure Calculation Description

**Numerator:**
Of the attributed population with Behavioral Health needs attributed to the facility, those that received a screening in the outpatient or ED setting 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*

**Denominator:**
The population with Behavioral Health needs attributed to the facility.

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Data Elements:**

- Attributed to the BH population
- Survey date
- Survey tool
- Survey tool result
- Exclusionary diagnosis or other reason (if applicable)

| Measure Collection Description | | |
|---|---|---|
| Setting of Care:<br>**Multi-setting (OP or ED)** | | Reporting Period:<br>**Annual** |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 – December 31, 2020** |
| Payment Method:<br>**NA** | | Measure Weight:<br>**NA** |
| Continuous Eligibility Period: NA | Risk Adjustment: **No** | Sampling: **Yes** |
| Continuous Eligibility / Sampling Methodology: **Sampling is permitted.** | | |

**Data Submission Requirements**:

1. All data must be submitted for performance eligible individuals only, in accordance with sampling guidance
2. Enter all relevant data, including multiple survey events, per eligible individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

# III. Measurement Specifications: Maternal Health Measure Set

## 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 | 14.29% |
| 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 | 14.29% |
| M3 | Postpartum Depression Screening – NQF #1401 | NCQA | Chart/EHR | "Year 0" (7/1/2020-12/31/2020) hospital reported data | Pay-for-performance in all years | 14.29% |
| M4 | Postpartum Care - NQF #1517 | NCQA | MMIS | "Year 0" (7/1/2020-12/31/2020) claims data | Pay-for-performance in all years | 14.29% |
| 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 | 14.29% |
| 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 | 14.29% |

| | | | | | | |
|---|---|---|---|---|---|---|
| M7 | Treatment of Severe Hypertension | Alliance for Innovation on Maternal Health (AIM) | Chart/EHR | Y1: 7/1/2021-12/31/2021 Hospital reported data | Pay-for-performance in all years | 14.29% |
| M8 | 3-Item Care Transitions Measure (CTM-3) | University of Colorado Denver Anschutz Medical Campus | Instrument | "Year 0" (7/1/2020-12/31/2020) Hospital reported data | Reporting only | 0% |
| M9 | Use of a Standardized Screening Tool for Social Determinants of Health | NJ DOH | Instrument | "Year 0" (7/1/2020-12/31/2020) Hospital reported data | Reporting only | 0% |

*Figure 10. Maternal Health Measures Grid*

# Measure M1: Severe Maternal Morbidity (SMM)

| Measure Description: |
|---|
| For the Maternal Health population served aged 12 to 55 years old, the percentage of births resulting in Severe Maternal Morbidities as defined by the CDC. |

| Data Source: | NQF #: |
|---|---|
| **MMIS** | **N/A** |
| Measure Steward: | Measure Steward Version: |
| **CDC** | **December 26, 2019** |

Statewide Benchmark:
**25.2/1,000 delivery hospitalizations including transfusions**

## Measure Calculation Description

**Numerator:**

- The number of women with severe maternal morbidities aged 12 to 55 years of age identified in the diagnosis and procedure code sets identified by CDC (Table M01_00). Individuals with a diagnosis of SARS-COV-2 at the time of delivery (Table M01_02) should be excluded from the numerator only. Individuals with a length of stay shorter than the 90th percentile for the MY (note: this will be calculated based upon the LOS data analyzed during the respective MY) will also be excluded.

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 ICD-10 may be used to track SMM when using administrative hospital discharge data.

For all pregnancy related codes O00-O9A:
1. Only identify events that occur during the birth admission
2. Are only applicable to maternity patients aged 12 – 55 years inclusive
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 M1M4M5Denom_APR_DRG_Detail) at the ACH during the MY.

**Exclusions:**

- Pregnancy complications and abnormal products of conception (Table M01_02).

**Result:**
The result is expressed as a rate.

**Improvement Direction:**
Lower

**Measure Deviations from Original Specifications:**

- Excluded lengths of stay shorter than the 90th percentile for the measurement year to align with NJ Maternal Health Hospital Report Card specification.
- Excluded individuals from the numerator with a diagnosis of SARS-COV-2 at the time of delivery.

**Data Elements:**

- Attributed to the maternal health population
- 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 | | | |
|---|---|---|---|
| Setting of Care:<br>**Site of Birth Admission** | | Reporting Period:<br>**Annual** | |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**14.29%** | |
| Claim Type(s):<br><br>**01** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **No** | |

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

# Measure M2: PC-02 Cesarean Birth

| Measure Description: |
|---|
| This measure assesses the rate of nulliparous women 8 to 64 years of age with a term, singleton baby in a vertex position delivered by Cesarean birth. |

| Data Source: | NQF #: |
|---|---|
| **Chart/EHR** | **Based on 0471** |
| Measure Steward: | Measure Steward Version: |
| **The Joint Commission** | **November 20, 2020** |

Statewide Benchmark:
**23.6/100 deliveries**

## Measure Calculation Description

**Numerator**

Individuals having an ICD-10-PCS Procedure Code for a Cesarean delivery (Table M02_03).

**Denominator**

Of the attributed population, nulliparous individuals who deliver:

- A live term singleton newborn (Table M02_00),
- In vertex presentation (Table M02_01),
- With > 37 (Table M02_02) completed.

Note: Nulliparous and vertex data elements have been added to the Standard Reporting Template; therefore, no clinical codes need to be explicitly added.

**Exclusions:**

- An ICD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for Multiple Gestations and Other Presentations (Table M2_04)
- Gestational age <= 37 or unable to determine (UTD) (Table M02_04)
- Less than 8 years or are greater than or equal to 65 years of age
- A length of stay > 120 days
- Active enrollment in any clinical trial

**Result:**
The result is expressed as a rate.

**Improvement Direction:**
Lower

**Measure Deviations from Original Specifications:**

- None

**Data Elements:**

- Attributed to the maternal health population
- Cesarean delivery (index date)
- Discharge date
- Gestational age
- Delivery in vertex presentation
- Previous live births

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 | | | |
|---|---|---|---|
| Setting of Care:<br>**Site of Birth Admission** | | Reporting Period:<br>**Annual** | |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**14.29%** | |
| Claim Type(s):<br><br>**01** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **Yes** | |

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

**Data Submission Guidelines**:

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling methodology

2. Enter all relevant data, including multiple events, per eligible individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

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

| Measure Description: | |
|---|---|
| The percentage of women who had a screening for maternal depression at least once between delivery (index date) and prior to discharge. | |
| Data Source:<br>**Chart / EHR** | NQF #:<br>**Based on 1401** |
| Measure Steward:<br>**NCQA** | Measure Steward Version:<br>**HEDIS® MY 2020 & MY 2021 (ECDS)**<br>**July 31, 2014** |
| Statewide Benchmark:<br>**90%** | |

**Measure Calculation Description**

**Numerator:**
Women who had a documented result of a maternal depression screening (Table M03_01) using an age-appropriate standardized instrument (as indicated by Logical Observation Identifiers Names and Codes (LOINC) if available, Table M03_03, and tool score, or medical notes that clearly reflect the tool name and tool score) at least once between delivery and prior to discharge by any licensed practitioner.

