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Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations Monitoring Metrics Technical Specifications

Version 1

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Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations Monitoring Metrics Technical Specifications

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TABLES

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METRICS

ACRONYMS

AAP	Adults' Access to Preventive/Ambulatory Health Services (measure)
AHRQ	Agency for Healthcare Research and Quality
ALOS	Average Length of Stay
AD	Adult Core Set
AMA	American Medical Association
AOD	Alcohol or Other Drug Dependence
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (measure)
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics (measure)
APP	Use of first-line psychosocial care for children and adolescents on antipsychotics (measure)
BDI or BDI-II	Beck Depression Inventory
BDI-PC	Beck Depression Inventory-Primary Care Version
BH	Behavioral Health
CCBHC	Certified Community Behavioral Health Clinics Demonstration
CCS	Clinical Classification Software
CDF	Screening for Depression and Follow-Up Plan
CES-D	Center for Epidemiologic Studies Depression Scale
CH	Child Core Set
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid & CHIP Services
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CSDD	Cornell Scale for Depression in Dementia
DADS	Duke Anxiety- Depression Scale
DEPS	Depression Scale
DNI	Do Not Intubate
DNR	Do Not Resuscitate
DO	Doctor of Osteopathy
DY	Demonstration Year
ED	Emergency Department

EHR	Electronic Health Record
FFP	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year
FUA	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (measure)
FUH	Follow-Up After Hospitalization for Mental Illness (measure)
FUM	Follow-up After Emergency Department Visit for Mental Illness (measure)
GDS	Geriatric Depression Scale
HAM-D	Hamilton Rating Scale for Depression
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HPCMI	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (measure)
HWR	Hospital-Wide Readmission (HWR)
ICD	International Classification of Diseases
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (measure)
IMD	Institution for Mental Diseases
IOP/PH	Intensive Outpatient Care/Partial Hospitalization
IPF	Inpatient Psychiatric Facility
IPFQR	Inpatient Psychiatric Facility Quality Reporting Program
IPSD	Index Prescription Start Date
LDL	Low-Density Lipoprotein
LOINC	Logical Observation Identifiers Names and Codes
MCO	Managed Care Organization
MD	Doctor of Medicine
MDD	Major Depressive Disorder
MLD	Medication List Directory
MPT	Mental Health Utilization measure
MSIS	Medicaid Statistical Information System
NBCC	National Board for Certified Counselors
NCQA	National Committee for Quality Assurance

NDC	National Drug Code
NEC	Not Elsewhere Classified
NQF	National Quality Forum
NPI	National Provider Identifier
PHQ-9	Patient Health Questionnaire
PMH-20	All-cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care (measure)
POS	Place of Service
PTA	Prior To Admission
QDWI	Qualified Disabled and Working Individuals
QI	Qualified Individuals
QID-SR	Quick Inventory of Depressive Symptomatology Self-Report
QMB	Qualified Medicare Beneficiary
RN	Registered Nurse
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SLMB	Specified Low-Income Medicare Beneficiary
SMDL	State Medicaid Director Letter
SMI	Serious Mental Illness
SUB-2	Alcohol Use Brief Intervention Provided or Offered (measure)
SUD	Substance Use Disorder
TJC	The Joint Commission
T-MSIS	Transformed Medicaid Statistical Information System
UB	Uniform Bill Codes
VS	Value Set
WHO	World Health Organization

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I. BACKGROUND AND INTRODUCTION

This document provides instructions on how to calculate and report monitoring metrics for states with section 1115 demonstrations that focus on serious mental illness (SMI) and serious emotional disturbance (SED).[1]

Center for Medicaid and Chip Services (CMCS) selected SMI/SED demonstration monitoring metrics with input from subject matter experts and members of the state technical advisory group for Medicaid monitoring and evaluation. These metrics consist of (1) established quality measures endorsed by NQF or included in other Medicaid Quality Measures measure sets[2] and (2) CMS-constructed implementation performance metrics to track the goals and milestones presented in the State Medicaid Directors Letter dated November 13, 2018 (SMDL #18-011). The implementation performance metrics often refer to definitions included in established quality measures, but they did not go through the measure endorsement process and are intended only for monitoring progress of SMI/SED demonstrations.

A. Overview of 1115 SMI/SED demonstration monitoring metrics

There are 40 metrics representing several demonstration milestones (Table 1).

Table 1. Summary of 1115 SMI/SED monitoring metrics

Demonstration milestones[a]	Number of metrics[b]
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	2
Milestone 2: Improving Care Coordination and Transitions to Community-Based Care	10
Milestone 3: Increasing Access to Continuum of Care including Crisis Stabilization Services	8
Milestone 4: Earlier Identification and Engagement in Treatment including through Increased Integration	11
Other SMI/SED Metrics	9
Total	**40**

[a] Milestones included in this table are from the State Medicaid Director Letter #18-011.

[b] Each metric is listed under a primary milestone above. However, some metrics may address multiple milestones.

This set of metrics will be updated annually. As part of the annual update, metrics may be removed, or added as new metrics are tested, endorsed, or selected for use.

Table 2 lists 1115 SMI/SED demonstration monitoring metrics by demonstration milestone and provides key reporting parameters, including the measurement period and population groups for each metric. The following reporting instructions apply to all metrics:

[1] See the acronyms list on page vii for definitions of all acronyms in this document.

[2] The 2019 Child Core Set and Adult Core Set.

- **Measurement period.** This parameter identifies the measurement period (the data collection time frame) for each metric. Measurement periods may be month, quarter, or year. Section B provides detailed guidance and reporting instructions for measurement period.
- **Reporting level.** This parameter identifies the groups for which the metric should be reported. SMI/SED demonstrations can operate at multiple levels: statewide; within a given geographic area, such as a county; or within a model of care, such as an accountable care organization. Model of care refers to the delivery system used to implement the demonstration. For example, if demonstration services are provided by managed care organizations (MCOs) for some beneficiaries and Medicaid fee-for-service (FFS) for others, then the state could report metrics separately for each MCO and the fee-for-service population. In addition, states may operate more than one SMI/SED program within a demonstration, each providing different services for different beneficiaries. States must report all metrics for the SMI/SED demonstration population overall. If a state includes multiple programs that it runs separately by geographic area or model of care, states may report metrics separately for each area or model. Under those circumstances, reporting measures at the state level could obscure important differences across programs.
- **Demonstration population.** The SMI/SED demonstration population is defined as any beneficiary with a SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Any beneficiary with an IMD stay for SMI would also be captured in this population.
    - **Subpopulations.** Some subpopulations have unique treatment needs with respect to SMI/SED. When instructed by metric specifications, states should calculate and report metrics for each stratification within subgroups. These subgroups are as follows:
    - *Standardized definition of SMI.* We refer to the National Committee for Quality Assurance (NCQA) definition of SMI as the standardized definition of SMI[3]. NCQA defines individuals with SMI as those who meet at least one of the following criteria within the measurement period: (1) at least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression, OR; (2) at least two visits in an outpatient, intensive outpatient (IOP), partial hospitalization (PH), emergency department (ED), or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia, OR; (3) at least two visits in an outpatient, IOP, PH, ED, or nonacute inpatient setting on different dates of service with a diagnosis of bipolar I disorder. See Table B.1 for applicable value sets and Appendix E for details.
    - *State-specific definition of SMI.* States may have their own distinct definition of SMI and report according to the definition they provide in their monitoring protocols, specifically within the document: 1115 SMI Monitoring Workbook.xlsx on the "Protocol-SMI & SED definitions" tab.
    - *Age groups (children <16, transition-age youth, 16-24, adults 25–64, and older adults 65+)*. Determine beneficiary age status as of the first day of the measurement period.

[3] CMS acknowledges that the NCQA definition is somewhat narrowly targeted to three conditions (schizophrenia, bipolar I disorder, and major depression) and may not capture the full range of individuals with SMI targeted by states. CMS is using the NCQA definition as method to gather relatively standardized data from states.

- *Dual–eligible status (Medicaid only or Medicare-Medicaid eligible).* Determine dual eligible status as of the first day of the measurement period. For reference, in T-MSIS, dual eligible status is determined by the eligibility file data element, DUAL-ELIGIBLE-CODE.[4]
- *Eligible for Medicaid on the basis of disability (yes, no).* Determine eligibility for Medicaid on the basis of disability based on ever qualifying for this subpopulation during the measurement period. For reference, in T-MSIS, eligibility based on disability is determined by the eligibility file data element, ELIGIBILITY-GROUP.
- *Criminal justice status (criminally involved, not criminally involved).* Determine criminal justice status based on ever qualifying for this subpopulation during the measurement period. There is no standard methodology across states for identifying criminal justice status; states will need to identify a method for flagging criminal involvement (such as by matching Medicaid beneficiaries to data from state law enforcement agencies).
- *Co-occurring SUD.* Determine co-occurring SUD for this subpopulation during the measurement period. States can identify beneficiaries with co-occurring SUD by identifying beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 11 months before the measurement period.
- *Co-occurring or physical health conditions*. Determine co-occurring physical health conditions for this subpopulation during the measurement period. States may use the definitions and ICD-10 codes in the CMS Chronic Conditions Data Warehouse (https://www.ccwdata.org/documents/10280/19139421/ccw-chronic-condition-algorithms.pdf) to identify co-occurring physical health conditions.

- **Data source.** This parameter identifies the likely data source(s) to be used to report each metric. Data sources include claims data, medical and administrative records, provider enrollment databases, and other state-specific databases.

