State of Missouri
MO HealthNet Division
Quality Improvement Strategy
(QIS)
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MO HealthNet Division (Missouri Medicaid)

TABLE OF CONTENTS

[1] 42 CFR = Code of Federal Regulations, Chapter 42

I. INTRODUCTION

A. Managed Care Goals, Objectives, and Overview

The Medicaid Program, authorized by federal legislation in 1965, provides health care access to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children. Since that time, legislative options and mandates have expanded the categories of eligibility to include Medicaid coverage for children and pregnant women in poverty, refugees, and children in state care. The Missouri Medicaid program is jointly financed by the federal government and Missouri State Government, and is administered by the State of Missouri. The agency charged with administration of the Medicaid program is the MO HealthNet Division (MHD), a division within the Department of Social Services.

The Managed Care Program enables Missouri to use the managed care system to provide Medicaid services to Section 1931 children and related poverty level populations; Section 1931 adults and related poverty populations, including pregnant women; Children's Health Insurance Program (CHIP) children; and foster care children in the Eastern, Central, and Western regions of the state.

In July 1982, Missouri received a four year federal demonstration grant to implement a managed health care program for Aid to Families with Dependent Children (AFDC) participants in Jackson County (Kansas City) in which primary care services were provided by four prepaid managed care organization (MCOs) and approximately thirty individual physicians, called physician sponsors. The four prepaid MCOs were reimbursed on a capitated basis and the physician sponsors were reimbursed on a fee-for-service basis. Each AFDC participant chose either a MCO or a physician sponsor, who was responsible for coordinating the health care provided to the participant. Medical services offered under the Missouri Medicaid Program were also available to managed health care enrollees; however, the majority of these services were either obtained through or referred by the chosen MCO or physician sponsor.

The original demonstration grant was extended to December 31, 1986, at which time the established program began operating under a waiver issued by the authority of Section 1915(b) of the Social Security Act and enrollment became mandatory.

In 1995, Missouri requested and received Waiver approval to implement a managed care program in the Eastern Region of the State. Missouri's Managed Care Program is authorized under Section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, Missouri is relying upon authority provided in the following subsections of section 1915(b):

- 1915(b) (1) – Requires enrollees to obtain medical care through specialty physician services arrangements.
- 1915(b)(2) – A locality will act as a central broker in assisting eligible individuals in choosing among competing MCOs in order to provide enrollees with more information about the range of health care options open to them.

- 1915(b)(4) – Requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards consistent with access, quality and efficient and economic provision of covered care and services.

Missouri waives the following sections of 1902 of the Act:
- 1902(a)(1) – Statewideness,
- 1902(a)(10)(B) - Comparability of Services, and
- 1902(a) (23) – Freedom of Choice.

Under this Waiver, Managed Care Organizations (MCOs) begin providing contracted services to certain targeted groups of Medicaid eligibles, including MO HealthNet for Families (MHF; aka Temporary Assistance for Needy Families (TANF), MO HealthNet for Pregnant Women and Newborns (aka Medicaid for Pregnant Women (MPW)), Refugees, MO HealthNet for Kids (MHK; aka Medicaid for Children), and Children in State Care and Custody. MHD eligibles in the targeted groups who receive Supplemental Security Income (SSI) or who meet the medical definition for SSI may choose not to enroll or voluntarily disenroll from the Managed Care Program at anytime.

Population exclusions include:
- Individuals dually eligible for Medicare and Medicaid.
- Individuals in long-term care facilities.
- Individuals who participate in a Home and Community Based Waiver.
- Individuals eligible for Aid to the Blind and Blind Pension.
- Permanently and Totally Disabled individuals.
- Pregnant women eligible for the Presumptive Eligibility Program.
- Individuals eligible under Presumptive Eligibility for Children.
- Uninsured women losing their MHD eligibility 60 days after the birth of their child would be eligible for women's health services for one year plus 60 days, regardless of income level. This population will obtain their services through the MHD Fee-For-Service Program.
- Breast and Cervical Cancer Control Project (BCCCP) participants.
- Individuals eligible under Voluntary Placement Agreement for Children.
- Children placed in foster homes or residential care by the Department of Mental Health.
- AIDS Waiver participants.
- Individuals eligible under MO Children with Developmental Disabilities Waiver.
- Individuals eligible under Qualified Medicare Beneficiary – QMB.
- Children placed in residential care by their parents, if eligible for MHD on the date of placement.
- Individuals under the Temporary Assignment Category.
- Individuals eligible under MORx.

Children's Health Insurance Program (CHIP)

Missouri's Children's Health Insurance Program (CHIP) was a Medicaid expansion implemented on September 1, 1998 through a waiver under Section 1115 of the Social Security Act and a Title XXI Plan that covered children under the age of 19 in families with a gross income of 300 percent of the Federal poverty level (FPL). Coverage was provided through the Managed Care

delivery system in areas of the State covered by the Section 1915(b) waiver and through the MHD Fee-For-Service Program in the remainder of the State. Uninsured women losing their MHD eligibility sixty (60) days after the birth of their child were covered for women's health services for an additional year, regardless of their income level. This population receives services through the MHD Fee-For-Service Program.

Effective September 1, 2007 the Centers for Medicare and Medicaid Services (CMS) approved Missouri's request for a combination Children's Health Insurance Program (CHIP), consisting of a MO HealthNet Expansion and a Separate Child Health Program. The Women's Health Services Program transitioned to the Missouri Women's Health Services Program Section 1115(a) Demonstration Waiver.

The new MO HealthNet For Kids Program occurs under a Title XXI CHIP State Plan, and covers uninsured children under the age of one with family income more than 185% of the Federal poverty level (FPL), but less than 300% of the FPL and uninsured children age one through age 18 with family income between 151% and 300% of the FPL. No new eligible is excluded because of pre-existing illness or condition. Children in families with income above 150% of FPL are not eligible if they have access to affordable insurance.

Children eligible for the MO HealthNet for Kids Program receive a benefit package of essential medically necessary health services, excluding NEMT. This benefit is so unheard of in any health insurance plan that its inclusion serves as a significant incentive for dropping of private coverage. Prescription drugs are subject to the national drug rebate program requirements. The MHD Fee-For-Service Program is utilized in regions where Managed Care is not available. When Managed Care begins in these areas, Title XXI eligibles will be enrolled in Managed Care.

Presumptive Eligibility for Children

In 2005 Missouri began to provide presumptive eligibility for children in families with income of 150% of FPL or below until a decision is made on regular MO HealthNet for Kids Program eligibility. Uninsured children age one through age five with family income more than 133% of the Federal Poverty Level (FPL) but less than 151% of the FPL, and uninsured children ages 6 through 18 with family income more than 100% of the FPL but less than 151% of the FPL are covered under the CHIP Expansion Program.

Children eligible for the CHIP Expansion Program receive the MHD package of essential medically necessary health services, including Non-Emergency Medical Transportation (NEMT). Prescription drugs are subject to the national drug rebate program requirements. Fee-For-Service is utilized in regions where Managed Care is not available. When Managed Care begins in these areas, Title XXI eligibles will be enrolled in Managed Care. No new eligible is excluded because of pre-existing illness or condition.

Program of All-Inclusive Care for the Elderly (PACE)

This program is a comprehensive service delivery system for the frail elderly. To be eligible to enroll in the PACE Program individuals must be 55 years of age or older, reside in the service area of the PACE organization, be determined by the Missouri Department of Health and Senior Services (DHSS) to need the level of care required for nursing facility services, and be

recommended by the PACE staff for PACE Program services as the best option for their care. Individuals may be entitled to Medicare Part A, enrolled under Medicare Part B or be eligible for MHD to enroll in the PACE Program. The PACE Organization provides a full range of preventive, primary, acute, and long-term care services 24 hours per day, 7 days per week to PACE participants.

Alexian Brothers Community Services (ABCS), currently the only PACE organization in the state, received permanent provider status and became fully operational effective November 1, 2001. ABCS is operational in all zip codes in St. Louis County and St. Louis City.

Medicaid Waivers

Congress enacted Section 2176 of Public Law 97-35 of the Social Security Act, entitled the Omnibus Budget Reconciliation Act. Through this enactment in 1981, certain statutory limitations have been waived in order to give states, who have received approval from the Department of Health and Human Services, the opportunity for innovation in providing home and community based services to eligible persons who would otherwise require institutionalization in a nursing facility, hospital or intermediate care facility for the mentally retarded (ICF/MR). Currently, Missouri operates a number of waivers, as described in Attachment A.

Anticipated Benefits of the Managed Care Program

The goal of the Managed Care program is to furnish high quality, continuity, and accessibility of health care services to enrollees, while providing the State with significant cost efficiencies.

The State realizes that the keys to a successful Managed Care Program include the provision of effective high quality services, the satisfaction of enrollees, and the involvement of stakeholders. Managed Care is an opportunity to deliver high quality, patient-centered evidence-based care in a way that also stabilizes costs and gains budget predictability by making payments on a predetermined, per-member-per-month basis and providing a more accountable, coordinated system of care for beneficiaries, with an emphasis on preventive and primary care services. Specifically, Managed Care provides:

- Integrated Care - Care coordination is a fundamental underlying principle of managed care. Case management focuses on enhancing and coordinating a member's care across an episode or continuum of care; obtaining and coordinating services and resources needed by members and their families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual members; addressing and resolving patterns of issues that have negative impact; and creating opportunities and systems to enhance outcomes. Thus, MCO case managers emphasize health promotion through preventive care such as screenings, vaccinations, and evaluation of the home environment. Comprehensive transitional care includes follow-up from inpatient and other settings. When needed, referrals to community and support services are made. The case management requirements include qualifications for case managers, frequency of contact with beneficiaries, screening and preventative services, and outcome standards.
- Quality - MCOs are held to rigid quality metrics and performance measurements. Missouri requires participating MCOs to be accredited by the National Committee for Quality Assurance (NCQA) at a level of accredited or better.

- Access - One of the biggest benefits of utilizing managed care is the requirement that each MCO must provide members with access to health care services. MCOs are required to ensure that their provider networks consist of the right types and sufficient numbers of providers and specialists for their members. There are strict network adequacy standards that ensure all members have access to care, including specialty care that they need.
- Cost-Savings - MCOs place emphasis on preventive care services, and ensure coordination of care across the healthcare spectrum through an effectively managed provider network, allowing MCOs to provide cost-saving measures for Medicaid beneficiaries without compromising quality or access.

MCOs provide budget predictability by absorbing any costs associated with cases of extreme illness and injury. FFS cannot provide the type of care coordination that MCOs provide at such a predictable rate.

Overview of Managed Care Quality Management Structure

Under Managed Care, oversight responsibility is shared among the State, the MCOs, and their providers. The State has direct oversight of its contracted MCOs and establishes payment rates for these entities as well as the parameters governing the amount, duration, and scope of benefits covered in these contracts. The MCOs establish standards dictated by the State for medical care and referral policies, determine payment methods, and rates for MCO providers.

The focus of administrative activities such as member grievances and provider appeals shifts from direct contact with the State to customer service and provider relations divisions within the MCO. The MCOs are accountable for improving the well-being of the enrollee. Customer service and care management functions provided by the MCO contribute to improved member involvement and better health outcomes and provide an opportunity to improve the quality of care being furnished.

The Quality Assessment & Improvement (QA&I) Advisory Group was created with the inception of Managed Care. The purpose of the QA&I Advisory Group is to impact service utilization through collaborative monitoring and continuous quality improvement activities. The QA&I Advisory Group and task forces assist in maintaining an open forum for collaboration and communication among MCOs, other stakeholders (i.e. advocates, consumers, and providers), and state agencies (the Departments of Mental Health; Social Services; Insurance, Financial Institutions, and Professional Registration; Elementary and Secondary Education; and Health and Senior Services). The QA&I Advisory Group meets quarterly.

The QA&I Advisory Group designate task forces as necessary to work on specific performance improvement initiatives. The initiative activities may include, but are not be limited to, identification of indicators, evaluation of outcomes, and the development of recommendations for intervention strategies. The task forces exist for a specific designated period and are terminated when the desired outcome is reached. Reports of task force meetings, actions and outcomes are regularly presented to the QA&I Advisory Group. Task force members include MCO quality staff, other stakeholders, and state agency staff.

The QA&I Advisory Group task forces that have been convened include, but are not limited to: Maternal Child Health, Dental, Behavioral Health, External Quality Review Organization (EQRO), and National Committee for Quality Assurance (NCQA). The task force leader/facilitator works directly with and is accountable to the chair of the QA&I Advisory Group. The chair of the QA&I Advisory Group works directly with state agency staff.

The All Plan members (MCO administrators) evaluate initiatives recommended by the QA&I Advisory Group. The All Plan members guide operations and promote and protect the health and safety of the Managed Care members. They create and foster an environment that provides quality care consistent with Managed Care member needs and the goals of the Managed Care Program.

The MCOS are required to link every member to a primary care provider (PCP); monitor the PCPs to ensure they are performing the duties described below and operating in compliance with MCO policies and procedures; the use of specialists as PCPs; and notifying PCPs of their assigned member(s) prior to the member's effective date with the PCP.

Goals and Objectives of the Managed Care Program

The goals of quality initiatives are to develop mechanisms to measure quality and to hold MCOs accountable for quality improvement and outcomes. There are many steps toward achieving these goals. The first approach is to use utilization data and/or encounter data to address "inputs" (e.g., types of providers, geographic access, staffing, etc) into how care is delivered. Most current performance measures are "process measures". Process measures can include clinical interventions (tests, medications, procedures, surgery) and administrative activities which are believed to lead to favorable member outcomes. Encounter data and process measures provide significant insight into the quality of care. The State conducts Readiness Reviews for MCOs new to the Managed Care Program to identify potential problems with an MCO's ability to meet contracting requirements before approving the contracts. Data systems are designed to facilitate cross-MCO comparison of enrollments; disenrollments; complaint, grievance, and appeal processing; quality; and fiscal soundness in order to identify aberrant patterns that warrant investigation.

Specific goals and objectives that play a significant role in the development of the quality strategy were based on prior reports and findings, and include the following:

Goal 1: To optimize the use of MHD Services by members.
Objectives:

- Increase the rate of Well Child Visits for children and adolescents by 2% annually*;
- Increase the percent of enrollees with a BMI recorded within the past 2 years by 5% annually;
- Increase Members Behavioral Health Utilization annually by 2%;
- Increase Behavioral Health Outpatient Visits annually by 2%;
- Decrease Behavioral Health Inpatient Readmission Rates annually by 2%;
- Decrease the number of preventable hospitalizations by 2% annually;
- Decrease the number of preventable asthma hospitalizations for children by 2 % annually;

*Healthcare Effectiveness Data and Information Set (HEDIS) Measures

- Decrease the number of Emergency Room visits by 2% annually;
- Decrease the number of Emergency Room asthma visits for children by 2% annually;
- Increase by 2% annually members having access to behavioral health providers within the geographic distances specified in the Network Adequacy Standards until > 90 percent have access to services;

Goal 2: To improve the range of care provided to the MHD members.
Objectives:
- Increase the Use of Appropriate Medications for Children with Asthma by 2% annually*;
- Increase the EPSDT screening rate by 2% annually;
- Increase the percentage of children who had the HEDIS-recommended number of vaccines by their second birthday by 2% annually*;
- Increase the percentage of enrolled members age 12-21 who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year by 2% annually *;
- Increase 7-Day behavioral health inpatient follow-up visits by 2% annually;
- Increase 30-Day behavioral health inpatient follow-up visits by 5% annually;
- Increase rate of medication management for enrolled members with a diagnosis of major depression by 2% annually;
- Achieve rate of effective adherence to antipsychotic medications for enrolled members diagnosed with schizophrenia by 1% annually;
- Increase Breast Cancer Screenings by 2% annually;
- Increase Cervical Cancer Screenings by 2% annually *;
- Increase the percentage of enrolled members with a documented BMI by 2% annually;
- Decrease the percentage of self-identified tobacco users on the CAHPS survey by 2% annually;
- Decrease the percentage of enrollees receiving opioid prescriptions from more than 5 different prescribers in a 90-day period by 5% annually;
- Increase the percentage of enrollees with diabetes who receive an annual hemoglobin A1c test by 3% annually*;
- Increase the percentage of enrollees with diabetes who receive an annual LDL-C screening test by 3% annually*;
- Increase the percentage of enrollees with diabetes who have blood pressure reading <140/90 by 3% annually*;

Goal 3: To improve the access/availability of care provided to the MHD members.
Objectives:
- Increase the number of primary care providers enrolled in the MHD Program by 2% annually;
- Increase the number of children who receive annual dental visits by 3% annually *;
- Increase the number of pregnant members receiving Prenatal and Postpartum Care by 2% annually *;
- Increase the number of members using Ambulatory Care by 2% annually *;

*Healthcare Effectiveness Data and Information Set (HEDIS) Measures

- Increase the percentage of enrollees with targeted conditions who receive case management services by 10% annually;
- Increase the Identification of Alcohol and Other Drug Services by 2% annually;
- Increase the number of participants who self select a Primary Care Provider by 5% annually;
- Increase by 2% annually the full time equivalent (FTE) of behavioral health providers (Psychiatrists, Psychologists, Other behavioral health providers) per 1000 members;
- Increase the number psychiatrists accepting new patients by 2% annually;
- Increase the number of psychiatric practices with appointment availability for Emergent (non-life threatening) appointments within 6 hours, Urgent appointments within 48 hours, and routine appointments within 10 business days, by 2% annually;
- Increase the number of PCP practices with appointment availability for Emergent (non-life threatening) appointments within 6 hours, Urgent appointments within 48 hours, and routine appointments within 10 business days, by 2% annually;
- Increase the percentage of PCP practices that offer early morning, evening, and weekend appointments by 2% annually;
- Increase the percent of patients who are seen within 30 minutes of their scheduled outpatient appointment time by 5% annually;

Goal 4: Satisfaction with the Experience of Care
Objectives:
- Annual Case Management Satisfaction Survey shows improvement on at least 50% of the measures;
- Annual CAHPS MCO Survey, Child Version* shows improvement on at least 50% of the measures;
- Annual CAHPS MCO Survey, Adult Version* shows improvement on at least 50% of the measures.

B. Development and Review of Quality Improvement Strategy (QIS)

Missouri's Quality Improvement Strategy (QIS) is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes to coordinate, assess, and continually improve the delivery of quality care and services to participants in the Managed Care Programs. The QIS provides a framework to communicate the State's vision, objectives, and monitoring strategies addressing issues of health care cost, quality, and timely access.

The QIS is developed through collaborative partnerships with members, stakeholders, other state agencies, MCOs, and community groups.

The goal is to ensure that:
- Quality health care services are provided to Managed Care members;
- MCOs are in compliance with Federal, State, and contract requirements; and
- A collaborative process is maintained to collegially work with the MCOs to improve care.

Quality Strategy Objectives
MHD, in collaboration with the DMH and DHSS, identifies measures that must be reported by the MCOs to MHD and DHSS. The measures that are monitored are reported to and approved

by the members of the QA&I Advisory Group and the All Plan Group. MHD, in collaboration with the MCOs, DMH, and DHSS identifies benchmarks and targets for the measures.

This QI strategy supports the following MHD objectives:

- Assessment of the quality, accessibility, and appropriateness of care and services furnished to members, including those with special health care needs, centered on evidenced based practice;
- Use of care management with emphasis on the individual member to ensure that members have a medical home which focuses attention on the wellness of the member and includes personal responsibility and investment on the part of the member;
- Use of data regarding the race, ethnicity, primary language spoken, and other socioeconomic and cultural factors of each member to improve care delivery;
- Use of national performance measures and levels when identified and developed by CMS in consultation with states and other relevant stakeholders, and those state specific factors identified by the state;
- Development of an effective information system that supports initial and ongoing operation and review of the quality strategy;
- Continued process for public input that provides for the integration of various perspectives and priorities and will facilitate improvements in member health status;
- Appropriate use of sanctions, including intermediate sanctions, to assure appropriate delivery of care to members; and
- Compliance with regulatory and contractual requirements.

Member Input - 42 CFR 438.202(b)

The State realizes that the keys to a successful Managed Care Program include the provision of effective and high quality services, the satisfaction of enrollees, and the involvement of stakeholders. In awareness of the importance of stakeholder involvement, the State formed the Consumer Advisory Committee (CAC) comprised of at least 15 members representing assorted advocacy groups, MCOs, and Managed Care members. The function of the CAC is to advise the Director of MHD on issues relating to member participation in the Managed Care Program. Consumer input into services, processes, and programs is obtained through quarterly meetings of the CAC group and from annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys conducted by the MCOs. As the State develops and refines educational materials, the CAC is instrumental in making recommendations to enhance consumer education as well as any changes needed to improve either the care provided or the way care is delivered.