**Approved depression screening tools**:

1A. Beck Depression Inventory (BDI)
1B. Beck Depression Inventory (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-2)
7. Patient Health Questionnaire (PHQ-9*)
8. PROMIS Depression Total Score (T Score)
9. Zung Self-Rating Depression Scale
10. Other
11. Edinburgh Postnatal Depression Scale (EPDS)

*The PHQ-2 should be used as a "first-step" approach; if the patient screens positive, she should be further evaluated with the PHQ-9

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

**Denominator:**

All live births of women in the defined QIP-NJ Maternal Health Population who delivered (Table M03_Deliveries) at the hospital during the MY.

**Exclusions**:
Individuals that:

- Were transferred to another facility before or after delivery
- Expired prior to discharge (Table M03_02)
- Delivered in hospice or used hospice during the measurement period (Table M03_Hospice)

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Changed denominator from a count of children to a count of post-partum women
- 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"
- Because of the time-sensitive targeted intervention irrespective of an existing behavioral health diagnosis, removed four value sets ("Depression Case Management Encounter", "Behavioral Health Encounter", "Depression or Other Behavioral Health Condition", and "Follow Up Visit"

**Major Changes HEDIS MY 2020 and MY 2021:**
N/A

**Data Elements:**

- Attributed to the maternal health population
- Delivery
- Depression screen with standardized validation tool

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 | | | |
|---|---|---|---|
| Setting of Care:<br>**Inpatient** | | Reporting Period:<br>**Annual** | |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**14.29%** | |
| Claim Type(s):<br><br>**01** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **Yes** | |

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

**Data Submission Requirements**

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance.
2. Enter all relevant data, including multiple events, per eligible individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

# Measure M4: Postpartum Care (PPC)

| Measure Description: | |
|---|---|
| The percentage of deliveries of live births on or before October 7 of the MY. For these women, the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. | |
| Data Source:<br>**MMIS** | NQF #:<br>**Based on 1517** |
| Measure Steward:<br>**NCQA** | Measure Steward Version:<br>**HEDIS® MY 2020 & MY 2021**<br>**October 25, 2016** |
| Statewide Benchmark:<br>**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 (M04_DetailOID > Postpartum Visits Value Set).
- Cervical cytology (M04_DetailOID > Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set).
- A bundled service (M04_DetailOID > 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).
- Services provided via telephone (M04_DetailOID > Telephone Visits Value Set), e-visits and virtual check-ins (M04_DetailOID > Online Assessments Value Set) may be used.

**Denominator:**
Individuals who delivered a live birth on or before October 7 of the MY. Include women who delivered in any setting except hospice.

Note on Multiple births: Women who had two separate deliveries (different dates of service) within the MY count twice. Women who had multiple live births during one pregnancy count once.

Follow the steps below to identify the eligible population:

**Step 1**: Identify deliveries.
Identify all women with a delivery (M1M4M5Denom_APR_DRG_Detail) before October 7 of the MY.

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 (M04_DetailOID > 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**:
Services:

- Provided in an acute inpatient setting (M04_DetailOID > Acute Inpatient Value Set; Acute Inpatient POS Value Set)
- Provided in hospice delivery setting (M04_DetailOID > Hospice Encounter or Hospice Intervention Value Set)
- Resulting in non-live births (M04_DetailOID > Non-live Births Value Set)

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Adjusted timeframes to align with the QIP-NJ MY.

Although PPC typically also includes a measure of prenatal care, this has been removed to focus on hospital related care.

**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 (M04_DetailOID > Telephone Visits Value Set) e-visits and virtual check-ins (M04_DetailOID > Online Assessments Value Set)
  Continuous eligibility requirements have been removed for this measure

**Data Elements:**

- Attributed to the maternal health population
- 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**

| Setting of Care:<br>**Outpatient** | | Reporting Period:<br>**Annual** | |
|---|---|---|---|
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 – December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**14.29%** | |
| Claim Type(s):<br><br>**04, 14, 15, 19, 23** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **No** | |

Continuous Eligibility / Sampling Methodology: **Sampling is permitted.**

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

| Measure Description: |
|---|
| The percentage of pregnant women aged 18 years old through 64 years old 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: | NQF #: |
|---|---|
| **MMIS** | **Based on 0004** |
| Measure Steward: | Measure Steward Version: |
| **NCQA** | **HEDIS® MY 2020 & MY 2021**<br>**June 10, 2019** |

Statewide Benchmark:
**55%**

## Measure Calculation Description

**Definitions:**

| | |
|---|---|
| Intake Period | July 1–November 14 of the MY. The Intake Period is used to capture new episodes of AOD abuse and dependence. |
| Index Episode | The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.<br>*For ED or observation visits that result in an inpatient stay*, the inpatient discharge is the index episode. |
| Date of service for services billed weekly or monthly | For an opioid treatment service that bills monthly or weekly (OUD Weekly Non-Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events). |
| IESD | Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.<br>*For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, or ED visit (not resulting in an inpatient stay),* the IESD is the date of service.<br>*For an inpatient stay or for detoxification that occurred during an inpatient stay,* the IESD is the date of discharge.<br>*For detoxification* (other than detoxification that occurred during an inpatient stay), the IESD is the date of service. |

| | |
|---|---|
| | *For ED or observation visits that result in an inpatient stay,* the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).<br>*For direct transfers*, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort). |
| Negative Diagnosis History | A period of 60 days (2 months) before the IESD when the individual had no claims/encounters with a diagnosis of AOD abuse or dependence.<br>*For an inpatient stay,* use the admission date to determine the Negative Diagnosis History.<br>*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.<br>*For direct transfers,* use the first admission to determine the Negative Diagnosis History. |
| Direct transfer | A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example:<br>An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer.<br>An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer.<br>An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays.<br>Use the following method to identify admissions to and discharges from inpatient settings.<br>3. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).<br>4. Identify the admission and discharge dates for the stay. |

**Numerator:**
Individuals who have Initiation of AOD treatment within 14 days of the IESD.

- If the IESD 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 individual is compliant.
- If the IESD 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 individual is compliant.
- If the IESD was not an inpatient discharge, the individual 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 IESD 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 IESD 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 IESD 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 IESD 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 an individual is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the individual only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.

- Exclude the individual 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 MY.

**Denominator:**
Individuals who gave birth at the ACH (M1M4M5Denom_APR_DRG_Detail) within the measurement period 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 IESD. Identify all individuals in the specified age range within the attributed population 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 individuals with more than one episode of AOD abuse or dependence, use the first episode.

For individuals 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 IESD and stratify based on age and AOD diagnosis cohort.

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

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

The total is not a sum of the diagnosis cohorts. Count individuals 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 individuals with multiple diagnoses during the IESD only once for the total rate for the denominator.

**Step 3:** Test for Negative Diagnosis History. Exclude individuals 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. Individuals 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**:

- Exclude individuals 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.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**
Limited to the maternal health population.