[4] The T-MSIS data dictionary can be accessed at https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html. Additional resources for reporting on dually eligible beneficiaries is available on Medicaid.gov. See, for example, https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/integrated-medicare-medicaid-data.pdf, and https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/data-analytics/index.html

Table 2. Overview of section 1115 SMI/SED demonstration monitoring metrics, by measurement domain

	Metric name	Endorsement; Use in other programs	Data source	Required or recommended	Reporting level		Subpopulations	Measurement Period
					Demonstration	Model/ Area		
	Milestone 1[A]							
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	NQF #1663; IPFQR	Medical record review or claims	Recommended	X	X	None	Year
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NQF #2801; Child Core Set	Claims	Required	X	X	None	Year
	Milestone 2[A]							
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)		Claims	Required	X	X	None	Year
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	Based on NQF #2860; Medicare Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)	Claims	Required	X	X	None	Year
5	Medication Reconciliation Upon Admission	Based on NQF #3317	Electronic/ paper medical records	Recommended	X	X	None	Year
6	Medication Continuation Following Inpatient Psychiatric Discharge	Based on NQF #3205	Claims	Required	X	X	None	Year
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	NQF #0576; IPFQR; Child Core Set; Scorecard	Claims	Required	X	X	None	Year
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	NQF #0576; IPFQR; Adult Core Set; Scorecard	Claims	Required	X	X	None	Year
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	NQF #2605; Adult Core Set	Claims	Required	X	X	None	Year
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	NQF #2605; Adult Core Set	Claims	Required	X	X	None	Year
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	None	State data on cause of death, linked to claims	Recommended	X	X	Age only	Year

Table 2 (*continued*)

	Metric name	Endorsement; Use in other programs	Data source	Required or recommended	Reporting level		Subpopulations	Measurement Period
					Demonstration	Model/ Area		
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	None	State data on cause of death, linked to claims	Recommended	X	X	Age only	Year
	Milestone 3 [A]							
13	Mental Health Services Utilization - Inpatient	None	Claims	Required	X	X	X	Month
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	None	Claims	Required	X	X	X	Month
15	Mental Health Services Utilization - Outpatient	None	Claims	Required	X	X	X	Month
16	Mental Health Services Utilization - ED	None	Claims	Required	X	X	X	Month
17	Mental Health Services Utilization - Telehealth	None	Claims	Required	X	X	X	Month
18	Mental Health Services Utilization - Any Services	None	Claims	Required	X	X	X	Month
19a	Average Length of Stay in IMDs	None	Claims	Required	X	X	None	Year
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	None	Claims	Required	X	X	None	Year
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	None	Claims	Required	X	X	None	Year
	Milestone 4 [A]							
21	Count of Beneficiaries With SMI/SED (monthly)	None	Claims	Required	X	X	X	Month
22	Count of Beneficiaries With SMI/SED (annually)	None	Claims	Required	X	X	X	Year
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	NQF #2607; Adult Core Set	Claims, Medical Records	Required	X	X	None	Year
24	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	NQF #0418/0418e; Adult Core Set	Claims or electronic medical records	Recommended	X	X	None	Year
25	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	CMS; NQF #0418/0418e; Child Core Set	Claims or electronic medical records	Recommended	X	X	None	Year

Table 2 (*continued*)

	Metric name	Endorsement; Use in other programs	Data source	Required or recommended	Reporting level		Subpopulations	Measurement Period
					Demonstration	Model/ Area		
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	None	Claims	Required	X	X	None	Year
27	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NQF #2600	Claims	Recommended	X	X	None	Year
28	Alcohol Screening and Follow-up for People with Serious Mental Illness	NQF #2599	Claims	Recommended	X	X	None	Year
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Certified Community Behavioral Health Clinics Demonstration (CCBHC)	Claims	Required	X	X	None	Year
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	NQF #3313	Claims	Required	X	X	None	Year
31	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Child Core Set	Claims	Required	X	X	None	Year
	Other SMI/SED metrics							
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	None	Claims	Required	X	X	None	Year
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	None	Claims	Required	X	X	None	Year
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	None	Claims	Required	X	X	None	Year
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	None	Claims	Required	X	X	None	Year
36	Grievances Related to Services for SMI/SED	None	Administrative records	Required	X	X	None	Quarter
37	Appeals Related to Services for SMI/SED	None	Administrative records	Required	X	X	None	Quarter

Table 2 (*continued*)

	Metric name	Endorsement; Use in other programs	Data source	Required or recommended	Reporting level		Subpopulations	Measurement Period
					Demonstration	Model/ Area		
38	Critical Incidents Related to Services for SMI/SED	None	Administrative records	Required	X	X	None	Quarter
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	None	Claims	Required	X	X	None	Year
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	None	Claims	Required	X	X	None	Year

[A] Milestones included in this table are from the State Medicaid Director Letter #18-011.

B. Reporting 1115 SMI/SED demonstration monitoring metrics defined by CMS

This section provides reporting guidance applicable to 1115 SMI/SED demonstration monitoring metrics. The technical specifications for calculating each metric can be found in Chapter II.

Technical assistance. To help states collect, report, and use the 1115 SMI/SED demonstration monitoring metrics, CMS offers technical assistance. Please submit technical assistance requests to: 1115MonitoringAndEvaluation@cms.hhs.gov. When you contact this mailbox, please copy your CMS project officer on the message.

Metric type. This document describes three types of 1115 SMI/SED demonstration metrics:

- *CMS constructed metrics.* Many of the metrics for the 1115 SMI/SED demonstration were constructed by CMS. The technical specifications for these metrics are included in this document. Many of these metrics reference HEDIS 2019 value sets or other lists that contain complete sets of codes used to identify a treatment service or diagnosis. When referenced, use these value sets to calculate a metric. Established value sets are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov.
- *Established quality measures.* Some metrics are established quality measures available from the Medicaid and CHIP Child Core Set, the Medicaid Adult Core Set, NQF, or the measure steward.[5] To help states calculate these metrics, this document references the original measure specifications and associated value sets, which are available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov.
- *State-identified metrics.* In addition to the metrics provided by CMS, a state can propose metrics specific to its demonstration. These metrics are referred to as "state-identified metrics" within this document.

Measurement period. When reporting 1115 SMI/SED demonstration monitoring metrics, use the following guidance for determining the measurement periods.

- For metrics where the measurement period is a month, the first measurement period is the first month of the demonstration. For example, if the demonstration started on March 1, the first month is March 1 through March 31. The second month is April 1 through April 30.
- For metrics where the measurement period is a quarter, the first quarter of the demonstration spans the first three months of the demonstration. For example, if the demonstration started on March 1, the first quarter is March 1 through May 31.
- For the CMS-constructed metrics where the measurement period is a year, the first measurement period is the first year of the demonstration. For example, if the

[5] Metrics that are established quality measures include: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 23, 24, 25, 26, 27, 28, 29, 30, and 31.

demonstration started on March 1, 2019 the measurement period is March 1, 2019 through February 29, 2020.

- For metrics that are established quality measures, the first annual measurement period is the first calendar year of the demonstration. For example, if the demonstration started on March 1, 2019, the first calendar year is January 1, 2019 through December 31, 2019, to align with the measurement period for these measures in other quality reporting programs.

Baseline period. The baseline period is the first measurement period.

- For metrics where the measurement period is a month or a quarter, as well as CMS-constructed and state-identified metrics where the measurement period is a year, the baseline year will be the first SMI/SED demonstration year (DY). For example, for a demonstration that started on March 1, 2019, the baseline year is March 1, 2019 through February 29, 2020.
    - For states where the first SMI/SED DY (DY1) is less than 12 months, the state should report the 12 months preceding the end of SMI/SED DY1 as its baseline reporting period (including months before the start of the demonstration). For example, if the state has a 10-month SMI/SED DY1 starting March 1, 2019 and ending December 31, 2019, the baseline year is January 1, 2019 through December 31, 2019.
- For metrics that are established quality measures, the calendar year in which the demonstration started will become the baseline year. For example, for a demonstration that started on March 1, 2019, the baseline year for established quality measures would be January 1, 2019 through Dec 31, 2019.
    - For established quality measures calculated over a 2-year period, the baseline is the calendar year in which the demonstration started and the prior year. For each subsequent report period shift the period for the denominator forward one year.
    - For states where the SMI/SED DY1 is less than 12 months, the state should use the last day of SMI/SED DY1 to identify the appropriate calendar year for reporting. If the last day of SMI/SED DY1 is December 31, that same calendar year will be the baseline year for established quality measures. Otherwise, the baseline year will be the prior calendar year. For example, if a state has a 10-month SMI/SED DY1 starting on January 1, 2020 and ending on October 31, 2020, calendar year 2019 would be the baseline period.
- For states with SMI/SED demonstrations that begin in the middle of a month, the state should start its baseline period on the first date of the month. This applies to all baseline periods (month, quarter, and year). For example, if a state's SMI/SED demonstration began on March 15, the state's first measurement month is March 1 through March 31. The second month is April 1 through April 30.
- For states with a demonstration start date that falls after the demonstration approval date, the baseline year begins on the demonstration start date.

Please confirm the measurement and baseline periods for your state with your project officer.

Table 3 below illustrates these guidelines, using the demonstration start date of March 1, 2019 as an example.

