MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: ILLINOIS-SPECIFIC REPORTING REQUIREMENTS

Effective as of January 1, 2015, issued August 7, 2015

Table of Contents

Illinois-Specific Reporting Requirements Appendix

Introduction

The measures in this appendix are required reporting for all MMPs in the Illinois Capitated Demonstration. CMS and the state reserve the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model: Core Reporting Requirements, which can be found at the following web address:

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology.

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®[1] and HOS. CMS and the state will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

MMPs should contact the IL Help Desk at ILHelpDesk@norc.org with any questions about the Illinois state-specific appendix or the data submission process.

Definitions

Calendar Year: All annual measures are reported on a calendar year basis. Calendar year 2014 (CY1) will be an abbreviated year, with data reported for the time period beginning March 1, 2014 and ending December 31, 2014. Calendar year 2015 (CY2) will represent January 1, 2015 through December 31, 2015.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: 1/1 – 3/31, 4/1 – 6/30, 7/1 – 9/30, 10/1 – 12/31. The first quarterly reporting period in CY1 will be an abbreviated quarter with data reported for the time period beginning March 1, 2014 and ending March 31, 2014. All subsequent quarterly reporting periods will align

[1] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).

with calendar quarters. Reporting due dates for quarterly measures will occur two months after the end of the quarterly reporting period, (e.g., plans would submit data on May 31 for the January 1- March 31 quarter).

Implementation Period: The period of time starting with the first effective enrollment date, March 1, 2014 through December 31, 2014.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Primary Care Provider (PCP): Nurse practitioners, physician assistants or physicians who are board certified or eligible for certification in one of the following specialties: family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics.

Variation from the Core Document

Core Measures 2.1, 2.2, and 2.3

For the following measures, the specifications for reporting will differ from the core requirement. Guidance for reporting Health Risk Screenings and Health Risk Assessments is provided below:

- Core Measure 2.1 - Members with an assessment completed within 90 days of enrollment.
    - For this measure, MMPs should report data on the number of members with a Health Risk Screening (HRS) completed within 90 days of enrollment. However, as outlined in section 2.6.1.1 of the three-way contract, if the MMP completed a Health Risk Assessment (HRA) in place of a HRS for any members, the MMP should include those members when it reports on the number of members who had an assessment completed within 90 days of enrollment (Core 2.1 Element D). If a MMP completed both an HRS and an HRA for a given member, that member should only be counted once when reporting Core 2.1.
- Core Measure 2.2 – Members with an assessment completed.
    - For this measure, MMPs should report data on the number of members with a Health Risk Screening (HRS) completed. However, as outlined in section 2.6.1.1 of the three-way contract, if the MMP

completed a Health Risk Assessment (HRA) in place of an HRS for any members, the MMP should include those members when it reports on the number of members who had an assessment completed within the reporting period (Core 2.2 Element A) and the number of members enrolled for 90 days or longer who had an assessment completed (Core 2.2 Element C). If the MMP completed both an HRS and an HRA for a given member, that member should only be counted once when reporting Core 2.2.

- Core Measure 2.3 – Members with an annual reassessment.
    - For members classified as no or low risk, the MMP can conduct the annual reassessment using the Health Risk Screening (HRS) tool. However, as indicated in section 2.6.1.1 of the three-way contract, the MMP has the option to administer a Health Risk Assessment (HRA) in place of the HRS.
    - For members classified as moderate or high risk, the MMP must conduct the annual reassessment using the HRA tool.
    - When reporting Core 2.3, the MMP should include all annual reassessments completed, regardless if the annual reassessment was conducted using the HRA or HRS tool (i.e., include all no and low risk members with an annual HRA/HRS and all moderate and high risk members with an annual HRA). If the MMP completed both an annual HRS and an annual HRA for a given member, only one annual reassessment should be counted for that member when reporting Core 2.3.

<u>Core Measure 9.2 – Nursing Facility (NF) Diversion</u>

The following section provides additional guidance about identifying individuals enrolled in the MMP as “nursing home certifiable,” or meeting the nursing facility level of care (NF LOC), for the purposes of reporting Core 9.2.

Within Core 9.2, “nursing home certifiable” members are defined as “members living in the community, but requiring an institutional level of care” (see the 2015 Core Reporting Requirements, pages 75-76). Illinois MMPs should use Determination of Need (DON) scores, supplemented by claims or enrollment data, to categorize members as nursing home certifiable. Individuals with DON scores of 29 or higher, as stated on the service plan shared with the MMP, can be considered nursing home certifiable.

In addition, MMPs should use other sources of data to confirm this information. Specifically:

- The daily 834 file distributed to MMPs by the state identifies waiver members by a two-digit waiver code (see below) and nursing home residents by a 12-digit code indicating the specific facility where the member resides. All waiver

members can be categorized as nursing home certifiable provided they meet all other criteria for the measure elements. Nursing home residents may be considered nursing home certifiable if they meet all other criteria for the measure elements and have resided in the nursing facility for no more than 100 days.

- Claims data or rate cells to identify individuals using nursing home services or waiver services.
- The Department of Rehabilitative Services (DORS) or Department of Aging's systems, which identify whether the member is on a waiver as well as the date the member became eligible for a waiver.

The two-digit waiver codes used to indicate members' waiver enrollments are as follows:

Department of Aging		**Traumatic Brain Injury**		**AIDS**	
A0	Aging	B0	TBI	C0	AIDS
AT	**Aging Pre-Transition	BT	**TBI Pre-Transition	VT	**AIDS Pre-Transition
AY	**Aging Transition Year	BY	**TBI Transition Year	VY	**AIDS Transition Year
AW	**Aging Withdrawal	BW	**TBI Withdrawal	VW	**AIDS Withdrawal
Tech. Dependent Children		**Department of Mental Health**		**Department of Rehabilitation**	
G0	TDC Hospital Residing Care	MT	**MH Pre-Transition	H0	Physically Disabled
G1	TDC SNF/PED Care	MY	**MH Transition Year	HT	**DORS Pre-Transition
G4	TDC Hospital Negotiated Rate	MW	**MH Withdrawal	HY	**DORS Transition Year
G5	TDC SNF/PED Care Negotiated Rate			HW	**DORS Withdrawal
Developmentally Disabled		**Department of Health and Family Services**		**Children with Complex Needs**	
D0	DD Adult	DB	Death Date Presumed	BK	Children with Complex Behavioral Needs
D1	DD Children In home support	DC	Death Date Certified	CK	Children with Complex Medical Needs
D2	DD Children Residential	CB	Colbert Consent Decree		
DT	**DD Children Pre-Transition	WM	Williams Consent Decree		
DY	**DD Transition Year	FO	Supportive Living Facility resident		
DW	**DD Withdrawal				

**All Pre-Transition, Transition and Withdrawal codes are part of DHFS 'Money Follows the Person' Program.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: (ⁱ). This document contains only

Demonstration Year 1 (DY1) quality withhold measures. CMS and the state will update the quality withhold measures for subsequent demonstration years closer to the start of Demonstration Year 2 (DY2). For more information, refer to the Quality Withhold Technical Notes (DY 1): Illinois Specific Measures at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are *not* required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member's enrollment status.

Guidance on Screenings, Assessments, and Care Plans for Members with a Break in Coverage

Screenings and Assessments

If a MMP already completed a Health Risk Screening (HRS) or Health Risk Assessment (HRA) for a member that was previously enrolled, the MMP is not necessarily required to conduct a new HRS or HRA if the member rejoins the same MMP within one year of his/her most recent HRS or HRA. Instead, the MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the HRS or HRA was conducted; and
2. Ask the member (or his/her authorized representative) if there has been a change in the member's health status or needs since the HRS or HRA was conducted.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or his/her authorized representative) to determine if there was a change in the member's health status or needs.

If a change is identified, the MMP must conduct a new HRS or HRA within the timeframe prescribed by the contract. For members that are stratified as no or low risk, the MMP must conduct an HRS (unless the plan opts to conduct an HRA in place of an HRS, as permitted by the contract). For members that are stratified as moderate or high risk, the MMP must conduct an HRA.

If there are no changes, the MMP is not required to conduct a new HRS or HRA unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct a new HRS or HRA on all re-enrollees regardless of status, it may continue to do so.

Once the MMP has conducted a new HRS or HRA as needed or confirmed that the prior HRS or HRA is still accurate, the MMP can mark the HRS or HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications and additional guidance for Core 2.1 and Core 2.2 (MMPs should refer to the guidance provided above in the "Variation from the Core Document" section). If the re-enrolled member is stratified as moderate or high-risk, the HRA completion would also be counted in measure IL2.2. When reporting these measures, the MMP should count the 90 days from the member's most recent enrollment effective date, and should report the HRS or HRA based on the date the prior HRS or HRA was either confirmed to be accurate or a new HRS or HRA was completed.

If the MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the MMP may report that member as unable to be reached so long as the MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss his/her health status with the MMP, then the MMP may report that member as unwilling to participate in the HRS or HRA.

If the MMP did not complete an HRS or HRA for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's HRS or HRA was completed, the MMP is required to conduct an HRS or HRA for the member within the timeframe prescribed by the contract. For members that are stratified as no or low risk, the MMP must conduct an HRS (unless the plan opts to conduct an HRA in place of an HRS as permitted by the contract). For members that are stratified as moderate or high risk, the MMP must conduct an HRA. The MMP must make the requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members that refused the HRS or HRA during their prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

Care Plans

If the MMP conducts a new HRS or HRA for the re-enrolled member, the MMP must revise the care plan accordingly within the timeframe prescribed by the contract. Once the care plan is revised, the MMP may mark the care plan as complete for the member's current enrollment. If the MMP determines that the prior HRS or HRA is still accurate and, therefore, no updates are required to the previously developed care plan, the MMP may mark the care plan as complete for the current enrollment at the same time that the HRS or HRA is marked complete. The MMP would then follow the applicable state-specific measure specifications for reporting the completion. Please note, for purposes of reporting, the care plan for the re-enrolled member should be classified as an *initial* care plan.

If the MMP did not complete a care plan for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's care plan was completed, the MMP is required to develop a care plan for the member within the timeframe prescribed by the contract. The MMP must also follow the above guidance regarding reaching out to members that previously refused to participate or were not reached.

Reassessments and Care Plan Updates

As required by the contract, the MMP must analyze predictive modeling reports and other surveillance data of all members to identify risk level changes on a monthly basis. If risk levels change, the MMP must conduct reassessments as necessary and update the care plans and interventions. The MMP must also review care plans and interventions at least every 30 days for high-risk members and at least every 90 days for moderate-risk members. The MMP must conduct reassessments as necessary based on such reviews.

The MMP must also follow contract requirements regarding the completion of annual reassessments (HRS or HRA as applicable) and updates to care plans. If the MMP determined that a HRS/HRA or care plan from a member's prior enrollment was accurate and marked that HRS/HRA or care plan as complete for the member's current enrollment, the MMP should count continuously from the date that the HRS/HRA or care plan was completed in the prior enrollment period to determine the due date for the annual reassessment and care plan update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the HRS or HRA was actually completed, even if that date was during the member's prior enrollment period.