**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.
- Continuous eligibility requirements have been removed for this measure
- Note: 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. Only the age stratification that includes all ages (Total) will be used for QIP-NJ

**Data Elements:**

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

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 | | | |
|---|---|---|---|
| Setting of Care:<br>**Multi-setting** | | Reporting Period:<br>**Annual** | |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**14.29%** | |
| Claim Type(s):<br><br>**01, 03, 04, 14, 15, 18, 19** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: No | Risk Adjustment: **No** | Sampling: **No** | |

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

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

| Measure Description: |
|---|
| Percentage of individuals, 18 through 64 years of age, discharged from a birth admission 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. |

| Data Source: | NQF #: |
|---|---|
| **Chart/EHR** | **Based on 0648** |
| Measure Steward: | Measure Steward Version: |
| **AMA-PCPI** | **June 28, 2017** |

| Statewide Benchmark: |
|---|
| **80%** |

## Measure Calculation Description

**Numerator:**
Individuals 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 EHR.

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

**Denominator:**
Of the attributed behavioral health population, individuals 18 years and older discharged from an inpatient facility (Table BH09M06_01a) to home/self-care or any other designated site of care (Table BH09M06_01b) with a Maternal Health Diagnosis (Table M06_00).

**Exclusions:**

- Individuals who expired (Table BH09M06_02)
- Individuals who left against medical advice or discontinued care (Table BH09M06_02)

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Added limitation to the maternal health population.
- Limited eligible population to 18-64 years of age.

**Data Elements**:
- Attributed to the maternal health population
- 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 | | |
|---|---|---|
| Setting of Care:<br>**Inpatient** | | Reporting Period:<br>**Annual** |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**14.29%** |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **Yes** |
| Continuous Eligibility / Sampling Methodology: **Sampling is permitted.** | | |

**Data Submission Requirements:**

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance
2. Enter all relevant data, including multiple events, per eligible individual

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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

# Measure M7: Treatment of Severe Hypertension (SHTN)

| 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: | NQF #: |
|---|---|
| **Chart/EHR** | **N/A** |
| Measure Steward: | Measure Steward Version: |
| **Alliance for Innovation on Maternal Health (AIM)** | **--** |

| Statewide Benchmark: |
|---|
| **80%** |

**Measure Calculation Description**

**Numerator:**
Among the denominator, cases that were treated within one hour of SHTN diagnosis with a first-line agent, including:

- IV Labetalol,
- IV Hydralazine,
- PO Nifedipine

SHTN may be reflected in either the systolic or diastolic blood pressure:

- A systolic blood pressure (BP) >= 160 mm Hg or
- A diastolic blood pressure >=110 mm Hg reading

First-line agents (Table M07_00) must be dispensed within one hour of the second reading of SHTN. If the first-line agent is not found in table M07_00, confirm it is on the FDA's approved list of first-line agents. This will ensure it is a valid code and compliant with this measure's numerator. 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. Recommended dispensing intervals:

- IV Labetalol = 20 minutes
- IV Hydralazine and PO Nifedipine = 10 minutes

**Denominator:**

Number of women with persistent new-onset[10] SHTN, 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 M07_01)

AND

- Two or more readings of SHTN defined as
    - A systolic blood pressure >= 160 mm Hg or
    - A diastolic blood pressure >=110 mm Hg reading

  That are taken at greater than 15-minute intervals and no more than 60 minutes apart

For this measure, records should be reported 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 consecutive BP readings.

Include all individual BP readings.

**Exclusion:**

- Women with an exacerbation of chronic hypertension (Table M07_02). Chronic Hypertension is defined by the American College of Obstetricians and Gynecologists (ACOG) as a diagnosis of hypertension (systolic blood pressure ≥ 140 mm Hg or diastolic blood pressure ≥ 90 mm Hg) prior to pregnancy or at fewer than 20 weeks gestation.
- 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 M07_02)

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- None

**Data Elements:**

- Attributed to the maternal health population
- The maternal medical record will be used to validate diagnosis and treatment.

**Measure Collection Description**

[10] New onset is defined as the first instance of the individual presenting at the facility.

| Setting of Care:<br>**Inpatient or Emergency Department** | | Reporting Period:<br>**Annual** | |
|---|---|---|---|
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | | Baseline Period:<br>**July 1, 2020 –December 31, 2020** | |
| Payment Method:<br>**P4P** | | Measure Weight:<br>**14.29%** | |
| Claim Type(s):<br><br>**01** | **01** – Inpatient Hospital<br>**02** – Long Term Care<br>**03** – Outpatient Hospital<br>**04** – Physician<br>**05** – Chiropractor<br>**06** – Home Health<br>**07** – Transportation<br>**08** – Vision | **09** – Supplies, DME<br>**10** – Podiatry<br>**11** – Dental<br>**12** – Pharmacy<br>**13** – EPDST/Healthstart<br>**14** – Institutional Crossover<br>**15** – Professional Crossover | **16** – Lab<br>**17** – Prosthetic and Orthotics<br>**18** – Independent Clinic<br>**19** – Psychologists<br>**21** – Optometrists<br>**22** – Mid Level Practitioner<br>**23** – Hearing Aid |
| Continuous Eligibility Period: **No** | Risk Adjustment: **No** | Sampling: **Yes** | |

Continuous Eligibility/ Risk Adjustment/ Sampling Methodology: **Sampling is permitted.**

**Data Submission Requirements**

As this measure examines multiple instances of blood pressure readings per individual, 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 an individual presents with an SMM episode and has three separate blood pressure readings occurring, the second followed by treatment with a first-line agent.

Individual 0000012 is seen in the emergency room on April 1, 2020 at *02:00 PM*:

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

Individual 0000012 has follow-up on April 1, 2020at *02:30 PM*:

- Blood pressure reading is 160/110

Individual 0000012 has Labetalol (NDC: 101350641) administered on April 1, 2020 at *02:50 PM*

Individual 0000012 has follow-up on April 1, 2020 at *03:15 PM*:

- Blood pressure reading is 130/80

As Individual 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, in accordance with the sampling guidance.
2. Enter all relevant data, including multiple events, per eligible Individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

# 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 individual reported quality of preparation for self-care response among individuals aged 18 years and older discharged from general ACHs within the past 30 days. |

| Data Source: | NQF #: |
|---|---|
| **Instrument Based Data** | **Based on 0228** |
| Measure Steward: | Measure Steward Version: |
| **University of Colorado Denver Anschutz Medical Campus** | **December 16, 2019** |
| Statewide Benchmark: | |
| **N/A** | |

## Measure Calculation Description

**Numerator:**
The numerator is the hospital level sum of the CTM-3 scores for all eligible sampled individuals. Hospitals may submit results from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and/or Experience of Care and Health Outcomes (ECHO) surveys in lieu of administering an independent survey.

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

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

3. When I left the hospital, I clearly understood the purpose for taking each of my medications.

   ☐ Strongly Disagree

☐ Disagree

☐ Agree

☐ Strongly Agree

☐ I was not given any medication when I left the hospital

There are 4 response options for Q1 and Q2: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4

There are 5 response options for Q3: Strongly Disagree = 1, Disagree = 2, Agree = 3, Strongly Agree = 4, I was not given any medication when I left the hospital = 5.

Therefore, the range of total raw score per individual is 3 to 13.

**Denominator:**
Of the attributed maternal health population, the number of eligible sampled adults discharged from a general ACH.