Table 3. Example of alignment between demonstration years and measurement periods

Demonstration Start Date: March 1, 2019	Measurement Period							
	Month		Quarter		Year			
	Start Date	End Date	Start Date	End Date	Start Date	End Date	Start Date	End Date
	CMS-constructed and state-identified metrics						Established quality measures	
Measurement Baseline year	Mar 1 Apr 1 May 1 June 1 Feb 1	Mar 31 Apr 30 May 31 June 30 Feb 29	Mar 1 June 1 Sep 1 Dec 1	May 31 Aug 31 Nov 30 Feb 29	Mar 1, 2019	Feb 29, 2020	Jan 1, 2019	Dec 31, 2019
Measurement Year 1	Month as defined in the Baseline year row		Quarter as defined in the Baseline year row		Mar 1, 2020	Feb 28, 2021	Jan 1, 2020	Dec 31, 2020
Measurement Year 2					Mar 1, 2021	Feb 28, 2022	Jan 1, 2021	Dec 31, 2021
Measurement Year 3					Mar 1, 2022	Feb 28, 2023	Jan 1, 2022	Dec 31, 2022
Measurement Year 4					Mar 1, 2023	Feb 29, 2024	Jan 1, 2023	Dec 31, 2023

Metric calculation and reporting. States should report data to CMS in accordance with the schedule and format agreed upon in the approved monitoring protocol. Because of the dynamic nature of Medicaid data, metrics should be produced at the same time in each measurement period throughout the demonstration. This applies even if data are not shared with CMS until a later date. For example, if a state submits data quarterly, the submission should contain three monthly values for each monthly metric, each produced at the same time relative to its measurement period.

Guidelines for including metrics and narrative information in monitoring reports are as follows:

- Each quarterly report should contain (1) narrative information on implementation for the most recent demonstration quarter, (2) grievances and appeals metrics, and qualitative information on referrals into treatment for the most recent demonstration quarter, and (3) all other monthly and quarterly metrics for the prior quarter (which allows at least 90 days for claims run-out and other considerations for data completeness).

- To allow for adequate time to implement annual specification updates from measure stewards, annual metrics that are established quality measures should be reported:

  - For states with demonstration years (DYs) that end March 31 through November 30: in the annual report
  - For states with demonstration years that end January 31 or February 28: in the first quarterly report of the next demonstration year
  - For states with demonstration years that end December 31: in the second quarterly report of the next demonstration year

- All other annual metrics should be reported in the first quarterly report of the following demonstration year, rather than in the annual report. This allows at least 90 days for claims run-out and other considerations for data completeness.

Table 4 illustrates these guidelines, which apply to both CMS-constructed and state-identified metrics.

Table 4. Reporting in quarterly and annual monitoring reports

Report name:	DY1 Q1 report	DY1 Q2 report	DY1 Q3 report	DY1 Q4 (annual) report	DY2 Q1 report	DY2 Q2 report
Report due date:	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 90 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends
Measurement periods, by reporting category						
Narrative information on implementation	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2
Grievances and appeals and qualitative information on referral into treatment	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2
Other monthly and quarterly metrics	NA	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY4 Q1
Annual metrics that are established quality measures*	NA	NA	NA	States with DYs ending 3/31 – 11/30: DY1 (Q1-Q4)	States with DYs ending on 1/31 or 2/28: DY1 (Q1-Q4)	States with DYs ending on 12/31: DY1 (Q1-Q4)
Other annual metrics	NA	NA	NA	NA	DY1	NA

DY = Demonstration year

NA = not applicable (information not expected to be included in report)

Note: The state is expected to submit retrospective metrics data in the state's second monitoring report submission after monitoring protocol approval

* Metrics that are established quality measures should be calculated for the calendar year. All other metrics should be calculated for the SMI/SED demonstration year.

Manual version. For measurement periods in calendar year 2019, states should use version 1 of this manual (dated October 11, 2019). The technical specifications manual will be updated annually in May to provide current specifications and value sets.

General guidance. When reporting 1115 SMI/SED demonstration monitoring metrics, please follow these guidelines for all metrics:

- **Supporting measure specifications, value sets, and code lists.** Many monitoring metrics reference value sets, code lists, or full specifications for established quality measures. See Appendix C for instructions on how to access and use these supporting materials to calculate monitoring metrics.
- **Eligible population.** The eligible population for each metrics will vary based on whether the metric is a CMS-constructed metric or an established quality measure.
  - For CMS-defined quarterly and annual metrics, beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period are eligible for inclusion in metric calculations. Beneficiaries enrolled for any amount of time during the measurement period should be included in calculations for monthly metrics. Beneficiaries with partial benefits are only eligible for inclusion in metric calculations (using the same enrollment criteria as beneficiaries with full benefits) if they are eligible to receive the services described in the metric numerator. Any additional eligibility criteria are presented in metric specifications in Chapter II.
    - The metrics should include full benefit enrollees including individuals entitled to the full scope of Medicaid benefits, enrolled in an alternative benchmark-equivalent plan, eligible for only pregnancy-related services, or otherwise eligible for full coverage of Medicaid SMI/SED treatment services.
    - The metrics should exclude beneficiaries who are:
      - only entitled to restricted benefits based on alien status;
      - only entitled to restricted benefits based on Medicare dual-eligibility status including QMB, SLMB, QDWI and QI;
      - have a first source of payment other than Medicaid or Medicare for SMI/SED services (for example private insurance or eligibility for Medicaid only after spenddown);
      - only eligible for family planning services; or
      - inmates in a facility by operation of criminal law
    - The exclusion criteria should only apply to the metric measurement period and not to the look back period for CMS-constructed measures. That is, beneficiaries who would not meet the inclusion criteria during a look back period, but who meet the criteria during the measurement period, should still be included.
  - For established quality measures in the Medicaid Child and Adult Sets, refer to the technical specifications included in Appendix D. For other established quality measures, refer to the original measure specifications, provided separately by CMS.
- **Claim type.** For monitoring metrics defined by CMS, use only paid claims to identify whether a treatment service was provided to Medicaid beneficiaries. For established quality measures, follow guidance from the measure steward. For example, some HEDIS measures use paid, suspended, pending and denied claims.
- **State-specific codes.** States may use state-specific diagnosis, procedure, or other types of codes. When applicable, states should supplement the codes referenced in metric specifications with state-specific codes that are not included in the value sets. State-specific

codes must be for services specific to mental health treatment. These modifications should be noted as part of the state's metrics submission, as described in the Monitoring Report Template Instructions.

C. Using technical specifications

Table 5 defines the elements included in specifications for metrics in Chapter II. The description column explains each metric element.

Table 5. Table shell for the metrics' technical specifications

Metric #: Metric Name	
Metric element	**Description**
Measure sets/endorsements	Describes whether the metric is included in other Medicaid Quality Measures measure sets (such as Core Set) and is endorsed by NQF. When applicable, this element also names the measure steward.
Description	Brief measure description.
Numerator	When the metric is a rate, this element describes the numerator in the rate equation. When the metric is a count, this element describes the counted variable. This element is not used in metrics that reference established quality measures.
Denominator/ Population of interest	When the metric is a rate, this element describes the denominator in the rate equation. When the metric is a count, this element describes the population of interest. This element is not used in metrics that reference established quality measures.
Metric calculation	When the metric is a rate, this element provides instructions for calculating the metric. This element is not used when the metric is a count.
Additional guidance	Any additional guidance required to report this metric.
Measurement period (Metric type)	Measurement period describes whether the measurement period is a month, quarter, or year. Metric type describes whether the metric is CMS-constructed or an established quality measure.
Reporting category	Reporting category describes the category associated with reporting guidelines for including metrics in monitoring reports (see Table 4 above). Categories include grievances and appeals and qualitative information on referral into treatment, other monthly and quarterly metrics, annual metrics that are established quality measures, and other annual metrics
Reporting level	Describes the groups for which to report the metric.
Subpopulations	Describes population subgroups that states must report separately.
Relationship to other metrics	Describes components of a metric that are used in other 1115 SMI/SED demonstration metrics.
Data source	Describes the likely data source(s) used to report this metric.
Claim type	Describes the types of claims to include when calculating the metric.

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II. METRIC SPECIFICATIONS

Metric #1: SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	
Metric element	**Description**
Measure sets/endorsements	NQF #1663 Measure steward: The Joint Commission
Description	Two rates will be reported for this measure: 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. 2. SUB-2a: Patients who received the brief intervention during the hospital stay.
Metric calculation	Calculation instructions are located in The Specifications Manual for National Hospital Inpatient Quality Measures v5.6; see measure SUB-2, Alcohol Use Brief Intervention Provided or Offered, and measure SUB-2a, Alcohol Use Brief Intervention. The specification is located in "2l-SUB2.pdf" and references ICD-10 codes in "Appendix - A1.xls." See also the Data Dictionary for the measure data elements in "1b-AlphaDD.pdf"
Additional guidance	The Specifications Manual for National Hospital Inpatient Quality Measures v5.6 is available at https://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Medical record review or claims
Claim type	Not specified

Metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set) NQF #2801 Measure steward: NCQA
Description	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #3 All-Cause Emergency Department (ED) Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	
Metric element	**Description**
Measure sets/endorsements	CMS
Description	Number of all-cause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria of beneficiaries with SMI.
Metric calculation	Calculation instructions are located in the full measure specification, which CMS will provide separately. States should follow the instructions for the observed (i.e., unadjusted) measure rates.
Additional guidance	The specifications and value sets for this measure are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use only paid claims

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	
Metric element	**Description**
Measure sets/endorsements	Medicare Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) Based on NQF #2860 Measure steward: CMS
Description	The rate of unplanned, 30-day, readmission rate for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.
Numerator	The count of 30-day readmissions. A readmission is defined as any admission, for any reason, to an IPF or a short-stay acute care hospital (including CAHs) that occurs within 30 days after the discharge date from an eligible index admission to an IPF, except those considered planned. The measure uses the CMS 30-day Hospital-Wide Readmission (HWR) Measure Planned Readmission Algorithm, Version 4.0.
Denominator	The count of index hospital admissions to IPFs

Metric calculation	The measure population consists of eligible index admissions to IPFs. A readmission within 30-days will also be eligible as an index admission, if it meets all other eligibility criteria. Patients may have more than one index admission within the measurement period.
	