Guidance on Adopting Screenings and Assessments Completed Previously by the MMP's Affiliated Integrated Care Program

When a member moves from an Integrated Care Program (ICP) plan to an MMAI MMP within 90 days of completing a Health Risk Screening (HRS) or Health Risk Assessment (HRA), the MMP is not necessarily required to conduct a new

HRS/HRA. Instead, the MMP must contact the member (or his/her authorized representative) to ensure that the HRS/HRA is up to date and that there has been no change to the member's health status or needs in the prior 90 days. If the MMP confirms and documents that there have been no changes, then the MMP is not required to complete a new HRS/HRA. If there has been a change in the member's health status or needs since the initial HRS/HRA, regardless of when the ICP plan completed the HRS/HRA, the MMP must attempt to conduct a new HRS and/or HRA (when applicable).

If it has been more than 90 days since the original HRS/HRA was completed while the member was enrolled in the ICP plan, the MMP must attempt to complete a new HRS and/or HRA (when applicable). The MMP is required to follow contractual requirements when conducting HRSs and HRAs.

Once the MMP has conducted a new HRS/HRA as needed or confirmed that the prior HRS/HRA is still accurate, the MMP can mark the HRS/HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications and additional guidance for Core 2.1 and Core 2.2 (MMPs should refer to the guidance provided above in the "Variation from the Core Document" section). If the re-enrolled member is stratified as moderate or high-risk, the HRA completion would also be counted in measure IL2.2. When reporting these measures, the MMP should count the 90 days from the member's most recent enrollment effective date, and should report the HRS/HRA based on the date the prior HRS/HRA was either confirmed to be accurate or a new HRS/HRA was completed.

For Core 2.3, members with an annual reassessment, MMPs should determine whether members are eligible for an annual HRS/HRA using the actual date the initial HRS/HRA was completed, even if that date occurred when the member was enrolled in the ICP plan.

Code Tables

The measure specifications in this document include references to code tables that will be used to determined data elements. These code tables are either HEDIS Value Sets or can be found in Appendix A.

Illinois' Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	3-1-14 through 12-31-14	From the first effective enrollment date through the end of tenth month of the demonstration.
	Ongoing Period	3-1-14 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third demonstration year.

Data Submission

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative (FAI) Data Collection System (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00p.m. ET on the applicable due date. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

(Note: Prior to the first use of the system, all MMPs will receive an email notification with the username and password that has been assigned to their MMP. This information will be used to log in to the FAI system and complete the data submission.)

All MMPs will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through the Health Plan Management System (HPMS).

Please note, late submissions may result in compliance action from CMS.

Resubmission of Data to the FAI Data Collection System or HPMS

MMPs must comply with the following steps to resubmit data after an established due date:

1. Email the IL HelpDesk (ILHelpDesk@norc.org) to request resubmission.
    - Specify in the email which measures need resubmission;
    - Specify for which reporting period(s) the resubmission is needed; and
    - Provide a brief explanation for why the data need to be resubmitted.

2. After review of the request, the IL HelpDesk will notify the MMP once the FAI Data Collection System and/or HPMS has been re-opened.

3. Resubmit data through the applicable reporting system.

4. Notify the IL HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

Section IL. Access

IL1.1 Adults access to preventive/ambulatory health services. (ICP AAP Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL1. Access	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members 21-44 years old.	Total number of members 21-44 years old who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members 21-44 years old with one or more ambulatory or preventive care visits during the reporting period.	Of the total reported in A, the number of members 21-44 years old with one or more ambulatory or preventive care visits during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members 45-64 years old.	Total number of members 45-64 years old who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members 45-64 years old with one or more ambulatory or preventive care visits during the reporting period.	Of the total reported in C, the number of members 45-64 years old with one or more ambulatory or preventive care visits during the reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members 65 years and older.	Total number of members 65 years and older who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
F.	Total number of members 65 years and older with one or more ambulatory or preventive care visits during the reporting period.	Of the total reported in E, the number of members 65 years and older with one or more ambulatory or preventive care visits during the reporting period.	Field Type: Numeric Note: Is a subset of E.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- MMPs should validate that data element F is less than or equal to data element E.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members:

- 21-44 years old members with one or more ambulatory or preventive care visits during the reporting period.
- 45-64 years old with one or more ambulatory or preventive care visits during the reporting period.
- 65 and older with one or more ambulatory or preventive care visits during the reporting period.
- 21 and older with one or more ambulatory or preventive care visits during the reporting period (i.e., the sum of data elements A, C, and E divided by the sum of data elements B, D, and F).

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Members must be enrolled on December 31 of the reporting period to be included in this measure.
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- The total analysis (i.e., the fourth bullet point in the analysis section) is the sum of the age stratifications (i.e., 21-44, 45-64, and 65 and older).
- Codes to identify preventive/ambulatory health services are provided in the HEDIS Ambulatory Visits and Other Ambulatory Visits value sets.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section ILII. Assessment

IL2.1 Behavioral health risk assessment and follow-up. (ICP IBHR Measure)

CONTINOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL2. Assessment	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of newly enrolled members.	Total number of newly enrolled members in the MMP who were continuously enrolled for at least 90 days during the reporting period.	Field Type: Numeric
B.	Total number of new members with a behavioral health risk assessment (BHRA) completed within 60 days of enrollment.	Of the total reported in A, the number of new members with a BHRA completed within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.
C.	Total number of new members with a BHRA with a positive finding for behavioral health issues.	Of the total reported in B, the number of new members with a BHRA with a positive finding for behavioral health issues.	Field type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after the positive BHRA, including the date of discharge.	Of the total reported in C, the number of members who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after the positive BHRA, including the date of discharge.	Field type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of newly enrolled members with a:

- BHRA completed within 60 days of enrollment.
- Positive BHRA who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after the positive BHRA.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 60th day of enrollment should be based on each member's enrollment effective date. For purposes of reporting this measure, 60 days of enrollment will be equivalent to two full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- The first reporting period, CY1, begins on March 1, 2014 and ends on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, the new member must be continuously enrolled for at least 90 days between the first day of the reporting period (March 1, 2014) and October 3, 2014, with no gaps in enrollment.
- Beginning CY2, the new member must be continuously enrolled for at least 90 days between October 4 of the prior reporting period (e.g., October 4, 2014) and October 3 of the current reporting period (e.g., October 3, 2015), with no gaps in enrollment.
- A newly enrolled member is a member not previously enrolled in the MMP in the prior six months. A member may be included in this measure multiple times if they have multiple "new" enrollments during the reporting period, as enrollments more than six months apart would necessitate a new BHRA to be completed.
- Any of the following HEDIS value sets may be used to meet criteria for a follow-up visit.
    i. A visit (HEDIS FUH Stand Alone Visits value set) with a mental health practitioner;
    ii. A visit (HEDIS FUH Visits Group 1 **AND** HEDIS FUH POS Group 1 value sets) with a mental health practitioner;
    iii. A visit (HEDIS FUH Visits Group 2 **AND** HEDIS FUH POS Group 2 value sets) with a mental health practitioner;
    iv. A visit to a behavioral healthcare facility (HEDIS FUH RevCodes Group 1 value set);
    v. A visit to a non-behavioral healthcare facility (HEDIS FUH RevCodes Group 2 value set) with a mental health practitioner; or
    vi. A visit to a non-behavioral healthcare facility (HEDIS FUH RevCodes Group 2 value set) with a diagnosis of mental illness (HEDIS Mental Illness value set).

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL2.2 Moderate and high-risk members with a health risk assessment completed within 90 days of enrollment.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL2. Assessment	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
IL2. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of moderate risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of moderate risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of moderate risk members who are documented as unwilling to complete a health risk assessment (HRA) within 90 days of enrollment.	Of the total reported in A, the number of moderate risk members who are documented as unwilling to complete a HRA within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of moderate risk members the MMP was unable to reach, following five documented attempts within 60 days of enrollment.	Of the total reported in A, the number of moderate risk members the MMP was unable to reach, following five documented attempts within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of moderate risk members with a HRA completed within 90 days of enrollment.	Of the total reported in A, the number of moderate risk members with a HRA completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of high risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of high risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of high risk members who are documented as unwilling to complete a HRA within 90 days of enrollment.	Of the total reported in E, the number of high risk members who are documented as unwilling to complete a HRA within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
G.	Total number of high risk members the MMP was unable to reach, following five documented attempts within 60 days of enrollment.	Of the total reported in E, the number of high risk members the MMP was unable to reach, following five documented attempts within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
H.	Total number of high risk members with a HRA completed within 90 days of enrollment.	Of the total reported in E, the number of high risk members with a HRA completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark is set at the percentage achieved by the highest scoring MMP minus 10 percentage points.
- For withhold purposes, the measure is calculated as follows:
    i. Denominator: Total number of moderate and high risk members enrolled whose 90th day of enrollment occurred within the reporting period (Data Elements A and E), summed over the applicable number of quarters. Members who refused the assessment (Data Elements B and F) and who could not be reached (Data Elements C and G) will be removed from the denominator.
    ii. Numerator: Total number of moderate and high risk members with a health risk assessment completed within 90 days of enrollment (Data Elements D and H), summed over the applicable number of quarters.
- For more information, refer to the Quality Withhold Technical Notes (DY 1): Illinois Specific Measures.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- MMPs should validate that data elements F, G, and H are less than or equal to data element E.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Moderate risk members who were unable to be reached within 60 days to have a HRA.
- Moderate risk members who refused to have a HRA completed within 90 days of enrollment.
- Moderate risk members who had a HRA completed within 90 days of enrollment.
- Moderate risk members who were willing to participate and who could be reached who had a HRA completed within 90 days of enrollment.
- High risk members who were unable to be reached within 60 days to have a HRA.
- High risk members who refused to have a HRA completed within 90 days of enrollment.
- High risk members who had a HRA completed within 90 days of enrollment.
- High risk members who were willing to participate and who could be reached who had a HRA completed within 90 days of enrollment.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A and Element E regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members whose 90th day of enrollment occurred during the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's effective date. For purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should only report HRAs completed when reporting this measure, as opposed to Health Risk Screenings (HRS).
- MMPs should refer to IL's three-way contract for specific requirements pertaining to a HRA.
- Moderate risk members are members identified as needing supportive Care Management services.
- High risk members are members identified as needing intensive Care Management services.
- For data elements B and F, MMPs should report the number of members who were unwilling to participate in the HRA if a member (or his or her authorized representative):
  i. Affirmatively declines to participate in the HRA. Member communicates this refusal by phone, mail, fax, or in person.
  ii. Expresses willingness to complete the HRA but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the HRA within 90 days). Discussions with the member must be documented by the MMP.
  iii. Expresses willingness to complete the HRA, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
  iv. Initially agrees to complete the HRA, but then declines to answer a majority of the questions in the assessment.
- For data elements C and G, MMPs should report the number of members the MMP was unable to reach after the requisite number of attempts to contact the member. MMPs should refer to the IL three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may

validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.