**Exclusions:**

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

**Result:**
The result is expressed as an average score.

**Improvement Direction:**
Higher

**Measure Deviations from Original Specifications:**

- Permit the submission of data from HCAHPS surveys in addition to independent survey design.

**Data Elements:**

- Attributed to the maternal health population
- 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

| Setting of Care:<br>**Inpatient** | Reporting Period:<br>**Annual** |
|---|---|
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | Baseline Period:<br>**July 1, 2020 –December 31, 2020** |
| Payment Method:<br>**N/A** | Measure Weight:<br>**N/A** |
| Risk Adjustment: **No** | Sampling: **Yes** |

Sampling or Risk Adjustment Methodology: **Sampling is permitted.**

## 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.
    4. Electronic – Submission of data is allowed if secure transmission protocols exist and if data may be appropriately mapped into respective answers.

Where CTM-3 questions or survey guidance differ from CMS guidance for HCAHPS, hospitals submitting HCAHPS results should defer to CMS guidance.

Note: any inquiries about the mode of delivery for the survey should be directed to QIP-NJ@pcgus.com.

## Data Submission Requirements

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance
2. Enter all relevant data, including multiple survey events, per eligible individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

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

| **Measure Description:**<br>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 five SDOH domains identified by the State: Housing, Food Security, Transportation, Social Supports, and Domestic Violence. | |
|---|---|
| Data Source:<br>**Instrument Based** | NQF #:<br>**N/A** |
| Measure Steward:<br>**NJ DOH** | Measure Steward Version:<br>**July 1, 2021** |
| Statewide Benchmark:<br>**N/A** | |

## 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. 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*

**Denominator:**
The maternal health population attributed to the facility.

**Result:**
The result is expressed as a percentage.

**Improvement Direction:**
Higher

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

- AAFP: Social Determinants of Health
- NJ Perinatal Risk Assessment (PRA)

| Measure Collection Description | |
|---|---|
| Setting of Care:<br>**Multi-setting (IP, OP, ED)** | Reporting Period:<br>**Annual** |
| Measurement Period:<br>**July 1, 2021 – December 31, 2021** | Baseline Period:<br>**July 1, 2020 –December 31, 2020** |
| Payment Method:<br>**N/A** | Measure Weight:<br>**N/A** |
| Risk Adjustment: **No** | Sampling: **Yes** |

Sampling Methodology: **Sampling is permitted.**

**Data Submission Requirements**

1. All data must be submitted for performance eligible individuals only, in accordance with the sampling guidance
2. Enter all relevant data, including multiple screening events, per eligible individual
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
5. Please refer to the "Standard Reporting Template" for more detail on submission requirements

# Appendix A: Value Code Sets by Measure

## Measure Change Log Summary

The purpose of the Measure Change Log is to clarify major measure modifications between each draft release of the Databook and Value Set Compendium (VSC). Major measure modifications are defined as those changes, including addition or deletion of value sets, that significantly impact the measure calculations. Below indicates those implemented in version 1.3 from 1.2.

**Pre-Measures**

- Attribution: tab "Attr_Diagnoses_BH" added to the VSC

## A. Behavioral Health Measures Grid

| Measure # | Measure Name and NQF # | Measure Steward | Data Source | Major Modifications v 1.3 |
|---|---|---|---|---|
| BH1 | 30 Day All-Cause Unplanned Readmission Following Psychiatric Inpatient Hospitalization- NQF #2860 | CMS | MMIS | • No major changes |
| BH2 | Follow-Up After Hospitalization for Mental Illness –30-days Post-Discharge- NQF #0576 | NCQA | MMIS | • No major changes |
| BH3 | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (30 day) – NQF #3488 | NCQA | MMIS | • Observation value set added to exclusions |
| BH4 | Follow-Up After Emergency Department Visit for Mental Illness (30 day) – NQF #3489 | NCQA | MMIS | • Added Inpatient Stay (exclusions) value set to BH4_DetailOID table |

| | | | | |
|---|---|---|---|---|
| BH5 | Initiation of Alcohol and Other Drug Abuse or Dependence Treatment – NQF #0004 | NCQA | MMIS | • Added H0018 (Short term residential) & H0019 (Long term residential) codes |
| BH6 | Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - NQF #0004 | NCQA | MMIS | • Added H0018 (Short term residential) & H0019 (Long term residential) codes |
| BH7 | Preventative Care and Screening: Screening for Depression and Follow-Up – NQF #0418 | CMS | Chart/EHR | • BH07 Non dx-->BH07_00 Continuous eligibility requirements have been removed for this measure |
| BH8 | Substance Use Screening and Intervention Composite – NQF #2597 | ASAM | Chart/EHR | • BH08 Non dx-->BH08_00<br>• Added additional Revenue codes from BH07 |
| BH9 | Timely Transmission of the Transition Record- NQF #0648 | AMA-PCPI | Chart/EHR | • No major changes |
| BH10 | 3-Item Care Transitions Measure (CTM-3) | University of Colorado Denver Anschutz Medical Campus | N/A | • Results of CTM-3 to be expressed as an average score instead of a percentage. |
| BH11 | Use of a Standardized Screening Tool for Social Determinants of Health | NJ DOH | N/A | • SDOH_S field removed from the Standard Reporting Template |

## B. Maternal Health Measures Grid

| Measure # | Measure Name and NQF # | Measure Steward | Data Source | Major Modifications v 1.3 |
|---|---|---|---|---|
| M1 | Severe Maternal Morbidity (SMM) | CDC | MMIS | • No major changes |
| M2 | PC-02 Cesarean Birth - NQF #0471 | Joint Commission | Chart/EHR | • ADDED CODES: 10E0XZZ & 10D07Z6 to Table M2_03<br>• Revised Table M02_04: Codes to Identify Multiple Gestations and Other Presentations, and removed codes listed with more than seven characters.<br>• M2_04: Added additional exclusionary codes; gestational weeks Z3A.26-Z3A.37 |
| M3 | Postpartum Depression Screening – NQF #1401 | NCQA | Chart/EHR | • Added M03_03 table to VSC<br>• Added CPT codes: 59409 & 59514 to Delivery Value Set (M03_Deliveries)<br>• Continuous eligibility requirements have been removed for this measure<br>• PDS_DetailOID split to M03_Deliveries (Denominator) and M03_Hospice (Denominator Exclusions) |
| M4 | Postpartum Care - NQF #1517 | NCQA | MMIS | • Continuous eligibility requirements have been removed for this measure<br>• PPC_DetailOID renamed to M04_DetailOID |
| M5 | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment in Pregnant Women -NQF #0004 | NCQA | MMIS | • Continuous eligibility requirements have been removed for this measure<br>• Added H0018 (Short term residential) & H0019 (Long term residential) codes |

| | | | | |
|---|---|---|---|---|
| M6 | Timely Transmission of the Transition Record- NQF #0648 | AMA-PCPI | Chart/EHR | • No major changes |
| M7 | Treatment of Severe Hypertension | Alliance for Innovation on Maternal Health (AIM) | Chart/EHR | • Updated language to indicate NDC Codes will be compared against FDA Listings<br>• Numerator "OR" Criteria changed to "AND"<br>• Added additional exclusion codes (M07_02) |
| M8 | 3-Item Care Transitions Measure (CTM-3) | University of Colorado Denver Anschutz Medical Campus | Instrument | • Results of CTM-3 to be expressed as an average score instead of a percentage. |
| M9 | Use of a Standardized Screening Tool for Social Determinants of Health | NJ DOH | Instrument | • SDOH_S field removed from the Standard Reporting Template |