Public Input - 42 CFR 438.202(b)

In an effort to involve various stakeholders, especially those persons with special health care needs, the State has used the following forums:

- Quarterly meetings with provider groups, such as physicians, dentists, hospice providers, the Drug Utilization Review Board, the Managed Care All Plan Administrators, the CAC, and the QA&I Advisory Group and related subgroups;
- Frequent interactions with the State's Advocates for Family Health (ombudsmen services) regarding ways to assist Managed Care members access care easier and ways to coordinate care with other state agencies;
- Publication of the Managed Care contract on the State web site;

- Publication of provider bulletins on the State website regarding MHD Managed Care issues; and
- Collaboration and regular meetings with Department of Health and Senior Services (DHSS), DMH, and the Department of Elementary and Secondary Education (DESE), as well as with sister agencies within the Department of Social Services.

In addition to these on-going activities, a large amount of information was gathered by the State during the testimony and hearings held on House Bill (HB) 335 passed by the Missouri General Assembly in 1997 which addressed Managed Care issues such as patient's rights, grievances and appeals, the definition of an emergency, network adequacy, and member notice in utilization review decisions. Literally hundreds of providers, advocates, and citizens (including those with special health care needs) testified in support of this legislation. The testimony helped shape this law which was incorporated into the State's Managed Care contracts with MCOs.

Quality Improvement Strategy (QIS) Approval
After comments are gathered from these stakeholders, policy is developed or changed to incorporate suggestions that impact the MHD Managed Care Program. The final QIS document is then presented to the QA&I Advisory and All Plan groups for approval, and then sent to CMS for their final review and approval.

Quality Improvement Strategy (QIS) Annual Review - 42 CFR 438.202(d)
The QIS is evaluated on an annual basis by MHD and MCO quality staff for effectiveness. This process includes obtaining input from stakeholders (i.e. advocates, consumers, and providers), the QA&I Advisory Group, the CAC, and other state agencies (the DMH, Department of Social Services (DSS); the Department of Insurance, Financial Institutions, and Professional Registration (DIFP); Elementary and Secondary Education (DESE); and DHSS). Results of the annual External Quality Review (EQR) and the MCOs annual evaluation of their QA&I Programs are considered during the QIS annual evaluation. If there is significant change in outcome or indicator status that is not self-limiting and impacts more than one area of the population's health status, modifications will be made to the QIS reporting process. The QIS may be reviewed and revised more frequently if program changes occur that impact quality activities or threaten the potential effectiveness of the strategy.

II. ASSESSMENT

A. Quality and Appropriateness of Care and Services

Missouri assesses the quality and appropriateness of care delivered to the MO HealthNet Managed Care members through collection and analysis of data from many sources. MCOs are required to have in place mechanisms to assess the quality and appropriateness of care furnished to all members, with particular emphasis on children with special health care needs. These mechanisms may include but are not limited to performance measures and performance improvement projects [42 CFR 438.204(b)(4)].

The MCOs receive a monthly special healthcare needs list from the state agency and are required identify for MHD those members that are currently receiving case management. The MCOs' internal processes are to be used to evaluate the need for case management and document the findings in the member's record.

Special Health Care Needs - 42 CFR 438.204(b)(1)
The special health care needs (SHCNs) population in Missouri is defined as:

- Children with Autism Spectrum Disorder.
- Children that without services such as private duty nursing, home health, durable medical equipment/supplies, and case management may require hospitalization or institutionalization; and
- Individuals qualifying to receive services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a) (1) (D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.

42 CFR 438.208(c)(1) To identify persons with Special Health Care Needs (SHCNs), the Health Benefit Manager (HBM) administers the Managed Care Health Risk Assessment (HRA) to the enrollee during open enrollment periods. The HBM includes an HRA form for eligible members in each household in the enrollment packet for mail-in purposes. The HBM also administers the HRA via telephone at the time of a telephone enrollment or transfer request. If the mail-in enrollment information does not include a completed HRA, the HBM must make an attempt to contact the individual by telephone for the information. There should be a health risk assessment for each eligible in the household. The completed HRAs are provided nightly to the MCOs as they are collected.

The HRA provides the MCO with important information about the health risks of new members. By providing opportunities for early identification of enrollees who are pregnant; have SHCNs; conditions such as asthma, diabetes, high blood pressure; behavioral health treatment or counseling; substance abuse treatment or counseling; physical, speech, or occupational therapy; or special equipment (i.e. to help with moving, walking, talking, hearing, breathing, feeding, personal care, etc.) assessments may be made for referral to case management or disease management.

The MCOs have developed condition-specific detailed assessment forms. Based upon assessment results and in partnership with the member, a more detailed care plan may be developed or the appropriate frequency of follow–up outreach identified. Follow-up care may include, specialist referrals, accessing durable medical equipment, medical supplies, and home health services. Where appropriate, case managers provide coordination and continuity of services to enrollees. MCOs are required to complete a treatment plan for all members meeting the requirements of persons with special health care needs as defined above. All treatment plans must comply with 42 CFR 438.208 and include requirements for direct access to specialists.

Procedures for Race, Ethnicity, Primary Language, and Data Collection - 42 CFR 438.204(b)(2)
Missouri updated its procedures for collecting racial and ethnic data consistent with the Office of Management and Budget (OMB) revised standards via Administrative Notice (A-14-2003) on September 11, 2003. Missouri follows the guidance presented in the Notice for obtaining

information when individuals fail to self-identify themselves. The two ethnic categories are: Hispanic or Latino and Non Hispanic or Latino. The five racial categories are: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White. During the application process, the applicant identifies race, ethnicity, and primary spoken language.

The Managed Care contract includes language requirements compliant with Federal regulations. The MCOs are notified of member enrollment/disenrollment information via a nightly enrollment file and a weekly enrollment reconciliation file. To facilitate care delivery appropriate to member needs, the enrollment file also includes race, primary language spoken, and selective health information. The MCOs utilize information on language to provide interpretive services, develop educational materials for employee training, and facilitate member needs in the context of their language requirements.

B. National Performance Measures

Missouri is currently reporting the following voluntary child measures in the CHIP Annual Report:

- Timeliness of Prenatal Care
- Childhood Immunization Status
- Adolescent Immunization Status
- Chlamydia Screening
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- Adolescent Well-Care Visit
- Percentage of Eligibles That Received Preventive Dental Services
- Percentage of Children that Received Dental Treatment Services
- Ambulatory Care – Emergency Department (ED) Visits
- Follow-up after Hospitalization for Mental Illness
- CAHPS Health Plan Survey – Child Questionnaire

The State's goals associated with these measures are to:

- Reduce the number of uninsured by .02% annually.
- Increase the number of children enrolled in CHIP by .02% annually.
- Increase the number of children in the MHD program, excluding CHIP, by 2% annually.
- Increase the number of primary care providers enrolled in MHD by 2% annually.
- Increase by 5% the number of participants in Missouri who have self selected a primary care provider at the time of enrollment.
- Increase by 3% the number of children who receive annual dental visits (HEDIS measure).
- Increase the EPSDT screening rate annually by 2%

In addition, the State was awarded an Adult Quality Grant from CMS in December 2012, and is currently building processes to enable reporting of data for 16 measures from the Initial Core Set of adult measures, beginning in 2013. The measures selected are:

- Flu Shots for Adults Ages 50-64
- Adult BMI assessment

- Breast cancer screening
- Cervical cancer screening
- Medical assistance with smoking and tobacco use cessation
- Chlamydia screening in women age 21-24
- Follow-up after hospitalization for mental illness
- Annual HIV/AIDS medical visit
- Comprehensive diabetes care: LDL-C screening
- Comprehensive diabetes care: Hemoglobin A1c testing
- Antidepressant medication management
- Adherence to antipsychotics for individuals with schizophrenia
- Annual monitoring for patients on persistent medications
- CAHPS Health Plan Survey - Adult Questionnaire
- Initiation and engagement of alcohol and other drug dependence treatment
- Postpartum Care Rate

C. Monitoring and Compliance - *42 CFR 438.204(b)(3)*

The State has developed a comprehensive program to assess all aspects of MCO performance. Contract provisions established for the MCOs incorporate specific standards for the elements outlined in 42 CFR 438.204(b)(3) addressing access to care, structure and operations, and quality measurement and improvement. Missouri requires the MCOs to have internal quality assurance programs, and ensures their compliance by monitoring the MCO performance. MCOs in turn are responsible for communicating established standards to their network providers and subcontracted benefit management organizations. They monitor provider compliance, and enforce corrective actions as needed.

The State's monitoring program consists of a variety of tools, activities, and reports, as described below:

Access to Care

MCOs must comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration (DIFP) in 20 CSR 400-7.095 as amended. MCOs submit network files as part of the annual access plan required by DIFP, and the State uses these plans to calculate enrollee access rates by county and statewide and to determine if the provider network is capable of meeting the needs of the MCO enrollees.

The State also receives annual data from the MCOs addressing access to behavioral healthcare services. This includes counts and FTEs for several mental health specialists (psychiatrists, child psychiatrists, doctoral psychologists), practice type (children, adults, both), and information about appointment availability by age (0-6, 7-12, 13-17, 18+) and appointment type (new, routine, urgent, emergency).

MCOs are required to assess the availability of PCPs for 24-hour and 7-days-per-week availability. The MCO provider representatives and the Quality staff generally perform this task by monitoring grievances and conducting provider office site visits, "secret shopper" calls, and interviews with staff. The MCOs report monitoring results to the State staff.

Structure and Operations
The State agency collects the following operational data from the MCOs:

- Fraud and Abuse Activities Reports (quarterly)
- Timeliness of Claim Adjudication Report (quarterly)
- Complaint, Grievance, and Appeal Report (quarterly)
- Disease Management Update Report (quarterly)
- Verification of Review of Education and Marketing Materials (annually)
- Call Center Report (quarterly)
- Special Needs Report (monthly)
- Lead Poisoning Prevention Report (monthly)

Encounter Data Validation
Encounter data is used by the State for rate setting and quality improvement evaluation, and the State conducts a complex process for assuring validity of encounter claims submitted by the MCOs. This involves using software algorithms as well as conducting a review of medical records for a random sample of claims in order to assure completeness and accuracy of submitted data.

As a result of continued encounter data validation, the MCOs are more consistent in their reporting or secondary and additional diagnosis codes as compared to the past. This improvement in consistency advances the State closer to its goal of using full medical data in risk-adjusted efficiency analysis and for future risk-adjusted rate setting.

Healthcare Effectiveness Data and Information Set (HEDIS) Performance Measures
Managed Care performance measures are required to be reported in accordance with HEDIS specifications to the DHSS and MHD per State regulation 19 CSR 10-5.010 and the Managed Care contract. Both DHSS and MHD analyze the performance measures to compare MCOs' performance to the statewide average.

Member and Provider Complaints, Grievances, and Appeals
MCOs are required to submit quarterly member and provider complaint, grievance, and appeal reports per the Managed Care contract. MHD analyzes the quarterly reports for quality and effectiveness of care and access. The data is compiled into uniform region and statewide reports. In order to accurately compare MCOs and regions, the number of complaints, grievances, and appeals being reported is calculated based on 'per 1000 members' of each MCO's enrollment for the quarter being reported.

The MCO data is primarily utilized to monitor marketing, enrollment/disenrollment, program integrity, information to beneficiaries, timely access, grievances, PCP/specialist capacity, coordination/continuity, coverage authorization, provider selection, and quality of care. The data is analyzed to identify trends; to ensure that quality health care services are provided to enrollees; to ensure MCOs are in compliance with federal, state, and contract requirements; and to contribute to a process that partners with MCOs to improve care. The MCO analysis findings are reported to the QA&I Advisory Group. The advisory group members discuss the findings to identify opportunities for improvement.

MHD's Provider Communications (PCU) and Participant Services Units (PSU) have the responsibility for hotline calls from MO HealthNet participants and providers regarding all aspects of the MO HealthNet Program. These Units refer Managed Care issues to the respective MCO or to MHD's Contract Compliance Unit (CCU). The CCU also received issues from the Ombudsmen Program and written communications from enrollees and providers.

Maternal and Child Health Indicators

The Maternal and Child Health (MCH) Indicators are used to examine the impact of the Managed Care Program on maternal/infant and child health since the inception of the Managed Care Program; and to compare this progress with Non-Medicaid and MO HealthNet Fee-for-Service participant groups.

The *Maternal and Child Health Indicators and Trends Report* is compiled annually by the Department of Health and Senior Services (DHSS) from publicly reported vital health statistics and hospital discharge data sets. Aggregate data from the Managed Care Program baseline (1995 to the present) are available for the maternal/infant and child health indicators.

The Maternal and Child Health Indicators provide a mechanism for examining trends and the significance of trends among the Managed Care enrollee, MO HealthNet Fee-For-Service participants, and the Non-Medicaid (in the Managed Care Program Regions) groups of women and children in Missouri. The comparison of trends within groups over time provides some control over a variety of demographic variables and allows for examining progress over time within groups. Nine maternal/infant health and four child health indicators considered important indices of the impact and progress of the Managed Care Program were selected for analysis.

Behavioral Health

The QA&I Advisory Group monitors and reviews behavioral health dashboard metrics that are reported to the State on a quarterly and/or annual basis. In addition, the State collaborates with the DMH to conduct annual Behavioral Health Reviews of each MCO and their subcontracted Behavioral Health Organization. These consist of surveys and comprehensive on-site behavioral health operational reviews designed to monitor areas of particular concern such as case management, behavioral health provider availability, and other issues identified through routine monitoring activities.

The reviews address the following areas:

- Adequacy of quality monitoring systems including oversight of staff performance; caseloads; network access; provider practice patterns; utilization; denial and complaint trends and other quality data.
- Involvement of the Medical Director in utilization and quality management.
- Effectiveness of executive management and MCO oversight and reports.
- Performance on a number of key metrics including telephone response, staff turnover, network access, and utilization and complaint rates.

Quality Measurement and Improvement

The MHD Evidence-Based Decision Support Unit (EBDSU) evaluates process measures, clinical outcomes, and service utilization rates. Measures consist of nationally defined standards as well

as locally developed metrics. In addition, the EBDSU houses the Behavioral Health Program which conducts reviews of behavioral health services within Managed Care, covering a variety of indicators addressing network adequacy, utilization, timely service availability, and hospitalization follow-up, among others. The resulting data from these efforts drive program and policy decisions. Missouri was recently awarded a CMS Adult Quality Grant which will permit refinement and expansion of these capabilities.

Results from the analysis and evaluation activities are compiled and presented through regularly scheduled meetings of the QA&I Advisory Group. The QA&I Advisory Group reviews these results to identify opportunities for improvement. The QA&I Advisory Group may form a task force to review the areas for improvement and provide input to the QA&I Advisory Group regarding actions needed. The QA&I Advisory Group recommends actions to be taken by the MCOs to the All Plan Group.

D. External Quality Review (EQR) *- 42 CFR 438.204(d)*

The Federal and State regulatory requirements and performance standards as they apply to MCOs are evaluated annually for the State in accordance with 42 CFR 438.310 (a) and 42 CFR 438.310 (b) by an independent EQRO, including a review of the services covered under each MCO contract for: a) timeliness, b) outcomes, and c) accessibility, using definitions contained in 42 CFR 438.320.

Behavioral Health Concepts, Inc. has been the EQRO for Missouri since 2001. Their current contact is effective through September 13, 2017.

The specification of activities to be performed by the EQRO broadly includes:
- Measurement of quality and appropriateness of care and services,
- Synthesis of results compared to the standards, and
- Recommendations based on the findings.

The report also includes the following for each mandatory and state agency selected optional activity performed:
- Objectives,
- Technical methods of data collection and analysis,
- Description of data obtained,
- Conclusions drawn from the data, and
- Recommendations for improving the quality of health care services furnished by each MCO.

The EQRO does not currently perform any of the optional activities as mentioned in 42 CFR 438.358.

***42 CFR* 438.360(b)(4)** The EQRO does not use information from Medicare or private accreditation reviews.

The EQRO holds a review exit conference with MCO administrative and clinical management staff to address findings and recommendations, and presents a summary report, including

findings and recommendations, at the Managed Care Quality Assessment and Improvement (QA&I) Advisory Committee and the All Plan meetings.

The EQR results are used to monitor information provided to beneficiaries, grievances, timely access, coordination/continuity, coverage authorization, provider selection, and quality of care. Information from the onsite review is used to ensure compliance with contractual requirements and to ensure quality of health care services. The Quality Assessment and Improvement (QA&I) Advisory Group recommend actions to be taken by the MCOs on the EQR areas for improvement.

The EQR Reports are available on the Department of Social Services, MO HealthNet Division website: http://dss.mo.gov/mhd/mc/pages/eqro.htm.

III. STATE STANDARDS

A. Access Standards

The State is highly invested in assuring access to care for all its members, as evidenced by contract requirement in the areas listed below. We are presently developing a series of processes and associated metrics for more formal monitoring and reporting by the MCOs in these areas.

Availability of Services - 42 CFR 438.206
Standards for access to care include availability of appointments for routine and urgent services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services as required by 42 CFR 438.206. Managed Care Program standards promote early intervention at the appropriate level of care, and ensure that preventive and primary care services are available and accessible to enrollees. MCOs must establish accessibility standards to ensure that each member has a primary care provider (PCP) and access to specialists for medically necessary services. Access standards must address availability of routine appointments and medically necessary specialty care services, appointment follow-up procedures and missed appointments, first prenatal visit, waiting times in provider offices, telephone medical advice, urgent care, and after-hours calls availability for PCPs or appropriate licensed professional under his/her supervision. The following activities and reports document the MHD's endeavors to monitor access to care and status of available services:

Care Coordination/Case Management
MCOs must maintain procedures for monitoring the coordination of care, determining whether case management services are needed, establishing referral processes, initiating and maintaining disease management services, and processing authorizations for members receiving out-of-network services. The MCOs will report the case management log and case management measures as defined by MHD.

MHD works collaboratively with the contracted MCOs to meet requirements in 42 CFR 438.208 for care coordination for individuals with special health care needs. Missouri is a 209 (b) State and does not track individuals with Social Security Income (SSI) as a separate eligibility group.

A process was developed and maintained to identify enrollees with special health care needs. This information is communicated to the MCOs monthly. The information contains identifying information regarding enrollees in the following subpopulations: individuals eligible for SSI under Title XVI; individuals in foster care or other out-of-home placement, individuals receiving foster care or adoption subsidy, and individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the State in terms of either program participant or special health care needs.

The progress made to date has focused on development and implementation of processes for identification and assessment of individuals with special health care needs. To ensure that MCOs meet the needs of persons with special health care challenges, the State's policies emphasize uninterrupted care, including direct access to specialists. Special attention has been given to transition of care from Fee-For-Service to Managed Care. For example, prior to discontinuing any personal care services, the MCO must work with the State to evaluate the continuing needs of the enrollee.

A communication process has been established with MCO case managers. State staff is in communication with MCO case managers on a frequent basis regarding care issues.

Provider Networks - 42 CFR 438.206(b)(1),(c)(1)(iv)-(vi)

MCOs must regularly monitor their provider network to ensure that service accessibility standards are being met, that provider listings of panel status (open and closed) are accurate, that members have and use their primary care providers, and that emergency rooms are not being used unnecessarily. As part of this monitoring the MCOs, at a minimum, require their providers to report on the number of members they will take as patients or limitations to the number of referrals accepted and report to the MCO when they have reached eighty-five percent (85%) of capacity. The MCOs have and implement policies and procedures describing their network development and monitoring activities to include methods for ensuring adequate capacity for members.

MCOs notify the state agency within five (5) business days of first awareness/notification of change to the composition of the provider network or the health care service subcontractors' provider network that materially affect the MCO's ability to make available all covered services in a timely manner. At a minimum, the MCO notifies the state agency when there is:

- A decrease in the total number of primary care providers by more than five percent (5%);
- A loss of any hospital regardless of whether the loss will result in the MCO failing to meet the service accessibility standards defined in 20 CSR 400-7.095; or
- Other adverse changes to the composition of the provider network which impair or deny the members adequate access to in-network providers, including but not limited to reporting to the state agency when a provider has reached eighty-five percent (85%) of capacity.