- If a member initially could not be reached after five outreach attempts within 60 days of enrollment, but then subsequently completes the HRA within 90 days of enrollment, the member should be classified in data elements D or H, not data elements C or G.
- If a member initially could not be reached after five outreach attempts within 60 days of enrollment, but then subsequently is contacted and refuses to complete the HRA within 90 days of enrollment, the member should be classified in data elements B or F, not data elements C or G.
- There may be certain circumstances that make it impossible or inappropriate to complete a HRA within 90 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a HRA. However, MMPs should not include such members in the counts for data elements B, C, F, and G. However, this member would be included in data element A or E.
- If a member's HRA was started but not completed within 90 days of enrollment, then the HRA should not be considered completed and, therefore, would not be counted in data elements B, C, D, F, G, or H. However, this member would be included in data element A or E.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section ILIII. Care Coordination

IL3.1 Members with care plans within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
IL3. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of members who were documented as unwilling to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to complete a care plan within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	Total number of members with a care plan completed within 90 days of enrollment.	Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members who were unable to be reached to have a care plan completed within 90 days of enrollment.
- Members who refused to have a care plan completed within 90 days of enrollment.
- Members who had a care plan completed within 90 days of enrollment.
- Members that were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

- The 90th day of enrollment should be based on each member's enrollment effective date. For purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members whose 90th day of enrollment occurred within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A includes all members whose 90th day of enrollment occurred during the reporting period, regardless of that member's current risk stratification (i.e., include all low, moderate, and high risk members).
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to IL's three-way contract for specific requirements pertaining to a care plan.
- For data element B, MMPs should report the number of members who were unwilling to participate in the development of the care plan if a member (or his or her authorized representative):
    i. Affirmatively declines to participate in the care plan. Member communicates this refusal by phone, mail, fax, or in person.
    ii. Expresses willingness to complete the care plan but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the MMP.
    iii. Expresses willingness to complete the care plan, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    iv. Initially agrees to complete the care plan, but then declines to participate in the care plan.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the IL three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.

- There may be certain circumstances that make it impossible or inappropriate to complete a care plan within 90 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan. However, MMPs should not include such members in the counts for data elements B and C. However, this member would be included in data element A.
- Care plans that are in the process of being developed on the 90th day of the member's enrollment should not be considered complete and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL3.2 Members with documented discussions of care goals.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
IL3. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial care plan developed.	Total number of members with an initial care plan developed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the initial care plan.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the initial care plan.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of existing care plans revised.	Total number of existing care plans revised during the reporting period.	Field Type: Numeric
D.	Total number of revised care plans with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised care plans with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark is set at the percentage achieved by the highest scoring MMP minus 10 percentage points.
- For withhold purposes, the measure is calculated as follows:
    i. Denominator: Total number of members with an initial care plan developed (Data Element A) summed over the applicable number of quarters.
    ii. Numerator: Total number of members with at least one documented discussion of care goals in the initial care plan (Data Element B) summed over the applicable number of quarters.
- For more information, refer to the Quality Withhold Technical Notes (DY 1): Illinois Specific Measures.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members who had an initial care plan developed during the reporting period who had at least one documented discussion of care goals in the care plan.
- Care plans revised during the reporting period that had at least one documented discussion of new or existing care goals.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should include all care plans that meet the criteria outlined in data element C, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all care plans regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all care plans that were created for the first time during the reporting period (i.e., the member did not previously have a care plan developed prior to the start of the reporting period). There can be no more than one initial care plan per member.
- MMPs should only include members in data element B when the discussion of care goals is clearly documented in the member's initial care plan.
- Data element C should include all existing care plans that were revised during the reporting period. MMPs should refer to the IL three-way contract for specific requirements pertaining to updating the care plan.
- MMPs should only include care plans in data element D when a new or previously documented care goal is discussed and is clearly documented in the member's revised care plan. If the initial care plan

clearly documented the discussions of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the care plan, then that care plan should not be reported in data element D.

- If a member has an initial care plan completed during the reporting period, and has their care plan revised during the same reporting period, the member should be reported in data element A and the member's revised care plan should be reported in data element C.
- If a member's care plan is revised multiple times during the same reporting period, each revision should be reported in data element C. For example, if a member's care plan is revised twice during the same reporting period, two care plans should be counted in data element C.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL3.3 Ambulatory care follow-up with a provider within 14 days of emergency department (ED) visit. (ICP IAPE Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of ED visits.	Total number of ED visits that occurred during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of ED visits that resulted in an ambulatory care follow-up visit with a provider within 14 days following the ED visit.	Of the total reported in A, the number of ED visits that resulted in an ambulatory care follow-up visit with a provider within 14 days following the ED visit.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of ED visits that resulted in an ambulatory care follow-up visit with a provider within 14 days of the ED visit.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all ED visits for members that meet the criteria outlined in Element A, regardless of whether the member is disenrolled as of the end of the reporting period (i.e., include ED visits for all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- The denominator for this measure is based on ED visits, not members.
- The first reporting period, CY1, begins on March 1, 2014 and end on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, include all events for those members who have one or more ED visit

on or between the first day of the reporting period (March 1, 2014) and December 17, 2014.

- Beginning CY2, include all events for those members who have one or more ED visit between December 18 of the prior reporting period (e.g., December 18, 2014) and December 17 of the current reporting period (e.g., December 17, 2015).
- The 14 days following December 17 are the lookout period for follow-up visits related to index events occurring on December 17.
- The member needs to be enrolled from the date of the ED discharge through 14 days after the ED discharge, with no gaps in enrollment, to be included in this measure.
- Count each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit.
- Count multiple ED visits on the same date of service as one visit.
- To identify ED visits use ***either*** the HEDIS ED value set or the HEDIS ED Procedure Code ***with*** ED POS value sets.
- Codes to determine follow-up visits are provided in the HEDIS Ambulatory Visits and Other Ambulatory Visits value sets.
- Exclude ED discharges in which the patient was transferred directly or admitted within 14 days to an acute or non-acute facility. These ED discharges are excluded because the hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- Exclude ED visits with a principal diagnosis for mental illness or chemical dependency (HEDIS Mental and Behavioral Disorders value set).
- Exclude ED visits with a principal diagnosis of poisoning with a secondary diagnosis indicating an alcohol or drug related mental health diagnosis as provided in **Table IL-13**.
- Exclude discharges due to death, discharge status code 20.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL3.4 Ambulatory care follow-up with a provider within 14 days of inpatient discharge. (ICP IAPI Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of inpatient hospital discharges.	Total number of inpatient hospital discharges that occurred during the reporting period.	Field Type: Numeric
B.	Total number of inpatient hospital discharges that resulted in an ambulatory care follow-up visit with a provider within 14 days following the inpatient discharge.	Of the total reported in A, the number of inpatient hospital discharges that resulted in an ambulatory care follow-up visit with a provider within 14 days following the inpatient discharge.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of inpatient discharges that resulted in an ambulatory care follow-up visit with a provider within 14 days following the inpatient discharge.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all inpatient discharges for members who meet the criteria outlined in Element A, regardless of whether the member is disenrolled as of the end of the reporting period (i.e., include all inpatient discharges for members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- The denominator for this measure is based on inpatient hospital discharges, not members.
- The first reporting period, CY1, begins on March 1, 2014 and ends on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, include all events for those members who have more than one discharge on or between the first day of the reporting period (March 1, 2014) and December 17, 2014.
- Beginning CY2, include all events for those members who have one or more discharges on or between December 18 of the prior reporting period (e.g., December 18, 2014) and December 17 of the current reporting period (e.g., December 17, 2015).
- The 14 days following December 17 are the lookout period for follow-up visits related to index events occurring on December 17.
- The member needs to be enrolled from the date of the discharge through 14 days after the discharge, with no gaps in enrollment.
- Codes to determine follow-up visits are provided in the HEDIS Ambulatory Visits and Other Ambulatory Visits value sets.
- Codes to identify inpatient discharges are provided in the HEDIS Surgery MS-DRG, Medicine MS-DRG and Newborn/Neonates MS-DRG value sets. If the MMP does not capture MS-DRG, then use the codes provided in **Table IL-1**.
- Exclude discharges in which the patient was transferred directly or readmitted within 14 days after discharge to an acute or non-acute facility. These discharges are excluded because re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place.
- Exclude inpatient discharges with a principal diagnosis of mental illness or chemical dependency (HEDIS Mental and Behavioral Disorders value set).
- Exclude inpatient discharges with a principal diagnosis of poisoning with a secondary diagnosis indicating an alcohol or drug related mental health diagnosis as provided in **Table IL-13**.

- Exclude inpatient hospitalizations for deliveries (births) using the HEDIS Maternity, Maternity Diagnosis and Maternity MS-DRG value sets and **Table IL-14**.
- Exclude discharges due to death (Discharge status code 20).

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL3.5 Follow-up with a provider within 30 days after an initial behavioral health diagnosis. (ICP IFUP Measure) – ***Suspended for 2015***

IL3.6 Movement of members within service populations. (ICP IMWS Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled.	Total number of members enrolled as of the first day of the reporting period.	Field Type: Numeric
B.	Total number of members in the Community.	Of the total reported in A, the number of members in the Community as of the first day of the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members classified as remaining in the Community.	Of the total reported in B, the number of members classified as remaining in the Community as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members classified as being in an LTSS waiver.	Of the total reported in B, the number of members classified as being in an LTSS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.
E.	Total number of members classified as being in Long Term Care (LTC).	Of the total reported in B, the number of members classified as being in LTC as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.
F.	Total number of members no longer enrolled.	Of the total reported in B, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.
G.	Total number of members in an LTSS waiver.	Of the total reported in A, the number of members in an LTSS waiver as of the first day of the reporting period.	Field Type: Numeric Note: Is a subset of A.
H.	Total number of members classified as being in the Community.	Of the total reported in G, the number of members classified as being in the Community as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.
I.	Total number of members classified as remaining in an LTSS waiver.	Of the total reported in G, the number of members classified as remaining in an LTSS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.
J.	Total number of members classified as being in LTC.	Of the total reported in G, the number of members classified as being in LTC as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.
K.	Total number of members no longer enrolled.	Of the total reported in G, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of G.

Element Letter	Element Name	Definition	Allowable Values
L.	Total number of members in LTC.	Of the total reported in A, the number of members in LTC as of the first day of the reporting period.	Field Type: Numeric Note: Is a subset of A.
M.	Total number of members classified as being in the Community.	Of the total reported in L, the number of members classified as being in the Community as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.
N.	Total number of members classified as being in an LTSS waiver.	Of the total reported in L, the number of members classified as being in an LTSS waiver as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.
O.	Total number of members classified as remaining in LTC.	Of the total reported in L, the number of members classified as remaining in LTC as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.
P.	Total number of members no longer enrolled.	Of the total reported in L, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of L.
Q.	Total number of members who had no movement between services.	Of the total reported in A, the number of members who remained in the same service classification as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of A. Is the sum of C, I and O.
R.	Total number of members no longer enrolled.	Of the total reported in A, the number of members no longer enrolled in the MMP as of the last day of the reporting period.	Field Type: Numeric Note: Is a subset of A. Is the sum of F, K, and P.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.

- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above are subsets of other elements.
- MMPs should validate that data elements C, D, E, and F are less than or equal to data element B.
- MMPs should validate that data elements H, I, J, and K are less than or equal to data element G.
- MMPs should validate that data elements M, N, O, and P are less than or equal to data element L.
- MMPs should validate that data elements B, G, L, Q, and R are less than or equal to data element A.
- MMPs should validate that data element B is the sum of data elements C, D, E and F.
- MMPs should validate that data element G is the sum of data elements H, I, J and K.
- MMPs should validate that data element L is the sum of data elements M, N, O and P.
- MMPs should validate that data element R is the sum of data elements F, K and P.
- MMPs should validate that data element Q is the sum of data elements C, I and O.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members in the Community as of the first day of the reporting period who were classified as remaining in the Community as of the last day of the reporting period.
- Members in the Community as of the first day of the reporting period who were classified as being in an LTSS waiver as of the last day of the reporting period.
- Members in the Community as of the first day of the reporting period who were classified as being in LTC as of the last day of the reporting period.
- Members in the Community as of the first day of the reporting period who were no longer enrolled in the MMP as of the last day of the reporting period.
- Members in an LTSS waiver as of the first day of the reporting period who were classified as being in the Community as of the last day of the reporting period.