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

| Table Name | Table Description | Measure Component |
|---|---|---|
| **Table BH01_00** | AHRQ Modified CCS-Mapped to ICD-10-CM Psychiatric Principal Discharge Diagnosis categories | Denominator |
| **Table BH01_01** | AHRQ Modified CCS-Mapped to ICD-10-PCS Procedure categories that are always planned | Denominator Exclusion |
| **Table BH01_02** | AHRQ Modified CCS-Mapped to ICD-10-CM Diagnosis categories that are always planned | Denominator Exclusion |
| **Table BH01_03** | AHRQ Modified CCS-Mapped to ICD-10-CM Procedure categories that are potentially planned | Denominator Exclusion |
| **Table BH01_04** | AHRQ Modified CCS-Mapped to ICD-10-CM Diagnosis categories that are considered planned if not coinciding with principal discharge diagnosis or complication | Denominator Exclusion |

***The numerator is defined by filtering out "always planned" and "potentially planned" diagnoses and procedures**

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

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| NJ Place of Service Value Set | N/A | Numerator |
| Mental Health Follow-Up Revenue & CPT/HCPCS Value Set | N/A | Numerator |
| Adult Mental Health Rehabilitation (AMHR) Value Set | N/A | Denominator Exclusion |
| Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| Nonacute Inpatient Stay | 2.16.840.1.113883.3.464.1004.1398 | Denominator Exclusion |
| Inpatient Stay | 2.16.840.1.113883.3.464.1004.1395 | Denominator |
| Intentional Self-Harm | 2.16.840.1.113883.3.464.1004.1468 | Denominator |
| Mental Health Diagnosis | 2.16.840.1.113883.3.464.1004.1178 | Denominator |
| Mental Illness | 2.16.840.1.113883.3.464.1004.1179 | Denominator |

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

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| NJ Place of Service Value Set | N/A | Numerator |
| AOD Treatment Service Follow-up CPT/HCPCS Value Set | N/A | Numerator |
| Telephone Visits | 2.16.840.1.113883.3.464.1004.1246 | Numerator |
| ED | 2.16.840.1.113883.3.464.1004.1086 | Denominator |
| AOD Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1013 | Denominator |
| Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| Inpatient Stay | 2.16.840.1.113883.3.464.1004.1395 | Denominator Exclusion |
| Observation | 2.16.840.1.113883.3.464.1004.1191 | Denominator Exclusion |

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

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| NJ Place of Service Value Set | N/A | Numerator |
| Mental Health Follow-Up Revenue & CPT/HCPCS Value Set | N/A | Numerator |
| Adult Mental Health Rehabilitation (AMHR) Value Set | N/A | Denominator Exclusion |
| Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| Inpatient Stay | 2.16.840.1.113883.3.464.1004.1395 | Denominator Exclusion |
| ED | 2.16.840.1.113883.3.464.1004.1086 | Denominator |
| Intentional Self-Harm | 2.16.840.1.113883.3.464.1004.1468 | Denominator |
| Mental Health Diagnosis | 2.16.840.1.113883.3.464.1004.1178 | Denominator |
| Mental Illness | 2.16.840.1.113883.3.464.1004.1179 | Denominator |

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

*For Medication Assisted Treatment, additional value and code sets are provided

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Alcohol Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1424 | Denominator |
| AOD Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1013 | Denominator |
| AOD Medication Treatment | 2.16.840.1.113883.3.464.1004.2017 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Detoxification | 2.16.840.1.113883.3.464.1004.1076 | Denominator (combined with Dependence v.s.) |
| ED | 2.16.840.1.113883.3.464.1004.1086 | Denominator (combined with Dependence v.s.) |
| Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| IET POS Group 1 | 2.16.840.1.113883.3.464.1004.1129 | Denominator (combined with Dependence v.s.) |
| IET POS Group 2 | 2.16.840.1.113883.3.464.1004.1130 | Denominator (combined with Dependence v.s.) |
| IET Stand Alone Visits | 2.16.840.1.113883.3.464.1004.1131 | Numerator (combined with Dependence v.s.) |
| IET Visits Group 1 | 2.16.840.1.113883.3.464.1004.1132 | Numerator (combined with Dependence v.s.) |
| IET Visits Group 2 | 2.16.840.1.113883.3.464.1004.1133 | Numerator (combined with Dependence v.s.) |
| Inpatient Stay | 2.16.840.1.113883.3.464.1004.1395 | Numerator and Denominator |
| Observation | 2.16.840.1.113883.3.464.1004.1191 | Numerator (combined with Dependence v.s.) |
| Online Assessments | 2.16.840.1.113883.3.464.1004.1446 | Denominator (combined with Dependence v.s.) |
| Opioid Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1425 | Denominator |
| Other Drug Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1426 | Denominator |
| OUD Monthly Office Based Treatment | 2.16.840.1.113883.3.464.1004.2220 | Denominator (combined with Dependence v.s.) |
| OUD Weekly Drug Treatment Service | 2.16.840.1.113883.3.464.1004.2221 | Denominator (combined with Dependence v.s.) |
| OUD Weekly Non-Drug Service | 2.16.840.1.113883.3.464.1004.2222 | Denominator (combined with Dependence v.s.) |

| | | |
|---|---|---|
| Telephone Visits | 2.16.840.1.113883.3.464.1004.1246 | Denominator (combined with Dependence v.s.) |

***Opioid Use Disorder Treatment Medications List**

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Buprenorphine Implant | 2.16.840.1.113883.3.464.1004.1970 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Injection | 2.16.840.1.113883.3.464.1004.1969 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Naloxone | 2.16.840.1.113883.3.464.1004.1971 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Oral | 2.16.840.1.113883.3.464.1004.1968 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Oral Weekly | 2.16.840.1.113883.3.464.1004.2219 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Methadone Oral | 2.16.840.1.113883.3.464.1004.1972 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Methadone Oral Weekly | 2.16.840.1.113883.3.464.1004.2218 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Naltrexone Injection | 2.16.840.1.113883.3.464.1004.1967 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |

***Alcohol Use Disorder Treatment Medications List**

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Aldehyde dehydrogenase inhibitors | N/A | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Antagonist | N/A, 2.16.840.1.113883.3.464.1004.1967 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Other | N/A | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |

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

*For Medication Assisted Treatment, additional value and code sets are provided

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Alcohol Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1424 | Denominator |
| AOD Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1013 | Denominator |
| AOD Medication Treatment | 2.16.840.1.113883.3.464.1004.2017 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Detoxification | 2.16.840.1.113883.3.464.1004.1076 | Denominator (combined with Dependence v.s.) |
| ED | 2.16.840.1.113883.3.464.1004.1086 | Denominator (combined with Dependence v.s.) |
| Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| IET POS Group 1 | 2.16.840.1.113883.3.464.1004.1129 | Denominator (combined with Dependence v.s.) |
| IET POS Group 2 | 2.16.840.1.113883.3.464.1004.1130 | Denominator (combined with Dependence v.s.) |
| IET Stand Alone Visits | 2.16.840.1.113883.3.464.1004.1131 | Numerator (combined with Dependence v.s.) |
| IET Visits Group 1 | 2.16.840.1.113883.3.464.1004.1132 | Numerator (combined with Dependence v.s.) |
| IET Visits Group 2 | 2.16.840.1.113883.3.464.1004.1133 | Numerator (combined with Dependence v.s.) |
| Inpatient Stay | 2.16.840.1.113883.3.464.1004.1395 | Numerator and Denominator |
| Observation | 2.16.840.1.113883.3.464.1004.1191 | Numerator (combined with Dependence v.s.) |
| Online Assessments | 2.16.840.1.113883.3.464.1004.1446 | Denominator (combined with Dependence v.s.) |
| Opioid Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1425 | Denominator |
| Other Drug Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1426 | Denominator |
| OUD Monthly Office Based Treatment | 2.16.840.1.113883.3.464.1004.2220 | Denominator (combined with Dependence v.s.) |
| OUD Weekly Drug Treatment Service | 2.16.840.1.113883.3.464.1004.2221 | Denominator (combined with Dependence v.s.) |
| OUD Weekly Non-Drug Service | 2.16.840.1.113883.3.464.1004.2222 | Denominator (combined with Dependence v.s.) |

| | | |
|---|---|---|
| Telephone Visits | 2.16.840.1.113883.3.464.1004.1246 | Denominator (combined with Dependence v.s.) |

***Opioid Use Disorder Treatment Medications List**

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Buprenorphine Implant | 2.16.840.1.113883.3.464.1004.1970 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Injection | 2.16.840.1.113883.3.464.1004.1969 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Naloxone | 2.16.840.1.113883.3.464.1004.1971 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Oral | 2.16.840.1.113883.3.464.1004.1968 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Oral Weekly | 2.16.840.1.113883.3.464.1004.2219 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Methadone Oral | 2.16.840.1.113883.3.464.1004.1972 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Methadone Oral Weekly | 2.16.840.1.113883.3.464.1004.2218 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Naltrexone Injection | 2.16.840.1.113883.3.464.1004.1967 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |

***Alcohol Use Disorder Treatment Medications List**

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Aldehyde dehydrogenase inhibitors | N/A | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Antagonist | N/A, 2.16.840.1.113883.3.464.1004.1967 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Other | N/A | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |

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

| Table Name | Table Description | Measure Component |
|---|---|---|
| **Table BH07_00** | ED and Outpatient Hospital Revenue & CPT/HCPCS Value Set | Denominator |
| **Table BH07_01** | Codes to Document Depression Screen | Numerator |
| **Table BH07_02a** | Codes for Exclusionary Diagnoses | Denominator Exclusion |
| **Table BH07_02b** | Codes for Hospice | Denominator Exclusion |
| **Table BH07_02c** | Adult Mental Health Rehabilitation (AMHR) Value Set | Denominator Exclusion |
| **Table BH07_03** | Codes for Validated Screen Tools | Numerator |

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

## Measure BH8: Substance Use Screening and Intervention Composite

**BH08_00 Value Set: Health Visits**

| Value Set OID | Value Set Name | Measure Component |
|---|---|---|
| Annual Wellness Visit | 2.16.840.1.113883.3.526.2.1363 | Numerator |

**BH08_00 Value Set: Screening Tools & SBIRT**

| Value Set OID | Value Set Name | Measure Component |
|---|---|---|
| AUDIT Alcohol Screening | 2.16.840.1.113883.3.526.2.1919 | Numerator |
| AUDIT-C Alcohol Screening | 2.16.840.1.113883.3.526.2.1929 | Numerator |
| Single Question Alcohol Screening | 2.16.840.1.113883.3.526.2.1930 | Numerator |
| Alcohol and/or drug screening (Other) | N/A | Numerator |
| DAST Prescription and Illicit Drug Use Screening | 2.16.840.1.113883.3.526.2.1932 | Numerator |
| DAST-10 Prescription and Illicit Drug Use Screening | 2.16.840.1.113883.3.526.2.1933 | Numerator |
| Single Question Prescription and Illicit Drug Use Screening | 2.16.840.1.113883.3.526.2.1934 | Numerator |
| Tobacco Use Cessation Counseling | 2.16.840.1.113883.3.526.2.424 | Numerator |
| Tobacco Use Screening | 2.16.840.1.113883.3.526.2.1372 | Numerator |

**BH08_01 Value Set: Exclusions**

| Value Set | Value Set Description | Measure Component |
|---|---|---|
| BH08_01: Codes for Hospice | Codes to identify hospice | Denominator Exclusion |
| BH08_01: Documentation of chronic pain management | Documentation that a pain contract agreement exists | Denominator Exclusion |
| BH08_01: Medical Reasons for Not Screening | Documentation of medical reason(s) for not screening | Denominator Exclusion |

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with

participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

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

| Table Name | Table Description | Measure Component |
|---|---|---|
| **Table BH09_00** | Codes to Identify a Behavioral Health Diagnosis | Denominator |
| **Table BH09M06_01a** | Codes to Identify Patients Discharged from Inpatient Facility (Type of Bill) | Denominator |
| **Table BH09M06_01b** | Codes to Identify Patients Discharged from Inpatient Facility (Discharge Status) | Denominator |
| **Table BH09M06_02** | Codes to Identify Discharge Exclusions | Denominator Exclusion |

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

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

Please refer to the measure specifications for Measure BH10 for the list of tools acceptable for this measure. If your hospital uses a tool that is not listed in the measure specifications, please email the name of the tool and a copy or screenshot of the tool to QIP-NJ@pcgus.com, and it will be considered for inclusion. DOH will review submitted tools and approve them on a case-by-case basis.

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

Please refer to the measure specifications for Measure BH11 for the list of tools acceptable for this measure. If your hospital uses a tool that is not listed in the measure specifications, please email the name of the tool and a copy or screenshot of the tool to QIP-NJ@pcgus.com, and it will be considered for inclusion. DOH will review submitted tools and approve them on a case-by-case basis.