	Step 1. Identify the Eligible population:
	Identify beneficiaries who meet the following criteria:
	• Age 18 or older at admission
	• Discharged alive
	• Enrolled in Medicaid during the month of and at least one month after the index admission
	
	Step 2. Exclude beneficiaries who are:
	• Discharged against medical advice because the IPF may have limited opportunity to complete treatment and prepare for discharge
	• With unreliable demographic and vital status data defined as the following:
	  ○ Age greater than 115 years
	  ○ Missing gender
	  ○ Discharge status of "dead" but with subsequent admissions
	  ○ Death date prior to admission date
	  ○ Death date within the admission and discharge dates but the discharge status was not "dead"
	• With readmissions on the day of discharge or day following discharge because those readmissions are likely transfers to another inpatient facility. The hospital that discharges the patient to home or a non-acute care setting is accountable for subsequent readmissions.
	• With readmissions two days following discharge because readmissions to the same IPF within two days of discharge are combined into the same claim as the index admission and do not appear as readmissions due to the interrupted stay billing policy. Therefore, complete data on readmissions within two days of discharge are not available.
	
	Step 3: Calculate the Denominator: count of index admissions with discharge dates between January 1 and December 31.
	To identify index admissions, identify discharges with a psychiatric principal diagnosis included in one of the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software (CCS) ICD groupings below. (More information on grouping ICD codes into clinically coherent groups is available at the following link: https://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp.)

Metric #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	
Metric element	**Description**
Metric calculation	○ Primary discharge diagnosis clinical categories designating psychiatric illness for measure cohort ▪ 650 - Adjustment disorders ▪ 651 - Anxiety disorders ▪ 652 - Attention-deficit, conduct, and disruptive behavior disorders ▪ 653 - Delirium, dementia, and amnestic and other cognitive disorders ▪ 654 - Developmental disorders ▪ 655 - Disorders usually diagnosed in infancy, childhood, or adolescence ▪ 656 - Impulse control disorders, NEC ▪ 657 - Mood disorders ▪ 658 - Personality disorders ▪ 659 - Schizophrenia and other psychotic disorders ▪ 660 - Alcohol-related disorders ▪ 661 - Substance-related disorders ▪ 662- Suicide and intentional self-inflicted injury ▪ 663 - Screening and history of mental health and substance abuse codes ▪ 670 - Miscellaneous disorders *Step 4: Calculate the Numerator: Count of 30-day Readmissions* Among beneficiaries identified in Step 3, identify the readmissions to an IPF or a short-stay acute care hospital (including CAHs) that occurs within 30 days after the discharge date from an eligible index admission to an IPF. Step 3. *Exclude admissions considered planned* Identify admission considered planned as determined by the CMS 30-day Hospital-Wide Readmission (HWR) Measure Planned Readmission Algorithm, Version 4.0 available at: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841. Step 4: Calculate the rate of readmissions: number readmissions (Step 4) / number of index admissions (Step 3)
Additional guidance	This measure is based on the 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF) in the IPFQR program. The program manual for IPFQR is available at: https://www.qualitynet.org/files/5d0d3993764be766b0103982?filename=181203_FY19_IPFQR_CBM_Specs.pdf
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, and denied claims.)

Metric #5: Medication Reconciliation Upon Admission	
Metric element	**Description**
Measure sets/endorsements	CMS NQF #3317
Description	Percentage of patients for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.
Numerator	Number of admissions with a designated PTA medication list generated by referencing one or more external sources of medications for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.
Denominator	Admissions to an inpatient facility from home or a non-acute setting
Metric calculation	Calculation instructions are located in the full measure specification, which CMS will provide separately
Additional guidance	The specifications and value sets for this measure are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Electronic/paper medical records
Claim type	Not specified

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019

Metric #6: Medication Continuation Following Inpatient Psychiatric Discharge	
Metric element	**Description**
Measure sets/endorsements	CMS Based on NQF# 3205
Description	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.
Metric calculation	Calculation instructions are located in the full measure specification, which CMS will provide separately
Additional guidance	The specifications and value sets for this measure are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use only paid claims. (Do not use suspended, pending, or denied claims.)

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #7: Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set) NQF #0576 Measure steward: NCQA
Description	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the child received follow-up within 30 days after discharge • Percentage of discharges for which the child received follow-up within 7 days after discharge
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #0576 Measure steward: NCQA
Description	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional self-harm and who had a follow-up visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #2605 Measure steward: NCQA
Description	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #10: Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #2605 Measure steward: NCQA
Description	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #11: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.
Numerator	Count the number of suicide or overdose deaths among eligible beneficiaries Step 1: Determine the beneficiaries in the Denominator. Retain only stays with discharge dates that fall within the measurement period. Step 2: Using state data (e.g. medical examiner data or death records) identify beneficiaries with the following ICD-10 codes for underlying cause of death in the measurement period: • U03 (other means) • X40 – X44 (unintentional drug poisonings) • X60- X64 (suicidal drug poisonings) • X70 – X84 (intentional self-harm) • X85 (homicide drug poisoning) • Y10-Y19 (drug poisoning of undetermined intent) • Y20-Y34 (other events of undetermined intent) • Y87 (other means) Step 3: Subtract the date of death from the death record from the discharge date for any stays for the same beneficiary and calculate the number of beneficiaries with a date of death within 7 and within 30 days of a mental health stay discharge date.

Metric #11: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	
Metric element	**Description**
Population of Interest	Beneficiaries with SMI/SED enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period or the 30 days prior to the beginning of the measurement period. Step 1a. Identify claims with a place of service or UB Revenue code listed below: *Place of Service Codes:* • 51 - Inpatient Psychiatric Facility • 56 – Psychiatric Residential Treatment Center • From the 2016 HEDIS *BH Stand Alone Acute Inpatient* Value Set • From the 2016 HEDIS *BH Acute Inpatient* Value Set • From the 2016 HEDIS *BH Nonacute inpatient* *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2016 BH Stand Alone Nonacute Inpatient Value Set • From the HEDIS 2019 Inpatient Stay value set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set Step 2. Retain claims that meet the criteria in both Step 1a and 1b for residential or inpatient treatment Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
Metric calculation	Calculate the number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of a mental health stay discharge date.
Additional guidance	Data sources for suicide deaths may vary by state. For example, some states may have access to a centralized state medical examiner system, whereas other states may have decentralized systems containing death records. When suicide deaths occur, coroners and medical examiners are instructed to record the cause of death on the death certificate using ICD-10 codes. States may also have more detailed information on cause of death. If available, state-specific data sources may be used to identify suicide deaths. Use the discharge date to identify claims in the measurement period. Do not count beneficiaries for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, then combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics

Metric #11: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	
Metric element	**Description**
Reporting level	Demonstration Model Subpopulations
Subpopulations	Age groups
Relationship to other metrics	None
Data source	State data on cause of death
Claim type	Not applicable

Metric #12: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	
Metric element	**Description**
Measure sets/endorsements	None
Description	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.
Numerator	The number of suicide or overdose deaths among eligible beneficiaries Step 1: Using the beneficiaries in the identified in the Denominator. Retain only stays with discharge dates that fall within the measurement period. Step 2: Using state data (e.g. medical examiner data or death records) identify beneficiaries with the following ICD-10 codes for underlying cause of death in the measurement period: • U03 (other means) • X40 – X44 (unintentional drug poisonings) • X60- X64 (suicidal drug poisonings) • X70 – X84 (intentional self-harm) • X85 (homicide drug poisoning) • Y10-Y19 (drug poisoning of undetermined intent) • Y20-Y34 (other events of undetermined intent) • Y87 (other means) Step 3: Subtract the date of death from the death record from the discharge date for any stays for the same beneficiary and calculate the number of beneficiaries with a date of death within 7 and within 30 days of a mental health stay discharge date.