- Members in an LTSS waiver as of the first day of the reporting period who were classified as remaining in an LTSS waiver as of the last day of the reporting period.
- Members in an LTSS waiver as of the first day of the reporting period who were classified as being in LTC as of the last day of the reporting period.
- Members in an LTSS waiver as of the first day of the reporting period who were no longer enrolled in the MMP as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were classified as being in the Community as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were classified as being in an LTSS waiver as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were classified as remaining in LTC as of the last day of the reporting period.
- Members in LTC as of the first day of the reporting period who were no longer enrolled in the MMP as of the last day of the reporting period.
- Members enrolled as of the first day of the reporting period who had no movement between services as of the last day of the reporting period.
- Members enrolled in the MMP as of the first day of the reporting period who were no longer enrolled as of the last day of the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Exclude LTC stays of 90 days or less. Report these members in the classification they were in prior to the short stay.
- Members are classified as in the Community, an LTSS waiver, or Nursing Facility (i.e., LTC) in accordance with the most accurate data they have access to. This may be claims data for waiver services or Nursing Facilities or a lack of these types of claims for Community. Or it may be the rate cell definitions provided on page 174 of the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an LTSS waiver.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section ILIV. Enrollee Protections

IL4.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL4. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
IL4. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of total critical incident and abuse reports per 1,000 members receiving LTSS during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless if the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider, and are not limited to only those providers defined as LTSS providers.
- To identify members receiving LTSS, MMPs should refer to the daily eligibility file provided by the Illinois Department of Healthcare and Family Services. If a member is on an HCBS waiver, a two-digit waiver code is included on that file indicating which waiver the client is enrolled in. If a member is in a Long Term Care (LTC) facility, the name of the LTC facility and the 12-digit provider number for that facility is included on the daily file.
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
- Abuse refers to:

  1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;

2. Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
3. Rape or sexual assault;
4. Corporal punishment or striking of an individual;
5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
6. Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section ILV. Organizational Structure and Staffing

IL5.1 Americans with Disabilities Act (ADA) compliance.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	ADA Compliance Plan	ADA Compliance Plan that describes the policies and procedures for maintaining ADA compliance.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	ADA Compliance or Quality Officer	Identification of staff person responsible for ADA compliance.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
C.	Provider Site Assessment	Assessment tool used to evaluate provider site compliance with the ADA requirements.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- The quality withhold benchmark is set at 100% compliance. The MMP must submit an ADA Compliance Plan that aligns with the requirements outlined in this measure specification. If deficiencies are identified in the MMP's ADA Compliance Plan or the policies/procedures described therein, the MMP may still meet this measure if it submits a strategy to correct the deficiencies within 7 business days of notification of completion of the review. The MMP must submit documentation of the corrections within 30 days after notification of completion of the review to validate the implementation of the corrective strategy. For more information, refer to the Quality Withhold Technical Notes (DY 1): Illinois Specific Measures.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm that all required information is included in each element as outlined below.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will verify that each reported element follows the requirements outlined below.

- **ADA Compliance Plan (Element A)** – The ADA Compliance Plan should clearly describe the policies and procedures for maintaining compliance with the ADA requirements. The plan can either be part of the organization's overall compliance plan or a separate document that just describes ADA compliance. The plan should include:
  i. Process for maintaining ADA compliance
  ii. Person and committee responsible for oversight
  iii. Description of training for network provider staff
  iv. Description of training for Interdisciplinary Care Team members
  v. Description of provider site assessment for compliance and frequency of assessment
  vi. Description of how non-compliant findings are remediated, including:
    - Process for documenting non-compliance
    - Process for documenting actions taken to remediate non-compliance
    - Individual(s) responsible for remediation
    - Timeline for remediation
    - Monitoring and oversight of the remediation process
  vii. Committee meeting minutes to validate oversight of the ADA Compliance Plan
  viii. Annual assessment of the ADA Compliance Plan, including:
    - Assessment of completion of planned activities and that the objectives of the plan were met
    - Identification of issues or barriers that impacted meeting the objectives of the work plan
    - Recommended interventions to overcome barriers and issues identified
    - Overall effectiveness of the ADA Compliance Plan
- **ADA Compliance or Quality Officer (Element B)** – This document should identify the staff person responsible for ADA compliance and also provide his/her job description.
- **Provider Site Assessment Tool (Element C)** – The assessment tool should contain all elements to assess physical site compliance, including the following areas:
  i. Parking accessibility

ii. Exterior Building
iii. Interior Building
iv. Office reception area
v. Restroom
vi. Exam room
vii. Exam table
viii. Scale

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should refer to the Illinois three-way contract (Section 2.9.1.6) for specific requirements pertaining to ADA physical access compliance.
- The ADA Compliance Officer or Quality Officer may be the same individual that serves as the MMP Compliance Officer.
- MMPs should refer to the following links for additional guidance on physical access for individuals with mobility disabilities: http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm and http://www.adachecklist.org

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx
- For data submission, each data element above should be uploaded as a separate attachment.
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx".
- File name= IL_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE)_(ELEMENTNAME).docx.
- Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), (SUBMISSIONDATE) the year, month, and date of the submission in YYYYMMDD format (e.g., March 30, 2014 would be 20140330), and (ELEMENTNAME) with the element name listed below.
- For element letter "A", the (ELEMENTNAME) should be (PLAN).
- For element letter "B", the (ELEMENTNAME) should be (OFFICER).
- For element letter "C", the (ELEMENTNAME) should be (ASSESSMENT).

IL5.2 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of care coordinators who have been employed by the MMP for at least 30 days.	Total number of new care coordinators who have been employed by the MMP for at least 30 days during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators that have undergone training for supporting self-direction under the demonstration within the past 12 months.	Of the total reported in A, the number of new care coordinators that have undergone training for supporting self-direction under the demonstration within the past 12 months.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of new care coordinators that have undergone state-based training for supporting self-direction.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should refer to IL's three-way contract for specific requirements pertaining to a care coordinator.
- MMPs should refer to IL's three-way contract, section 2.6.7, for more information on self-directed care.
- A care coordinator includes all full-time and part-time staff, who have been employed by the MMP for at least 30 days.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section ILVI. Performance and Quality Improvement

IL6.1 Adherence to antipsychotic medications for individuals with schizophrenia. (ICP SAA Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with schizophrenia.	Total number of members with schizophrenia, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who achieved a proportion of days covered (PDC) of at least 80% for their antipsychotic medications.	Of the total reported in A, the number of members who achieved a PDC of at least 80% for their antipsychotic medications during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members who achieved a PDC of at least 80% for their antipsychotic medications during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- IPSD is the index prescription start date. It is the earliest prescription dispensing date for any antipsychotic medication between January 1 and September 30 of the reporting period.
- Treatment period is the period of time beginning on the IPSD through the last day of the reporting period.
- PDC is the proportion of days covered. It is the number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
- Oral medication dispensing event is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events.
    i. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.
- Long-acting injections dispensing event count as one dispensing event. Multiple J codes or National Drug Codes (NDC) for the same or different medication on the same day are counted as a single dispensing event.
- Follow the instructions below to determine how to calculate the number of days covered for oral medications.
    i. If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate

number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.

ii. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator.

iii. If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator).

- For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.

- To calculate number of days covered for long-acting injections, use the days-supply specified for the medication in **Table IL-6** SAA-A.
  i. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply.
  ii. For multiple J Codes or NDCs for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Follow the steps outlined below to identify the <u>eligible population</u> (data element A).

Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the reporting period.

- At least one acute inpatient claim/encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:
  - HEDIS BH Stand Alone Acute Inpatient value set ***WITH*** HEDIS Schizophrenia value set.

  - HEDIS BH Acute Inpatient value set ***WITH*** HEDIS BH Acute Inpatient POS value set ***AND*** HEDIS Schizophrenia value set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meets criteria:
  - HEDIS BH Stand Alone Outpatient/PH/IOP value set ***WITH*** HEDIS Schizophrenia value set.
  - HEDIS BH Outpatient/PH/IOP value set ***WITH*** HEDIS BH Outpatient/PH/IOP POS value set ***AND*** HEDIS Schizophrenia value set.
  - HEDIS ED value set ***WITH*** HEDIS Schizophrenia value set.
  - HEDIS BH ED value set ***WITH*** HEDIS BH ED POS value set ***AND*** HEDIS Schizophrenia value set.
  - HEDIS BH Stand Alone Nonacute Inpatient value set ***WITH*** HEDIS Schizophrenia value set.
  - HEDIS BH Nonacute Inpatient value set ***WITH*** HEDIS BH Nonacute Inpatient POS value set ***AND*** HEDIS Schizophrenia value set.

Step 2: Identify required exclusions.
- Exclude members with a diagnosis of dementia (HEDIS Dementia value set) during the reporting period.
- Exclude members who did not have at least two antipsychotic medication dispensing events during the reporting period (**Table IL-6** SAA-A; HEDIS Long-Acting Injections 14 Days Supply and Long-Acting Injections 28 Days Supply value sets).

- Follow the steps outlined below to identify <u>numerator compliance</u> (data element B).

Step 1: Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (**Table IL-6** SAA-A; HEDIS Long-Acting Injections 14 Days Supply and Long-Acting Injections 28 Days Supply value sets) during the reporting period.

Step 2: Determine the treatment period. Calculate the number of days from the IPSD (inclusive) to the end of the reporting period.

Step 3: Count the days covered by at least one antipsychotic medications (**Table IL-6** SAA-A; HEDIS Long-Acting Injections 14 Days Supply and Long-Acting Injections 28 Days Supply value sets) during the treatment period. To ensure that the days supply does not exceed the treatment period, subtract any days supply that extends beyond December 31 of the reporting period.

Step 4: Calculate the member's PDC using the following equation. Round to two decimal places, using the .5 rule.

$$\frac{\textbf{Total days covered by an antipsychotic medication in the treatment period (Step 3)}}{\textbf{Total days in treatment period (Step 2)}}$$

Step 5: Sum the number of members whose PDC is ≥80% for their treatment period.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL6.2 Cervical cancer screening. (ICP CCS Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of female members 24-64 years old.	Total number of female members 24-64 years old, who were continuously enrolled during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of female members sampled that met inclusion criteria.	Of the total reported in A, the number of female members sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of female members who were appropriately screened for cervical cancer.	Of the total reported in B, the number of female members who were appropriately screened for cervical cancer during the reporting period.	Field Type: Numeric Note: Is a subset of B.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A and greater than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of female members 24-64 years old who were appropriately screened for cervical cancer during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all female members ages 24-64 regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included. A subset of all members that are eligible will be included in the sample.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria this measure will be reported beginning CY2.

Administrative Specifications

- The MMP should refer to the HEDIS® Value Sets listed in steps 1 and 2 to identify numerator positive hits when using administrative data.

  Step 1: Identify women 24-64 years of age as of December 31 of the reporting period who had a cervical cytology (HEDIS Cervical Cytology value set) during the reporting period or the two years prior to the reporting period.

  Step 2: From the women who did not meet step 1 criteria, identify women 30-64 years of age as of December 31 of the reporting period who had cervical cytology (HEDIS Cervical Cytology value set) and a human papillomavirus (HPV) test (HEDIS HPV Tests value set) with service dates four or less days apart during the reporting period or the four years prior to the reporting period And who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the reporting period, then the HPV test must include a service date on or between November 27 and December 5 of the reporting period.

  Step 3: Sum the events from steps 1 and 2 to obtain the rate.
- Exclude hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (HEDIS Absence of Cervix value set) any time during the member's history through December 31 of the reporting period.

