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For July 1, 2019 Reporting

HEDIS Measures

For all HEDIS measures, please refer to the National Committee for Quality Assurance's HEDIS® 2019 Technical Specifications for Health Plans.

Agency-Defined Measures

Mental Health Readmission Rate (RER)

Description: The percentage of acute care facility discharges for enrollees who were hospitalized for a mental health diagnosis that resulted in a readmission for a mental health diagnosis within 30 days.

Age: 6 years and older as of the date of discharge.

Data Collection Method: Administrative data. No sampling allowed.

Continuous Enrollment Criteria: Continuously enrolled for 30 days following discharge.

Exclusions:

Discharges for:

- Enrollees who died during the hospital stay or within 30 days of discharge.
- Enrollees who were not discharged to a community setting or who were admitted to a non-community setting within 30 days after discharge. Such non-community settings include the Statewide Inpatient Psychiatric Program (SIPP), Department of Juvenile Justice or Child Welfare Behavioral Health Overlay Service facility, hospice, nursing facilities, state mental health facilities, acute medical hospitals, and correctional institutions.
- Enrollees who receive Florida Assertive Community Treatment services

Special Instruction: Discharges occurring at the end of the measurement year may result in a readmission in January and should be included in the numerator.

Denominator: Discharges to the community from an acute care facility (inpatient or crisis stabilization unit) with a principal diagnosis of mental illness and that met continuous enrollment criteria. Please refer to the Mental Illness Value Set in the most recent edition of the HEDIS Technical Specifications for Health Plans for the FUH measure and follow the steps found in the HEDIS Technical Specifications to identify acute inpatient discharges.

Numerator: Discharges that result in a readmission to an acute care facility (inpatient or crisis stabilization unit) with a principal diagnosis of mental illness and that met continuous enrollment criteria. Please refer to the Mental Illness Value Set in the most recent edition of the HEDIS

Technical Specifications for Health Plans for the FUH measure and follow the steps found in the HEDIS Technical Specifications to identify acute inpatient discharges.

HEDIS/Agency-Defined Measures

Follow-up after Hospitalization for Mental Illness (FHM)

Description: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health diagnoses and who had a follow-up visit with a mental health practitioner.

Data Collection Method: Administrative data. No sampling allowed.

Eligible Population

Age: 6 years and older as of the date of discharge. Report three age stratifications and total rate:

- 6-17 years
- 18-64 years
- 65 years and older
- Total

Continuous enrollment: Date of discharge through 30 days after discharge.

Allowable gap: No gaps in enrollment.

Anchor date: None.

Event/diagnosis: An acute inpatient discharge with a principal diagnosis of mental illness (HEDIS Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

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

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

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

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

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.
If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental illness or intentional self-harm (HEDIS Mental Health Diagnosis Value Set; HEDIS Intentional Self-Harm Value Set), county only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis, exclude both the original and the readmission/direct transfer discharge.

Exclusions: Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (HEDIS Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (HEDIS Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

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

Exclude enrollees who receive Florida Assertive Community Treatment services.

Administrative Specification

Denominator: The eligible population.

Numerators

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge. Do not include visits that occur on the date of discharge.

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

- An outpatient visit (HEDIS Visit Setting Unspecified Value Set ***with*** HEDIS Outpatient POS Value Set ***with*** a mental health practitioner, with or without a telehealth modifier (HEDIS Telehealth Modifier Value Set).
- An outpatient visit (HEDIS BH Outpatient Value Set ***with*** a mental health practitioner, with or without a telehealth modifier (HEDIS Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (HEDIS Visit Setting Unspecified Value Set ***with*** HEDIS Partial Hospitalization POS Value Set ***with*** a mental health practitioner, with or without a telehealth modifier (HEDIS Telehealth Modifier Value Set).
- An intensive outpatient encounter or partial hospitalization (HEDIS Partial Hospitalization/Intensive Outpatient Value Set) ***with*** a mental health practitioner.
- A community mental health center visit (HEDIS Visit Setting Unspecified Value Set ***with*** HEDIS Community Mental Health Center POS Value Set ***with*** a mental health practitioner, with or without a telehealth modifier (HEDIS Telehealth Modifier Value Set).
- Electroconvulsive therapy (HEDIS Electroconvulsive Therapy Value Set) ***with*** (HEDIS Ambulatory Surgical Center POS Value Set; HEDIS Community Mental Health Center POS Value Set; HEDIS Outpatient POS Value Set; Partial Hospitalization POS Value Set) ***with*** a mental health practitioner.
- A telehealth visit: HEDIS Visit Setting Unspecified Value Set ***with*** HEDIS Telehealth POS Value Set ***with*** a mental health practitioner, with or without a telehealth modifier (HEDIS Telehealth Modifier Value Set).
- An observation visit (HEDIS Observation Value Set) ***with*** a mental health practitioner.
- Transitional care management services (HEDIS Transitional Care Management Services Value Set), ***with*** a mental health practitioner, with or without a telehealth modifier (HEDIS Telehealth Modifier Value Set).