Metric #12: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	
Metric element	**Description**
Denominator	Beneficiaries with SMI/SED enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period or the 30 days prior to the beginning of the measurement period. Step 1a. Identify claims for inpatient or residential stays using the place of service or UB Revenue codes listed below: *Place of Service Codes:* • 51 - Inpatient Psychiatric Facility • 56 – Psychiatric Residential Treatment Center • From the 2016 HEDIS *BH Stand Alone Acute Inpatient* Value Set • From the 2016 HEDIS *BH Acute Inpatient* Value Set • From the 2016 HEDIS *BH Nonacute inpatient* *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2016 BH Stand Alone Nonacute Inpatient Value Set • From the HEDIS 2019 Inpatient Stay value set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set Step 2. Retain claims that meet the criteria in both Step 1a and 1b for residential or inpatient treatment Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
Metric calculation	Calculate the rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health by dividing the total number of beneficiaries in the numerator by the number of beneficiaries in the denominator, as follows: Rate for 7 days: Total of beneficiaries with a date of death within 7 days of a mental health stay discharge date/ Total number of beneficiaries with a primary mental health diagnosis and an inpatient or residential stay Rate for 30 days: Total of beneficiaries with a date of death within 30 days of a mental health stay discharge date/ Total number of beneficiaries with a primary mental health diagnosis and an inpatient or residential stay

Metric #12: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	
Metric element	**Description**
Additional guidance	Data sources for suicide deaths may vary by state. For example, some states may have access to a centralized state medical examiner system, whereas other states may have decentralized systems containing death records. When suicide deaths occur, coroners and medical examiners are instructed to record the cause of death on the death certificate using ICD-10 codes. States may also have more detailed information on cause of death. If available, state-specific data sources may be used to identify suicide deaths Use the discharge date to identify claims in the measurement period. Do not count beneficiaries for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, then combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Age groups
Relationship to other metrics	None
Data source	State data on cause of death
Claim type	Not applicable

Metric #13: Mental Health Services Utilization - Inpatient	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration or with SMI/SED who use inpatient services related to mental health during the measurement period
Numerator	The total number of unique beneficiaries (de-duplicated total) who have a claim for inpatient services related to mental health during the measurement period Step 1. Identify claims that have a revenue code from the HEDIS 2019 Inpatient Stay Value Set and have a primary diagnosis code in the HEDIS 2019 Mental Health Diagnosis Value Set. Step 2. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1.
Population of interest	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period
Additional guidance	Use the discharge date to identify claims in the measurement period. Do not count beneficiaries for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, then combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health conditions
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration or with SMI/SED who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period
Numerator	The total number of unique beneficiaries (de-duplicated total) who have a claim for intensive outpatient and/or partial hospitalization services related to mental health during the measurement period Step 1. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set Step 2. Retain claims with a code from any of the following HEDIS 2019 Value Sets: • Partial Hospitalization/Intensive Outpatient • MPT IOP/PH Group 1 **with** a corresponding code from Partial Hospitalization POS or Community Mental Health Center POS o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting • Electroconvulsive Therapy **with** a corresponding code from Partial Hospitalization POS or Community Mental Health Center POS o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting • Transcranial Magnetic Stimulation **with** a corresponding code from Partial Hospitalization POS or Community Mental Health Center POS o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting • MPT IOP/PH Group 2 **with** a corresponding code from Partial Hospitalization POS o States should ensure that the visit was billed by a mental health practitioner • MPT IOP/PH Group 2 **with** a corresponding code from Community Mental Health Center POS o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting o States should ensure that the visit was billed by a mental health practitioner Step 3. Exclude any claims with a code in the Telehealth Modifier or Telehealth POS value sets Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1, 2, and 3.
Population of interest	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period
Additional guidance	None
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups

Metric #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	
Metric element	**Description**
	Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health condition
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #15: Mental Health Services Utilization - Outpatient	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration or with SMI/SED who used outpatient services related to mental health during the measurement period

Numerator	The number of unique beneficiaries (de-duplicated total) with an outpatient service related to mental health during the measurement period
	
	Step 1. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set
	
	Step 2. Retain claims with a code from any of the following HEDIS 2019 Value Sets:
	
	• MPT Stand Alone Outpatient Group 1
	• MPT Stand Alone Outpatient Group 2
	  o States should ensure the visit was billed by a mental health practitioner
	• Observation
	  o States should ensure the visit was billed by a mental health practitioner
	• Visit Setting Unspecified **with** a corresponding code from Outpatient POS
	• Electroconvulsive Therapy **with** a corresponding code from Outpatient POS or Ambulatory Surgical Center POS
	• Transcranial Magnetic Stimulation **with** a corresponding code from Outpatient POS or Ambulatory Surgical Center POS
	• Visit Setting Unspecified **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an outpatient setting
	• Electroconvulsive Therapy **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an outpatient setting
	• Transcranial Magnetic Stimulation **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an outpatient setting
	
	Step 3. Exclude any claims with a code in the Inpatient Stay, Telehealth Modifier, or Telehealth POS value sets
	
	Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1- 3.

Population of interest	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period
Additional guidance	None
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Reporting level	Demonstration Model Subpopulations

Metric #15: Mental Health Services Utilization - Outpatient	
Metric element	**Description**
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health conditions
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #16: Mental Health Services Utilization - ED	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration or with SMI/SED who use emergency department services for mental health during the measurement period
Numerator	The total number of unique beneficiaries (de-duplicated total) who have a claim for emergency services for mental health during the measurement period Step 1. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set. Step 2. Retain claims with a code from any of the following HEDIS 2019 Value Sets: • ED • Visit Setting Unspecified **with** a corresponding code from ED POS • Visit Setting Unspecified **with** a corresponding code from Community Mental Health Center POS, where the organization can confirm that the visit was in an ED setting (this POS code can be used in settings other than the ED). Step 3. Exclude any claims with a code in the Inpatient Stay, Telehealth Modifier, or Telehealth POS value sets Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1- 3.
Population of interest	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period
Additional guidance	None
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health conditions
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #17: Mental Health Services Utilization - Telehealth	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration or with SMI/SED who used telehealth services related to mental health during the measurement period
Numerator	The number of unique beneficiaries (de-duplicated total) with SMI/SED with a service claim for telehealth services related to mental health during the measurement period Step 1. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set. Step 2. Retain claims with a code from any of the following HEDIS 2019 Value Sets: • Visit Setting Unspecified **with** a corresponding code from Telehealth Modifier **and** Telehealth POS • MPT IOP/PH Group 1 **with** a corresponding code from Telehealth Modifier **and** Telehealth POS • MPT IOP/PH Group 2 **with** a corresponding code from Telehealth Modifier **and** Telehealth POS ○ States should ensure the visit was billed by a mental health practitioner Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
Population of interest	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period
Additional guidance	None
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health conditions
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #18: Mental Health Services Utilization– Any Services	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration or with SMI/SED who used any services related to mental health during the measurement period.

Numerator	The number of unique beneficiaries (de-duplicated total) with a service claim for any services related to mental health during the measurement period
	
	Step 1. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set.
	
	Step 2. Retain claims with a code from any of the following HEDIS 2019 Value Sets:
	
	• Inpatient Stay
	• Partial Hospitalization/Intensive Outpatient
	• MPT IOP/PH Group 1 **with** a corresponding code from Partial Hospitalization POS or Community Mental Health Center POS
	  ○ States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• Electroconvulsive Therapy **with** a corresponding code from Partial Hospitalization POS or Community Mental Health Center POS
	  ○ States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• Transcranial Magnetic Stimulation **with** a corresponding code from Partial Hospitalization POS
	  ○ States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• Transcranial Magnetic Stimulation **with** a corresponding code from Community Mental Health Center POS
	  ○ States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• MPT IOP/PH Group 2 **with** a corresponding code from Partial Hospitalization POS
	  ○ States should ensure that the visit was billed by a mental health practitioner
	• MPT IOP/PH Group 2 **with** a corresponding code from Community Mental Health Center POS
	  ○ States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	  ○ States should ensure that the visit was billed by a mental health practitioner
	• MPT Stand Alone Outpatient Group 1
	• MPT Stand Alone Outpatient Group 2
	  ○ States should ensure the visit was billed by a mental health practitioner
	• Observation
	  ○ States should ensure the visit was billed by a mental health practitioner
	• Visit Setting Unspecified **with** a corresponding code from Outpatient POS or ED POS or (Telehealth Modifier **and** Telehealth POS)
	• Electroconvulsive Therapy **with** a corresponding code from Outpatient POS or Ambulatory Surgical Center POS
	• Transcranial Magnetic Stimulation **with** a corresponding code from Outpatient POS or Ambulatory Surgical Center POS

Metric #18: Mental Health Services Utilization– Any Services	
Metric element	**Description**

Numerator (continued)	• Visit Setting Unspecified **with** a corresponding code from Community Mental Health Center POS
	  ○ States should ensure that the visit was in an outpatient setting
	• Electroconvulsive Therapy **with** a corresponding code from Community Mental Health Center POS
	  ○ States should ensure that the visit was in an outpatient setting
	• Transcranial Magnetic Stimulation **with** a corresponding code from Community Mental Health Center POS
	  ○ States should ensure that the visit was in an outpatient setting
	• ED Value Set
	• MPT IOP/PH Group 1 **with** a corresponding code from Telehealth Modifier **and** Telehealth POS
	• MPT IOP/PH Group 2 **with** a corresponding code from Telehealth Modifier **and** Telehealth POS
	  ○ States should ensure the visit was billed by a mental health practitioner
	
	Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.