Hybrid Specifications

- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.

- Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- The MMP should refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- When reviewing a members medical record, the following steps should be used to identify numerator compliance.

  Step 1: Identify the number of women who are 24–64 years of age as of December 31 of the reporting period who had cervical cytology during the reporting period, or the two years prior to the reporting period. Documentation in the medical record must include both of the following:
  - A note indicating the date when the cervical cytology was performed.
  - The result or finding.

  - Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.
  - Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
  - Lab results that indicate the sample contained “no endocervical cells” may be used if a valid result was reported for the test.

  Step 2: From the women who did <u>not</u> meet step 1 criteria, identify the number of women who are 30–64 years of age as of December 31 of the reporting period who had cervical cytology and an HPV test on the same date of service during the reporting period or the four years prior to the reporting period. Documentation in the medical record must include both of the following:
  - A note indicating the date when the cervical cytology and the HPV test were performed.
  - The result or finding.

  - Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that “no cervical cells were present”; this is not considered appropriate screening.

- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
- In administrative data, there is flexibility in the date of service to allow for a potential lag in claims.
- In medical record data, an HPV test performed without accompanying cervical cytology on the same date of service does not constitute co-testing and does not meet criteria for inclusion in this rate.
- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

Step 3: Sum the events from Steps 1-2 to obtain the rate.

- Exclude the following (these are optional exclusions):
  i. Hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (HEDIS Absence of cervix value set) any time during the member's history through December 31 of the reporting period. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.
  ii. Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL6.3 Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications. (ICP SSD Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with schizophrenia or bipolar disorder.	Total number of members with schizophrenia or bipolar disorder, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who had a glucose test or an HbA1c test performed.	Of the total reported in A, the number of members who had a glucose test or HbA1c test performed during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of members with schizophrenia or bipolar disorder who had a glucose test or HbA1c test performed during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Follow the steps outlined below to identify the eligible population (data element A).
    i. **Step 1**: Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the reporting period:
        - At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
            - HEDIS BH Stand Alone Acute Inpatient value set ***WITH*** HEDIS Schizophrenia value set.
            - HEDIS BH Stand Alone Acute Inpatient value set ***WITH*** HEDIS Bipolar Disorder value set.
            - HEDIS BH Acute Inpatient value set ***WITH*** HEDIS BH Acute Inpatient POS value set ***AND*** HEDIS Schizophrenia value set.
            - HEDIS BH Acute Inpatient value set ***WITH*** HEDIS BH Acute Inpatient POS value set ***AND*** HEDIS Bipolar Disorder value set.
        - At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia.
            - HEDIS BH Stand Alone Outpatient/PH/IOP value set ***WITH*** HEDIS Schizophrenia value set.
            - HEDIS BH Outpatient/PH/IOP value set ***WITH*** HEDIS BH Outpatient/PH/IOP POS value set ***AND*** HEDIS Schizophrenia value set.
            - HEDIS ED value set ***WITH*** HEDIS Schizophrenia value set.

- HEDIS BH ED value set ***WITH*** HEDIS BH ED POS value set ***AND*** HEDIS Schizophrenia value set.
- HEDIS BH Stand Alone Nonacute Inpatient value set ***WITH*** HEDIS Schizophrenia value set.
- HEDIS BH Nonacute Inpatient value set ***WITH*** HEDIS BH Nonacute Inpatient POS value set ***AND*** HEDIS Schizophrenia value set.

o At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder.

- HEDIS BH Stand Alone Outpatient/PH/IOP value set ***WITH*** HEDIS Bipolar Disorder value set.
- HEDIS BH Outpatient/PH/IOP value set ***WITH*** HEDIS BH Outpatient/PH/IOP POS value set ***AND*** HEDIS Bipolar Disorder value set.
- HEDIS ED value set ***WITH*** HEDIS Bipolar Disorder value set.
- HEDIS BH ED value set ***WITH*** HEDIS BH ED POS value set ***AND*** HEDIS Bipolar Disorder value set.
- HEDIS BH Stand Alone Nonacute Inpatient value set ***WITH*** HEDIS Bipolar Disorder value set.
- HEDIS BH Nonacute Inpatient value set ***WITH*** HEDIS BH Nonacute Inpatient POS value set ***AND*** HEDIS Bipolar Disorder value set.

2**. Step 2**: Exclude members who met any of the following criteria:

o Members with diabetes. The MMP must use both claim/encounter data and pharmacy data to identify members with diabetes, but a member only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the current reporting period or the prior reporting period.

- *Claim/encounter data*. Members who met any of the following criteria during the reporting period or the prior reporting period:
  i. At least two outpatient visits (HEDIS Outpatient value set), observation visits (HEDIS Observation value set), or

nonacute inpatient encounters (HEDIS Nonacute Inpatient value set), on different dates of service, with a diagnosis of diabetes (HEDIS Diabetes value set).

1. The visit type does not have to be the same for the two visits.

ii. At least one acute inpatient encounter (HEDIS Acute Inpatient value set), with a diagnosis of diabetes (HEDIS Diabetes value set).

iii. At least one ED visit (HEDIS ED value set) with a diagnosis of diabetes (HEDIS Diabetes value set).

- *Pharmacy data*. Members who were dispensed insulin or oral hypoglycemic/antihyperglycemics (**Table IL-5** CDC-A) during the reporting period or the prior reporting period on an ambulatory basis.

- Members who had no antipsychotic medications dispensed during the reporting period. The MMP must use both claim/encounter data and pharmacy data to identify dispensing events, but an event only needs to be identified by one method to be excluded from the measure.
  - *Claim/encounter data*. An antipsychotic medication (HEDIS Long Acting Injections value set).
  - *Pharmacy data*. Dispensed an antipsychotic medication (**Table IL-6** SSD-D) on an ambulatory basis.

- Refer to codes provided in HEDIS Glucose Tests value set to identify glucose tests.
- Refer to codes provided in HEDIS HbA1c Tests value set to identify HbA1c tests.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL6.4 Comprehensive diabetes care (administrative method). (ICP SCDC Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members age 18-75 who have a diagnosis of diabetes.	Total number of members age 18-75 who were continuously enrolled in the MMP during the current reporting period, who had a diagnosis of diabetes during the current reporting period or the prior reporting period, and who were enrolled on December 31 of the current reporting period.	Field Type: Numeric
B.	Total number of days the member was enrolled.	Of the total reported in A, the number of days the member was enrolled during the reporting period.	Field Type: Numeric
C.	Total number of days supply for all statin prescriptions filled.	Of the total reported in B, the number of days supply for all statin prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of days supply for all ACE/ARB prescriptions filled.	Of the total reported in B, the number of days supply for all ACE/ARB prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of B.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements C and D are less than or equal to data element B.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of :

- Days members age 18-75[2] diagnosed with diabetes were enrolled during the reporting period.
- Days supply for all statin prescriptions filled during the reporting period.
- Days supply for all ACE/ARB prescriptions filled during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- This measure must be calculated using the administrative methodology.
- This measure uses the total number of days, rather than number of eligible members, to identify the denominator.
- Members must have been continuously enrolled during the reporting period to be included in this measure.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

[2] The Illinois Demonstration population includes individuals 21 years of age and older; therefore, all members will be 18 years and older.

- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Codes to identify members with diabetes are listed in HEDIS Diabetes value set.
- There are two ways to identify members with diabetes:
    i. Pharmacy data, OR
    ii. Claims/encounter data

  The MMP must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified has having diabetes during the current reporting period or the prior reporting period.
- To identify members with diabetes using pharmacy data, refer to the prescriptions provided in (**Table IL-5** CDC-A) to identify members who were dispensed insulin or hypoglycemics/antihyperglycemics during the current reporting period or the prior reporting period.
- MMPs should also reference the complete list of medications and NDC codes NCQA has posted to www.ncqa.org.
- To identify members with diabetes using claim/encounter data, include all members who met any of the following criteria during the current reporting period or the prior reporting period (count services that occur over both years):
    i. At least two outpatient visits (HEDIS Outpatient value set), observation visits (HEDIS Observation value set), or nonacute inpatient encounters (HEDIS Nonacute Inpatient value set), on different dates of service, with a diagnosis of diabetes (HEDIS Diabetes value set).
        - The visit type does not have to be the same for the two visits.
    ii. At least one acute inpatient encounter (HEDIS Acute Inpatient value set) with a diagnosis of diabetes (HEDIS Diabetes value set).
- Refer to pharmacy codes provided in **Table IL-7** to identify all statin prescriptions.
- Refer to pharmacy codes provided in **Table IL-8** to identify all ACE/ARB prescriptions.
- Exclude members with a contraindication for Statin Therapy identified in **Table IL-15**.
- Exclude members with a contraindication for ACE inhibitors and ARB identified in **Table IL-16**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL6.5 Medication monitoring for patients with psychotic disorders. (ICP IMMP Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members diagnosed with a psychotic disorder.	Total number of members who were continuously enrolled in the MMP during the current reporting period, who were diagnosed with a psychotic disorder during the prior reporting period, and who were enrolled on December 31 of the current reporting period.	Field Type: Numeric
B.	Total number of members who received at least 150 days supply of medication.	Of the total reported in A, the number of members who received at least 150 days supply of medication during the current reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who received at least 335 days supply of medication.	Of the total reported in A, the number of members who received at least 335 days supply of medication during the current reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members diagnosed with a psychotic disorder during the prior reporting period who:

- Received at least 150 days supply of medication during the current reporting period (6-month adherence rate).
- Received at least 335 days supply of medication during the current reporting period (12-month adherence rate).

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Refer to the codes in **Table IL-19** to identify members diagnosed with a psychotic disorder in the prior reporting period.
- To calculate the number of days covered for oral medications, identify all prescriptions filled during the year and count the days supplied. Two or more prescriptions on the same date of service count as one prescription.
- To calculate number of days covered for long-acting injections, use the days supply specified for the medication in HEDIS Long-Acting Injections 14 Days Supply and Long-Acting Injections 28 Days Supply

value sets. For multiple J codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply. For multiple J codes or NDCs with the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

- For prescriptions filled at the end of the prior reporting period, days covered are the actual number of calendar days covered with prescriptions within the current reporting period (e.g., a prescription of 90 days' supply dispensed on December 1 of the current reporting period counts as 30 days covered, and a 90 days' supply dispensed on December 1 of the prior reporting period count as 60 days covered).
- To identify a six-month course of treatment, data element B, refer to the medications listed in **Table IL-20**.
- To identify a twelve-month course of treatment, data element C, refer to the medications listed in **Table IL-20**.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL6.6 Annual monitoring for patients on persistent medications. (ICP MPM Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who received at least 180 treatment days of ACE inhibitors or ARBs.	Total number of members who were continuously enrolled in the MMP during the reporting period, who received at least 180 treatment days of ACE inhibitors or ARBs during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who received at least one serum potassium and a serum creatinine therapeutic monitoring test.	Of the total reported in A, the number of members who received at least one serum potassium and a serum creatinine therapeutic monitoring test during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who received at least 180 treatment days of digoxin.	Total number of members who were continuously enrolled in the MMP during the reporting period, who received at least 180 treatment days of digoxin during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members who received at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test.	Of the total reported in C, the number of members who received at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test during the reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members who received at least 180 treatment days of a diuretic.	Total number of members who were continuously enrolled in the MMP during the reporting period, who received at least 180 treatment days of a diuretic during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
F.	Total number of members who received at least one serum potassium and a serum creatinine therapeutic monitoring test.	Of the total reported in E, the number of members who received at least one serum potassium and a serum creatinine therapeutic monitoring test during the reporting period.	Field Type: Numeric Note: Is a subset of E.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.