Access to a Women's Health Specialist - 42 CFR 438.206(b)(2)

In accordance with State law, the MCOs must allow members direct access to the services of the in-network OB/GYN of their choice for the provision of covered services.

Second Opinion - 42 CFR 438.206(b)(3)
The MCOs are required to provide for a second opinion, at no cost to members, from qualified health care professionals. The MCO must have and implement policies and procedures for rendering second opinions both in-network and out-of-network when requested by a Managed Care member. These policies and procedures shall address whether there is a need for referral by the primary care provider or self-referral. Missouri Revised Statutes Section 208.152 states that certain elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

Direct Access and Standing Referrals - 42 CFR 438.206(b)(4)
The MCOs are required by contract to have direct access and standing referral policies and procedures that address how a member, including but not limited to those with special health care needs, may request and obtain:

- A referral to an out-of-network provider when the MCO does not have a health care provider in the network with appropriate training or experience to meet the particular health care needs of the member;
- A standing referral from a specialist if the member has a condition which requires on-going care from a specialist; and
- Access to a specialty care center if the member has a life-threatening condition or disease either of which requires specialized medical care over a prolonged period of time.

Payment Disputes - 42 CFR 438.206(b)(5)
All disputes between the MCO and in-network and out-of-network providers is solely between such providers and the MCO. In the case of any disputes regarding payment for covered services between the MCO and providers, the member shall not be charged for any of the disputed costs.

Provider Credentialing - 42 CFR 438.206(b)(6)
The MCOs are required to have written credentialing and re-credentialing policies and procedures for determining and assuring that all in-network providers are licensed by the State in which they practice and are qualified to perform their services. The MCOs are required to monitor the in-network providers, report the results of the monitoring process, and discipline in-network providers found to be out-of-compliance with the MCO's medical management standards. The policies and procedures shall include the time frame in which the credentialing and re-credentialing must take place. The credentialing and re-credentialing process shall not take longer than one hundred eighty (180) days. The MCO shall use the Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180, as amended.

Timely Access to Care and Services - 42 CFR 438.206(c)(1)(i)
The MCOs must ensure that waiting times (defined as time spent both in the lobby and in the examination room prior to being seen by a provider) for appointments do not exceed one hour from the scheduled appointment time.

The MCO is required by contract to have in its network the capacity to ensure that the time elapsed between the request for appointments and the scheduled appointments does not exceed the following:

- Urgent care appointments for illness injuries which require care immediately but do not constitute emergencies (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services): Appointments within twenty-four (24) hours.
- Routine care with symptoms (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever): Appointments within one (1) week or five (5) business days whichever is earlier.
- Routine care without symptoms (e.g. well child exams, routine physical exams): Appointments within thirty (30) calendar days.
- Behavioral health and substance abuse services: Aftercare appointments within seven (7) calendar days after hospital discharge.

Twenty-Four Hour Access - 42 CFR 438.206(c)(1)(ii)

- The MCO must ensure that emergency medical/behavioral health services are available twenty-four (24) hours seven (7) days per week to treat an emergency medical condition.
- The MCO is required to provide an accommodation, if needed, to ensure all members equal access to twenty-four (24) hours per day health care coverage.

Comprehensive Benefit Package - 42 CFR 438.206(c)(1)(iii)

The MCO must provide all covered medical and behavioral health services in the comprehensive benefit package for each member as of the effective date of coverage according to the medical and behavioral health needs of the member. The MCO ensure all members have equal access to health care coverage twenty-four (24) hours per day, seven (7) days per week. The MCO shall provide covered services under the Managed Care contract in the United States, including the District of Columbia, the Northern Mariana Islands, American Samoa, Guam, Puerto Rico, and the Virgin Islands. The MCO is prohibited from providing payments for items or services provided under the contract to any financial institution or entity located outside the United States. The MCO shall provide services according to the medical and behavioral health needs of the member.

Cultural Competency - 42 CFR 438.206(c)(2)

The MCO must ensure that all MCO members receive equitable and effective treatment in a culturally and linguistically appropriate manner. The MCO shall exhibit congruent behaviors, attitudes, and policies that come together in a system that enables effective work in cross-cultural situations. The MCO shall adhere to the following standards:

- The MCO shall ensure that members receive from all providers and staff effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- The MCO shall implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership that are representative of the demographic characteristics of the region.
- The MCO shall ensure that staff, at all levels and across all disciplines, receives ongoing education and training in culturally and linguistically appropriate service delivery.

- The MCO shall provide to members, in their preferred language, both verbal offers and written notices, when required, informing them of their right to receive language assistance services.
- The MCO shall make available easily-understood member-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the region.
- The MCO shall develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- The MCO shall ensure that data on the individual member's race, ethnicity, and spoken and written language are collected in health records, integrated into the MCO's management information systems, and periodically updated.
- The MCO shall maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the region.
- The MCO shall develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and member involvement in designing and implementing culturally and linguistically appropriate services in health care.
- The MCO shall ensure that the grievance and appeal resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural grievance and appeals by the member.
- The MCO shall regularly make information available to the public about the MCO's progress and successful innovations in implementing culturally and linguistically appropriate services and provide public notice in their communities about the availability of this information.

Adequate Capacity and Services - 42 CFR 438.207
Provider Networks - 42 CFR 438.207(a),(b)(1)-(2)

The MCO shall establish and maintain MCO provider networks in geographically accessible locations, in accordance with the travel distance standards specified herein. The MCO's network shall consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, substance abuse providers, dentists, emergent and non-emergent transportation services, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified herein. In order to maintain geographically accessible locations for members, the MCO shall look to providers in contiguous and other counties for full development of the network.

In order to ensure that members have access to a broad range of providers and to limit the potential for disenrollment due to lack of access to providers or services, the MCO shall not have a contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another MCO or in which the MCO represents or agrees that it will not contract with another provider. The MCO shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.

To ensure a broad range of treatment options are available, the MCO shall include in its network a mix of behavioral health and substance abuse providers with experience in treating children, adolescents, and adults.

The MCO shall include at least one Community Mental Health Center (CMHC) in the MCO provider network located in the contracted region. To the maximum extent possible, the MCO shall include additional CMHCs in its network.

The behavioral health provider network may include licensed psychiatrists, provisionally licensed psychologists, licensed psychologists, licensed psychiatric advance practice nurses, provisional licensed professional counselors, licensed professional counselors, licensed master social workers, licensed clinical social workers, licensed psychiatric clinical nurse specialists, licensed psychiatric mental health nurse practitioners, licensed home health psychiatric nurse, licensed psychiatric nurse, Missouri certified substance abuse counselors, and State certified behavioral health or substance abuse programs. To be considered adequate, the behavioral health provider network shall, at a minimum, include QBHPs, Qualified Substance Abuse Professionals (QSAP), licensed psychiatrists, licensed psychologists, licensed psychiatric nurses, licensed professional counselors, licensed clinical social workers, and licensed clinical nurse specialists.

The MCO shall regularly monitor its provider network to ensure that service accessibility standards described herein are being met, that provider listings of panel status (open and closed) are accurate, that members have and use their primary care providers (PCPs), and that emergency rooms are not being used unnecessarily. As part of the monitoring, the MCO shall, at a minimum, require that its providers report on the number of members they will take as patients or the limitations to the number of referrals accepted and report to the MCO when they have reached eighty-five percent (85%) of capacity. The MCO shall have and implement policies and procedures that describe its network development and monitoring activities, including methods for ensuring adequate capacity for members.

In accordance with State requirements specified at 20 CSR 400-7.095, the MCO shall file an annual (March 1 of each year) access plan with the Department of Insurance, Financial Institutions and Professional Registration that describes the adequacy of its provider network, measures to adhere to access standard requirements, and measures to address identified access issues.

Coordination and Continuity of Care - 42 CFR 438.208(b)(1)-(4),(c)(1)-(4)

The MCO shall have written policies and procedures for all its primary care provider activities. At a minimum, these policies and procedures shall provide for the linking of every member to a primary care provider; the monitoring of primary care providers to ensure they are performing their duties and operating in compliance with MCO policies and procedures; the use of specialists as primary care provider; follow up of visits, tests, and imaging and coordination of transitions of care; protection of members' privacy per HIPAA; and notifying primary care providers of their assigned member(s) prior to the member’s effective date with the primary care provider. MCOs

The MCO must offer its members freedom of choice in selecting a primary care provider. The MCO must decrease the number of members assigned to a primary care provider if necessary to maintain the appointment availability standards described herein. To the degree possible, the MCO should adjust the primary care provider's member assignments prospectively (before care has been initiated) and take steps to minimize the need for such adjustment to the primary care provider's member assignments.

The MCO is required to perform an assessment for case management within thirty (30) days of enrollment for new members with special health care needs including those with Autism Spectrum Disorder. Individuals with special health care needs are those individuals that without services such as private duty nursing, home health, durable medical equipment/supplies, and case management may require hospitalization or institutionalization.

The disease management program must include the development of treatment plans that serve as the outline for all of the activities and interventions in the program. At a minimum, the activities and interventions associated with the treatment plan shall address condition monitoring, member adherence to the treatment plan, consideration of other co-morbidities, and condition-related lifestyle issues.

The MCO is required to allow specialists to serve as primary care providers for members with disabling conditions or chronic conditions which require ongoing care from a specialist so long as the specialist agrees, in writing, to accept the member as a primary care patient.

The MCOs shall have direct access and standing referral policies and procedures that address how a member, including but not limited to those with special health care needs, may request and obtain:

- A referral to an out-of-network provider when the MCOs does not have a health care provider in the network with appropriate training or experience to meet the particular health care needs of the member;
- A standing referral from a specialist if the member has a condition which requires on-going care from a specialist; and
- Access to a specialty care center if the member has a life-threatening condition or disease either of which requires specialized medical care over a prolonged period of time.

Coverage and Authorization of Services - 42 CFR 438.210

The MCO is responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered [42 CFR 438.210(a)(3)(i)]. The MCO is required to provide medically necessary services to children from birth through age twenty (20), which are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified by an HCY/EPSDT screen. Services shall be furnished in the most appropriate setting. Services provided shall not be less in amount, duration, or scope than those services available to the State's fee-for-service members [42 CFR 438.210(a)(2)]. A detailed list of covered services, including the amount, duration, and scope of each service, is found in Attachment B [42 CFR 438.210(a)(1)].

The MCOs utilize evidence-based clinical practice guidelines that have been formally adopted by the MCOs' Quality Management/Quality Improvement (QM/QI) committee or other clinical committee to support the plan of care.

The state agency has established the following Clinical Practice Guidelines for the MCOs;

- For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, MCOs must use the same criteria as the MO HealthNet Fee-For-Service Program.
- For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, MCOs must use the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). If the member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, MCOs must continue to authorize inpatient care. In the event of disagreement, MCOs must provide full detail of its scoring of the LOCUS/CALOCUS to the provider of service.

The MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition [42 CFR 438.210(a)(3)(ii)]. Services may be limited by medical necessity [42 CFR 438.210(a)(3)(iii)]. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered [42 CFR 438.210(a)(4)].

In reference to medically necessary care, behavioral health services shall be provided in accordance with a process of behavioral health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of behavioral health assessment shall include distinct criteria for children and adolescents.

The MCO may manage specific services as long as the MCO provides services that are medically necessary. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The MCO may develop criteria by which it reviews future treatment options, sets prior authorization criteria, or exercises other administrative options for the MCO's administration of medical and behavioral health care benefits [42 CFR 438.210(b)(2)].

Prior Authorization Staff must be available to authorize services twenty-four (24) hours per day, seven (7) days per week. The MCOs is required to specify, in writing, the procedures for prior authorization of non-emergency services and the timeframes in which authorizations will be processed (approved or denied) and providers and members are notified. Prior Authorization Staff shall be directly supervised by a Missouri-licensed registered nurse, physician, or

physician's assistant. Prior authorization functions for behavioral health services shall be performed and/or supervised by a licensed Qualified Behavioral Health Professional.

Service Authorization Policies and Procedures - 42 CFR 438.210(b)(1)
The MCO must have and implement written utilization management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims that comply with Federal and State laws and regulations, as amended. The utilization management policies and procedures must be clearly specified in provider contracts or provider manuals and consistently applied in accordance with the established utilization management guidelines. As part of the MCO's utilization management function, the MCO shall also have processes to identify both over and under utilization problems for inpatient and outpatient services, undertake corrective action, and follow-up. This review must consider the expected utilization of services regarding the characteristics and health care needs of the member population. In addition, the MCO shall use an emergency room log, or equivalent method, to track emergency room services (e.g. daily emergency room report from targeted high volume facilities).

Service Denials - 42 CFR 438.210(b)(3),(d)(e)
The MCOs must ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease:

- An appeal of a denial that is based on lack of medical necessity.
- An appeal that involves clinical issues.

Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

Notice of Service Denial/Reduction - 42 CFR 438.210(c)
The MCOs must provide notice to requesting providers and members when the MCO denies or provides limited authorization of a requested service, including the type or level of service; reduces, suspends, or terminates a previously authorized service; denies, in whole or in part, of payment for a service; fails to provide services in a timely manner as defined in the appointment standards described in the Managed Care contract; or fails to act within timeframes for the MCO's prior authorization review process.

B. Structure and Operations Standards

MHD has established contractual standards and processes for evaluating the operational structure and procedures MCOs use for internal and external communication, monitoring and the provision of consultation and technical assistance as required by 42 CFR 438.207.

Provider Selection - 42 CFR 438.206, 42 CFR 438.214(a),(c)
The MCOs have and implement policies and procedures that describe its network development and monitoring activities, including methods for ensuring adequate capacity for members.

Structural operations also include the MCO's internal operational systems and processes for monitoring and communicating with the MHD and network providers. Contractual requirements include standards for provider selection, enrollee informing, confidentiality, enrollment disenrollment, grievance systems, and subcontracted and delegated relationships.

The health plan's provider selection policies and procedures cannot discriminate against particular providers that serve high risk populations or specialize in conditions that require costly treatment. This section may not be construed to:

- Require the health plan to contract with providers beyond the number necessary to meet the needs of its members;
- Preclude the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- Preclude the health plan from establishing measures that are designed to maintain quality of services, control costs, and are consistent with its responsibilities to members.

Provider Credentialing - 42 CFR 438.214(b)(1)-(2),(d),(e) (42 CFR 438.206(b)(6))
The MCOs are required to use the Universal Credentialing Data Source Form (UCDS), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180, as amended.

The MCOs have written credentialing and re-credentialing policies and procedures for determining and assuring that all in-network providers are licensed by the State in which they practice and are qualified to perform their services. The MCOs are required to have written policies and procedures for monitoring the in-network providers, reporting the results of the monitoring process, and disciplining in-network providers found to be out-of-compliance with the MCOs's medical management standards. The policies and procedures shall include the time frame in which the credentialing and re-credentialing must take place. The credentialing and re-credentialing process shall not take longer than one hundred eighty (180) days. The MCOs' provider selection policies and procedures cannot discriminate against particular providers that serve high risk populations or specialize in conditions that require costly treatment.

As part of credentialing and re-credentialing, the MCOs screen all health care service subcontractors to determine whether the subcontractor or any of its employees or subcontractors has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care program (as defined in Section 1128B(f) of the Act); has failed to renew license or certification registration; has revoked professional license or certification; or has been terminated by the state agency. The screening consists of, at a minimum, consulting the following databases on at least a monthly basis: the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) located online at https://www.epls.gov. The screening also consists of consulting the following additional databases, consistent with State and Federal requirements:

- National Plan and Provider Enumeration System (NPPES; https://nppes.cms.hhs.gov)
- Missouri Division of Professional Registration website (http://pr.mo.gov/)
- Other State or Federal required databases

The MCOs deny credentialing or re-credentialing to any subcontractor that falls within this section. In addition, the MCOs terminate the provider contract of any subcontractor for which a check reveals that the subcontractor falls within this section.

Enrollee Information - 42 CFR 438.218 (42 CFR 438.10)

The state agency operates a toll-free telephone line to make helpline operators available to all MO HealthNet Managed Care eligibles to provide assistance in selecting and enrolling into a MCOs. Helpline operators also will be available by telephone to assist MO HealthNet Managed Care eligibles who would like to change MCOs. The MCOs shall refer MO HealthNet Managed Care eligibles and members to the toll-free helpline when needed. The helpline operator responsibilities will include the following:

- Educating the eligible and family about Managed Care in general, including the requirement to enroll in a MCOs, the way services typically are accessed under Managed Care, the role of the primary care provider, the MCOs member's right to choose a primary care provider subject to the capacity of the provider, the responsibilities of the MCOs member, and the member's rights including the right to file grievances and appeals and to request a State fair hearing.
- Educating the eligible and family about benefits available through the MCOs, both in-network and out-of-network.
- Informing the eligible and family of available MCOs and outlining criteria that might be important when making a choice (e.g., presence or absence of existing provider(s) in the MCOs provider network).
- Identifying any sources of Third Party Liability that were not identified by the FSD eligibility specialist.
- Administering a health risk assessment screen when possible, as designated by the state agency that collects baseline health status data to be used as part of the MCOs' program evaluation. Any baseline health status data shall be made available to the MCOs.
- Inquiring and recording primary language information.
- Explaining options for obtaining services outside the MCOs network.
- Providing a listing of the MCOs primary care providers generated from the provider demographic electronic file submitted by the MCOs to the state agency.

Written Material Requirements

- The MCOs shall develop appropriate methods for communicating with visual and hearing impaired members and accommodating the physically disabled. The MCOs shall offer members standard materials, such as the member handbook and enrollment materials in alternative formats (i.e., large print, Braille, cassette, and diskette) immediately upon request from members with sensory impairments.
- If the MCOs have more than two hundred (200) members, or five (5) percent of its program membership (whichever is less), who speak a single language other than English as a primary language, the MCOs shall make available general services and materials, such as the MCOs's member handbook, in that language. The MCOs shall include, on all materials, language blocks in those languages that tell members that translated documents are available and how to obtain them.
- All written materials shall be worded such that the materials are understandable to a member who reads at the sixth (6th) grade reading level.

Confidentiality - 42 CFR 438.224

The MCOs agree and understand that all discussions with the MCOs and all information gained by the MCOs as a result of the MCOs' performance under the contract, including member information, medical records, data, and data elements established, collected, maintained, or used in the administration of the Managed Care contract must be confidential and that no reports, documentation, or material prepared as required by the contract are released to the public without the prior written consent of the state agency.

If required by the state agency, the MCOs and any required MCO personnel must sign specific documents regarding confidentiality, security, or other similar documents upon request. Failure of the MCOs and any required personnel to sign such documents shall be considered a breach of contract and subject to the cancellation provisions of this document.

The MCOs must provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.

The MCOs shall not disclose the contents of member information or records to anyone other than the state agency, the member or the member's legal guardian, or other parties with the member's written consent.

In complying with the requirements of this section, the MCOs and the state agency shall follow the requirements of 42 CFR Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance and 42 CFR Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.

The MCOs are required to have written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services.

Enrollment and Disenrollment - 42 CFR 438.226

The MCOs may request disenrollment of members, subject to the conditions described below:

- Member persistently refuses to follow prescribed treatments or comply with MCOs requirements that are consistent with Federal and State laws and regulations, as amended.
- Member consistently misses appointments without prior notification to the provider.
- Member fraudulently misuses the MO HealthNet Managed Care Program or demonstrates abusive or threatening conduct. Giving or loaning a member's membership card to another person, for the purpose of using services, constitutes a fraudulent action that may justify a MCOs's request to disenrollment the member.
- Member requests a home birth service.

The MCOs shall not initiate disenrollment:

- Because of a medical diagnosis or the health status of a member;
- Because of the member's attempt to exercise his or her rights under the grievance system;
- Because of pre-existing medical conditions or high cost medical bills or an anticipated need for health care; or
- Due to behaviors resulting from a physical or behavioral health condition.

Prior to requesting a disenrollment or transfer of a member, the MCOs shall document at least three (3) interventions over a period of ninety (90) calendar days which occurred through treatment, member education, coordination of services, and case management to resolve any difficulty leading to the request, unless the member has demonstrated abusive or threatening behavior in which case only one (1) attempt is required. The MCOs shall cite at least one (1) of the above examples of good cause before requesting that the state agency disenroll that member. If the MCOs intends to proceed with disenrollment during the ninety (90) calendar day period, the MCOs shall give a notice citing the appropriate reason to both the member and the state agency at least thirty (30) calendar days before the end of the ninety (90) calendar day period. The MCOs shall document all notifications regarding requests for disenrollment.