Population of interest	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period
Additional guidance	None
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health conditions
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #19a: Average Length of Stay in IMDs	
Metric element	**Description**
Measure sets/endorsements	None
Description	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD.
Numerator	CMS will ask states to report three rates for this metric: 1. ALOS for all IMDs and populations 2. ALOS among short-term stays (less than or equal to 60 days) 3. ALOS among long-term stays (greater than 60 days) For each rate (total population, short-term, and long-term stays): Step 1. Determine length of stay for each discharge identified in the denominator. Length of stay is calculated based on the number of days between a beneficiary's admission date and discharge date from an IMD. A beneficiary admitted and discharged on the same day is treated as a one-day stay. Step 2. Sum the total number of days in an IMD by summing the lengths of stay from the denominator
Denominator	Separately for short-term and all stays, identify the total number of inpatient and residential discharges from an IMD for mental health treatment. Step 1. Identify qualifying IMD discharges for inpatient or residential treatment for mental health during the measurement period. This method may be specific to each state; some states maintain centralized databases of IMD stays. Alternatively, states may be able to identify IMD stays in T-MSIS data or through other methods. Step 1a. Identify claims for inpatient or residential stays using the place of service or UB Revenue codes listed below: *Place of Service Codes:* • 51 - Inpatient Psychiatric Facility • 56 – Psychiatric Residential Treatment Center *HCPCS Codes:* o H0017 – Behavioral health; residential o H0018 – Behavioral health; short-term residential o H0019 – Behavioral health; long-term residential o T2048 – Behavioral health; long-term care residential *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2019 Inpatient Stay Value Set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set

Metric #19a: Average Length of Stay in IMDs	
Metric element	**Description**
Denominator (continued)	Step 2. Retain claims that meet the criteria in both Step 1a and 1b for residential or inpatient treatment in an IMD. (See the additional guidance section for a definition of IMDs). Step 3. De-duplicate and sum the discharges from Step 2 to identify the total number of discharges from an IMD for beneficiaries with a mental health diagnosis. Step 4. Stratify IMD discharges during the measurement period into short-term, long-term and all stays.
Metric calculation	For each rate, calculate the mean length of stay by dividing the total number of days in an IMD for all discharges in the numerator by the number of discharges in the denominator, as follows: Total number of days in an IMD / Number of discharges
Additional guidance	Use the discharge date to identify claims in the measurement period for residential and inpatient services. Do not count beneficiaries for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • Combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims. An IMD is defined as a hospital, nursing facility, or other institution that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases. Some states have published lists of IMDs in which the designation is made by the state. If available, states can use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance.

Metric #19a: Average Length of Stay in IMDs	
Metric element	**Description**
Additional guidance (continued)	Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs. 5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases. a. When applying the 50 percent guideline determine whether <u>each</u> patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims State-specific IMD database
Claim type	If using claims, only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: States may be asked to provide CMS with the standard deviation based on the mean calculated in this metric as part of the midpoint assessment. For details, see Appendix F.

Metric #19b: Average Length of Stay in IMDs (IMDs receiving FFP only)	
Metric element	**Description**
Measure sets/endorsements	None
Description	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP).
Numerator	CMS will ask states to report three rates for this metric: 1. ALOS for all IMDs and populations 2. ALOS among short-term stays (less than or equal to 60 days) 3. ALOS among long-term stays (greater than 60 days) For each rate (total population, short-term, and long-term stays): Step 1. Determine length of stay for each discharge identified in the denominator. Length of stay is calculated based on the number of days between a beneficiary's admission date and discharge date from an IMD. A beneficiary admitted and discharged on the same day is treated as a one-day stay. Step 2. Sum the total number of days in an IMD by summing the lengths of stay from the denominator
Denominator	Separately for short-term and all stays, identify the total number of inpatient and residential discharges from an IMD for mental health treatment. Limit to IMDs receiving FFP. Step 1. Identify qualifying IMD discharges for inpatient or residential treatment for mental health during the measurement period. This method may be specific to each state; some states maintain centralized databases of IMD stays. Alternatively, states may be able to identify IMD stays in T-MSIS data or through other methods. Step 1a. Identify claims for inpatient or residential stays using the place of service or UB Revenue codes listed below: *Place of Service Codes:* • 51 - Inpatient Psychiatric Facility • 56 – Psychiatric Residential Treatment Center *HCPCS Codes:* o H0017 – Behavioral health; residential o H0018 – Behavioral health; short-term residential o H0019 – Behavioral health; long-term residential o T2048 – Behavioral health; long-term care residential *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2019 Inpatient Stay Value Set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set

Metric #19b: Average Length of Stay in IMDs (IMDs receiving FFP only)	
Metric element	**Description**
Denominator (continued)	Step 2. Retain claims that meet the criteria in both Step 1a and 1b for residential or inpatient treatment in an IMD. (See the additional guidance section for a definition of IMDs). Step 3. De-duplicate and sum the discharges from Step 2 to identify the total number of discharges from an IMD for beneficiaries with a mental health diagnosis. Step 4. Stratify IMD discharges during the measurement period into short-term, long-term and all stays.
Metric calculation	For each rate, calculate the mean length of stay by dividing the total number of days in an IMD for all discharges in the numerator by the number of discharges in the denominator, as follows: Total number of days in an IMD / Number of discharges
Additional guidance	Use the discharge date to identify claims in the measurement period for residential and inpatient services. Do not count beneficiaries for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • Combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims. An IMD is defined as a hospital, nursing facility, or other institution that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases. States should limit to IMDs receiving federal financial participation (FFP). Some states have published lists of IMDs in which the designation is made by the state. If available, states can use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance.

Metric #19b: Average Length of Stay in IMDs (IMDs receiving FFP only)	
Metric element	**Description**
Additional guidance (continued)	Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs. 5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases. a. When applying the 50 percent guideline determine whether <u>each</u> patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims State-specific IMD database
Claim type	If using claims, only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: States may be asked to provide CMS with the standard deviation based on the mean calculated in this metric as part of the midpoint assessment. For details, see Appendix F.

Metric #20: Beneficiaries With SMI/SED Treated in an IMD for Mental Health	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries with SMI/SED who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year.
Numerator	The number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have a service claim with a mental health diagnosis and who received inpatient/residential treatment in an IMD within the measurement period Step 1a. Identify qualifying IMD discharges for inpatient or residential treatment mental health during the measurement period. This method may be specific to each state; some states maintain centralized databases of IMD stays. Alternatively, states may be able to identify IMD stays in T-MSIS data or through other methods. Step 1b. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* o 51 - Inpatient Psychiatric Facility o 56 – Psychiatric Residential Treatment Center *HCPCS Codes:* o H0017 – Behavioral health; residential o H0018 – Behavioral health; short-term residential o H0019 – Behavioral health; long-term residential o T2048 – Behavioral health; long-term care residential *UB Revenue Codes:* o 1001 – Residential treatment, psychiatric o HEDIS 2019 Inpatient Stay Value Set Step 2. Identify claims with a primary mental health diagnosis from the HEDIS 2019 *Mental Health Diagnosis* Value Set Step 3. Retain claims for inpatient/residential treatment in an IMD found in Step 1a or Step 2. (See the additional guidance section for a definition of IMDs.) Only include IMDs receiving Federal Financial Participation under the demonstration. Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2, and 3.
Population of interest	Medicaid beneficiaries in the demonstration or with SMI/SED enrolled for any amount of time during the measurement period
Additional guidance	Use the discharge date to identify claims in the measurement period. Do not count beneficiaries for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, then combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims.

Metric #20: Beneficiaries With SMI/SED Treated in an IMD for Mental Health	
Metric element	**Description**
Additional guidance (continued)	An IMD is defined as a hospital, nursing facility, or other institution that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases. Only include IMDs receiving Federal Financial Participation under the demonstration. Some states have published lists of IMDs in which the designation is made by the state. If available, use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance. Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs. 5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases. a. When applying the 50 percent guideline determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #21: Count of Beneficiaries With SMI/SED (monthly)	
Metric element	**Description**
Measure sets/endorsements	None
Description	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility, or provider claims have sufficient qualifying facility, or provider claims to qualify as having SMI/SED-related treatment during the measurement period and/or in the 11 months before the measurement period
Numerator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility, or provider claims to qualify as having SMI/SED-related treatment during the measurement period and/or in the 11 months before the measurement period
Population of interest	All Medicaid beneficiaries with SMI/SED as identified by the state
Additional guidance	States should identify the SMI/SED demonstration population used in this metric based on a history of SMI/SED diagnosis.
Measurement period (Metric Type)	Month (CMS-constructed)
Reporting Category	Other monthly and quarterly metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health conditions
Relationship to other metrics	The approach to identify SMI/SED beneficiaries also applies to metric #22
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #22: Count of Beneficiaries With SMI/SED (annually)	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration (with a diagnosis and service history indicating SMI/SED) during the measurement period and/or in the 12 months before the measurement period
Numerator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility, or provider claims have sufficient qualifying facility, or provider claims to qualify as having SMI/SED-related treatment during the measurement period and/or in the 12 months before the measurement period
Population of interest	All Medicaid beneficiaries with SMI/SED as identified by the state
Additional guidance	States should identify the SMI/SED demonstration population used in this metric based on a history of SMI/SED diagnosis.
Measurement period (Metric Type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model Subpopulations
Subpopulations	Standardized Definition of SMI State-specific Definition of SMI Age groups Dually eligible for Medicare and Medicaid Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health conditions
Relationship to other metrics	The approach to identify SMI/SED beneficiaries also applies to metric #21
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #2607 Measure steward: NCQA
Description	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is >9.0%.
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims, Medical Records
Claim type	Include paid, suspended, pending, and denied claims.

Metric #24: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #0418 Measure steward: CMS
Description	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims or electronic medical records
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #25: Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set) NQF #0418 Measure steward: CMS
Description	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	None
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims or electronic medical records
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	
Metric element	**Description**
Measure sets/endorsements	Adjusted, HEDIS measure Measure steward: NCQA
Description	The percentage of Medicaid beneficiaries with SMI who had an ambulatory or preventive care visit during the measurement period.
Metric calculation	Step 1. Identify claims during the measurement period with a diagnosis code (any diagnosis code on the claim) from the HEDIS 2019 Mental Health Diagnosis Value Set Step 2. Using the claims in step 1 to identify the denominator population, follow instructions for calculating this metric, which can be found in the HEDIS 2019 Technical Specifications for Health Plans, Measure AAP: Adults' Access to Preventive/Ambulatory Health Services.
Additional guidance	The original HEDIS measure is called Access to Preventive/Ambulatory Health Services for Adult Beneficiaries. CMS will provide this measure specification separately.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	
Metric element	**Description**
Measure sets/endorsements	Measure steward: NCQA NQF #2600
Description	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported, one for adults with SMI and the other for adults with AOD.
Metric calculation	Calculation instructions are located in the full measure specification, which CMS will provide separately
Additional guidance	The specifications and value sets for this measure are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.