- MMPs should validate that data element F is less than or equal to data element E.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who received at least 180 treatment days of:

- ACE inhibitors or ARBs during the reporting period who received at least one serum potassium and a serum creatinine therapeutic monitoring test during the reporting period.
- Digoxin during the reporting period who received at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test during the reporting period.
- Diuretic during the reporting period who received at least one serum potassium and a serum creatinine therapeutic monitoring test during the reporting period.
- Ambulatory medication therapy for a select therapeutic agent during the reporting period and at least one therapeutic monitoring event for the therapeutic agent in the reporting period (i.e., the sum of B, D, and F divided by the sum of A, C, and E).

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Treatment days are the actual number of calendar days covered with prescriptions within the reporting period (i.e., a prescription of 90 days' supply dispensed on December 1 of the reporting period counts as 30 treatment days). Sum the days' supply for all medications and subtract any days supply that extends beyond December of the reporting period.
    1. Medications dispensed in the year prior to the reporting period must be counted toward the 180 treatment days.
- Exclude members from each eligible population rate who had an inpatient (acute or non-acute) claim/encounter during the reporting period.

- Refer to the codes in (**Table IL-8** CDC-L) to identify ACE inhibitors and ARBs.
- For data element A, a member may switch therapy with any medication listed in (**Table IL-8** CDC-L) during the reporting period and have the days' supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator requirements).
- Refer to the codes in (**Table IL-21** MPM-B) to identify members on digoxin.
- Refer to the codes in (**Table IL-22** MPM-C) to identify members on a diuretic.
- For data element E, a members may switch therapy with and medication listed in (**Table IL-22** MPM-C) during the reporting period and have the days' supply for those medications count toward the total 180 treatment days.
- For members in data element B and F who received at least one serum potassium and a serum creatinine therapeutic monitoring test during the reporting period, any of the following during the reporting period meet criteria:
    i. A lab panel test (HEDIS Lab Panel value set)
    ii. A serum potassium test (HEDIS Serum Potassium value set) ***and*** a serum creatinine test (HEDIS Serum Creatinine value set)
- For members in data element D who received at least one serum potassium, at least one serum creatinine, and at least one serum digoxin therapeutic monitoring test during the reporting period, any of the following meet criteria:
    i. A lab panel test (HEDIS Lab Panel value set) ***and*** a serum digoxin test (HEDIS Digoxin Level value set)
    ii. A serum potassium test (HEDIS Serum Potassium value set) ***and*** a serum creatinine test (HEDIS Serum Creatinine value set) ***and*** a serum digoxin test (HEDIS Digoxin Level value set)
- For data elements B, D, and F, the tests do not have to occur on the same service date, only within the reporting period.

F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL6.7 Use of high-risk medications in the elderly. (ICP SDAE Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL6. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members age 60 – 65.	Total number of members age 60 – 65, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members age 60 – 65 who received at least one high-risk medication.	Of the total reported in A, the number of members age 60 – 65 who received at least one high-risk medication during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members age 60 – 65 who received at least two different high-risk medications.	Of the total reported in A, the number of members age 60 – 65 who received at least two different high-risk medications during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members age 66 and older.	Total number of members age 66 and older, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members age 66 and older who received at least one high-risk medication.	Of the total reported in D, the number of members age 66 and older who received at least one high-risk medication during the reporting period.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of members age 66 and older who received at least two different high-risk medications.	Of the total reported in D, the number of members age 66 and older who received at least two different high-risk medications during the reporting period.	Field Type: Numeric Note: Is a subset of D.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C are less than or equal to data element A.
- MMPs should validate that data elements E and F are less than or equal to data element D.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members age:

- 60 – 65 who received at least one high-risk medication during the reporting period.
- 60 – 65 who received at least two different high-risk medications during the reporting period.
- 66 and older who received at least one high-risk medication during the reporting period.
- 66 and older who received at least two different high-risk medications during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- A high-risk medication is defined as any of the following:
    1. A dispensed prescription for a medication listed in (**Table IL-23** DAE-A), or
        - For medications in (**Table IL-23** DAE-A), identify different drugs using the Drug ID field located in the NDC list on NCQA's Web site (www.ncqa.org).
    2. Dispensed prescriptions that meet days supply criteria within a medication class listed in (**Table IL-24** DAE-B), or
    3. A dispensed prescription that meets average daily dose criteria in (**Table IL-25** DAE-C).
- To calculate days supply:
    1. Calculate the days supply during the reporting period for medication classes in (**Table IL-24** DAE-B) . The intent is to sum the days supply for all medications within a medication class.
        - For example, a 30-days supply prescription for Zolpidem and a 30-days supply prescription for Zaleplon is equal to 60-days supply of a high-risk medication class.
    2. Sum the days supply and subtract any days supply that extends beyond December 31 of the reporting period.
        - For example, a prescription of 90 days supply dispensed on December 1 of the reporting period counts as 30 days supply
    3. For calculating data elements C and F, if the total days supply in a medication class is greater than or equal to 90 days, count as one high-risk medication. Assess each medication class separately.
- Medications dispensed in the year prior to the current reporting period with days supply that extend into the current reporting period must be counted toward the total days supply.
- To calculate daily dose:
    1. Calculate the average daily dose for medications listed in (**Table IL-25** DAE-C). Multiply the quantity of pills dispensed by the dose of each pill and divide by days supply.

    - For example, a 30-day prescription for digoxin containing 15 pills, .250mg each pill, has an average daily dose of 0.125mg.
- For calculating data elements C and F, if a member has two prescriptions for the same medication that meet the average daily dose criteria, count as one high-risk medication. If a member has two prescriptions for different medications that meet the average daily dose criteria, count as two high-risk medications.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section ILVII. Utilization

IL7.1 Coronary artery disease (CAD). (ICP ICAD Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year, beginning in CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with coronary artery disease (CAD).	Total number of members with CAD, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who had their cholesterol tested at least once.	Of the total reported in A, the number of members who had their cholesterol tested at least once during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of days members with CAD were enrolled.	Of the total reported in A, the number of days members with CAD were enrolled during the reporting period.	Field Type: Numeric
D.	Total number of days supply for all statin prescriptions filled.	Of the total reported in C, the number of days supply for all statin prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of C.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of days supply for all ACE/ARB prescriptions filled.	Of the total reported in C, the number of days supply for all ACE/ARB prescriptions filled during the reporting period.	Field Type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation Checks - validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data elements D and E are less than or equal to data element C.
- All data elements should be positive values.

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members with CAD who had their cholesterol tested at least once during the reporting period.
- Days supply for all statin prescriptions filled during the reporting period.
- Days supply for all ACE/ARB prescriptions filled during the reporting period.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Refer to the codes provided in **Table IL-4** to determine a diagnosis (primary or secondary) of CAD in any setting during the current reporting period or the year prior to the reporting period.
- Refer to the codes provided in HEDIS LDL-C Tests value set to identify cholesterol testing.
- Refer to the pharmacy codes provided in **Table IL-7** to identify total days supply for all statin prescriptions filled (data element D).
- Refer to the pharmacy codes provided in **Table IL-8** (CDC-L) to identify total days supply for all ACE/ARB prescriptions filled (data element E).
- For Statin and ACE/ARB numerators only, exclude the following:
    i. Members with a contraindication for Statin **Table IL-15**; and
    ii. Members with a contraindication for ACE Inhibitors and ARB **Table IL-16**.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL7.2 Heart Failure Admission Rate (PQI08).

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 18 – 64.	Total number of member months for members age 18 – 64 during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	The number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 18 – 64.	Of the total reported in A, the number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 18 – 64 during the reporting period.	Field Type: Numeric
C.	Total number of member months for members age 65 and older.	Total number of member months for members age 65 and older during the reporting period.	Field Type: Numeric
D.	The number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 65 and older.	Of the total reported in C, the number of discharges with an ICD-9-CM principal diagnosis code for CHF for members age 65 and older during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of discharges for members age:

- 18 – 64[3] with a primary diagnosis of CHF per 1,000 member months.
- 65 and older with a primary diagnosis of CHF per 1,000 member months.

[3] The Illinois Demonstration population includes individuals 21 years of age and older; therefore, all members will be 18 years and older.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include member months for all members who meet the criteria outlined in Element A and Element C, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 30th of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is currently enrolled in the MMP on January 30, Ms. X contributes one member month in January.
- For data elements A and C, use the members' age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an MMP tallies members on the 30th of each month and Ms. X turns 65 on April 3 and is enrolled for the entire year, then she contributes three member months (January, February, March) to the 18 – 64 age group category and nine months to the 65 and older age group category.
- For data elements B and D, age is based on the date of admission.
- Refer to the codes in **Table IL-26** to identify ICD-9-CM diagnosis codes for heart failure.
- Exclude claims and encounters that contain any of the following:
    i. Transfer from a hospital (different facility) (**Table IL-27**).
    ii. Transfer from a skilling nursing facility (SNF) or intermediate care facility (ICF) (**Table IL-27**).
    iii. Transfer from another health care facility (**Table IL-27**).
    iv. With missing gender, age, quarter, year, principal diagnosis, or county data
    v. MDC 14 (pregnancy, childbirth, and puerperium)
        1. Discharges with a principal diagnosis of heart failure are precluded from an assignment of MDC 14 by grouper software. Thus, obstetric discharges should not be considered in the PQI rate, though the specifications do not explicitly exclude obstetric cases.
    vi. With any listed ICD-9-CM procedure codes for cardiac procedure (**Table IL-28**).

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by

CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL7.3 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members that were continuously enrolled for six months during the reporting period.	Field Type: Numeric
B.	Total number of eligible members receiving HCBS.	Of the total reported in A, the number of eligible members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of eligible members receiving nursing facility services.	Of the total reported in A, the number of eligible members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of eligible members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of eligible members receiving both HCBS and nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will obtain enrollment data from CMS' Web site and will evaluate the following:
    - The percentage of members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.
    - The percentage of members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.
    - The percentage of members receiving both HCBS and nursing facility services during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A and who were continuously enrolled for 6 months during the reporting period, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of

whether they are currently enrolled or disenrolled as of the last day of the reporting period).

- Members receiving HCBS should only be counted for data element B (unduplicated). Members receiving nursing facility services should only be counted for data element C (unduplicated). Members receiving both HCBS and nursing facility services should only be counted for data element D (unduplicated). Data elements B, C and D are mutually exclusive.
- Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
- HCBS refers to Home and Community Based Services.
- Members are classified as in an HCBS waiver or nursing facility in accordance with the rate cell definitions provided on page 174 of the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an HCBS waiver.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL7.4 Average length of receipt in HCBS.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving HCBS.	Total number of members receiving HCBS during the reporting period.	Field Type: Numeric
B.	Total number of days members were enrolled in HCBS.	Of the total reported in A, the number of days members were enrolled in HCBS during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of days members were enrolled in HCBS during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPS should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- HCBS refers to Home and Community Based Services.
- Members are classified as in an HCBS waiver or nursing facility in accordance with the rate cell definitions provided on page 174 of the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an HCBS waiver.