- Members shall have the right to challenge the MCOs' initiated disenrollment to both the state agency and the MCOs through the appeal process within ninety (90) calendar days of the MCOs' request to the state agency for disenrollment of the member. When a member files an appeal, the process must be completed prior to the MCOs and the state agency continuing disenrollment procedures.
- Within fifteen (15) working days of the final notification (after no appeal or a final hearing decision), members shall be enrolled in another MCOs or transferred to another provider.

Member Grievance Systems - 42 CFR 438.228

The MCOs are required by the MHD Managed Care contract to have a system in place for members which includes a grievance process (an expression of dissatisfaction), an appeal process (a request for review of a denial or limited authorization of a requested service), and access to MHD's State Fair Hearing Process.

The MCO is required to develop and implement written policies and procedures that detail the operation of the grievance system and provide simplified instructions on how to file a grievance or appeal and how to request a State fair hearing.
The policies and procedures must be approved by the state agency prior to implementation.
The policies and procedures shall be approved by the MCO's governing body and be the direct responsibility of the governing body.

- The policies and procedures shall identify specific individuals who have authority to administer the grievance system policies.
- The MCO shall distribute to members upon enrollment a flyer explaining the grievance system. This flyer shall contain specific instructions about how to contact the MCO's member services, and shall identify the person from the MCO who receives and processes grievances and appeals. This flyer can be distributed with the member handbook but it must be a stand-alone document. The grievance system flyer shall be readily available in the member's primary language. In addition, the MCO shall demonstrate that they have procedures in place to notify all members in their primary language of grievance dispositions and appeal resolutions.
- The MCO shall also distribute the information on the grievance system to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim whichever is earlier. This information may be distributed to providers via the member flyer, a flyer designed for providers, or the grievance system policies and procedures.

- As part of the grievance system, the MCO shall ensure that MCO executives with the authority to require corrective action are involved in the grievance and appeal processes.
- The MCO shall thoroughly investigate each grievance and appeal using applicable statutory, regulatory, and contractual provisions, and the MCO's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.
- The MCO shall probe inquiries so as to validate the possibility of any inquiry actually being a grievance or appeal. The MCO shall identify any inquiry pattern.
- The MCO's grievance system shall not be a substitute for the State fair hearing process. The state agency shall maintain an independent State fair hearing process as required by Federal law and regulation, as amended. The State fair hearing process shall provide members with an opportunity for a State fair hearing before an impartial hearing officer. The parties to the State fair hearing include the MCO, as well as the member, and his or her representative or the representative of a deceased member's estate. The MCO shall comply with decisions reached as a result of the State fair hearing process. MCO members shall have the right to request information regarding:
  - The right to request a State fair hearing;
  - The procedures for exercising the rights to appeal or request a State fair hearing;
  - Representing themselves or use legal counsel, a relative, a friend, or other spokesperson;
  - The specific regulations that support or the change in Federal or State law that requires, the action;
  - The individual's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted; and
  - A State fair hearing within ninety (90) calendar days from the MCO's notice of action.

The State must reach its decisions within the specified timeframes:

- Standard resolution: within ninety (90) calendar days of the date the member filed the appeal with the MCO if the member filed initially with the MCO (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
- Expedited resolution (if the appeal was heard first through the MCO appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that:
  - Meets the criteria for an expedited appeal process but was not resolved using the MCO's expedited appeal timeframes, or
  - Was resolved wholly or partially adversely to the member using the MCO's expedited appeal timeframes.
- Expedited resolution (if the appeal was made directly to the State fair hearing process without accessing the MCO appeal process): within three (3) working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

Subcontractual Relationships and Delegation - 42 CFR 438.228(a),(b)(1)-(4)

Any subcontracts for the products/services must include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by the MCO. All disputes between the MCO and any subcontractors, shall be solely between such

subcontractors and the MCO. The State of Missouri shall not be liable in any way for any disputes arising between MCOs and their subcontractors.

All subcontracts for health care services must be in writing and shall comply with all provisions of the contract. The subcontracts must contain a provision for revoking the subcontract agreement or imposing other sanctions if the subcontractor's performance is inadequate. In addition, all subcontractors shall comply with the applicable provisions of Federal and State laws and regulations, as amended, and policies.

The MCOs shall have policies and procedures to monitor the performance of health care service subcontractors to ensure that such subcontractors comply with the provisions of the contract. Before any delegation of any functions and responsibilities to any subcontractor, the MCOs shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. In addition, the MCOs shall fully investigate and timely respond to issues involving subcontractors upon request of the state agency.

C. Measurement and Improvement Standards

Clinical Practice Guidelines - 42 CFR 438.236(b)-(c)
The MCOs utilize evidence-based clinical practice guidelines that have been formally adopted by the MCOs' Quality Management/Quality Improvement (QM/QI) committee or other clinical committee to support the plan of care.

The state agency has established the following Clinical Practice Guidelines for the MCOs:

- For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, MCOs must use the same criteria as the MO HealthNet Fee-For-Service Program.
- For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, MCOs must use the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System (CALOCUS). If the member scores less than an inpatient level of care on the LOCUS/CALOCUS but the services recommended are not available, MCOs must continue to authorize inpatient care. In the event of disagreement, MCOs must provide full detail of its scoring of the LOCUS/CALOCUS to the provider of service.

Quality Assessment and Improvement Program - 42 CFR 438.240(a),(b)(2)-(4)
MCO contracts require an ongoing program for quality assessment and performance improvement of the services provided to enrollees as required in 42 CFR 438.240. Quality measurement and improvement standards include clinical practice guidelines, quality assessment and performance improvement program, and health information systems. The clinical practice guidelines used by MCOs and providers are nationally recognized and accepted, based on valid and reliable clinical evidence and applicable to the populations served within the Managed Care Program. Quality improvement projects are designed to achieve ongoing measurement and intervention, significant improvement sustained over time in clinical and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Quality metrics are identified by the state and are submitted annually (or more frequently as required) by

the plans. A list of current performance measures required of the MCOs is found in Attachment C.

The MCOs are required to have written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically analyzed and evaluated to detect both underutilization and overutilization of services, for impact and effectiveness, and to assess the quality and appropriateness of car furnished to enrollees with special health care needs.

Performance Improvement Projects - 42 CFR 438.240(b)(1)

The MCOs conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction.

MCOs are required by contract to have two active Performance Improvement Projects (PIPs) annually. The MCOs report the status and results of one clinical and one non-clinical PIP to the state agency which must include the state-wide PIP and the MCO designated performance improvement projects. The MCO's must also participate in a statewide PIP identified by the lead agency. The performance improvement projects:

- Measure performance using objective quality indicators.
- Implement the system interventions to achieve improvement in quality.
- Evaluate the effectiveness of the interventions.
- Plan and initiate activities for increasing or sustaining improvement.
- Complete the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

The MCOs develop and implement PIPs as a result of activities through their quality programs and report results to the State annually. The PIPs are used to monitor grievances, information to beneficiaries, coordination/continuity, and quality of care to ensure compliance with contractual requirements and delivery of quality health care services. A complete list of current MCO PIPs is found in Attachment D.

Annual Quality Assessment and Improvement (QA&I) Evaluation and Report - 42 CFR 438.240(e)

The MCOs are required to submit an annual quality assessment improvement evaluation and report in the format prescribed by the state agency. The report must contain information concerning the effectiveness and impact of the MCO's quality assessment and improvement strategy. The report must provide information that indicates that data is collected, analyzed, and reported, and health operations are in compliance with State, Federal, and MO HealthNet Managed Care contractual requirements. The report must incorporate multiple year outcomes and trends. The report must show that the MCO's QA&I program is ongoing, continuous, and based upon evaluation of past outcomes. The state agency periodically reviews and updates the format. The MCO is required to provide this report in the most up-to-date format and comply

with all changes as specified by the state agency. The state agency provides the health plan with no less than ninety (90) calendar days notice of any change in the format requested.

Utilization Management

MCOs must develop, implement, continuously update and improve their Utilization Management (UM) program to ensure that they consistently use appropriate processes to review and approve the provision of medically necessary covered services.

Responsibilities include ensuring qualified staff for the UM program; separation of medical decisions from fiscal and administrative management; and established criteria for approving, modifying, deferring or denying requested services. MCOs must have internal mechanisms to track and monitor prior authorization, timeliness of determination, and a process to integrate reports on review of number and types of appeals, denials, deferrals and modifications.

Health Information Systems - 42 CFR 438.242(a),(b)(1)-(2)

The MCOs are required to have information systems capable of collecting, analyzing, integrating, and submitting the required data and reports. The MCOs must collect data on enrollee and provider characteristics and on services furnished to enrollees and ensure the data is accurate and complete. The External Quality Review Organization (EQRO), Behavioral Health Concepts, Inc. (BHC), ensures the accuracy and validity of the quality data submitted to the State on an annual basis.

The MCO is required to adhere to the Health Insurance Portability and Accountability Act (HIPAA) national standards related to claims processing. These shall include, but not be limited to, electronic transactions standards, federally required safeguard requirements including signature requirements described in Section 112821.1 of the CMS State Medicaid Manual and 42 CFR 455.18 and 455.19, and RSMo 376.383 and 376.384.

In accordance with 42 CFR 438.242, the MCO is required to have a Claims Processing and Management Information System (MIS) capable of:

- Meeting the Managed Care Program requirements and maintaining satisfactory performance throughout the life of the contract.
- Transmitting and receiving data,
- Supporting provider payments,
- Compiling data reporting requirements
- Processing claims,
- Retrieving and integrating enrollment data,
- Assigning primary care providers,
- Maintaining provider network data, and
- Submitting encounter data.

The Claims Processing and MIS should be of sufficient capacity to expand as needed due to member enrollment or program changes. The MCO shall employ or have available, the resources necessary to make modifications to claims processing edits or expansion of MIS capabilities as a result of changes in Managed Care policies and/or procedures. The state agency

will make every effort to give the MCO sixty (60) calendar day notice of changes in the Managed Care Program that may require the MCO to make system changes in order to comply.

The MCO shall have in place an electronic claims management (ECM) capability that accepts and processes claims submitted electronically with the exception of claims that require written documentation to justify payment (e.g., hysterectomy/sterilization consent forms, certification for medical necessity for abortion, necessary operative reports, etc.). As part of this ECM function, the MCO shall also provide on-line and phone-based capabilities to obtain claims processing status information and support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

CyberAccess℠
Also in 2006, a contract with ACS Heritage for a Clinical Management Services and System for Pharmacy Claims and Prior Authorization (CMSP) was signed and is in effect until 6/30/2017. The contract includes the operation of an innovative electronic web-based clinical editing process for point-of-sale pharmacy and medical claims, medical and drug prior authorization, and Drug Utilization Review (DUR) processes.

The CMSP claim processing system allows each claim to be referenced against the recipient's claims history including pharmacy, medical (ICD-9 codes), and procedural data (CPT codes) transparently. For those patients that meet any of the approval criteria, the claim will be paid automatically. In instances when a phone call is necessary, the hotline call center is available seven days a week, which allows providers prompt access to a paid claim for the requested product. In addition to receiving messages regarding the outcome of the processing of claims and the amount to be reimbursed, pharmacy providers receive prospective drug use review alert messages for their information at the time the prescriptions are dispensed.

The MCO shall provide the state agency with information concerning uniform utilization, quality assessment and improvement, member satisfaction, complaint, grievance, and appeal, and fraud and abuse detection data on a regular basis. On a periodic basis, the MCO shall make available clinical outcome data in areas of concern to the state agency. The MCO shall cooperate with the state agency in carrying out data validation steps. The state agency provides report formats and variable definitions for the MCO to use in reporting operational data. Data elements and reporting requirements are outlined in the MCO contract.

IV. IMPROVEMENT AND INTERVENTIONS

A. Current Interventions

Interventions for improvement of quality activities are determined based upon review and analysis of results of each activity and ongoing assessment of the participants' health care needs.

Disease Management Programs
Disease Management (DM) is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions.

Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. It continuously evaluates clinical, humanistic and economic outcomes with the goal of improving overall health (NCQA, 2014). Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. It is similar to case management, but more focused on a defined set of programs relative to an illness or syndrome.[2] , including but not limited to asthma, obesity, diabetes, hypertension, congestive heart failure, COPD, Schizophrenia, Bipolar Disorder, PTSD, Recurrent Major Depression, and Substance Dependence Disorder with Alcohol and IV Drug use.

- MCOs shall perform all contractually required DM functions. MCOs may use a Section 2703 designated health home providers to perform disease management functions if the health home practice is a member of the health plan network. In the event of such, the health plan shall have processes in place to monitor service delivery and ensure that all contractual requirements are adequately performed.
- MCOs shall develop and maintain DM program policies and procedures that describe how the programs will incorporate all components listed above. These policies and procedures shall address how the DM programs will coordinate with case management activities, in particular for members who would benefit from both.
- MCOs shall submit the disease management program reports to the State as contractually required.

Performance Based on HCY/EPSDT Participant Ratio

In accordance with CMS guidelines, the state agency requires eighty percent (80%) of eligible members to have HCY/EPSDT well child visits and, accordingly, has included an eighty percent (80%) participant ratio in the rates paid to the MCO. In accordance with CMS 416 reporting methodology, the state agency shall measure MCO's performance regarding the percentage of eligible members having HCY/EPSDT well child visits (participant ratio). The state agency applies state specific criteria to the CMS methodology to reflect the Managed Care Program. The state specific criteria reflects performance by Category of Aid and rate cell, the measurement schedule, and recognition of a month to be greater than twenty-seven (27) days. The participant ratio is defined as the number of total eligibles receiving at least one initial or periodic well child visit divided by the number of total eligibles who should receive at least one initial or periodic well child visit.

In the event that the HCY/EPSDT participant ratio is not equal to eighty percent (80%) of eligible members having an HCY/EPSDT well child visit as calculated using the CMS 416 reporting methodology, the state agency shall with five (5) calendar days prior notice make a pro rata adjustment to the monthly capitation payment to the MCO for each percentage point above or below eighty percent (80%), but not to exceed one hundred percent (100%). This pro rata adjustment shall be based on the portion of the monthly capitation payment related to HCY/EPSDT well child visits and shall be applied to each rate cell in which well child visits are required.

[2] Center for Health Care Strategies, Inc., Princeton, New Jersey, "Case Management in Managed Care for People with Developmental Disabilities: Models, Costs and Outcomes, January, 1999".

National Committee for Quality Assurance (NCQA) Accreditation
Effective October 1, 2011, the Managed Care MCOs must be NCQA accredited, at a level of "accredited" or better, for the MO HealthNet product. The MCOs must maintain such accreditation thereafter and throughout the duration of the contract. The State of Missouri will require all future Managed Care contractors to be NCQA accredited.

Automatic Assignment into MCOs
The state agency employs an algorithm to assign to the MCO, on a prorated basis, any Managed Care eligibles that do not make a voluntary selection of an MCO during open enrollment. For randomly assigned eligibles, the algorithm assigns points for the MCO's performance on selected HEDIS measures and for the inclusion of additional FQHCs, RHCs, CMHCs, or acute care safety net hospitals in the MCO's network, in addition to the minimum contractually required.

Health Homes
Section 2703 of the Affordable Care Act passed in 2010 allowed states to amend their Medicaid State Plans to offer health home services for Medicaid recipients with certain chronic conditions and risk factors. Missouri submitted two such amendments that were approved - one to develop a behavioral health home initiative through community mental health centers, and the other to develop a primary care health home initiative using federally qualified health centers, rural health clinics and other hospital-based clinics.

Goals of Missouri's health home initiative include improved health status of individuals with asthma/chronic obstructive pulmonary disease, developmental disabilities, diabetes, heart disease, serious mental illness, and who use tobacco and have a BMI greater than 25; improved coordination of medical and mental health care; and cost savings through the reduction of avoidable emergency department visits, hospitalizations, and readmissions through intensive care coordination and management.

Health homes work toward achieving these goals through providing the following services to their participants:

- **Comprehensive care management** (including identification of high-risk individuals and use of client information to determine level of participation in care management services; treatment plan development, which will include client goals, preferences and optimal clinical outcomes; and monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines)
- **Care coordination** (implementation of the individualized treatment plan (with active client involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports, including referral and linkages to long term services and supports)
- **Health promotion** (providing health education specific to an individual’s chronic conditions, development of self-management plans with the individual, education regarding the importance of immunizations and screenings, child physical and emotional development, providing support for improving social networks and providing health promoting lifestyle interventions, including substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity)

- **Comprehensive transitional care** (including appropriate inpatient and emergency department follow-up)
- **Individual and family support services** (including advocating for individuals and families, assisting with obtaining and adhering to medications and other prescribed treatments. In addition, health team members are responsible for identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services)
- **Referral to and coordination with community and support services** (providing, for example, assistance for clients to obtain and maintain eligibility for healthcare including long term services and supports, disability benefits, housing, personal need and legal services)

B. Intermediate Sanctions - ***42 CFR 438.204(e)***

Reports and Deliverables
For each working day that a report or deliverable is late, incorrect, or deficient, the MCO shall be liable to the state agency for liquidated damages as specified in the Managed Care contract.

Remedies for Failure to Provide Covered Services or to Perform Administrative Services
In the event the state agency determines the MCO failed substantially to provide one or more medically necessary covered services as required in the Managed Care contract, the state agency shall direct the MCO to provide such service. If the MCO continues to refuse to provide the covered service(s), the state agency shall authorize the members to obtain the covered service from another source and shall notify the MCO in writing that the MCO shall be charged (at the state agency's discretion) either the actual amount of the cost of such service or $500 per occurrence. In such event, the charges to the MCO shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the MCO. With such deductions, the state agency shall provide a list of the members with respect to whom payments were deducted, the nature of the service(s) that the MCO failed to provide, and payments the state agency made or will make to provide the medically necessary covered services. Use of the remedy under this section shall not foreclose the state agency from imposing any other applicable remedy listed herein. The failure to provide a covered service timely (i.e., in accordance with the timeframes specified herein, or when not specified herein, with reasonable promptness) shall be considered a violation resulting in either the actual amount of the cost of the service or $500 per occurrence.

In the event of any failure by the MCO to provide any services under the contract (including both covered services and administrative services), the state agency may, in addition to any other applicable remedies listed herein, require the MCO to submit and follow a corrective action plan, in order to ensure that the MCO corrects the error or resumes providing the service.

Basis for Imposing Intermediate Sanctions
In addition to the above, the state agency may impose intermediate sanctions when a MCO acts or fails to act as specified below. Before imposing intermediate sanctions, the state agency shall

give the MCO timely written notice that identifies the violation and explains the basis and nature of the sanction. A MCO is subject to intermediate sanctions if it:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under the contract, to a member covered under the contract.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the MO HealthNet program.
- Acts to discriminate among members on the basis of their health status or need for health care services.
- Misrepresents or falsifies information that it furnishes to CMS or to the state agency.
- Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
- Fails to comply with the requirements for PIPs, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
- Distributes directly or indirectly through any agent or independent subcontractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.
- Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Types of Intermediate Sanctions

The types of intermediate sanctions that the state agency may impose upon the MCO include:

- Civil monetary penalties in the following specified amounts
- Appointment of temporary management for a MCO as provided in 42 CFR 438.706.
- Special Rules for Temporary Management

C. Health Information Technology - *42 CFR 438.204(f)*

Missouri participates in the CMS Medicaid EHR incentives payment program, making its first payments in July 2011. In the first full year of operation (State Fiscal Year 2012) the program paid $73 million to 1037 providers, including 981 professionals and 56 hospitals. To date for the second year of operation, the program has paid an additional $47 million to 1213 professionals and 42 hospitals, and is on target to pay out close to the same total amount as in the first year. Missouri consistently ranks 12th among participating states in the total amount of incentive payments made, including Medicare and Medicaid incentive payments.

Participation continues to grow in 2012, as reflected by additional professional and hospital applications for first year payments. While the total amount paid out is expected to remain constant, a larger number of payments is being processed. This reflects strong participation in year 2 and the smaller payment amounts for participation beyond the first year.

As the program evolves and more participants meet meaningful use requirements, MO HealthNet is exploring ways to leverage the reported measures, particularly the Clinical Quality Measures (CQMs), in its evaluation of CHIPRA and Health Home programs. Currently, selected CQMs are used to evaluate the effectiveness of the Health Home pilot sites. As the program matures and solutions evolve to potentially collect those measures at a patient level, MO HealthNet will consider the possibility of additional uses of the

V. DELIVERY SYSTEM REFORMS

Missouri is having active and ongoing conversations regarding other delivery system reforms.