Note:

- Organizations may have different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).
- See below for the definition of mental health practitioner.

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Allowable Encounter/Claim Codes*

Plans may use the most recent version of the HEDIS value set codes for the FUH measure in addition to the service codes in the table below. In order to use the codes with 2-letter modifiers in the table, they must have the identified codes after them.

Community behavioral health codes			Evaluation and management codes
H2019	HR		H0004
H2019	HR	GT	
H2019	HQ		
H2030			
H2019	HO		
H2019	HN		
H2020	HA		
H2000	HP		
H2000	HP	GT	
H2000	HO		
H2010	HO		
H2010	HO	GT	
H0031	HO		
H0031	HO	GT	
H0031	TS		
H0031	HN		
H0031	HN	GT	
H0032			
H0032	TS		
T1015	GT		
H2010	HE		
H2010	HE	GT	
H2010	HQ		
T1023	HE		
H0046			
H0046	GT		
T1015	HE		
H2020	HA		

Mental Health Practitioner:

- A Florida licensed MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry.

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- A Florida Licensed Psychologist or a doctoral level psychologist practicing under the auspices of a community mental health center and being supervised by a licensed psychologist.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who is a Florida Licensed Clinical Social Worker; or who is a masters level social worker practicing under the auspices of a community mental health center and being supervised by a qualified supervisor as required by Chapter 491.
- A Florida-licensed registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/ mental health and two years of supervised clinical experience.
- A Florida-licensed Marriage and Family Therapist or a masters level marriage and family therapist practicing under the auspices of a community mental health center and being supervised by a qualified supervisor as required by Chapter 491.
- A Florida Licensed Mental Health Counselor or a masters level counselor practicing under the auspices of a community mental health center and being supervised by a qualified supervisor as required by Chapter 491.

CMS Child Core Set

For Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC), Contraceptive Care – Postpartum Women Ages 15-20 (CCP-CH) and Cesarean Birth (PC02-CH), please refer to the Medicaid and CHIP Child Core Set Technical Specifications and Resource Manual that was released by CMS in February 2018. Below is the link:

https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

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CMS Adult Core Set

For HIV Viral Load Suppression (VLS), Medical Assistance with Smoking and Tobacco Use Cessation (MSC), Contraceptive Care – Postpartum Women Ages 21-44 (CCP-AD), and Elective Delivery (PC01-AD), please refer to the Medicaid Adult Core Set Technical Specifications and Resource Manual that was released by CMS in May 2018. Below is the link:

https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

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HIV/AIDS Specialty Plan

Prescription of HIV Antiretroviral Therapy – (HAART)

Description: The percentage of enrollees with a HIV/AIDS diagnosis that have been prescribed HIV antiretroviral therapy.

Eligible Population: Enrollees with HIV/AIDS as identified by at least one encounter with ICD-10-CM diagnosis code B20, B97.35, or Z21 during the first six months of the measurement year.

Age: No age limitations.

Data Collection Method: Administrative data. No sampling allowed.

Continuous Enrollment Criteria: Continuously enrolled in the health plan for the measurement year with no more than one month gap in enrollment.

Anchor Date: December 31 of the measurement year.

Administrative Specification

Denominator: Number of enrollees in the plan diagnosed with HIV/AIDS.

Numerator: Number of enrollees who were prescribed a HIV antiretroviral therapy* regimen within the measurement year.

* HIV antiretroviral therapy regimen is defined by the following (see HIV-AIDS Attachment for July 1, 2019 Reporting):

a) At least three single-agent antiretroviral medications filled within 10 days of each other;
b) One two-agent combination medication with at least one other antiretroviral medication (from “a” or “b”) filled within 10 days of each other;
c) One three-agent combination medication.
d) One four-agent combination medication.