F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL7.5 Long Term Care urinary tract infection admission rate and bacterial pneumonia admission rate. (ICP IUTI and IBPR Measures)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of long term care (LTC) members.	The total number of LTC members enrolled in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of LTC member months.	Of the total reported in A, the number of LTC member months during the reporting period.	Field Type: Numeric
C.	Total number of urinary tract infection inpatient admissions for LTC members.	Of the total reported in B, the number of urinary tract infection inpatient admissions for LTC members during the reporting period.	Field Type: Numeric
D.	Total number of LTC bacterial pneumonia inpatient admissions for LTC members.	Of the total reported in B, the number of bacterial pneumonia inpatient admissions for LTC members during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the number of inpatient admissions by LTC members for:

- Urinary tract infections per 1,000 LTC member months.
- Bacterial pneumonia per 1,000 LTC member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPS should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all LTC members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Member must be enrolled in LTC at least 30 days prior to the inpatient hospital admission, with no gaps in enrollment.
- Refer to codes provided in **Table IL-9** to identify inpatient admissions for urinary tract infections as a principal diagnosis.
- For reporting urinary tract infection admissions, MMP should exclude transfers from another hospital and claims and encounters that contain any of the codes provided in **Table IL-17**.
- Refer to the codes provided in **Table IL-10** to identify inpatient admissions for bacterial pneumonia as a principal diagnosis.
- For reporting bacterial pneumonia admissions, MMP should exclude transfers from another hospital and claims and encounters that contain any of the codes provided in **Table IL-18**.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is currently enrolled in the organization on January 1, Ms. X contributes one member month in January.

- LTC refers to members receiving Long Term Care services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.
   - MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL7.6 Long Term Care prevalence of hospital acquired pressure ulcers. (ICP IPPU Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members residing in long term care (LTC) facilities.	The total number of members residing in LTC facilities during the reporting period.	Field Type: Numeric
B.	Total number of LTC member months.	Of the total reported in A, the number of LTC member months during the reporting period.	Field Type: Numeric
C.	Total number of inpatient hospital stays during the reporting period with a secondary diagnosis of stage II or greater pressure ulcers, identified as a hospital acquired condition.	Of the total reported in B, the number of inpatient hospital stays during the reporting period with a secondary diagnosis of stage II or greater pressure ulcers, identified as a hospital acquired condition.	Field Type: Numeric

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of inpatient stays with a secondary diagnosis of stage II or greater pressure ulcers, identified as a hospital acquired condition per 1,000 LTC member months.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Member must be enrolled in LTC at least 30 days prior to the inpatient hospital admission through hospital discharge, with no gaps in enrollment.
- The denominator for this measure is based on inpatient stays, not members.
- If a member has more than one qualifying inpatient stay, include all stays during the reporting period.
- Refer to codes provided in **Table IL-11** to identify stage II or greater hospital acquired pressure ulcers.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is currently enrolled in the organization on January 1, Ms. X contributes one member month in January.
- LTC refers to members receiving Long Term Care services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

IL7.7 Inpatient hospital 30-day readmission rates. (ICP IIHR Measure)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of live non-behavioral health inpatient hospital discharges.	Total number of live non-behavioral health inpatient hospital discharges during the reporting period.	Field Type: Numeric
B.	Total number of non-behavioral health inpatient hospital readmissions during the reporting period for the same discharge diagnosis from the initial hospitalization within 30 days of the hospital discharge date.	Of the total reported in A, the number of non-behavioral health inpatient hospital readmissions during the reporting period for the same discharge diagnosis from the initial hospitalization within 30 days of the hospital discharge date.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of live behavioral health inpatient hospital discharges.	Total number of live behavioral health inpatient hospital discharges during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of behavioral health inpatient hospital readmissions during the reporting period for the same mental health discharge diagnosis from the initial hospitalization within 30 days of the hospital discharge date.	Of the total reported in C, the number of behavioral health inpatient hospital readmissions during the reporting period for the same mental health discharge diagnosis from the initial hospitalization within 30 days of the hospital discharge date.	Field Type: Numeric Note: Is a subset of C.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of 30-day inpatient hospital readmissions for:

- Non-behavioral health inpatient stays.
- Behavioral health inpatient stays.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- The inpatient diagnosis for the readmission must be the same as the discharge diagnosis from the initial hospitalization, at the 3 digit classification level for the ICD-9 code (e.g., 428 rather than 428.01).
- The member must be continuously enrolled from the date of discharge through 30 days after discharge, with no gaps in enrollment. Medicaid-only members should not be included.
- MMPs should include all live non-behavioral health and all live behavioral health inpatient discharges for members who meet the

criteria outlined in Element A and Element C, respectively, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

- The denominator for this measure is based on discharges, not members.
- The first reporting period, CY1, begins on March 1, 2014 and ends on December 31, 2014. All subsequent reporting periods align with a full calendar year (i.e., January 1 through December 31). For CY1, include all events (that meet measure criteria) for those members who have more than one discharge on or between the first day of the reporting period (March 1, 2014) and December 1, 2014.
- Beginning CY2, include all events (that meet measure criteria) for those members who have more than one discharge on or between December 2 of the prior reporting period (e.g., December 2, 2014) and December 1 of the current reporting period (e.g., December 1, 2015).
- Codes to identify inpatient discharges are provided in HEDIS Surgery MS-DRG, Maternity MS-DRG, Medicine MS-DRG and Newborn/Neonates MS-DRG value sets. If the MMP does not capture MS-DRG, then use the codes provided in **Table IL-1**.
- For reporting data elements A and B, exclude inpatient discharges with a principal mental health diagnosis, defined in HEDIS Mental Health Diagnosis value set.
- For reporting data elements A and B, exclude discharges for pregnancies and deliveries, defined in **Table IL-12**.
- For reporting data elements A-D, exclude discharges due to death (Discharge Status code 20).
- Exclude transfers to an acute facility following the inpatient hospitalization. If the member was transferred, count the discharge from the facility to which the member was transferred.
- Exclude both the initial discharge and the direct transfer discharge if the direct transfer discharge occurs after December 1 of the reporting period.
- Exclude direct transfer to a non-acute facility within the 30 day follow-up period. Codes to identify non-acute care are provided in **Table IL-2**.
- For reporting data element C, include inpatient care at either a hospital or treatment facility *with* mental health as the principal diagnosis. Use one of the following criteria to identify mental health inpatient services:
    i. An inpatient facility code in conjunction with a principal mental health diagnosis (HEDIS Mental Health Diagnosis value set), ***or***
    ii. MS-DRGs (**Table IL-3**)

F. Data Submission – how MMPs will submit data collected to CMS and the state.
    - MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Appendix A. Illinois Measure Tables

Table IL-1: Codes to Identify Inpatient Discharges
Principal ICD-9-CM Diagnosis
001-289, 317-999, V01-V29, V40-V90

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Table IL-2 Codes to Identify Non-acute Care				
Description	**HCPCS**	**UB Revenue**	**UB Type of Bill**	**POS**
Hospice		0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	34
SNF		019x	21x, 22x, 28x	31, 32
Hospital transitional care, swing bed or rehabilitation			18x	
Rehabilitation		0118, 0128, 0138, 0148, 0158		
Respite		0655		
Intermediate care facility				54
Residential substance abuse treatment facility		1002		55
Psychiatric residential treatment center	T2048, H0017-H0019	1001		56
Comprehensive inpatient rehabilitation facility				61
Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g., ICF, SNF)				

Table IL-3: Codes to Identify Mental Health Inpatient Services
MS-DRG
876, 880-887; exclude discharges with ICD-9-CM Principal Diagnosis code 317-319

Note: DSM-IV codes mirror ICD-9-CM codes. A health plan that has access only to DSM-IV codes should use and document them. Follow the specifications outlined above for the ICD-9-CM codes.

Table IL-4: Codes to Identify CAD		
ICD-9-CM Diagnosis	**CPT-4**	**ICD-9 Procedures**
410.xx – 413.xx, 414.01, 414.8x, 414.9x	33510-33514, 33516-33519, 33521-33523, 33530, 33533-33536, 33572, 92980-92982, 92984, 92995, 92996, 92975, 92977, 92973	00.66, 36.0x – 36.3x, 36.9x

Table IL-5: Prescriptions to Identify Members with Diabetes (CDC-A)				
Description	**Prescription**			
Alpha-glucosidase inhibitors	• Acarbose	• Miglitol		
Amylin analogs	• Pramlinitide			
Antidiabetic combinations	• Alogliptin-metformin • Algoliptin-pioglitazone • Glimepiride-pioglitazone • Glimepiride-rosiglitazone • Glipizide-metformin • Glyburide-metformin	• Linagliptin-metformin • Metformin-pioglitazone • Metformin-repaglinide • Metformin-rosiglitazone	• Metformin-saxagliptin • Metformin-sitagliptin • Sitagliptin-simvastatin	
Insulin	• Insulin aspart • Insulin aspart-insulin aspart protamine • Insulin detemir • Insulin glargine • Insulin glulisine	• Insulin isophane human • Insulin isophane-insulin regular • Insulin lispro • Insulin lispro-insulin lispro protamine • Insulin regular human		
Meglitinides	• Nateglinide	• Repaglinide		
Miscellaneous antidiabetic agents	• Exenatide • Linagliptin • Liraglutide	• Metformin-repaglinide • Sitagliptin		
Sodium glucose cotransporter 2 (SGLT2) inhibitor	• Canagliflozin • Dapaglifozin			
Sulfonylureas	• Chlorpropamide • Tolbutamide	• Glimepiride • Glipizide	• Glyburide • Tolazamide	
Thiazolidinediones	• Pioglitazone	• Rosiglitazone		

Table IL-6: Codes to Identify Antipsychotic Medications (SAA-A)(SSD-D)			
Description	**Prescription**		**Days Supply**
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurisadone • Molindone	• Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone	
Phenothiazine antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine • Perphenazine-amitriptyline	• Prochlorperazine • Thioridazine • Trifluoperazine	
Psychotherapeutic combinations	• Fluoxetine-olanzapine		
Thioxanthenes	• Thiothixene		
Long-acting injections	• Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate	28 days supply
	• Risperidone		14 days supply

Table IL-7: Codes to Identify Statins and Cholesterol Lowering Medications				
STCC	**Description**	**Prescription**		
D7L	Bile salt sequestrants	• Cholestyramine • Colesevelam	• Colestipol	
M4D, M4E, M4L, M4M	Lipotropics	• Fenofibrate • Gemfibrozil • Lovastatin • Niacin • Niacin/Lovastatin	• Omega-3 Acid Ethyl Esters • Pravastatin Sodium • Simvastatin • Aspirin/Calcium Carb/Mag/Pravastatin • Ezetimibe/Simvastatin	• Atrovastatin Calcium • Ezetimibe • Fluvastatin • Rosuvastatin
M4I	Antihyperlip (HMGCOA) & Calcium channel blocker CMB	• Amlodipine / Atorvastatin		

Table IL-8: Prescriptions to Identify Members on ACE Inhibitors/ARBs (CDC-L)					
Description	**Prescription**				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	
Antihypertensive combinations	• Aliskiren-valsartan • Aliskiren- hydrochlorothiazide-amlodipine • Amlodipine-benazepril-amlodipine • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-telmisartan	• Amlodipine-valsartan • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan	• Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Trandolapril-verapamil		

Table IL-9: Codes to Identify Inpatient Urinary Tract Infections		
Principal ICD-9-CM Diagnosis		
590.10, 590.11, 590.2, 590.3, 590.80, 590.81, 590.9, 595.0, 595.9, 599.0		
WITH		
UB Type of Bill	***OR***	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Table IL-10: Codes to Identify Inpatient Bacterial Pneumonia		
Principal ICD-9-CM Diagnosis		
481, 482.2, 482.30-482.32, 482.39, 482.41, 482.42, 482.9, 483.0, 483.1, 483.8, 485, 486		
WITH		
UB Type of Bill	***OR***	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Table IL-11: Codes to Identify Hospital Acquired Pressure Ulcers, Stage II or Greater		
UB Type of Bill		
11x, 12x		
WITH		
Secondary ICD-9-CM Diagnosis	***And***	**Present on Admission (POA)**
707.22 – 707.24		N – No (not present at the time of inpatient admission) U – Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)