VI. CONCLUSIONS AND OPPORTUNITIES

MO HealthNet QA&I Advisory Group
The MO HealthNet QA&I Advisory Group continues to exhibit a well-attended, well-balanced process of communication of State/Federal quality program expectations and interventions. Meetings are open to additional stakeholders on a meeting agenda-driven basis. Consistent participation by the EQRO has facilitated a more efficient and effective process of identifying quality program opportunities, recommendations for improvement and active engagement of the MCOs in responding to audit findings to reduce past historical backlogs across fiscal years. The QA&I tracking log continues to be an important and positive tool for keeping all partners focused on critical improvement initiatives as guided by the State and CMS and implementing quality strategies.

HEDIS and Behavioral Health Measures
Through the QA&I Advisory Group the MO HealthNet Division, MCOs, and other stakeholders continue to monitor and evaluate for improvement the HEDIS measures and behavioral health measures. Beginning in 2012, the Managed Care plans will receive a Microsoft Access database each year, updated with data from all the measures reported to MHD annually by the plans. The database has a user-friendly interface, and allows the plans to produce charts and graphs showing trends for selected measures across time, and allowing comparisons between different measures within and even between plans. The list of measures can be sorted by overall ranking as well as overall gain between designated years. The MCOs can easily use this tool to spot trends in their performance that merit extra attention, and identify areas where they are performing more poorly than competing MCOs. Data provided in the database is easily exported by the MCO for further analyses in their own system, if they wish.

Partnerships with Other State Agencies, Public Stakeholders, and Consumers
A major area of strength has been the ongoing partnerships with the Department of Mental Health to improve health outcomes for those accessing behavioral health services and with the Department of Health and Senior Services to improve the health outcomes for the Maternal and Child population. Additionally, we solicit input through our CAC and other public meetings and continually monitor this feedback for opportunities for improvement.

Reviews of the MCO Behavioral Health Programs
MHD and DMH staff work together to perform the annual evaluation of each MCO's behavioral health operations regarding quality and utilization management. These reviews have proven to be valuable in determining opportunities for improvement.

Quality Grant

In December 2012, MHD was awarded an Adult Quality Grant from CMS. The purpose of this grant is to support States' efforts improve the quality of care for adults covered by Medicaid, specifically by enhancing capacity to collect and report on the Initial Core Set Measures for adults. As a recipient of an Adult Quality Grant, MHD is required to implement a grant project with the following three aims:

- Testing and evaluating methods for collection and reporting of the Initial Core Set Measures in varying delivery care settings (e.g. managed care, fee-for service, long term care settings such as nursing homes and intermediate care facilities).
- Developing staff capacity to report the data, analyze, and use the data for monitoring and improving access and the quality of care in Medicaid; and
- Conducting at least two Medicaid quality improvement projects related to the Initial Core Set Measures.

The measures selected for reporting have been described elsewhere in this document, and data will be collected and examined for MCOs as well as for MHD's fee-for-service population. While the MCOs report on some of the same measures as those selected for this grant, their methodology is typically the "hybrid" methodology, which involves using medical records as well as administrative data. MHD is not able to use medical records in their calculations, so all data for the grant, including managed care encounter claims, will be analyzed using the "administrative" methodology, in order that comparisons can be made across the entirety of the MHD Program.

The quality improvement projects selected for the grant will focus on improving medication adherence for persons diagnosed with depression who are newly receiving antidepressant medication, and on improving rates of tobacco use cessation in MHDs members.

MHD maintains a collaborative process to collegially work with the MCOs and other stakeholders to improve care. Goals, objectives, strategies, and initiatives identified throughout this document have been implemented with an emphasis on ensuring quality health care services are provided to the Managed Care members and that the MCOs are in compliance with Federal, State, and contract requirements

MHD is focused on continuous quality improvement through the collaboration with its partners and stakeholders supporting the mission of the Department of Social Services (DSS) to maintain or improve the quality of life for the people in the State of Missouri by providing the best possible services to the public, with respect, responsiveness, and accountability which will enable individuals and families to better fulfill their potential.

ATTACHMENTS

Attachment A: Waiver Programs

Waiver Program	*Program Description*	*Program Administrator*
Adult Daycare	This program offers daycare services to individuals aged 18-63 who have been assessed to certain impairments and unmet needs to the extent that they would require nursing home care in the absence of these services.	The Department of Health and Senior Services, Division of Senior and Disability Services administers this program.
Aged and Disabled	This program offers in-home services to individuals aged 63 or over who have been assessed to certain impairments and unmet needs to the extent that they would require nursing home care in the absence of these services. The services available include homemaker/chore, respite, home delivered meals, and adult day care.	The Department of Health and Senior Services, Division of Senior and Disability Services administers this program.
AIDS	This program provides in-home services to participants diagnosed by a physician as having AIDS or an HIV-related illness and is assessed as meeting a nursing home level of care. The services available include personal care, private duty nursing, attendant care, and supplies.	The Department of Health and Senior Services, Bureau of HIV, STD, and Hepatitis administers this program.
Independent Living	This program is similar to the Consumer-Directed State Plan Personal Care program, requiring the same eligibility criteria be met and offering additional personal assistance services beyond the limitations of the state plan. Additional services available include environmental accessibility adaptations, specialized medical equipment and supplies, and case management.	The Department of Health and Senior Services, Division of Senior and Disability Services administers this program.
Developmental Disabilities Comprehensive	This program offers services to individuals who have mental retardation and/or a developmental disability, who would, except for receipt of services through this program, require placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The services available through this program include residential and day habilitation, individualized support living, behavioral/physical/occupational/speech therapy, in and out of home respite, personal assistant, community specialist, counseling and crisis intervention, communication skills instruction, supported employment, transportation, environmental accessibility adaptations, specialized medical equipment and supplies, and support broker services.	The Department of Mental Health, Division of Developmental Disabilities administers this program.
Missouri Children with Developmental Disabilities	Also known as the Sarah Lopez Waiver was implemented October 1, 1995. The waiver grants Medicaid eligibility to those children who would be determined eligible for MO HealthNet if they were to reside in an institution, but whose families have chosen to have the child remain home. The MOCDD waiver permits the state to view only the child's income when making the eligibility determination. Services provided through the MOCDD waiver mirror those provided through the DD waiver with the exception of residential services.	The Department of Mental Health, Division of Developmental Disabilities administers this program.
Developmental Disabilities Community Support	This waiver is targeted to individuals who have a place to live in the community and receive substantial unpaid support from family members. The eligibility criteria and services available through this program are identical to the DD waiver program with the exception of residential habilitation and individualized supported living. The Department of Mental Health, Division of Developmental Disabilities administers this program.	The Department of Mental Health, Division of Developmental Disabilities administers this program.
Autism	This waiver was implemented July 1, 2009. The Autism Waiver provides services and supports to children, ages 3 through 18, with autism spectrum disorders to enable them to remain at home with their families. Services included in the Autism Waiver are: assistive technology, behavioral analysis services, community specialist services, environmental accessibility adaptations, person centered strategies consultation, personal assistant, professional assessment and monitoring, in and out-of-home respite, specialized medical equipment and supplies, support broker service and transportation. The Department of Mental Health, Division of Developmental Disabilities administers this program.	The Department of Mental Health, Division of Developmental Disabilities administers this program.
Partnership for Hope	The Partnership for Hope Waiver was implemented October 1, 2010. The purpose of this waiver is to prevent or delay institutional services for individuals who require minimal services in order to continue living in the community. This waiver is operated in 94 Missouri counties and includes: assistive technology, behavior analysis service, community employment, community specialist services, day service, dental, employer provided job supports, environmental accessibility adaptations, job discovery, job preparation, occupational, physical and speech therapy, personal assistant, positive behavior support, professional assessment and monitoring, specialized medical equipment and supplies, support broker services, temporary residential services, and transportation. The Department of Mental Health, Division of Developmental Disabilities administers this program.	The Department of Mental Health, Division of Developmental Disabilities administers this program.
Managed Care	Ø ***Managed Care (1915(b)) Waiver:*** Provides health care services for MO HealthNet beneficiaries through a Managed Care delivery system. All MO HealthNet beneficiaries are required to enroll in Managed Care except individuals who are in the Managed Care Program either because they receive SSI disability payments, they meet the SSI disability definition as determined by the Department of Social Services, or they receive adoption subsidy benefits. These individuals have the option of choosing to receive health care services on a fee-for-service basis or through the Managed Care program. The option is entirely up to the individual, parent, or guardian. Those individuals not residing in a Managed Care county receive their health care services on a fee-for-service basis.	
Women's Health Services Program	***(1115 Demonstration Waiver):*** Missouri's Women's Health Services Program expands the provisions of family planning and family planning-related services to uninsured women who are 18 through 55 years of age and losing their MO HealthNet eligibility 60 days after the birth of their child. These women are eligible for women's health services for a maximum of one year after their MO HealthNet eligibility expires. MO HealthNet also offers the Women's Health Services Program to uninsured women, ages 18 through 55, whose family income is at or below 185 percent of the Federal Poverty Level and assets total less than $250,000. There is no cost sharing for this coverage and services are obtained through the MO HealthNet Fee-For-Service program.	

Attachment A: Waiver Programs

Waiver Program	*Program Description*	*Program Administrator*
Medically Fragile Adult	Also known as the Physical Disabilities Waiver. Was implemented July 1, 1998. This program offers services to individuals who have serious and complex medical needs and are no longer eligible for services under the Healthy Children and Youth program. To be eligible, an individual must be age 21 or older and assessed as requiring placement in an ICF/MR absent these services. The services available include attendant care, private duty nursing and specialized medical equipment/supplies.	The Department of Health and Senior Services, Bureau of Special Health Care Needs administers this program.
Gateway to Better Health	***(1115 Demonstration Waiver):*** On February 16, 2010, the Missouri Department of Social Services, MO HealthNet Division, in partnership with the St. Louis Regional Health Commission, submitted a Section 1115 demonstration waiver to the Centers for Medicare and Medicaid Services. On July 28, 2010, the waiver was approved by CMS. The waiver provided the opportunity to transition from a direct payment model to a pilot coverage model by July 1, 2012. The pilot program is designed to provide primary, urgent, and specialty care coverage to uninsured adults in St. Louis City and St. Louis County, aged 19-64, who are below 133% of the Federal Poverty Level (FPL) through a coverage model known as Gateway to Better Health Blue. Additionally, individuals otherwise meeting the same requirements but with income up to 200% of the FPL may be enrolled into Gateway to Better Health Silver coverage, which includes urgent and specialty care services but excludes the primary care benefit. The goal of the project is to preserve and improve primary and specialty care access for uninsured residents of St. Louis city and county until access is assured through a more comprehensive coverage model. The State of Missouri is considering requesting a three-year extension of the Gateway to Better Health Demonstration, which is scheduled to expire on December 31, 2013.	

2.7 Comprehensive Benefit Package:

2.7.1 The health plan shall provide all covered medical and behavioral health services in the comprehensive benefit package for each member as of the effective date of coverage. The health plan shall provide covered services under this contract in the United States, including the District of Columbia, the Northern Mariana Islands, American Samoa, Guam, Puaerto Rico, and the Virgin Islands. The health plan is prohibited from providing payments for items or services provided under the contract to any financial institution or entity located outside the United States. The health plan shall provide services according to the medical and behavioral health needs of the member.

2.7.2 The health plan's services shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (45 CFR 146), which requires parity between mental health or substance abuse use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

2.7.3 The health plan may manage specific services as long as the health plan provides services that are medically necessary. The health plan shall have a process for allowing exceptions that are in accordance with 13 CSR 70-2.100. The health plan may develop criteria by which it reviews future treatment options, sets prior authorization criteria, or exercises other administrative options for the health plan's administration of medical and behavioral health care benefits. The health plan may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The health plan shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The health plan shall follow the requirements outlined in the policy statements found in Attachment 3.

2.7.4 **Preventable Serious Adverse Events Performed by Providers:** Services falling in a preventable serious adverse event category shall be denied MO HealthNet reimbursement. The state agency will be following CMS guidelines regarding preventable serious adverse events. A member shall not be liable for payment for any item or service related to a preventable serious adverse event.

2.7.5 The health plan shall include the following services within the comprehensive benefit package:

a. Ambulatory surgical center, birthing center;

b. Behavioral health and substance abuse services:

1) For children covered under MO HealthNet Managed Care within Category of Aid 4 and with dual diagnoses (physical and behavioral/substance use-related), the health plan shall be financially responsible for all inpatient hospital days if the primary, secondary, or tertiary diagnosis is a combination of physical and behavioral/substance use-related health. These admissions are subject to the prior authorization and concurrent review process identified by the health plan. The health plan shall not be responsible for all other behavioral health and substance abuse services for children within Category of Aid 4.

2) For all other members, the health plan shall provide all medically necessary behavioral health and substance abuse services included in the comprehensive benefit package. The state agency, in conjunction with the Department of Mental Health, has developed community-based services with an emphasis on the least restrictive setting. The health plan shall consider, when appropriate, using such services in lieu of using an out-of-home placement setting for members. Services which the health plan shall provide shall include, but not be limited to:

- Inpatient hospitalization, when provided by an acute hospital, or private or state psychiatric hospital.
- Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, provisional licensed clinical social worker, licensed counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, or State certified behavioral health or substance abuse program. These services must include outreach efforts on an as needed basis that recognize the unique behavioral health challenges of some members. These efforts may include phone contacts and home visits.
- Crisis intervention/access services, including but not limited to (1) intake, evaluation, and referral services, including services that are alternatives to out of the home placements, and (2) mobile crisis teams for on-site interventions.
- Alternative services which are reasonable, cost effective, and related to the member's treatment plan.
- Referral for screening to receive case management services.

3) With the member's or the member's parent/guardian's consent, the health plan shall notify the member's primary care provider when a member is admitted for behavioral health or substance abuse services.

4) The health plan shall have and implement protocols for coordinating the diagnosis, treatment, and care between primary care providers, behavioral health and substance abuse providers, and assigned case managers. These protocols shall include the expected response time for consults between primary care providers and behavioral health and substance abuse providers.

5) The health plan shall provide behavioral health and substance abuse services defined herein that are court ordered, ninety-six (96) hour detentions, and for involuntary commitments.

6) Behavioral Health Out-of-Network Referrals: If the health plan believes that a child or youth may require residential services in order to receive appropriate care and treatment for a serious emotional disorder, the health plan may apply to the Missouri Division of Comprehensive Psychiatric Services (CPS) for placement in accordance with the state agency's Managed Care policy statement entitled, *Behavioral Health and Substance Abuse Fee-For-Service*.

c. Dental services related to trauma to the mouth, jaw, teeth, or other contiguous sites as a result of injury, and dental services when the absence of dental treatment would adversely affect a pre-existing medical condition.

d. Durable medical equipment including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, diabetic supplies and equipment, and medically necessary equipment and supplies used in connection with physical, occupational, and speech therapies for all members with an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP).

e. **Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)**: The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid cover all medically necessary services listed in Section 1905 (a) of the Act to children from birth through age twenty (20). In Missouri, this program is known as the Healthy Children and Youth (HCY) Program. In accordance with the health plan's written policies and procedures, the health plan shall conduct outreach and education of children eligible for the HCY/EPSDT program, provide the full HCY/EPSDT services to all eligible children and young adults under the age of twenty-one (21), and conduct and document well child visits (screenings) using the State HCY/EPSDT screening form as amended. (The HCY screening form may be found on the Internet at: http://manuals.momed.com/ under MO HealthNet Manuals, Forms, Healthy Children and Youth Screening [HCY Screening].) The health plan shall provide the full scope of HCY/EPSDT services in accordance with the following:

1) The health plan shall ensure HCY/EPSDT well child visits are conducted on all eligible members under the age of twenty-one (21) to identify health and developmental problems. The state agency recognizes that the decision to not have a child screened is the right of the parent or guardian of the child. The health plan shall follow the state agency's Fee-For-Service policies for recognition of completion of all components of a full medical HCY/EPSDT well child visit service. A full HCY/EPSDT well child visits includes all of the components listed below. Segments of the full medical screen (partial screens) may be provided by different providers. An interperiodic screen is defined as any encounter with a health care professional acting within his or her scope of practice.

   - A comprehensive health and developmental history including assessment of both physical and behavioral health developments;
   - A comprehensive unclothed physical exam;
   - Health education (including anticipatory guidance);
   - Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
   - Appropriate immunizations according to age;
   - Annual verbal lead assessment beginning at age six (6) months and continuing through age seventy-two (72) months;
   - Blood level testing is mandatory at twelve (12) and twenty-four (24) months or annually if residing in a high-risk area of Missouri as defined by Department of Health and Senior Services regulation 19 CSR 20-8.030;
   - Hearing screening;
   - Vision screening; and
   - Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommended that preventive dental services begin at age six (6) through twelve (12) months and be repeated every six (6) months.

2) If a suspected problem is detected during a well child visit, the child must be evaluated as necessary, using the required assessment protocol, for further diagnosis. This diagnosis is used to determine treatment needs.

3) HCY/EPSDT requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate (defined as "prevent from worsening") defects, physical and behavioral health issues, and conditions discovered by the screening services or correct a problem discovered during an HCY/EPSDT visit. All medically necessary diagnosis and treatment services must be provided as long as they are permitted under the Medicaid statute, whether or not they are covered under the State's Medicaid plan, and without any regard to any restrictions the State may impose on services for adults.

4) The health plan shall establish a tracking system that provides information on compliance with HCY/EPSDT service provision requirements in the following areas:

   - Initial visit for newborns. The initial HCY/EPSDT well child visits shall be the newborn physical exam in the hospital.
   - Preventive pediatric visits according to the periodicity schedule inclusive of a verbal lead assessment and blood lead tests.
   - Diagnosis and/or treatment, or other referrals in accordance with HCY/EPSDT well child visit results.
   - The health plan shall ensure that the tracking system generates information consistent with the requirements regarding encounter data as specified elsewhere herein.

5) The health plan shall have an established process for reminders, follow-ups, and outreach to members. This process shall include, but not be limited to, notifying the parent(s) or guardian(s) of children of the needs and scheduling of periodic well child visits according to the

periodicity schedule. The health plan shall contact new members within thirty (30) calendar days of health plan enrollment to provide assistance in accessing HCY/EPSDT well child visit services. The health plan shall provide assistance to members in accessing subsequent HCY/EPSDT well child visits in accordance with the periodicity schedule. At the time of notification, the health plan shall offer transportation and scheduling assistance if necessary. For members with ME Codes 73 through 75, non-emergency medical transportation is not a covered benefit.

6) The health plan shall provide written notification to its families with eligible children when appropriate well child visits are due. The health plan shall follow-up with families that have failed to access well child visits after one hundred and twenty (120) calendar days of when the well child visit was due. The health plan shall provide to each PCP, on a monthly basis, a list of the eligible children who are not in compliance with the periodicity schedule.

7) For those children who have not had well child visits in accordance with the periodicity schedule established by the state agency, the health plan shall document its outreach and educational efforts to the parent or guardian informing them of: the importance of well child visits; that a well child visit is due; how and where to access services including necessary transportation (except to those children with ME Codes 73 through 75) and scheduling services; and a statement that service are provided without cost.

8) The health plan shall seek innovative, cooperative ways to enhance care coordination and delivery of HCY/EPSDT. This may include the use of a standardized data base system among health plans.

9) The health plan shall report HCY/EPSDT well child visits through encounter data submissions in accordance with the requirements regarding encounter data as specified elsewhere herein. The state agency shall use such encounter data submissions and other data sources to determine health plan compliance with CMS requirements that eighty percent (80%) of eligible members under the age of twenty-one (21) are receiving HCY/EPSDT well child visits in accordance with the periodicity schedule. The state agency shall use the participant ratio as calculated using the CMS 416 methodology for measuring the health plan's performance.

- The health plan shall report HCY/EPSDT well child visits in accordance with the appropriate well child visits codes established by the state agency. HCY/EPSDT screening codes are identified in the state agency's Managed Care Policy Statements. Services not reported as HCY/EPSDT well child visits in accordance with the appropriate codes will not be counted toward the health plan's participant ratio.
- In the event the state agency uses other data sources submitted by the health plan, the health plan shall certify the data provided. The data must be certified by one of the following:
  - The health plan's Chief Executive Officer;
  - The health plan's Chief Financial Officer; or
  - An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
- The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the data.
- The health plan shall submit the certification concurrently with the data.