Note: This specification is not intended to suggest appropriate medical practice. Instead, the specification is intended to capture appropriate treatment regimens in the most straightforward manner possible using administrative data. Certain combinations of medications should not be prescribed together. Clinicians should refer to treatment

guidelines published by the Health Resources and Services Administration, available at http://hab.hrsa.gov/

HIV Medical Visit Frequency (HIVV)

Description: The percentage of enrollees with a diagnosis of HIV/AIDS who were seen on an outpatient basis at least once every six months (with a minimum of 60 days between medical visits) by a physician, Physician Assistant or Advanced Registered Nurse Practitioner for an HIV-related medical visit within the measurement year.

Eligible Population: Enrollees with HIV/AIDS as identified by at least one encounter with an ICD-10-CM diagnosis code B20, B97.35, R75, or Z21 during the first six months of the measurement year.

Age: No age limitations.

Data Collection Method: Administrative data. No sampling allowed.

Continuous Enrollment Criteria: Continuously enrolled in the health plan for the measurement year with no more than one month gap in enrollment.

Anchor Date: December 31 of the measurement year.

Exclusions:

- Medical visits provided in an emergency department or inpatient setting and claims from lab, radiology, or home health may not be included in calculating the numerator. However, such claims may be used in determining the eligible population.
- Enrollees who died at any time during the measurement year.

Administrative Specification

Denominator: The eligible population.

Numerator: Enrollees who had at least one medical visit in each 6-month period of the measurement year with a minimum of 60 days between the first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period.

Gap in HIV Medical Visits (HIVG)

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Description: The percentage of enrollees with a diagnosis of HIV/AIDS who were not seen on an outpatient basis by a physician, Physician Assistant or Advanced Registered Nurse Practitioner for an HIV-related medical visit in the last 6 months of the measurement year.

Eligible Population: Enrollees with HIV/AIDS as identified by at least one encounter with an ICD-10-CM diagnosis code B20, B97.35, R75, or Z21 who had at least one medical visit in the first 6 months of the measurement year.

Age: No age limitations.

Data Collection Method: Administrative data. No sampling allowed.

Continuous Enrollment Criteria: Continuously enrolled in the health plan for the measurement year with no more than one month gap in enrollment.

Anchor Date: December 31 of the measurement year.

Exclusions:

- Medical visits provided in an emergency department or inpatient setting and claims from lab, radiology, or home health may not be included in calculating the numerator.
- Enrollees who died at any time during the measurement year.

Administrative Specification

Denominator: The eligible population.

Numerator: Enrollees who did not have a medical visit in the last 6 months of the measurement year.

Child Welfare Specialty Plan

To obtain measure specifications for the additional required performance measures for the Child Welfare specialty plan:

- For Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH), Contraceptive Care – Most and Moderately Effective Methods: Ages 15-20 (CCW-CH) and Developmental Screening in the First Three Years of Life (DEV-CH), please refer to the Medicaid and CHIP Child Core Set Technical Specifications and Resource Manual that was released by CMS in February 2018. Below is the link: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

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Children's Medical Services Plan

To obtain measure specifications for the additional required performance measures for the Children's Medical Services plan:

- For Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH), Contraceptive Care – Most and Moderately Effective Methods: Ages 15-20 (CCW-CH) and Developmental Screening in the First Three Years of Life (DEV-CH), please refer to the Medicaid and CHIP Child Core Set Technical Specifications and Resource Manual that was released by CMS in February 2018. Below is the link: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

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Serious Mental Illness Specialty Plan

To obtain measure specifications for the additional required performance measures for the Serious Mental Illness specialty plan:

- For Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD), and Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC), please refer to the National Committee for Quality Assurance's HEDIS® 2019 Technical Specifications for Health Plans.
- For Concurrent Use of Opioids and Benzodiazepines (COB-AD) and Screening for Depression and Follow-Up Plan – Ages 18+ (CDF-AD), please refer to the Medicaid Adult Core Set Technical Specifications and Resource Manual that was released by CMS in May 2018. Below is the link: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf
- For Screening for Depression and Follow-Up Plan – Ages 12-17 (CDF-CH), please refer to the Medicaid and CHIP Child Core Set Technical Specifications and Resource Manual that was released by CMS in February 2018. Below is the link: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf
- For Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use, please refer to the Electronic Clinical Quality Improvement Resource Center specifications. Below is the link: https://ecqi.healthit.gov/ecqm/measures/cms169v6

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