## Measure M1: Severe Maternal Morbidity (SMM)

| Table Name | Table Description | Measure Component |
|---|---|---|
| **Table M01_00** | Severe Maternal Morbidity Indicators and Corresponding ICD Codes | Numerator |
| **M1M4M5Denom_APR_DRG_Detail** | M1M2M5Denom_APR_DRG_Detail | Denominator |
| **Table M01_02** | Diagnoses and Procedures for Exclusion | Denominator Exclusions |

## Measure M2: PC-02 Cesarean Birth

| Table Name | Table Description | Measure Components |
|---|---|---|
| **Table M02_00** | Diagnosis and Procedure Codes to Identify Outcome of Delivery | Denominator |
| **Table M02_01** | Diagnosis Codes for Vertex Presentation | Denominator |
| **Table M02_02** | Diagnosis Codes to Identify Gestational Weeks Completed | Denominator |
| **Table M02_03** | Diagnosis and Procedure Codes to Identify Cesarean births | Numerator |
| **Table M02_04** | Diagnosis Codes to Identify Multiple Gestations and Other Presentations | Denominator Exclusions |

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

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

| Value Set Name / Table Name | Value Set OID / Table Description | Measure Component |
|---|---|---|
| M03_Deliveries | 2.16.840.1.113883.3.464.1004.1072 | Denominator |
| Table M03_01 | Codes to Document Depression Screen | Numerator |
| M03_Hospice > Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| M03_Hospice > Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| Table M03_02 | Codes to Identify Discharge Exclusions | Denominator Exclusion |
| Table M03_03 | LOINC Codes for Validated Screen Tools | Numerator |

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

## Measure M4: Postpartum Care (PPC)

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| M04_DetailOID > Acute Inpatient | 2.16.840.1.113883.3.464.1004.1810 | Denominator Exclusion |
| Acute Inpatient POS | 2.16.840.1.113883.3.464.1004.1027 | Denominator Exclusion |
| Cervical Cytology Lab Test | 2.16.840.1.113883.3.464.1004.1525 | Numerator |
| Cervical Cytology Result or Finding | 2.16.840.1.113883.3.464.1004.1524 | Numerator |
| M1M4M5Denom_APR_DRG_Detail | N/A | Denominator |
| Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| Non-live Births | 2.16.840.1.113883.3.464.1004.1187 | Denominator Exclusion |
| Online Assessments | 2.16.840.1.113883.3.464.1004.1446 | Numerator |
| Postpartum Bundled Services | 2.16.840.1.113883.3.464.1004.1217 | Numerator |
| Postpartum Visits | 2.16.840.1.113883.3.464.1004.1218 | Numerator |
| Pregnancy Diagnosis | 2.16.840.1.113883.3.464.1004.1220 | (Prenatal req.) |
| Prenatal Bundled Services | 2.16.840.1.113883.3.464.1004.1223 | (Prenatal req.) |
| Prenatal Visits | 2.16.840.1.113883.3.464.1004.1225 | (Prenatal req.) |
| Stand Alone Prenatal Visits | 2.16.840.1.113883.3.464.1004.1240 | (Prenatal req.) |

| | | |
|---|---|---|
| Telephone Visits | 2.16.840.1.113883.3.464.1004.1246 | Numerator |

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

IET Master Table

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| M1M4M5Denom_APR_DRG_Detail | N/A | Denominator |
| Alcohol Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1424 | Denominator |
| AOD Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1013 | Denominator |
| AOD Medication Treatment | 2.16.840.1.113883.3.464.1004.2017 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Detoxification | 2.16.840.1.113883.3.464.1004.1076 | Denominator (combined with Dependence v.s.) |
| ED | 2.16.840.1.113883.3.464.1004.1086 | Denominator (combined with Dependence v.s.) |
| Hospice Encounter | 2.16.840.1.113883.3.464.1004.1761 | Denominator Exclusion |
| Hospice Intervention | 2.16.840.1.113883.3.464.1004.1762 | Denominator Exclusion |
| IET POS Group 1 | 2.16.840.1.113883.3.464.1004.1129 | Denominator (combined with Dependence v.s.) |
| IET POS Group 2 | 2.16.840.1.113883.3.464.1004.1130 | Denominator (combined with Dependence v.s.) |
| IET Stand Alone Visits | 2.16.840.1.113883.3.464.1004.1131 | Numerator (combined with Dependence v.s.) |
| IET Visits Group 1 | 2.16.840.1.113883.3.464.1004.1132 | Numerator (combined with Dependence v.s.) |
| IET Visits Group 2 | 2.16.840.1.113883.3.464.1004.1133 | Numerator (combined with Dependence v.s.) |
| Inpatient Stay | 2.16.840.1.113883.3.464.1004.1395 | Numerator and Denominator |

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|---|---|---|
| Observation | 2.16.840.1.113883.3.464.1004.1191 | Numerator (combined with Dependence v.s.) |
| Online Assessments | 2.16.840.1.113883.3.464.1004.1446 | Denominator (combined with Dependence v.s.) |
| Opioid Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1425 | Denominator |
| Other Drug Abuse and Dependence | 2.16.840.1.113883.3.464.1004.1426 | Denominator |
| OUD Monthly Office Based Treatment | 2.16.840.1.113883.3.464.1004.2220 | Denominator (combined with Dependence v.s.) |
| OUD Weekly Drug Treatment Service | 2.16.840.1.113883.3.464.1004.2221 | Denominator (combined with Dependence v.s.) |
| OUD Weekly Non-Drug Service | 2.16.840.1.113883.3.464.1004.2222 | Denominator (combined with Dependence v.s.) |
| Telephone Visits | 2.16.840.1.113883.3.464.1004.1246 | Denominator (combined with Dependence v.s.) |

Opioid Use Disorder Treatment Medications List

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Buprenorphine Implant | 2.16.840.1.113883.3.464.1004.1970 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Injection | 2.16.840.1.113883.3.464.1004.1969 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Naloxone | 2.16.840.1.113883.3.464.1004.1971 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Buprenorphine Oral | 2.16.840.1.113883.3.464.1004.1968 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |

| | | |
|---|---|---|
| Buprenorphine Oral Weekly | 2.16.840.1.113883.3.464.1004.2219 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Methadone Oral | 2.16.840.1.113883.3.464.1004.1972 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Methadone Oral Weekly | 2.16.840.1.113883.3.464.1004.2218 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Naltrexone Injection | 2.16.840.1.113883.3.464.1004.1967 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |

Alcohol Use Disorder Treatment Medications List

| Value Set Name | Value Set OID | Measure Component |
|---|---|---|
| Aldehyde dehydrogenase inhibitors | N/A | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Antagonist | N/A, 2.16.840.1.113883.3.464.1004.1967 | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |
| Other | N/A | Denominator Exclusion (if dispensing event during 60 d prior to IESD) |

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

| Table Name | Table Description | Measure Component |
|---|---|---|
| | | |
| **Table M06_00** | Codes to Identify a Maternal Health Diagnosis | Denominator |
| **Table BH09M06_01a** | Codes to Identify Patients Discharged from Inpatient Facility (Type of Bill) | Denominator |
| **Table BH09M06_01b** | Codes to Identify Patients Discharged from Inpatient Facility (Discharge Status) | Denominator |
| **Table BH09M06_02** | Codes to Identify Discharge Exclusions | Denominator Exclusion |

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

## Measure M7: Treatment of Severe Hypertension

| Table Name | Table Description | Measure Component |
|---|---|---|
| **Table M07_00** | Recommended First-line Drug Therapies | Numerator |
| **Table M07_01** | Pre-existing or Gestational Hypertension, Eclampsia/Pre-eclampsia Codes | Denominator |
| **Table M07_02** | Gestational Edema and Unspecified Hypertension Codes | Denominator Exclusion |

Code sets for non-claims-based measures are provided as guidance for participating hospitals, but may not encompass all codes used by participating hosspitals and/or fully align with hospital- or system-specific chart/EHR documentation practices. The State is committed to working in close partnership with participating hospitals and providing technical assistance. Please submit any hospital- or system-specific questions via email to QIP-NJ@pcgus.com.