10) The health plan shall submit its HCY/EPSDT policies and procedures to the state agency for review and approval.

f. **Emergency Medical, Behavioral Health, and Substance Abuse Services, and Post-stabilization Care** Services:

1) Emergency medical, behavioral health, or substance abuse services means covered inpatient and outpatient services that are (1) furnished by a provider qualified to furnish these services and (2)

needed to evaluate or stabilize an emergency medical condition. An emergency medical condition means a medical, behavioral health, or substance use-related condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.

2) The health plan shall not limit what constitutes an emergency medical condition as defined herein on the basis of lists of diagnoses or symptoms.

3) Post-stabilization care services means covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.

g. **Family Planning Services**: The health plan shall be financially liable for payment to providers, whether in-network or out-of-network, in accordance with Federal freedom of choice provisions.

h. **Home Health Services**;

i. **Hospice Services**: Hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made.

j. **Inpatient Hospital Services**;

k. **Laboratory, Radiology, and Other Diagnostic Services**;

l. **Local Public Health Agencies Services**: The health plan is responsible for the following services provided by in-network providers and at local public health agencies whether in-network or out-of-network:

1) Sexually Transmitted Disease Services: All sexually transmitted disease (STD) services including screening, diagnosis, and treatment. In-network providers shall follow current Centers for Disease Control and Prevention (CDC) Sexually Transmitted Diseases Treatment Guidelines. The STD guidelines may be found on the Internet at: http://cdc.gov/std/treatment/ STD screening, diagnosis, and treatment services shall include:

- STD screening exam.
- Screening, diagnosis, and treatment for the following STDs: gonorrhea, syphilis, chancroid, granuloma inguinale, lymphogranuloma venereum, genital herpes, genital warts, trichomoniasis, chlamydia (cervicitis), chlamydia (urethritis), hepatitis B, and others as may be designated by the state agency.
- Screening, diagnosis, and treatment of vaginal or urethral discharge including non-gonococcal urethritis and mucopurulent cervicitis.
- Evaluation and initiation of treatment of pelvic inflammatory disease (PID).

- Diagnosis and preventive treatment of members who are reported as contacts/sex partners of any person diagnosed with a STD. The member shall be given the option of seeing an in-network provider first.
- The local public health agency shall encourage members to follow-up with their primary care provider; however, if the member chooses follow-up care at the local public health agency for confidentiality reasons, the health plan shall reimburse the local public health agency for follow-up office visits (not to exceed three (3) visits per episode).

2) Human Immunodeficiency Virus (HIV) Services: Human immunodeficiency virus (HIV) services relating to screening and diagnostic studies. In-network providers shall use The Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health –Care Settings. The HIV guidelines may be found on the Internet at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm.

3) Tuberculosis Services: Tuberculosis services include screening, diagnosis, and treatment. In-network providers shall follow current American Thoracic Society/CDC/Infectious Diseases Society of America Guidelines: Treatment of Tuberculosis MMWR 2003; 52 (No. RR-11), including the use of Mantoux PPD skin test or FDA-approved Interferon Gamma Release Assays (IGRAs) to screen for Tuberculosis. The Tuberculosis guidelines may be found on the Internet at: http://cdc.gov/mmwr/preview/mmwrhtml/rr5211a1.htm.

- All members diagnosed with tuberculosis infection or tuberculosis disease shall be reported to the local public health agency.
- All members receiving treatment for tuberculosis disease shall be referred to the local public health agency's tuberculosis contact person for directly observed therapy (DOT). The health plan shall communicate with the local public health agency's tuberculosis contact person to obtain information regarding the member's health status. The health plan shall communicate this information to the in-network provider. The health plan shall be responsible for care coordination and medically necessary follow-up treatment.
- All laboratory tests for tuberculosis shall meet the standards established by the CDC and the Missouri Department of Health and Senior Services. Sensitivity tests shall be performed on all initial specimens positive for M. Tuberculosis. The Department of Health and Senior Services encourage all sputum specimens to be submitted to the Department of Health and Senior Services' Tuberculosis Reference Laboratory at the Missouri Rehabilitation Center. Positive cultures for M Tuberculosis isolated at private laboratories must be sent to the TB Reference Laboratory (Required by Missouri Rule 19 CSR 20-20.080).

4) Childhood Immunizations: The health plan shall ensure that in-network providers fully immunize their members according to the most recent immunization recommendations designated by the state agency. The state agency shall provide the health plan's Medical Director with copies of the most recent recommendations upon contract award, upon request, and when the recommendations change.

- The health plan and its in-network providers shall enroll and obtain vaccines through the Missouri Department of Health and Senior Services Vaccines for Children (VFC) Program or any such vaccine supply program as designated by the state agency. Any time a member receives immunizations from a local public health agency, or at a Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) site, the health plan shall reimburse only the cost for administration at the current MO HealthNet program rates in effect at the time of the service, unless otherwise negotiated. Members with ME codes 73 through 75 are not eligible to receive vaccines through the VFC Program.
- The health plan shall reimburse governmental public health agencies for the cost of both administration and vaccines not available through the VFC program or vaccine supply program as designated by the state agency when the vaccine is deemed medically necessary.

- The health plan shall collaborate with the state agency and the Missouri Department of Health and Senior Services to determine the health plan's aggregate immunization level. The Missouri Department of Health and Senior Services, Immunization Program will offer consultation to the health plan to foster the exchange of immunization information, and to in-network providers for purposes of assessment, reminder/recall, and reporting.
- The health plan shall establish, as a quality assessment and improvement measure, a target rate of ninety percent (90%) for the number of two (2) year olds immunized.

5) Childhood lead poisoning prevention services shall include screening, diagnosis, treatment, and follow-up as indicated. In-network providers shall follow the CMS guidelines in effect for the specific time period and CDC guidelines: Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels Among Young Children. The Department of Health and Senior Services shall provide the health plan's Medical Director with copies of current protocols and guidelines upon contract award or at any time upon request. If there is a discrepancy between guidelines, the state agency requires use of the HCY/EPSDT Lead Risk Assessment Guide developed in accordance with CMS guidelines. The HCY/EPSDT Lead Risk Assessment Guide may be used separately or in conjunction with the HCY Screening form.

m. **Maternity Benefits for Inpatient Hospital and Certified Nurse Midwife**:

1) The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo, as amended.

2) The health plan may authorize a shorter length of hospital stay for services related to maternity and newborn care if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with Federal and State law, as amended. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization, and is documented in the member’s medical record.

3) The health plan shall provide coverage for post-discharge care to the mother and her newborn. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the State laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care", or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use.

n. Optical services include one (1) comprehensive or one(1) limited eye examination every two (2) years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), and one (1) pair eyeglasses every two (2) years (during any twenty-four (24) month period of time);

o. **Outpatient Hospital Services**;

p. **Personal Care Services**;

q. **Physician, Advanced Practice Nurse, and Certified Nurse Midwife Services**:

1) The health plan shall provide certified nurse midwife services that are medically appropriate either in- network or out-of network at the health plan's expense.

2) If the member elects a home birth, the health plan shall notify the state agency so that the member can be disenrolled from MO HealthNet Managed Care and enrolled in the MO HealthNet Fee-For-Service program.

r. Podiatry services with the exception of trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one (1) to five (5); debridement of nail(s) by any method(s), six (6) or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot;

s. **Transplant Related Services**: The health plan shall permit and authorize and shall be financially responsible for any inpatient, outpatient, physician, and related support services including presurgery assessment/evaluation prior to the date of the actual bone marrow/stem cell or solid organ transplant surgery. The bone marrow/stem cell or solid organ transplant will be prior authorized by the state agency and must be performed at a state agency's approved transplant facility in accordance with the MO HealthNet member's freedom of choice. The health plan shall be responsible for pre-transplant and post-transplant follow-up care. To ensure continuity of care, the health plan shall permit and authorize follow-up services and the health plan shall be responsible for the reimbursement of such services. The primary care provider shall be allowed to refer a transplant patient to the performing transplant facility for follow-up transplant care. The health plan shall reimburse out-of-network providers of transplant support services no less than the current MO HealthNet program rates in effect at the time of the services.

u. **Transportation Services**:

1) The health plan shall provide emergency transportation (ground and air) for its members.

2) The health plan shall provide non-emergency medical transportation to members except for children in ME Codes 73 - 75 (Refer to Attachment 1, Category of Aid 5) and children in State custody with the following ME Codes 08, 52, 57, and 64 (Refer to Attachment 1, Category of Aid 4) who do not have the ability to provide their own transportation (such as their own vehicle, friends, or relatives) to and from services required herein as well as to and from MO HealthNet Fee For Service covered services not included in the comprehensive benefit package.

2.7.5 **Cancer Screenings:** In accordance with State law, the health plan shall notify all members on an annual basis, in writing, of cancer screenings covered by the health plan and provide the current American Cancer Society guidelines for all cancer screenings.

2.7.6 **Additional Services:** In addition to the services listed in the comprehensive benefit package, herein, the health plan shall provide the following services to children under twenty-one (21) years of age and pregnant women with ME codes 18, 43, 44, 45, and 61.

a. Comprehensive Day Rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury)

b. Dental Services – All preventative, diagnostic, and treatment services as outlined in the Medicaid State Plan

c. Diabetes self management training for persons with gestational, Type I, or Type II diabetes

d. Hearing aids and related services

e. Optical services to include one (1) comprehensive or one (1) limited eye examination per year for refractive error, one (1) pair of eyeglasses per year, and, for children under age twenty-one (21), HCY/EPSDT optical screen and services

f. Podiatry services.

g. Services that are included in the comprehensive benefit package, medically necessary, and identified in the IFSP or IEP (except for physical therapy, occupational therapy, speech therapy, hearing aid, personal care, private duty nursing, or psychology/counseling services)

h. Therapy services (physical, occupational, and speech) that are not identified in an IEP or IFSP. This includes maintenance, developmental, and all other therapies.

2.7.7 **Services for Children in the Custody of the Jackson County Office of the Missouri Children's Division:** Children in the custody of the Jackson County office of the Missouri Children's Division (CD) and residing in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, or St. Clair counties receive additional medical care services.

a. In addition to the services outlined herein, the health plan shall provide the following services following the effective date of enrollment with the health plan. If the child is already enrolled with the health plan and enters custody, the health plan shall provide the following services from the time the child enters CD custody. The timeframes for these examinations begin with the time and date the child enters CD custody.

1) An initial physical examination is due the next working day following entry into custody. (This initial physical examination shall be paid by the state agency on a fee-for-service basis and arranged by CD if the child is not enrolled in a health plan at the time of the initial physical examination.) In all cases, if a child is enrolled with the health plan, the health plan shall be responsible for payment of the initial physical examination. CD, the Medical Case Management Agency, and the health plan shall work together to establish a notification process so that the health plan receives notification of the enrollment of a covered child who is under the jurisdiction of the court in Jackson County in a timely manner.

2) Follow-up examinations recommended by the provider during the initial physical examination; shall be done within thirty (30) calendar days.

b. The health plan shall follow the periodicity schedule for children up to and including age five (5) with annual examinations after age five (5) unless the child has physical health, behavioral health, or developmental health problems identified by the provider that require medically necessary treatment on a more frequent basis.

c. The health plan shall be responsible for determinations regarding medically necessary treatments, medically necessary appointments, and medically necessary services.

2.7.8 **Medically Necessary:** The health plan shall be responsible for providing covered services sufficient in amount, duration, and scope to reasonably achieve their purpose, and in accordance with accepted standards of practice in the medical community of the area in which the services are rendered. Services shall be furnished in the most appropriate setting. Services may be limited by medical necessity. A service shall be considered medically necessary if it (1) prevents, diagnoses, or treats a physical or behavioral health condition or injury; (2) is necessary for the member to achieve age appropriate growth and development; (3) minimizes the progression of disability; or (4) is necessary for the member to attain, maintain, or regain functional capacity. A service shall not be considered reasonable and medically

necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.

a. In reference to medically necessary care, behavioral health services shall be provided in accordance with a process of behavioral health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of behavioral health assessment shall include distinct criteria for children and adolescents.

b. The health plan shall provide medically necessary services to children from birth through age twenty (20), which are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified by an HCY/EPSDT screen. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

2.7.9 **Additional Health Benefits:** The health plan may offer additional health benefits not included in the comprehensive benefit package to their members. If the health plan offers additional health benefits, the health plan shall notify the state agency of these benefits prior to their offering and receive approval. The health plan shall notify the state agency no less than thirty (30) calendar days prior to discontinuing such benefits. The health plan shall not portray required health benefits or services as an additional health benefit.

Attachment C: Specifications for Measures to be Reported to MO HealthNet by the Managed Care Plans: Data Year 2013

1.01	MCPlan_TotalMembership_All_Count	The total number of health plan members, typically measured as of December 31st of the designated year. (Changed from Jan 1 to be consistent with HEDIS.)
1.02	MemberMonths_All_Age0-12_Count	The number of Member Months for the health plan's members aged 0-12. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section.
1.03	MemberMonths_All_Age13-17_Count	The number of Member Months for the health plan's members aged 13-17. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section.
1.04	MemberMonths_All_Age18-64_Count	The number of Member Months for the health plan's members aged 18-64. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section.
1.05	MemberMonths_All_Age65+_Count	The number of Member Months for the health plan's members aged 65+. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section.
2.01	MCPlan_TotalMembership_BHEligible_Count	The total number of Behavioral Health-eligible members, typically measured as of December 31st of the designated year. EXCLUDE foster care kids (COA-4), as their beahvioral health services are carved out. Count members who are ELIGIBLE for behavioral health services, even if none were received.
2.02	MemberMonths_BHEligible_Age0-12_Count	The number of Member Months for the health plan's Behavioral Health-eligible members aged 0-12. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section. EXCLUDE foster care kids (COA-4), as their beahvioral health services are carved out. Count member months for members who are ELIGIBLE for behavioral health services, even if none were received.

2.03	MemberMonths_BHEligible_Age13-17_Count	The number of Member Months for the health plan's Behavioral Health-eligible members aged 13-17. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section. EXCLUDE foster care kids (COA-4), as their beahvioral health services are carved out. Count member months for members who are ELIGIBLE for behavioral health services, even if none were received.
2.04	MemberMonths_BHEligible_Age18-64_Count	The number of Member Months for the health plan's Behavioral Health-eligible members aged 18-64. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section. EXCLUDE foster care kids (COA-4), as their beahvioral health services are carved out. Count member months for members who are ELIGIBLE for behavioral health services, even if none were received.
2.05	MemberMonths_BHEligible_Age65+_Count	The number of Member Months for the health plan's Behavioral Health-eligible members aged 65+. A person who is a plan member for 12 months counts as 12 member months. One who is a member for only 3 months out of the year counts as 3 member months. Use HEDIS specs for calculating member months as described in "HEDIS 2014 Technical Specifications for Health Plans Volume 2" in #9 of the "Guidelines for Utilization Measures" section. EXCLUDE foster care kids (COA-4), as their beahvioral health services are carved out. Count member months for members who are ELIGIBLE for behavioral health services, even if none were received.
3.00	ProviderCounts	See new Template for reporting information on providers, including psychiatrists, psychologists, social workers, nurses, and counselors.
6.01	GEOAccess_Psychiatrist_Adult_Percent	Percent of health plan members aged 18+ who have access to a psychiatrist within the travel distances set forth in the Managed Care contract. Use the specs from the Department of Insurance for this measure.
6.02	GEOAccess_Psychiatrist_Child_Percent	Percent of health plan members aged 0-17 who have access to a psychiatrist within the travel distances set forth in the Managed Care contract. Use the specs from the Department of Insurance for this measure.
6.03	GEOAccess_NonPsychiatristMH_Percent	Percent of health plan members who have access to a non-psychiatrist mental health provider within the travel distances set forth in the Managed Care contract. Use the specs from the Department of Insurance for this measure.
6.04	GEOAccess_InptMHFacility_Percent	Percent of health plan members who have access to an inpatient MH facility within the travel distances set forth in the Managed Care contract. Measured annually based on providers in network as of Jan 1 each year. Uses member residence ZIP codes and provider practice or facility location ZIP codes for analyses. Use the specs from the Department of Insurance for this measure.

6.05	GEOAccess_AmbulatoryMHFacility_Percent	Percent of health plan members who have access to an ambulatory MH facility within the travel distances set forth in the Managed Care contract. Use the specs from the Department of Insurance for this measure.
6.06	GEOAccess_ResidentialMHFacility_Percent	Percent of health plan members who have access to a residential MH facility within the travel distances set forth in the Managed Care contract. Use the specs from the Department of Insurance for this measure.
7.01	PsychPenetrationRate_Age0-12_Count	The count of health plan members aged 0-12 who access behavioral health services during the designated time period. Use HEDIS Mental Health Utilization section for definitions. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Any Services". Do not separate by gender.
7.02	PsychPenetrationRate_Age13-17_Count	The count of health plan members aged 13-17 who access behavioral health services during the designated time period. Use HEDIS Mental Health Utilization section for definitions. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Any Services". Do not separate by gender.
7.03	PsychPenetrationRate_Age18-64_Count	The count of health plan members aged 18-64 who access behavioral health services during the designated time period. Use HEDIS Mental Health Utilization section for definitions. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Any Services". Do not separate by gender.
7.04	PsychPenetrationRate_Age65+_Count	The count of health plan members aged 65+ who access behavioral health services during the designated time period. Use HEDIS Mental Health Utilization section for definitions. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Any Services". Do not separate by gender.
8.01	MPTUtilizationInpatient_Age0-12_Count	The count of health plan members age 0-12 who access Inpatient Services for behavioral health reasons during the designated time period. Use HEDIS Mental Health Utilization (MPT) specs. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender.
8.02	MPTUtilizationInpatient_Age13-17_Count	The count of health plan members age 13-17 who access Inpatient Services for behavioral health reasons during the designated time period. Use HEDIS Mental Health Utilization (MPT) specs. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender.
8.03	MPTUtilizationInpatient_Age18-64_Count	The count of health plan members age 18-64 who access Inpatient Services for behavioral health reasons during the designated time period. Use HEDIS Mental Health Utilization (MPT) specs. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender.

8.04	MPTUtilizationInpatient_Age65+_Count	The count of health plan members age 65+ who access Inpatient Services for behavioral health reasons during the designated time period. Use HEDIS Mental Health Utilization (MPT) specs. Report numbers from Table MPT-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender.
8.05	IADUtilizationInpatient_Age0-12_Count	The count of health plan members age 0-12 who access Inpatient Services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. Report numbers from Table IAD-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender.
8.06	IADUtilizationInpatient_Age13-17_Count	The count of health plan members age 13-17 who access Inpatient Services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. Report numbers from Table IAD-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender.
8.07	IADUtilizationInpatient_Age18-64_Count	The count of health plan members age 18-64 who access Inpatient Services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. Report numbers from Table IAD-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender. HEDIS has additional age breakdowns for this measure, but for us please combine the age groups 18-24, 25-34, and 35-64 into a single 18-64 age group.
8.08	IADUtilizationInpatient_Age65+_Count	The count of health plan members age 65+ who access Inpatient Services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. Report numbers from Table IAD-1/2/3, the unduplicated count of patients receiving "Inpatient Services". Do not separate by gender.
8.09	Inpatient_MHDischarges_Age0-12_Count	Count of discharges from a mental health inpatient stay (based on primary discharge diagnosis) for members age 0-12. Discharges do NOT need to be from a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.

8.10	Inpatient_MHDischarges_Age13-17_Count	Count of discharges from a mental health inpatient stay (based on primary discharge diagnosis) for members age 13-17. Discharges do NOT need to be from a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.
8.11	Inpatient_MHDischarges_Age18-64_Count	Count of discharges from a mental health inpatient stay (based on primary discharge diagnosis) for members age 18-64. Discharges do NOT need to be from a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.

8.12	Inpatient_MHDischarges_Age65+_Count	Count of discharges from a mental health inpatient stay (based on primary discharge diagnosis) for members age 65+. Discharges do NOT need to be from a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.
8.13	Inpatient_SADischarges_Age0-12_Count	Count of discharges from a substance abuse inpatient stay (based on primary discharge diagnosis) for members age 0-12. Discharges do NOT need to be from a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS “Chemical Dependency Value Set” to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.

8.14	Inpatient_SADischarges_Age13-17_Count	Count of discharges from a substance abuse inpatient stay (based on primary discharge diagnosis) for members age 13-17. Discharges do NOT need to be from a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS "Chemical Dependency Value Set" to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.
8.15	Inpatient_SADischarges_Age18-64_Count	Count of discharges from a substance abuse inpatient stay (based on primary discharge diagnosis) for members age 18-64. Discharges do NOT need to be from a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS "Chemical Dependency Value Set" to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.