Note: Measure specification and value set information shown was last updated in 2014. States should use their discretion on including state-specific codes to supplement the applicable value sets.

Metric #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	
Metric element	**Description**
Measure sets/endorsements	Measure steward: NCQA NQF #2599
Description	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.
Metric calculation	Calculation instructions are located in the full measure specification, which CMS will provide separately.
Additional guidance	Please use the measure steward's instructions for identifying the SMI population for this metric. The specifications and value sets for this measure are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: Measure specification and value set information shown was last updated in 2014. States should use their discretion on including state-specific codes to supplement the applicable value sets.

Metric #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Metric element	**Description**
Measure sets/endorsements	HEDIS 2019 Measure steward: NCQA
Description	The percentage of children and adolescents 1-17 years of age with ongoing antipsychotic medication use who had metabolic testing during the year.
Metric calculation	Follow instructions for calculating this metric, which can be found in the HEDIS 2019 Technical Specifications for Health Plans, Measure APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics.
Additional guidance	Calculation instructions are located in the full measure specification, which CMS will provide separately.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use only use paid claims. (Do not use suspended, pending, or denied claims).

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #30: Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	
Metric element	**Description**
Measure sets/endorsements	Measure steward: CMS NQF #3313
Description	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.
Metric calculation	Calculation instructions are located in the full measure specification, which CMS will provide separately.
Additional guidance	The specifications and value sets for this measure are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use paid, suspended, pending, and denied claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #31: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	
Metric element	**Description**
Measure sets/endorsements	FFY 2019 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set) Measure steward: NCQA
Description	Percentage of children and adolescents ages 1 to 17 who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
Metric calculation	Instructions for calculating this metric can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Measure Specifications
Additional guidance	
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, and pending claims.

Note: Measure specification shown applies to 2018 and is for illustrative purposes. The measure specification will be updated in Spring 2020 for reporting on 2019.

Metric #32: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Not Inpatient or Residential	
Metric element	**Description**
Measure sets/endorsements	None
Description	Total Medicaid costs for non-inpatient or residential services for mental health, among beneficiaries in the demonstration or with SMI/SED during the measurement period.
Numerator	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period Step 1. Identify FFS mental health claims as described below in the Population of Interest section. Step 2. Sum the total amount paid by Medicaid on these claims. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT. Step 3. Identify managed care mental health encounter records as described below in the denominator section. Step 4. Sum the amount paid by Medicaid for these encounters. There are several ways to estimate the amount paid by Medicaid on encounter claims: • If available, states should use payment rates reported by managed care organizations to identify costs for mental health encounters. • Determine the FFS cost to Medicaid for a service (such as by using an FFS Medicaid physician fee schedule) and apply that figure to encounter claims for the same service. This method may not be appropriate if there are no FFS claims for the same service types to use as a reference. Many states maintain the FFS fee schedules and frequently make them publicly available. • Use a Medicaid-to-Medicare Fee Index. These indices enable researchers to assume that Medicaid rates for a given service are set at a certain percentage of Medicare rates. In other words, they estimate the Medicaid fees for each state relative to the Medicare fees and provide a conversion factor. For each service, apply the conversion factor to the Medicare fee schedule to estimate the cost to Medicaid. o An example of Medicaid-to-Medicare fee comparisons is MACPAC's comparison of medical hospital payments between Medicaid and Medicare, available at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf. o The Medicare fee schedule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html. CMS's searchable Medicare Physician Fee schedule contains Medicare payment information for more than 10,000 services and can be found at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx. • Use Medicaid FFS equivalent amounts for encounter records reported in T-MSIS. Step 5. Sum the amount paid by Medicaid from Step 2 and Step 4 to determine total Medicaid spending associated with services for mental health during the measurement period.

Metric #32: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Not Inpatient or Residential	
Metric element	**Description**

Population of interest	Mental health treatment services provided during the measurement period.
	
	Step 1. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set.
	
	Step 2. Retain claims with a code from any of the following HEDIS 2019 Value Sets:
	
	• MPT Stand Alone Outpatient Group 1
	• MPT Stand Alone Outpatient Group 2
	  o States should ensure the visit was billed by a mental health practitioner
	• Observation
	  o States should ensure the visit was billed by a mental health practitioner
	• Visit Setting Unspecified **with** a corresponding code from Outpatient POS
	• Electroconvulsive Therapy **with** a corresponding code from Outpatient POS
	• Transcranial Magnetic Stimulation **with** a corresponding code from Outpatient POS
	• Visit Setting Unspecified **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an outpatient setting
	• Electroconvulsive Therapy **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an outpatient setting
	• Transcranial Magnetic Stimulation **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an outpatient setting
	• Electroconvulsive Therapy **with** a corresponding code from Ambulatory Surgical Center POS
	• Transcranial Magnetic Stimulation **with** a corresponding code from Ambulatory Surgical Center POS
	• Partial Hospitalization/Intensive Outpatient
	• MPT IOP/PH Group 1 **with** a corresponding code from Partial Hospitalization POS
	  o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• Electroconvulsive Therapy **with** a corresponding code from Partial Hospitalization POS
	  o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• Transcranial Magnetic Stimulation **with** a corresponding code from Partial Hospitalization POS
	  o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• MPT IOP/PH Group 1 **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• Electroconvulsive Therapy **with** a corresponding code from Community Mental Health Center POS
	  o States should ensure that the visit was in an intensive outpatient or partial hospitalization setting

Metric #32: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Not Inpatient or Residential	
Metric element	**Description**

Population of interest (continued)	• Transcranial Magnetic Stimulation **with** a corresponding code from Community Mental Health Center POS
	  ○ States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	• MPT IOP/PH Group 2 **with** a corresponding code from Partial Hospitalization POS
	  ○ States should ensure that the visit was billed by a mental health practitioner
	• MPT IOP/PH Group 2 **with** a corresponding code from Community Mental Health Center POS
	  ○ States should ensure that the visit was in an intensive outpatient or partial hospitalization setting
	  ○ States should ensure that the visit was billed by a mental health practitioner
	
	Step 3. Exclude any claims with a code in the Inpatient Stay
	Step 4. Retain claims that meet the criteria in Steps 1-3.

Additional guidance	States that use fee schedules to calculate this metric should update them each year to reflect changes in payment rates over time. However, to ensure consistency, the method used to calculate this metric should stay the same across measurement periods. For example, states should not calculate managed care costs using a Medicaid-to-Medicare Fee Index in one year and the MEDICAID-FFS-EQUIVALENT-AMT field in other years.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	Claims for services in 32 and 33 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #33: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Inpatient or Residential	
Metric element	**Description**
Measure sets/endorsements	None
Description	Total Medicaid costs for inpatient or residential services for mental health among beneficiaries with SMI/SED during the measurement period.
Numerator	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period Step 1. Identify FFS mental health claims as described below in the Population of Interest section. Step 2. Sum the total amount paid by Medicaid on these claims. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT. Step 3. Identify managed care mental health encounter records as described below in the population of interest section. Step 4. Sum the amount paid by Medicaid for these encounters. There are several ways to estimate the amount paid by Medicaid on encounter claims: • If available, states should use payment rates reported by managed care organizations to identify costs for mental health encounters. • Determine the FFS cost to Medicaid for a service (such as by using an FFS Medicaid physician fee schedule) and apply that figure to encounter claims for the same service. This method may not be appropriate if there are no FFS claims for the same service types to use as a reference. Many states maintain the FFS fee schedules and frequently make them publicly available. • Use a Medicaid-to-Medicare Fee Index. These indices enable researchers to assume that Medicaid rates for a given service are set at a certain percentage of Medicare rates. In other words, they estimate the Medicaid fees for each state relative to the Medicare fees and provide a conversion factor. For each service, apply the conversion factor to the Medicare fee schedule to estimate the cost to Medicaid. o An example of Medicaid-to-Medicare fee comparisons is MACPAC's comparison of medical hospital payments between Medicaid and Medicare, available at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf. o The Medicare fee schedule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html. CMS's searchable Medicare Physician Fee schedule contains Medicare payment information for more than 10,000 services and can be found at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx. • Use Medicaid FFS equivalent amounts for encounter records reported in T-MSIS. Step 5. Sum the amount paid by Medicaid from Step 2 and Step 4 to determine total Medicaid spending associated with mental health during the measurement period.