Table IL-12: Codes to Identify Pregnancies and Deliveries	
ICD-9-CM Diagnosis	**MS-DRG**
630-679	370-375

Table IL-13: Codes to Identify a Mental Health Related Poisoning		
Principal ICD-9-CM Diagnosis	***WITH***	**Secondary ICD-9-CM Diagnosis**
960-979		291-292, 303-305

Table IL-14: Additional Codes to Identify Maternity Exclusions
ICD-9-CM Diagnosis
V27.x

Table IL-15: Codes to Identify Contraindications for Statin Therapy	
• (V22) Pregnancy • (V24.1) Lactation Either above during treatment period	• (995.27) Hypersensitivity or allergy to previous Statin therapy • (571.4, 571.49, 070) Active liver disease or unexplained persistent elevations of hepatic transaminases

Table IL-16: Codes to Identify Contraindications for ACE/ARB	
• (V22) Pregnancy • (V24.1) Lactation Either above during treatment period • (440.1) Renal artery stenosis	• (425.1) Hypertrophic cardiomyopathy • (995.27) Hypersensitivity or allergy to previous ACE or ARB treatment • (995.1) Angioedema due to previous treatment with ACE inhibitors • (277.6) Hereditary angioedema

Table IL-17: Codes to Identify Exclusions for Urinary Tract Infection Admissions		
Exclusions	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure Codes**
Kidney/Urinary Tract Disorder	590.00, 590.01, 593.70-593.73, 753.0, 753.10 – 753.17, 753.19 – 753.23, 753.29, 753.3 – 753.6, 753.8, 753.9	
Immunocompromised States	042, 136.3, 199.2, 238.73, 238.76-238.79, 260-262, 279.00-279.06, 279.09-279.13, 279.19, 279.2-279.4, 279.41, 279.49-279.53, 279.8, 279.9, 284.09, 284.1, 288.0, 288.00 – 288.03, 288.09, 288.2, 288.4, 288.50, 288.51, 288.59, 289.53, 289.83, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 579.3, 585, 585.5, 585.6, 996.8, 996.80-996.87, 996.89, V42.0, V42.1, V42.6 – V42.8, V42.81-V42.84, V42.89, V45.1, V45.11, V56.0, V56.1, V56.2	00.18, 33.5, 33.6, 37.5, 41.00-41.09, 50.51, 50.59, 52.80-52.83, 52.85, 52.86, 55.69

Table IL-18: Codes to Identify Exclusions for Bacterial Pneumonia Admissions		
Exclusions	**ICD-9-CM Diagnosis**	**ICD-9-CM Procedure Codes**
Sickle Cell or HB-S Disease	282.41, 282.42, 282.60-282.64, 282.68, 282.69	
Immunocompromised States	042, 136.3, 199.2, 238.73, 238.76-238.79, 260-262, 279.00-279.06, 279.09-279.13, 279.19, 279.2-279.4, 279.41, 279.49-279.53, 279.8, 279.9, 284.09, 284.1, 288.0, 288.00 – 288.03, 288.09, 288.2, 288.4, 288.50, 288.51, 288.59, 289.53, 289.83, 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 579.3, 585, 585.5, 585.6, 996.8, 996.80-996.87, 996.89, V42.0, V42.1, V42.6 – V42.8, V42.81-V42.84, V42.89, V45.1, V45.11, V56.0, V56.1, V56.2	00.18, 33.5, 33.50-33.52, 33.6, 37.5, 41.00-41.09, 50.51, 50.59, 52.80-52.83, 52.85, 52.86, 55.69

Table IL-19: Codes to Identify Members with Psychotic Disorders		
Schizophrenic Disorders	**ICD-9-CM Diagnosis**	**Applicable 5th Digit Usage**
Disorganized type schizophrenia	295.1	2 – chronic 3 – subchronic with acute exacerbation 4 – chronic with acute exacerbation 5 – in remission
Catatonic type schizophrenia	295.2	
Paranoid type schizophrenia	295.3	
Schizoaffective disorder	295.7	
Episodic Mood Disorders	**ICD-9-CM Diagnosis**	**Applicable 5th Digit Usage**
Manic disorder, recurrent episode	296.1	2 – moderate 4 – severe, specified as with psychotic behavior 5 – in partial or unspecified remission
Major depressive disorder, recurrent episode	296.3	
Bipolar I disorder, most recent episode manic	296.4	
Bipolar I disorder, most recent episode depressed	296.5	
Bipolar I disorder, most recent episode (or current) mixed	296.6	
Bipolar I disorder, most recent episode unspecified	296.7	No applicable 5th digit
Other Nonorganic Psychoses	**ICD-9-CM Diagnosis**	**Applicable 5th Digit Usage**
Depressive type psychosis	298.0	No applicable 5th digit
Excitative type psychosis	298.1	No applicable 5th digit

Table IL-20: Medications to Treat Psychotic Disorders		
Description	**Prescription**	**Covered Days**
Miscellaneous antipsychotic agents	• Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurasidone • Molindone • Olanzapine • Paliperidone • Pimozide • Quetiapine • Risperidone • Ziprasidone	
Phenothiazine Antipsychotics	• Chlorpromazine • Fluphenazine • Perphenazine • Thioridazine • Trifluoperazine	
Psychotherapeutic combinations	• Fluoxetine-olanzapine • Perphenazine-Amitriptyline	
Thioxanthenes	• Thiothixene	
Long-acting injections	• Aripiprazole • Haloperidol–Decanoate • Olanzapine pamoate • Paliperidone palmitate	28 day supply (4 week)
	• Fluphenazine–Decanoate	21 day supply (3 week)
	• Risperidone	14 day supply (2 week)
Mood Stabilizers	• Lithium carbonate • Lithium citrate	
Anticonvulsants	• Carbamazepine • Lamotrigine • Oxcarbazepine • Topiramate • Valproic acid • Divalproex sodium • Sodium valproate	

Table IL-21 Drugs to Identify Members on Digoxin (MPM-B)	
Description	**Prescription**
Inotropic agents	Digoxin

Table IL-22: Drugs to Identify Members on Diuretics (MPM-C)				
Description	**Prescription**			
Antihypertensive combinations	• Aliskiren-hydrochlorothiazide • Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide		• Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan • Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan	
Loop diuretics	• Bumetanide	• Ethacrynic acid	• Furosemide	• Torsemide
Potassium-sparing diuretics	• Amiloride	• Eplerenone	• Spironolactone	• Triamterene
Thiazide diuretics	• Chlorothiazide • Chlorthalidone	• Hydrochlorothiazide • Indapamide	• Methyclothiazide • Metolazone	

Table IL-23: High-Risk Medications (DAE-A)			
Description	**Prescription**		
Anticholinergics (excludes TCAs), First-generation antihistamines	• Brompheniramine • Carbinoxamine • Chlorpheniramine • Clemastine	• Cyproheptadine • Dexbrompheniramine • Dexchlorpheniramine • Diphenhydramine (oral)	• Doxylamine • Hydroxyzine • Promethazine • Triprolidine
Anticholinergics (excludes TCAs), anti-Parkinson agents	• Benztropine (oral)	• Trihexyphenidyl	
Antithrombotics	• Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin)		• Ticlopidine
Cardiovascular, alpha agonists, central	• Guanabenz	• Guanfacine	• Methyldopa
Cardiovascular, other	• Disopyramide	• Nifedipine, immediate release	
Central nervous system, tertiary TCAs	• Amitriptyline • Clomipramine	• Imipramine	• Trimipramine
Central nervous system, barbiturates	• Amobarbital • Butabarbital • Butalbital	• Mephobarbital • Pentobarbital	• Phenobarbital • Secobarbital
Central nervous system, vasodilators	• Ergot mesylates	• Isoxsuprine	
Central nervous system, other	• Chloral Hydrate	• Meprobamate	• Thioridazine
Endocrine system, estrogens with or without progestins; include only oral and topical patch products	• Conjugated estrogen • Esterified estrogen	• Estradiol	• Estropipate
Endocrine system, sulfonylureas, long-duration	• Chlorpropamide	• Glyburide	
Endocrine system, other	• Desiccated thyroid	• Megestrol	
Gastrointestinal system, other	• Trimethobenzamide		
Pain medications, skeletal muscle relaxants	• Carisoprodol • Chlorzoxazone	• Cyclobenzaprine • Metaxalone	• Methocarbamol • Orphenadrine
Pain medications, other	• Indomethacin • Ketorolac, includes parenteral	• Meperidine	• Pentazocine

Table IL-24: High-Risk Medications with Days Supply Criteria (DAE-B)

Description	Prescription	Days Supply
Anti-Infectives, Other	• Nitrofurantoin • Nitrofurantoin macrocrystals • Nitrofurantoin macrocrystals-monohydrate	>90 days
Nonbenzodiazepine hypnotics	• Eszopiclone • Zolpidem • Zaleplon	>90 days

Table IL-25: High-Risk Medications with Average Daily Dose Criteria (DAE-C)

Description	Prescription	Average Daily Dose
Alpha agonists, central	• Reserpine	>0.1 mg/day
Cardiovascular, Other	• Digoxin	>0.125 mg/day
Tertiary TCAs (as single agent or as part of combination products)	• Doxepin	>6 mg/day

Table IL-26: Codes to Identify Heart Failure

Description	ICD-9-CM Diagnosis
Heart Failure	For discharges on or after October 1, 2002 398.91, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
	For discharges prior to October 1, 2002 402.01, 402.11, 402.91,404.01, 404.03, 404.11, 404.13, 404.91, 404.93

Table IL-27: Codes to Identify Transfers

Point of Origin UB-04 Codes
4 - Transfer from a hospital 5 - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 - Transfer from another health care facility
SID ASOURCE Codes
2 - Another hospital 3 - Another facility, including long-term care

Table IL-28: Codes to Identify Cardiac Procedures

ICD-9-CM Procedure
0050, 0051, 0052, 0053, 0054, 0056, 0057, 0066, 1751, 1752, 1755, 3500, 3501, 3502, 3503, 3504, 3510, 3511, 3512, 3513, 3514, 3520, 3521, 3522, 3523, 3524, 3525, 3526, 3527, 3528, 3531, 3532, 3533, 3534, 3535, 3539, 3541, 3542, 3550, 3551, 3552, 3553, 3554, 3555, 3560, 3561, 3562, 3563, 3570, 3571, 3572, 3573, 3581, 3582, 3583, 3584, 3591, 3592, 3593, 3594, 3595, 3596, , 3598, 3599, 3601, 3602, 3603, 3604, 3605, 3606, 3607, 3609, 3610, 3611, 3612, 3613, 3614, 3615, 3616, 3617, 3619, 362, 363, 3631, 3632, 3633, 3634, 3639, 3691, 3699, 3731, 3732, 3733, 3734, 3735, 3736, 3737, 37413751, 3752, 3753, 3754, 3755, 3760, 3761, 3762, 3763, 3764, 3765, 3766, 3770, 3771, 3772, 3773, 3774, 3775, 3776, 3777, 3778, 3779, 3780, 3781, 3782, 3783, 3785, 3786, 3787, 3789, 3794, 3795, 3796, 3797, 3798, 3826