8.16	Inpatient_SADischarges_Age65+_Count	Count of discharges from a substance abuse inpatient stay (based on primary discharge diagnosis) for members age 65+. Discharges do NOT need to be from a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Do NOT count inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis. Count DISCHARGES, and not MEMBERS who were hospitalized. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS “Chemical Dependency Value Set” to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0.
8.17	Inpatient_MHReadmissions_Age0-12_Count	Count of members age 0-12 discharged from a mental health inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal behavioral health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to mental health inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *A mental health inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous mental health inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.18	Inpatient_MHReadmissions_Age13-17_Count	Count of members age 13-17 discharged from a mental health inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal behavioral health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to mental health inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *A mental health inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous mental health inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.19	Inpatient_MHReadmissions_Age18-64_Count	Count of members age 18-64 discharged from a mental health inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal behavioral health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to mental health inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *An mental health inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous mental health inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.20	Inpatient_MHReadmissions_Age65+_Count	Count of members age 65+ discharged from a mental health inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized psychiatric hospital - it's the diagnosis that determines if it's a mental health inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal mental health diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal behavioral health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to mental health inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *An mental health inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous mental health inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.21	Inpatient_SAReadmissions_Age0-12_Count	Count of members age 0-12 discharged from a substance abuse inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS “Chemical Dependency Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to substance abuse inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *A substance abuse inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous substance abuse inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.22	Inpatient_SAReadmissions_Age13-17_Count	Count of members age 13-17 discharged from a substance abuse inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS “Chemical Dependency Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to substance abuse inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *A substance abuse inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous substance abuse inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.23	Inpatient_SAReadmissions_Age18-64_Count	Count of members age 18-64 discharged from a substance abuse inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS “Chemical Dependency Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to substance abuse inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *A substance abuse inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous substance abuse inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.24	Inpatient_SAReadmissions_Age65+_Count	Count of members age 65+ discharged from a substance abuse inpatient stay (based on primary discharge diagnosis) and readmitted within 30 days with either a primary mental health OR primary substance abuse diagnosis. The diagnosis does NOT need to be the same for both inpatient stays. Count MEMBERS who had one or more readmissions; do NOT count the total number of readmissions. Admissions do NOT need to be in a specialized hospital - it's the diagnosis that determines if it's a substance abuse inpatient stay. Inpatient stays that end in direct transfer to another acute facility for a principal substance abuse diagnosis should be counted as a single continuous inpatient event, using the admit date from the initial admission and the discharge date from the transfer, for the purposes of this measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS “Chemical Dependency Value Set”). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Also include discharges that fall on or between January 1 and January 30 of the year following the measurement year, but ONLY to determine if these January events are readmissions to substance abuse inpatient stays that were completed in December of the measurement year. *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. *A substance abuse inpatient stay is considered a re-admission if the Admit Date falls within 30 days of the Discharge Date of the most recent previous substance abuse inpatient stay, and is for a primary mental health or substance abuse diagnosis. Use HEDIS "Mental Health Diagnosis Value Set" and HEDIS "Chemical Dependency Value Set" to determine diagnoses.

8.25	Inpatient_MHDays_Age0-12_Count	Number of mental health inpatient days for members age 0-12. Basically, you're counting the length of stay for all of the behavioral health discharges reported in the "Inpatient_MHDischarges_Age0-12_Count" measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)

8.26	Inpatient_MHDays_Age13-17_Count	Number of mental health inpatient days for members age 13-17. Basically, you're counting the length of stay for all of the behavioral health discharges reported in the "Inpatient_MHDischarges_Age13-17_Count" measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range. *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)

8.27	Inpatient_MHDays_Age18-64_Count	Number of mental health inpatient days for members age 18-64. Basically, you're counting the length of stay for all of the behavioral health discharges reported in the "Inpatient_MHDischarges_Age18-64_Count" measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range. *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)

8.28	Inpatient_MHDays_Age65+_Count	Number of mental health inpatient days for members age 65+. Basically, you're counting the length of stay for all of the behavioral health discharges reported in the "Inpatient_MHDischarges_Age65+_Count" measure. Identify behavioral health discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis (use the HEDIS “Mental Health Diagnosis Value Set” to determine mental health diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range. *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)

8.29	Inpatient_SADays_Age0-12_Count	Number of substance abuse inpatient days for members age 0-12. Basically, you're counting the length of stay for all of the substance abuse discharges reported in the "Inpatient_SADischarges_Age0-12_Count" measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS “Chemical Dependency Value Set” to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range (NOTE: HEDIS excludes members younger than 6, but we're including them here.) *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)

8.30	Inpatient_SADays_Age13-17_Count	Number of substance abuse inpatient days for members age 13-17. Basically, you're counting the length of stay for all of the substance abuse discharges reported in the "Inpatient_SADischarges_Age13-17_Count" measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS "Chemical Dependency Value Set" to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range. *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)
8.31	Inpatient_SADays_Age18-64_Count	Number of substance abuse inpatient days for members age 18-64. Basically, you're counting the length of stay for all of the substance abuse discharges reported in the "Inpatient_SADischarges_Age18-64_Count" measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS "Chemical Dependency Value Set" to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range. *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)

8.32	Inpatient_SADays_Age65+_Count	Number of substance abuse inpatient days for members age 65+. Basically, you're counting the length of stay for all of the substance abuse discharges reported in the "Inpatient_SADischarges_Age65+_Count" measure. Identify substance abuse discharges using the following criteria: *Include all plan members in the specified age range. *Member is discharged alive from an acute inpatient setting with a principal substance abuse diagnosis (use the HEDIS "Chemical Dependency Value Set" to determine substance abuse diagnoses). *Include all discharges that fall on or between January 1 and December 31 of the measurement year. (NOTE: This is different from the HEDIS specs, which run through December 1.) *Use only Facility Claims to identify discharges. Do not use diagnoses from professional claims. Include paid claims as well as suspended, denied, or pending claims, and claims with paid amount = $0. Identify length of stay using the following criteria: *Include all plan members in the specified age range. *Use admit and discharge dates to identify days. *Do NOT use units of service. We want the actual length of stay, and not merely the number of days paid. *Count the date of admission, but not the date of discharge. (Typically, subtracting the date of admission from the date of discharge will accomplish this.)
8.33	InpatientFollowUp_7Days_MH_Age0-12_Count	Count of Members age 0-12 who had community follow-up within 7 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use "Mental Illness Value Set", instead substitute "Mental Health Diagnosis Value Set". *Break out results by designated age group.
8.34	InpatientFollowUp_7Days_MH_Age13-17_Count	Count of Members age 13-17 who had community follow-up within 7 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use "Mental Illness Value Set", instead substitute "Mental Health Diagnosis Value Set". *Break out results by designated age group.
8.35	InpatientFollowUp_7Days_MH_Age18-64_Count	Count of Members age 18-64 who had community follow-up within 7 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use "Mental Illness Value Set", instead substitute "Mental Health Diagnosis Value Set". *Break out results by designated age group.

8.36	InpatientFollowUp_7Days_MH_Age65+_Count	Count of Members age 65+ who had community follow-up within 7 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use “Mental Illness Value Set”, instead substitute “Mental Health Diagnosis Value Set”. *Break out results by designated age group.

8.37	InpatientFollowUp_7Days_SA_Age0-12_Count	Count members age 0-12 discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 0-12 as of the date of discharge. (HEDIS excludes those under age 6, but we're including them.) *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 7 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

8.38	InpatientFollowUp_7Days_SA_Age13-17_Count	Count members age 13-17 discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 13-17 as of the date of discharge. *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 7 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

8.39	InpatientFollowUp_7Days_SA_Age18-64_Count	Count members age 18-64 discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 18-64 as of the date of discharge. *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 7 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

8.40	InpatientFollowUp_7Days_SA_Age65+_Count	Count members age 65+ discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 65+ as of the date of discharge. *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 7 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

8.41	InpatientFollowUp_30Days_MH_Age0-12_Count	Count of Members age 0-12 who had community follow-up within 30 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use “Mental Illness Value Set”, instead substitute “Mental Health Diagnosis Value Set”. *Break out results by designated age group.
8.42	InpatientFollowUp_30Days_MH_Age13-17_Count	Count of Members age 13-17 who had community follow-up within 30 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use “Mental Illness Value Set”, instead substitute “Mental Health Diagnosis Value Set”. *Break out results by designated age group.
8.43	InpatientFollowUp_30Days_MH_Age18-64_Count	Count of Members age 18-64 who had community follow-up within 30 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use “Mental Illness Value Set”, instead substitute “Mental Health Diagnosis Value Set”. *Break out results by designated age group.
8.44	InpatientFollowUp_30Days_MH_Age65+_Count	Count of Members age 65+ who had community follow-up within 30 days after a mental health inpatient stay. Use the HEDIS FUH measure, except for the following modifications: *For each place in the HEDIS specs that use “Mental Illness Value Set”, instead substitute “Mental Health Diagnosis Value Set”. *Break out results by designated age group.

8.45	InpatientFollowUp_30Days_SA_Age0-12_Count	Count members age 0-12 discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 0-12 as of the date of discharge. *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 30 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

8.46	InpatientFollowUp_30Days_SA_Age13-17_Count	Count members age13-17 discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 13-17 as of the date of discharge. *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 30 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

8.47	InpatientFollowUp_30Days_SA_Age18-64_Count	Count members age 18-64 discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 18-64 as of the date of discharge. *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 30 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

8.48	InpatientFollowUp_30Days_SA_Age65+_Count	Count members age 65+ discharged alive from an acute inpatient setting with a principal diagnosis of substance abuse/dependence, using HEDIS Chemical Dependency Value Set, on or between January 1 and December 1 of the measurement year. *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. *Include all patients age 65+ as of the date of discharge. *Members must be continuously enrolled from the date of discharge through 30 days after discharge. No gaps in enrollment are permitted during that 30 day period. *If the discharge is followed by readmission or direct transfer to an acute facility for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. *Exclude discharges followed by readmission or direct transfer to a nonacute facility (HEDIS Nonacute Care Value Set) for a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within the 30-day follow-up period. *Also exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a principal diagnosis of non-substance abuse (any principal diagnosis code other than those included in the HEDIS Chemical Dependency Value Set). These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. NUMERATOR: An outpatient visit, intensive outpatient visit or partial hospitalization with a principal diagnosis of substance abuse (HEDIS Chemical Dependency Value Set) within 30 days after discharge. Include any such events that occur on the date of discharge. These are determined as follows: Outpatient: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Intensive Outpatient/Partial Hospitalization: IAD Stand Alone IOP/PH Value Set WITH Chemical Dependency Value Set IAD IOP/PH Value Set WITH POS 52 Value Set AND Chemical Dependency Value Set. IAD IOP/PH Value Set WITH POS 53 Value Set AND Chemical Dependency Value Set, where the organization can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting.) Count services provided by physicians and nonphysicians.

9.01	Utilization_MH_ER_Age0-12_Count	The count of health plan members age 0-12 accessing emergency department services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
9.02	Utilization_MH_ER_Age13-17_Count	The count of health plan members age 13-17 accessing emergency department services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

9.03	Utilization_MH_ER_Age18-64_Count	The count of health plan members age 18-64 accessing emergency department services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
9.04	Utilization_MH_ER_Age65+_Count	The count of health plan members age 65+ accessing emergency department services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

9.05	Utilization_SA_ER_Age0-12_Count	The count of health plan members age 0-12 accessing emergency department services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. No need to separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to separate for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
9.06	Utilization_SA_ER_Age13-17_Count	The count of health plan members age 13-17 accessing emergency department services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. No need to separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to separate for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

9.07	Utilization_SA_ER_Age18-64_Count	The count of health plan members age 18-64 accessing emergency department services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. No need to separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to separate for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
9.08	Utilization_SA_ER_Age65+_Count	The count of health plan members age 65+ accessing emergency department services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services. No need to separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to separate for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

9.09	ER_Visits_MH_Age0-12_Count	The count of emergency department VISITS for behavioral health reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for MPT - Mental Health Utilization, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_MH_ER_Age0-12_Count" above, except that you are counting VISITS and not PATIENTS.)
9.10	ER_Visits_MH_Age13-17_Count	The count of emergency department VISITS for behavioral health reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for MPT - Mental Health Utilization, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_MH_ER_Age13-17_Count" above, except that you are counting VISITS and not PATIENTS.)

9.11	ER_Visits_MH_Age18-64_Count	The count of emergency department VISITS for behavioral health reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for MPT - Mental Health Utilization, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_MH_ER_Age18-64_Count" above, except that you are counting VISITS and not PATIENTS.)
9.12	ER_Visits_MH_Age65+_Count	The count of emergency department VISITS for behavioral health reasons during the designated time period for health plan members age 65+. Use HEDIS specs for MPT - Mental Health Utilization, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs with the following: ER Services Report ED claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *ED Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_MH_ER_Age65+_Count" above, except that you are counting VISITS and not PATIENTS.)

9.13	ER_Visits_SA_Age0-12_Count	The count of emergency department VISITS for substance abuse reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_SA_ER_Age0-12_Count" above, except that you are counting VISITS and not PATIENTS.)
9.14	ER_Visits_SA_Age13-17_Count	The count of emergency department VISITS for substance abuse reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_SA_ER_Age13-17_Count" above, except that you are counting VISITS and not PATIENTS.)

9.15	ER_Visits_SA_Age18-64_Count	The count of emergency department VISITS for substance abuse reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_SA_ER_Age18-64_Count" above, except that you are counting VISITS and not PATIENTS.)
9.16	ER_Visits_SA_Age65+_Count	The count of emergency department VISITS for substance abuse reasons during the designated time period for health plan members age 65+. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, but count emergency department VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA ER Services Report ED claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *ED Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by including ONLY POS=23. EXCLUDE all other POS values.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "Utilization_SA_ER_Age65+_Count" above, except that you are counting VISITS and not PATIENTS.)

10.01	PartialHosp_MHDischarges_Age0-12_Count	The count of partial hospitalization DISCHARGES for behavioral health reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.02	PartialHosp_MHDischarges_Age13-17_Count	The count of partial hospitalization DISCHARGES for behavioral health reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.03	PartialHosp_MHDischarges_Age18-64_Count	The count of partial hospitalization DISCHARGES for behavioral health reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.04	PartialHosp_MHDischarges_Age65+_Count	The count of partial hospitalization DISCHARGES for behavioral health reasons during the designated time period for health plan members age 65+. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.05	PartialHosp_SADischarges_Age0-12_Count	The count of partial hospitalization DISCHARGES for substance abuse reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.06	PartialHosp_SADischarges_Age13-17_Count	The count of partial hospitalization DISCHARGES for substance abuse reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.07	PartialHosp_SADischarges_Age18-64_Count	The count of partial hospitalization DISCHARGES for substance abuse reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.08	PartialHosp_SADischarges_Age65+_Count	The count of partial hospitalization DISCHARGES for substance abuse reasons during the designated time period for health plan members age 65+. Use HEDIS specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Discharges: Report partial hospitalization DISCHARGES in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DISCHARGES from partial hospitalization, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.09	PartialHosp_MHDays_Age0-12_Count	The count of partial hospitalization DAYS for behavioral health reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.10	PartialHosp_MHDays_Age13-17_Count	The count of partial hospitalization DAYS for behavioral health reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.11	PartialHosp_MHDays_Age18-64_Count	The count of partial hospitalization DAYS for behavioral health reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.12	PartialHosp_MHDays_Age65+_Count	The count of partial hospitalization DAYS for behavioral health reasons during the designated time period for health plan members age 65+. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.13	PartialHosp_SADays_Age0-12_Count	The count of partial hospitalization DAYS for substance abuse reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.14	PartialHosp_SADays_Age13-17_Count	The count of partial hospitalization DAYS for substance abuse reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.15	PartialHosp_SADays_Age18-64_Count	The count of partial hospitalization DAYS for substance abuse reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.16	PartialHosp_SADays_Age65+_Count	The count of partial hospitalization DAYS for substance abuse reasons during the designated time period for health plan members age 65+. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Days: Report partial hospitalization DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS in partial hospitalization, and not PATIENTS. Calculate number of days using admit and discharge dates, and NOT by counting units of service. Count the admit date but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.17	PartialHosp_MHUtilization_Age0-12_Count	The count of health plan members age 0-12 accessing partial hospitalization services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.18	PartialHosp_MHUtilization_Age13-17_Count	The count of health plan members age 13-17 accessing partial hospitalization services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.19	PartialHosp_MHUtilization_Age18-64_Count	The count of health plan members age 18-64 accessing partial hospitalization services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.20	PartialHosp_MHUtilization_Age65+_Count	The count of health plan members age 65+ accessing partial hospitalization services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0912 or 0913, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.21	PartialHosp_SAUtilization_Age0-12_Count	The count of health plan members age 0-12 accessing partial hospitalization services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

10.22	PartialHosp_SAUtilization_Age13-17_Count	The count of health plan members age 13-17 accessing partial hospitalization services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.23	PartialHosp_SAUtilization_Age18-64_Count	The count of health plan members age 18-64 accessing partial hospitalization services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
10.24	PartialHosp_SAUtilization_Age65+_Count	The count of health plan members age 65+ accessing partial hospitalization services for substance abuse reasons. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Partial Hospitalization Utilization: Use partial hospitalization services in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0912 or 0913, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

11.01	IntensiveOP_MHUtilization_Age0-12_Count	The count of health plan members age 0-12 who access intensive outpatient services for behavioral health reasons during the designated time period. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS MPT specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.02	IntensiveOP_MHUtilization_Age13-17_Count	The count of health plan members age 13-17 who access intensive outpatient services for behavioral health reasons during the designated time period. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS MPT specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

11.03	IntensiveOP_MHUtilization_Age18-64_Count	The count of health plan members age 18-64 who access intensive outpatient services for behavioral health reasons during the designated time period. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS MPT specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.04	IntensiveOP_MHUtilization_Age65+_Count	The count of health plan members age 65+ who access intensive outpatient services for behavioral health reasons during the designated time period. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS MPT specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

11.05	IntensiveOP_SAUtilization_Age0-12_Count	The count of health plan members age 0-12 who access intensive outpatient services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.06	IntensiveOP_SAUtilization_Age13-17_Count	The count of health plan members age 13-17 who access intensive outpatient services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.07	IntensiveOP_SAUtilization_Age18-64_Count	The count of health plan members age 18-64 who access intensive outpatient services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

11.08	IntensiveOP_SAUtilization_Age65+_Count	The count of health plan members age 65+ who access intensive outpatient services for substance abuse reasons during the designated time period. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Utilization: Report intensive outpatient utilization in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Report the unduplicated count of patients receiving Intensive Outpatient services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.09	IntensiveOP_MHDays_Age0-12_Count	The count of intensive outpatient DAYS for behavioral health reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.10	IntensiveOP_MHDays_Age13-17_Count	The count of intensive outpatient DAYS for behavioral health reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.

11.11	IntensiveOP_MHDays_Age18-64_Count	The count of intensive outpatient DAYS for behavioral health reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.12	IntensiveOP_MHDays_Age65+_Count	The count of intensive outpatient DAYS for behavioral health reasons during the designated time period for health plan members age 65+. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 0905 or 0907, WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.13	IntensiveOP_SADays_Age0-12_Count	The count of intensive outpatient DAYS for substance abuse reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.

11.14	IntensiveOP_SADays_Age13-17_Count	The count of intensive outpatient DAYS for substance abuse reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.15	IntensiveOP_SADays_Age18-64_Count	The count of intensive outpatient DAYS for substance abuse reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.
11.16	IntensiveOP_SADays_Age65+_Count	The count of intensive outpatient DAYS for substance abuse reasons during the designated time period for health plan members age 65+. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Since the HEDIS specs lump Partial Hospitalization and Intensive Outpatient data together, we will need modify the specs to separate these for this measure. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Intensive Outpatient Days: Report intensive outpatient days in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 0906 or 0907, WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of intensive outpatient services, and not PATIENTS. Except for the above modifications, calculate the measure as written in the HEDIS specs.

12.01	Residential_MHDays_Age0-12_Count	The count of DAYS in residential care for behavioral health reasons during the designated time period for health plan members age 0-12. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for MPT – Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.02	Residential_MHDays_Age13-17_Count	The count of DAYS in residential care for behavioral health reasons during the designated time period for health plan members age 13-17. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for MPT – Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.03	Residential_MHDays_Age18-64_Count	The count of DAYS in residential care for behavioral health reasons during the designated time period for health plan members age 18-64. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for MPT – Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.