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

Please refer to the measure specifications for Measure M8 for the list of tools acceptable for this measure. If your hospital uses a tool that is not listed in the measure specifications, please email the name of the tool and a copy or screenshot of the tool to QIP-NJ@pcgus.com, and it will be considered for inclusion. DOH will review submitted tools and approve them on a case-by-case basis.

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

Please refer to the measure specifications for Measure M9 for the list of tools acceptable for this measure. If your hospital uses a tool that is not listed in the measure specifications, please email the name of the tool and a copy or screenshot of the tool to QIP-NJ@pcgus.com, and it will be considered for inclusion. DOH will review submitted tools and approve them on a case-by-case basis.

# Appendix B: Glossary of Terms

| Term | Definition |
|---|---|
| AAFP | American Academy of Family Physicians |
| ACH | Acute Care Hospital |
| AHRQ | Agency for Healthcare Research and Quality |
| AIM | Alliance for Innovation on Maternal Health |
| AMA | American Medical Association |
| AMA-PCPI | American Medical Association – Physician Consortium for Performance Improvement |
| AMHR | Adult Mental Health Rehabilitation |
| AOD | Alcohol or other drug |
| ASAM | American Society of Addiction Medicine |
| AUDIT | The Alcohol Use Disorders Identification Test |
| AUDIT-C | The Alcohol Use Disorders Identification Test-Concise |
| 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). |
| BDI | Beck Depression Inventory |
| BH | Behavioral Health |
| BP | Blood Pressure |
| CAGE Questionnaire for Detecting Alcoholism | Cut-Annoyed-Guilty-Eye Questionnaire for Detecting Alcoholism |
| CAGE-AID | CAGE Adapted to Include Drug Use |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| 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. |
| CCS | Clinical Classifications Software |
| 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. |
| CMS | Centers for Medicare and Medicaid Services |
| Continuous Eligibility | This field indicates whether continuous eligibility applies to the measure. If it does not, N/A will be marked. |
| Continuous Eligibility/ Risk Adjustment/ Sampling Methodology | This field provides instructions if any of these elements apply to the measure. |

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| CPT | Current Procedural Terminology |
| CTM-3 | 3-Item Care Transitions Measure |
| CUDOS | Clinically Useful Depression Outcome Scale |
| DAST | Drug Abuse Screening Test |
| 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. |
| Data Source | Indicates the method of the data collection (MMIS, Chart/EHR, Instrument-based) |
| Databook | Term used to refer to the Measurement Specifications and Submission Guidelines |
| Denominator | Defines the general criteria which identifies the patient population eligible for measurement. |
| DEPS | Depression Scale |
| DHS | Department of Human Services |
| DMAHS | Department of Medical Assistance and Human Services |
| DME | Durable Medical Equipment |
| DO | Doctor of Osteopathy |
| DOB | Date of Birth |
| DOH | Department of Health |
| DSRIP | Delivery System Reform Incentive Payment |
| ECDS | Electronic Clinical Data System |
| ECHO | Experience of Care & Health Outcomes |
| ED | Emergency Department |
| EHR | Electronic Health Record |
| EPDST | Early and Periodic Screening, Diagnostic and Treatment |
| Exceptions | Criteria used to remove a patient from the denominator when the patient does not receive a therapy or service and that therapy or service would not be appropriate due to patient-specific conditions. These are not absolute and are generally based on clinical judgment, individual patient characteristics, or patient preferences (may be medical or non-medical). |
| Exclusions | Criteria used to remove a patient from the denominator. These are absolute; therefore, clinical judgment does not enter into the decision-making process. |
| FFS | Fee-for-service |
| FND | Fagerstrom Test for Nicotine Dependence |
| FQHC | Federally Qualified Health Center |
| FUA-AD | Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence |
| FUH | Follow-Up After Hospitalization for Mental Illness |
| FUM | Follow0Up After Emergency Department Visit for Mental Illness |

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| HAM-D | Hamilton Rating Scale for Depression |
| HCPCS | Healthcare Common Procedure Coding System |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HTN | Hypertension |
| ICD | International Classification of Disease |
| IESD | Index Episode Start Date |
| IET – E | Engagement in Alcohol and Other Drug Abuse or Dependence Treatment |
| IET - I | Initiation of Alcohol and Other Drug Abuse or Dependence Treatment |
| 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. |
| IPF | Inpatient Facility |
| ITG | Improvement Target Goal |
| LOINC | Logical Observation Identifiers Names and Codes |
| MAT | Medication Assisted Treatment |
| MCO | Managed Care Organization |
| MD | Doctor of Medicine |
| MDI | Major Depression Inventory |
| 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. |
| 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). |
| 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 is provided. When codes were referenced from multiple versions of the measure, the source for each code type is noted. |
| MMC | Medicaid Managed Care |
| MMCO | Medicaid Managed Care Organization |

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| MMIS | Medicaid Management Information System |
| MSIS | Medicaid Statistical Information System |
| Multi-Setting | This refers to any MMIS or EHR measure that considers care that was received across multiple cares settings. |
| MY | Measurement Year |
| NCQA | National Committee for Quality Assurance |
| NDC | National Drug Code |
| NIDA | National Institute on Drug Abuse |
| NJ | New Jersey |
| NMASSIST | NIDA-Modified Alcohol, Smoking and Substance. Involvement Screening Test |
| 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. |
| NUBC | National Uniform Billing Committee |
| Numerator | Defines the specific criteria that identifies the portion of the patient population that meet the specific performance measurement. |
| OID | Object Identifier |
| OUD | Opioid Use Disorder |
| 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. |
| P4P | Pay for Performance |
| PCG | Public Consulting Group |
| PCP | Primary care physician |
| PDS | Preventative Care and Screening: Screening for Depression and Follow-Up |
| PDS-E | Postpartum Depression Screening |
| 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. |
| PHQ | Patient Health Questionnaire |
| POS | Place of Service |
| PPC | Postpartum Care |
| PRA | Perinatal Risk Assessment |
| PRAPARE | Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences |
| PROMIS | Patient-Reported Outcomes Measurement Information System |
| QIP-NJ | Quality Improvement Program - New Jersey |
| QMC | Quality Measures Committee |
| 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 |

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| | number of events compared to another unit of measurement, for example the utilization per member months. |
| Result | The calculated performance. This can be expressed as either a rate or percentage |
| Risk Adjustment | This field indicates whether risk adjustment applies to the measure. If it does not, NA will be marked. |
| RN | Registered Nurse |
| Sampling | This field indicates whether sampling applies to the measure. If it does not, NA will be marked. |
| SBIRT | Screening, brief intervention, and referral to treatment |
| SDOH | Social Determinants of Health |
| Setting of Care | This field lists where the service(s) was rendered and helps identify which provider type has the information available. |
| SFTP | Secure Files Transfer Portal |
| SHTN | Severe hypertension |
| SMM | Severe Maternal Morbidity |
| SUD | Substance use disorder |
| TAPS | Tobacco, Alcohol, Prescription Medication and other Substance Use |
| TICS | Two-Item Conjoint Screen |
| VBP | Value-Based Purchasing |
| VSC | Value Set Compendium |