12.04	Residential_MHDays_Age65+_Count	The count of DAYS in residential care for behavioral health reasons during the designated time period for health plan members age 65+. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for MPT – Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.05	Residential_SADays_Age0-12_Count	The count of DAYS in residential care for substance abuse reasons during the designated time period for health plan members age 0-12. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.06	Residential_SADays_Age13-17_Count	The count of DAYS in residential care for substance abuse reasons during the designated time period for health plan members age 13-17. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.

12.07	Residential_SADays_Age18-64_Count	The count of DAYS in residential care for substance abuse reasons during the designated time period for health plan members age 18-64. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.08	Residential_SADays_Age65+_Count	The count of DAYS in residential care for substance abuse reasons during the designated time period for health plan members age 65+. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Calculate number of discharges. Use HEDIS Specs for IAD – Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Days: Report residential service DAYS in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Count DAYS of residential services, and not PATIENTS. Calculate days by using admit date and discharge date - DO NOT use units of service. Count the admit date, but not the discharge date. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.09	Residential_MHUtilization_Age0-12_Count	The count of health plan members age 0-12 accessing residential services for behavioral health reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

12.10	Residential_MHUtilization_Age13-17_Count	The count of health plan members age 13-17 accessing residential services for behavioral health reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.11	Residential_MHUtilization_Age18-64_Count	The count of health plan members age 18-64 accessing residential services for behavioral health reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.12	Residential_MHUtilization_Age65+_Count	The count of health plan members age 65+ accessing residential services for behavioral health reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for MPT - Mental Health Utilization, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL mental health diagnosis: *UB REV Code 1001 WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

12.13	Residential_SAUtilization_Age0-12_Count	The count of health plan members age 0-12 accessing residential services for substance abuse reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.14	Residential_SAUtilization_Age13-17_Count	The count of health plan members age 13-17 accessing residential services for substance abuse reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
12.15	Residential_SAUtilization_Age18-64_Count	The count of health plan members age 18-64 accessing residential services for substance abuse reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.

12.16	Residential_SAUtilization_Age65+_Count	The count of health plan members age 65+ accessing residential services for substance abuse reasons. Do not separate counts by gender. Include paid claims and ALSO denied claims and claims with paid = $0. Use HEDIS specs for IAD - Identification of Alcohol and Other Drug Services, WITH MODIFICATIONS as described below. Replace the "Intensive Outpatient and Partial Hospitalization" part of the "Calculations" section of the HEDIS IAD specs as follows: Residential Services Utilization: Use residential service in conjunction with a PRINCIPAL substance abuse diagnosis: *UB REV Code 1002 WITH Chemical Dependency Value Set. Count services provided by physicians and nonphysicians. Report the unique count of health plan members receiving such services. Except for the above modifications, calculate the measure as written in the HEDIS specs.
13.01	Outpt_Visits_MH_Age0-12_Count	Count of outpatient service VISITS for mental health reasons during the designated time period for health plan members age 0-12. Use HEDIS specs for MPT - Mental Health Utilization, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate counts by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "MPTUtilizationInpatient_Age0-12_Count" above, except that you are counting VISITS and not PATIENTS.)

13.02	Outpt_Visits_MH_Age13-17_Count	Count of outpatient service VISITS for mental health reasons during the designated time period for health plan members age 13-17. Use HEDIS specs for MPT - Mental Health Utilization, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate counts by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "MPTUtilizationInpatient_Age13-17_Count" above, except that you are counting VISITS and not PATIENTS.)

13.03	Outpt_Visits_MH_Age18-64_Count	Count of outpatient service VISITS for mental health reasons during the designated time period for health plan members age 18-64. Use HEDIS specs for MPT - Mental Health Utilization, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate counts by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "MPTUtilizationInpatient_Age18-64_Count" above, except that you are counting VISITS and not PATIENTS.)

13.04	Outpt_Visits_MH_Age65+_Count	Count of outpatient service VISITS for mental health reasons during the designated time period for health plan members age 65+. Use HEDIS specs for MPT - Mental Health Utilization, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate counts by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "MPTUtilizationInpatient_Age65+_Count" above, except that you are counting VISITS and not PATIENTS.)
13.05	Outpt_Visits_SA_Age0-12_Count	The count of outpatient service VISITS for substance abuse reasons during the designated time period for health plan members age 0-12. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "IADUtilizationInpatient_Age0-12_Count" above, except that you are counting VISITS and not PATIENTS.)

13.06	Outpt_Visits_SA_Age13-17_Count	The count of outpatient service VISITS for substance abuse reasons during the designated time period for health plan members age 13-17. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "IADUtilizationInpatient_Age13-17_Count" above, except that you are counting VISITS and not PATIENTS.)
13.07	Outpt_Visits_SA_Age18-64_Count	The count of outpatient service VISITS for substance abuse reasons during the designated time period for health plan members age 18-64. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "IADUtilizationInpatient_Age18-64_Count" above, except that you are counting VISITS and not PATIENTS.)

13.08	Outpt_Visits_SA_Age65+_Count	The count of outpatient service VISITS for substance abuse reasons during the designated time period for health plan members age 65+. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services, but count outpatient VISITS and not PATIENTS or EPISODES OF CARE. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs. (This spec is the same as for "IADUtilizationInpatient_Age65+_Count" above, except that you are counting VISITS and not PATIENTS.)
13.09	Utilization_MH_Outpatient_Age0-12_Count	The count of health plan members age 0-12 accessing outpatient services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

13.10	Utilization_MH_Outpatient_Age13-17_Count	The count of health plan members age 13-17 accessing outpatient services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
13.11	Utilization_MH_Outpatient_Age18-64_Count	The count of health plan members age 18-64 accessing outpatient services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

13.12	Utilization_MH_Outpatient_Age65+_Count	The count of health plan members age 65+ accessing outpatient services for behavioral health reasons. Use HEDIS specs for MPT - Mental Health Utilization. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Mental Health Utilization specs as follows: Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL mental health diagnosis. Any of the following code combinations meet criteria: *MPT Stand Alone Outpatient Group 1 Value Set WITH Mental Health Diagnosis Value Set. *Observation Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) *MPT Outpatient/ED Value Set WITH MPT Outpatient/ED POS Value Set AND Mental Health Diagnosis Value Set. HOWEVER: MODIFY the MPT Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). *MPT Stand Alone Outpatient Group 2 Value Set WITH Mental Health Diagnosis Value Set. (NOTE: Although HEDIS requires this to be billed by a mental health practitioner, we do NOT. Any practitioner is acceptable.) Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
13.13	Utilization_SA_Outpatient_Age0-12_Count	The count of health plan members age 0-12 accessing outpatient services for substance abuse reasons. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

13.14	Utilization_SA_Outpatient_Age13-17_Count	The count of health plan members age 13-17 accessing outpatient services for substance abuse reasons. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
13.15	Utilization_SA_Outpatient_Age18-64_Count	The count of health plan members age 18-64 accessing outpatient services for substance abuse reasons. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.

13.16	Utilization_SA_Outpatient_Age65+_Count	The count of health plan members age 65+ accessing outpatient services for substance abuse reasons. Use HEDIS Specs for IAD - Identification of Alcohol and Other Drug Services. Do not separate patients by gender. Since the HEDIS specs lump Outpatient and ED visits together, we will need to modify the specs to separate these for this measure. Replace the "Outpatient and ED" part of the "Calculations" section of the HEDIS Identification of Alcohol and Other Drug Services criteria with the following: SA Outpatient Services: Report outpatient claims/encounters in conjunction with a PRINCIPAL chemical dependency diagnosis. (NOTE: HEDIS asks for ANY chemical dependency diagnosis; we are asking for PRINCIPAL). Any of the following code combinations meet criteria: *IAD Stand Alone Outpatient Value Set WITH Chemical Dependency Value Set. *Observation Value Set WITH Chemical Dependency Value Set. *IAD Outpatient/ED Value Set WITH IAD Outpatient/ED POS Value Set AND Chemical Dependency Value Set. HOWEVER: MODIFY the IAD Outpatient/ED POS Value Set by REMOVING POS=23 (hospital emergency room), and ADDING POS=53 (community mental health center). Count services provided by physicians and nonphysicians. Only include observation stays that do not result in an inpatient stay. Except for the above modifications, calculate the measure as written in the HEDIS specs.
15.01	CM_MHAdmissions_CurrentlyEnrolled_Count	Number of psychiatric inpatient admissions for patients who were enrolled in behavioral health case management at the time of admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Psychiatric admissions are determined by a primary admission diagnosis that matches those in the HEDIS “Mental Health Diagnosis Value Set”. Count HOSPITALIZATIONS and not PATIENTS.
15.02	CM_MHAdmissions<7Days_Count	Number of psychiatric inpatient admissions for patients who had been discharged from behavioral health case management between 0-7 days prior to the admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Psychiatric admissions are determined by a primary admission diagnosis that matches those in the HEDIS “Mental Health Diagnosis Value Set”. Count HOSPITALIZATIONS and not PATIENTS.
15.03	CM_MHAdmissions31-90Days_Count	Number of psychiatric inpatient admissions for patients who had been discharged from behavioral health case management between 8-30 days prior to the admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Psychiatric admissions are determined by a primary admissions diagnosis that matches those in the HEDIS “Mental Health Diagnosis Value Set”. Count HOSPITALIZATIONS and not PATIENTS.
15.04	CM_MHAdmissions8-30Days_Count	Number of psychiatric inpatient admissions for patients who had been discharged from behavioral health case management between 31-90 days prior to the admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Psychiatric admissions are determined by a primary admissions diagnosis that matches those in the HEDIS “Mental Health Diagnosis Value Set”. Count HOSPITALIZATIONS and not PATIENTS.

15.05	CM_MedAdmissions_CurrentlyEnrolled_Count	Number of medical inpatient admissions for patients who were enrolled in medical case management at the time of admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Medical admissions are determined by a primary admission diagnosis that does NOT match those in the HEDIS "Mental Health Diagnosis Value Set". Count HOSPITALIZATIONS and not PATIENTS.
15.06	CM_MedAdmissions<7Days_Count	Number of medical inpatient admissions for patients who had been discharged from medical case management between 0-7 days prior to the admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Medical admissions are determined by a primary admissions diagnosis that does NOT match those in the HEDIS "Mental Health Diagnosis Value Set". Count HOSPITALIZATIONS and not PATIENTS.
15.07	CM_MedAdmissions8-30Days_Count	Number of medical inpatient admissions for patients who had been discharged from medical case management between 8-30 days prior to the admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Medical admissions are determined by a primary admissions diagnosis that does NOT match those in the HEDIS "Mental Health Diagnosis Value Set". Count HOSPITALIZATIONS and not PATIENTS.
15.08	CM_MedAdmissions31-90Days_Count	Number of medical inpatient admissions for patients who had been discharged from medical case management between 31-90 days prior to the admission. (Do NOT include patients enrolled in BOTH behavioral health and medical case management – there are separate measures for them.) Use an inpatient facility code to identify hospitalizations. Medical admissions are determined by a primary admissions diagnosis that does NOT match those in the HEDIS "Mental Health Diagnosis Value Set". Count HOSPITALIZATIONS and not PATIENTS.
15.09	CM_BothAdmissions_CurrentlyEnrolled_Count	Number of inpatient admissions for any reason for patients who were enrolled in BOTH behavioral health and medical case management at the time of admission. Use an inpatient facility code to identify hospitalizations. Count HOSPITALIZATIONS and not PATIENTS.
15.10	CM_BothAdmissions<7Days_Count	Number of inpatient admissions for any reason for patients who had been discharged from BOTH behavioral health and medical case management between 0-7 days prior to the admission. Use an inpatient facility code to identify hospitalizations. Count HOSPITALIZATIONS and not PATIENTS.
15.11	CM_BothAdmissions8-30Days_Count	Number of inpatient admissions for any reason for patients who had been discharged from BOTH behavioral health and medical case management between 8-30 days prior to the admission. Use an inpatient facility code to identify hospitalizations. Count HOSPITALIZATIONS and not PATIENTS.
15.12	CM_BothAdmissions31-90Days_Count	Number of inpatient admissions for any reason for patients who had been discharged from BOTH behavioral health and medical case management between 31-90 days prior to the admission. Use an inpatient facility code to identify hospitalizations. Count HOSPITALIZATIONS and not PATIENTS.

16.01	PriorAuths_Requested_Count	A count of all prior authorization requests the Plan received during the designated time period.
16.02	PriorAuths_Denied_Count	A count of all prior authorization requests the Plan received during the designated time period that were subsequently denied by the Plan.
16.03	PriorAuths_Appealed_Count	A count of all denied prior authorization requests during the designated time period that were appealed.
16.04	PriorAuths_AppealsOverturned_Count	A count of all denied prior authorization requests during the designated time period that were appealed and where the denial was subsequently overturned.
20.00	AltSvcs_OTHER_Count	Alternative Services is a "catch-all" category for services that the Health Plans wish to report to MHD, but for which there is no designated measure. In the past, this has included things such as Applied Behavior Analysis, Consultations, CSTAR services, etc. However, in practice, the Health Plans rarely report such services. Starting with 2013 data, any plan wishing to report Alternate Services must inform MHD of the service(s) they wish to include, along with the proposed methodology for counting the services. MHD will review the methodology and provide standardized specs to all Health Plans for collecting that particular service. Reporting these alternative services will still be optional, but in the event that 2 or more plans wish to report the same alternative service, MHD wants the same specs used by all plans.

MO HealthNet MCO	PIP Topic or Problem Statement	Purpose of Project
Home State Health Plan	Notification of Pregnancy (NOP) form receipt	To increase the volume of NOP forms received from providers. Increasing NOP receipt early in pregnancy allows us to identify pregnant members and begin outreach and enrollment into our Start Smart for your Baby program to help improve outcomes
Home State Health Plan	Improving Oral Health, Statewide PIP	Improve member access to dental services to increase the rate of dental care and improve dental health for our members.
HCUSA	Improving Coordination of Care for members diagnosed with ADHD and prescribed medications	ADHD is one of the five most prevalent behavioral health diagnoses among all members served by HealthCare USA. Relevance regarding ADHD as a preventive health program becomes even more substantiated since children ages 0 to12 rank second in the utilization of behavioral health services. Even though children are receiving services through a provider, we want to ensure that parents/caregivers are also accessing necessary services.
HCUSA	Decreasing Non-Emergent/Avoidable Emergency Department (ED) Utilization	HealthCare USA identified an increase in utilization of the ED for all emergent and non-emergent/avoidable cases. Non-urgent and avoidable ED utilization affects the quality of care and long-term health outcomes for members and impacts the member's ability to establish a health care home.
HCUSA	Improving Post-Discharge Management of Members Discharged from an Inpatient Service for Mental Illness	Compliance with planned aftercare has been shown to play a major role in decreasing the rate of re-hospitalization of mentally ill persons. An inverse relationship has been found between the number of post-discharge follow-up visits and the likelihood of re-hospitalization Improving compliance with ambulatory follow-up appointments after discharge from inpatient mental health treatment is an important factor in preventing re-hospitalization.
HCUSA	Readmission Performance Improvement Project	There are many contributing factors to hospital readmissions. Studies suggest re-hospitalizations can be prevented by identifying patients at risk for readmission before hospital discharge, having follow-up strategies after discharge, and managing chronic diseases with office-based services.
HCUSA	MO HealthNet (MHD) Collaborative Performance Improvement Project (PIP)	Oral health is an integral component of children's overall health and well-being. Dental care is the most prevalent unmet health need among children. Statistics from the Centers for Disease Control and Prevention reveal that over two-thirds of children have decay in their permanent teeth.
HCUSA	Improving Oral Health	The connection between oral health and general health is not often made by Medicaid recipients who frequently encounter other socio-economic challenges. More than half of the children on Medicaid received no dental service in 2007. During this same time period in Missouri, the rate of dental service utilization was 27.9%.
Missouri Care	Asthma Management – Use of Appropriate Medications for People with Asthma (ASM)	Increase use of controller medications among members with persistent asthma
Missouri Care	Increasing rates of Inhaled Corticosteroid Use for Primary Treatment of Asthma (ASM)	Increase use of controller medications among members with persistent asthma
Missouri Care	Adolescent Well Care (AWC)	Increase the % of members 12 through 21 years of age who had at least one well-care visit
Missouri Care	Chlamydia Screening (CHL)	Increase % of sexually active females ages 16-24 who receive a Chlamydia Screening
Missouri Care	Annual Dental Visits (ADV) – Statewide PIP and Missouri Care PIP	Increase the % of members ages 2-21 who received at least one annual dental visit
Missouri Care	Managing Coexisting Conditions	Analysis of the management of Depression during pregnancy concerning Missouri Care Health Plan members
Missouri Care	Lead Screening in Children (LSC)	Increase the % of members aged 2 years who had a lead test

MO HealthNet MCO	PIP Topic or Problem Statement	Purpose of Project
Missouri Care	Follow-Up After Hospitalization for Mental Illness – 7 days (FUH - 7)	Increase access to follow-up appointments within 7 days after discharge from hospital
Missouri Care	ER Utilization	Reduce inappropriate ER utilization
Missouri Care	Comprehensive Diabetes Care (CDC)	Increase the % of diabetic members ages 18-75 years who need a HbA1c test, a LDL-C test, a nephropathy exam, and an eye exam
Missouri Care	Increasing Rates in HbA1c Testing and LDL-C Controlled for Comprehensive Diabetes Care Measure (CDC)	Increase the % of diabetic members ages 18-75 years who need a HbA1c and LDL-C test
Missouri Care	Increasing the Percentage of Dilated Retinal Eye Exams for Diabetic Members & the communication of the results with the member's PCP (CDC)	Increase communication between the optometrist/ophthalmologist and the member's PCP as shown by the increase in the % of diabetic retinal eye exam results found in the PCP record.
Missouri Care	Antidepressant Medication Management (AMM)	Increase the % of members diagnosed, treated, and continued on antidepressant medication for 84 and 180 days
Missouri Care	Follow-Up Care for Children Prescribed ADHD Medication(ADD)	Increase the follow-up time for children diagnosed and taking medication for ADHD
Missouri Care	Satisfaction with UM Process	Analysis of UM satisfaction process as it relates to Missouri Care Health Plan members & practitioners.
Missouri Care	Specialty Care Availability	Analysis of Practitioner Provider Specialty Care Availability within Missouri Care Health Plan
Missouri Care	Cultural Needs	Analysis of Providers & members as it relates to Cultural competency within Missouri Care Health Plan.
Missouri Care	Member Satisfaction	Analysis of member satisfaction concerning the Missouri Care Health plan experience
Missouri Care	Disease Management Satisfaction	Analysis of Missouri Care Health Plan member satisfaction with Disease Management program
Missouri Care	Case Management Satisfaction	Analysis of Missouri Care Health Plan member satisfaction with Case management
Missouri Care	PCP Availability	Analysis of Missouri Care Health Plan Primary Medical Providers Availability in relationship to Missouri Care Health Plan members
Missouri Care	PCP Accessibility	Analysis of Missouri Care Health Plan Primary Care Physician Accessibility in relationship to Missouri Care Health Plan members
Missouri Care	Exchange of Information: Continuity & Coordination between Medical & Behavioral Healthcare	Analysis of the exchange of information between Missouri Care Health Plan primary care practitioners & behavioral health practitioners to facilitate better coordination & continuity of Missouri Care Health Plan members.
Missouri Care	Improving Birth Outcomes	Analysis of the effect of case management, prenatal visits & birth outcomes as it relates to Missouri Care Health Plan prematurity & low birth weight.
Missouri Care	Behavioral Health Screening of Adolescents in the Primary Care Setting	Analysis of Missouri Care Health Plan primary care setting & the screening of behavioral health for adolescents.
Missouri Care	Behavioral Health Readmission Rates	Analysis of the effectiveness of Missouri Care Health Plan case management & readmission rates of those members discharged with a primary behavioral health diagnosis.
Missouri Care	Behavioral Health Care Practitioners Availability	Analysis of the distribution & availability of Missouri Care BH Practitioners as it relates to Missouri Care Membership.
Missouri Care	Behavioral Health Care Practitioner Accessibility	Analysis of Missouri Care Health Plan Behavioral Health Care Practitioner accessibility in relationship to Missouri Care Health Plan members