Metric #33: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Inpatient or Residential	
Metric element	**Description**
Population of Interest	Mental health treatment services provided during the measurement period. Step 1. Identify beneficiaries with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set. Step 2. Retain claims with a place of service, HCPCS, or UB Revenue code listed below claims with a code from any of the following: *Place of Service Codes:* o 51 - Inpatient Psychiatric Facility o 56 – Psychiatric Residential Treatment Center o HEDIS 2016 *BH Stand Alone Acute Inpatient* Value Set o HEDIS 2016 HEDIS *BH Acute Inpatient* Value Set o HEDIS 2016 HEDIS *BH Nonacute inpatient* *HCPCS Codes:* o *H0017 – Behavioral health; residential* o *H0018 – Behavioral health; short-term residential* o *H0019 – Behavioral health; long-term residential* o *T2048 – Behavioral health; long-term care residential* *UB Revenue Codes:* o 1001 – Residential treatment, psychiatric o HEDIS 2016 BH Stand Alone Nonacute Inpatient Value Set o HEDIS 2019 Inpatient Stay Value Set Step 3. Exclude any claims with a code Telehealth Modifier, Telehealth POS, MPT Stand Alone Outpatient Group 1, MPT Stand Alone Outpatient Group 2, Observation, Outpatient POS, Community Mental Health Center POS, Ambulatory Surgical Center POS, or Partial Hospitalization POS value sets Step 4. Retain claims that meet the criteria in Steps 1-3.
Additional guidance	States that use fee schedules to calculate this metric should update them each year to reflect changes in payment rates over time. However, to ensure consistency, the method used to calculate this metric should stay the same across measurement periods. For example, states should not calculate managed care costs using a Medicaid-to-Medicare Fee Index in one year and the MEDICAID-FFS-EQUIVALENT-AMT field in other years.
Measurement period (Metric type)	Year (CMS constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	Claims for services in 32 and 33 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #34: Per Capita Costs Associated With Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	
Metric element	**Description**
Measure sets/endorsements	None
Description	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries with SMI/SED during the measurement period
Numerator	Total Medicaid costs for mental health services for beneficiaries with SMI/SED during the measurement period for non-inpatient, non-residential mental health services.
Denominator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility, or provider claims have sufficient qualifying facility, or provider claims to qualify as having SMI/SED -related treatment during the measurement period and/or in the 12 months before the measurement period.
Metric calculation	Calculate per capita costs by dividing spending on mental health treatment in the numerator by the number of beneficiaries in the denominator.
Additional guidance	States that use fee schedules to calculate this metric should update them each year to reflect changes in payment rates over time. However, to ensure consistency, the method used to calculate this metric should stay the same across measurement periods. For example, states should not calculate managed care costs using a Medicaid-to-Medicare Fee Index in one year and the MEDICAID-FFS-EQUIVALENT-AMT field in other years.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	The Numerator for this metrics is the same as total spending calculated in metric #32 The Denominator is the annual count of beneficiaries that have SMI/SED as calculated in metric #22 Claims for services in #34 and #35 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #35: Per Capita Costs Associated With Mental Health Services Among Beneficiaries with SMI/SED - Inpatient or Residential	
Metric element	**Description**
Measure sets/endorsements	None
Description	Per capita costs for not inpatient or residential services for mental health, among beneficiaries with SMI/SED during the measurement period
Numerator	Medicaid costs for mental health services for beneficiaries with SMI/SED during the measurement period for non-inpatient, non-residential mental health services.
Denominator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility, or provider claims have sufficient qualifying facility, or provider claims to qualify as having SMI/SED -related treatment during the measurement period and/or in the 12 months before the measurement period.
Metric calculation	Calculate per capita spending by dividing spending on mental health treatment in the numerator by the number of beneficiaries in the denominator.
Additional guidance	States that use fee schedules to calculate this metric should update them each year to reflect changes in payment rates over time. However, to ensure consistency, the method used to calculate this metric should stay the same across measurement periods. For example, states should not calculate managed care costs using a Medicaid-to-Medicare Fee Index in one year and the MEDICAID-FFS-EQUIVALENT-AMT field in other years.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	The Numerator for this metrics is the same as total spending calculated in metric #33 The Denominator is the annual count of beneficiaries that have SMI/SED as calculated in metric #22. Claims for services in #34 and #35 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #36: Grievances Related to services for SMI/SED	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of grievances filed during the measurement period that are related to services for SMI/SED
Numerator	Number of grievances related to SMI/SED services by or on behalf of enrollees during the measurement period. Count each grievance once, regardless of whether more than one grievance is filed by the same enrollee. There is no national process for filing and resolving grievances; each state determines the process and levels of review a grievance may take.
Additional guidance	None
Measurement period (Metric type)	Quarter (CMS-constructed)
Reporting Category	Grievances and appeals and qualitative information on referral into treatment
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Administrative records
Claim type	Not applicable

Metric #37: Appeals Related to Services for SMI/SED	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of appeals filed during the measurement period that are related to services for SMI/SED
Numerator	Number of appeals related to SMI/SED services filed by or on behalf of enrollees during the reporting quarter, by type (that is, reason for the appeal). Count each appeal once, regardless of whether more than one appeal is filed by the same enrollee. Appeals that are processed through multiple levels of review should only be counted once. There is no typology for tracking appeals filed by Medicaid beneficiaries; each state tracks and categorizes appeals differently. States should report appeal types according to their own definition.
Additional guidance	None
Measurement period (Metric type)	Quarter (CMS-constructed)
Reporting category	Grievances and appeals and qualitative information on referral into treatment
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Administrative records
Claim type	Not applicable

Metric #38: Critical Incidents Related to Services for SMI/SED	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of critical incidents filed during the measurement period that are related to services for SMI/SED
Numerator	The number of critical incidents related to SMI/SED services filed by or on behalf of enrollees during the measurement period. Count each critical incident once, regardless of whether more than one critical incident is filed by the same enrollee. There is no national typology for tracking critical incidents; each state tracks and categorizes critical incidents differently.
Additional guidance	None
Measurement period (Metric type)	Quarter (CMS-constructed)
Reporting category	Grievances and appeals and qualitative information on referral into treatment
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Administrative records
Claim type	Not applicable

Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED	
Metric element	**Description**
Measure sets/endorsements	None
Description	Total Medicaid costs for beneficiaries with SMI/SED who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.

Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED	
Metric element	**Description**

Numerator	The sum of all Medicaid costs on inpatient or residential treatment for mental health within IMDs among beneficiaries with SMI/SED during the measurement period.
	
	Step 1. Identify FFS mental health claims as described below in the population of interest section.
	
	Step 2. Sum the total amount paid by Medicaid on these claims. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT.
	
	Step 3. Identify managed care mental health encounter records as described below in the Population of interest section.
	
	Step 4. Sum the amount paid by Medicaid for these encounters. There are several ways to estimate the amount paid by Medicaid on encounter claims:
	
	• If available, states should use payment rates reported by managed care organizations to identify costs for mental health encounters.
	• Determine the FFS cost to Medicaid for a service (such as by using an FFS Medicaid physician fee schedule) and apply that figure to encounter claims for the same service. This method may not be appropriate if there are no FFS claims for the same service types to use as a reference. Many states maintain the FFS fee schedules and frequently make them publicly available.
	• Use a Medicaid-to-Medicare Fee Index. These indices enable researchers to assume that Medicaid rates for a given service are set at a certain percentage of Medicare rates. In other words, they estimate the Medicaid fees for each state relative to the Medicare fees and provide a conversion factor. For each service, apply the conversion factor to the Medicare fee schedule to estimate the cost to Medicaid.
	  ○ An example of Medicaid-to-Medicare fee comparisons is MACPAC's comparison of medical hospital payments between Medicaid and Medicare, available at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf.
	  ○ The Medicare fee schedule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html. CMS's searchable Medicare Physician Fee schedule contains Medicare payment information for more than 10,000 services and can be found at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.
	• Use Medicaid FFS equivalent amounts for encounter records reported in T-MSIS. This field, MEDICAID-FFS-EQUIVALENT-AMT, should be populated with the amount that would have been paid had the services been provided on a FFS basis.
	
	Step 5. Exclude any room and board costs, if included in steps 2 and 4.
	Step 6. Sum the net amount paid by Medicaid from steps 2 and 5 to determine total Medicaid spending associated with treatment for mental health in an IMD during the measurement period.

Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED	
Metric element	**Description**
Population of interest	Mental health inpatient or residential treatment provided within IMDs during the measurement period. Step 1. Identify qualifying IMD discharges for inpatient or residential treatment mental health during the measurement period. This method may be specific to each state; some states maintain centralized databases of IMD stays. Alternatively, states may be able to identify IMD stays in T-MSIS data or through other methods. Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 51 - Inpatient Psychiatric Facility • 56 – Psychiatric Residential Treatment Center *HCPCS Codes:* o H0017 – Behavioral health; residential o H0018 – Behavioral health; short-term residential o H0019 – Behavioral health; long-term residential o T2048 – Behavioral health; long-term care residential *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2019 Inpatient Stay Value Set Step 2. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set Step 3. Among records identified in Step 1 and 2, identify inpatient or residential treatment stays in IMDs. (See the additional guidance section for a definition of an IMD.) Only include IMDs receiving Federal Financial Participation under the demonstration. Step 4. Identify and retain all claims or encounter records associated with stays identified in Step 3.

Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED	
Metric element	**Description**
Additional guidance	Use the discharge date to identify claims in the measurement period for residential and inpatient services. Do not count expenditures for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • Combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims. States that use fee schedules to calculate this metric should update them each year to reflect changes in payment rates over time. However, to ensure consistency, the method used to calculate this metric should stay the same across measurement periods. For example, states should not calculate managed care costs using a Medicaid-to-Medicare Fee Index in one year and the MEDICAID-FFS-EQUIVALENT-AMT field in other years. An IMD is defined as a hospital, nursing facility, or other institution that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases. Only include IMDs receiving Federal Financial Participation under the demonstration. Some states have published lists of IMDs in which the designation is made by the state. If available, use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance. Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs. 5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases. a. When applying the 50 percent guideline determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Year (CMS-constructed)

Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED	
Metric element	**Description**
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #40: Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	
Metric element	**Description**
Measure sets/endorsements	None
Description	Per capita Medicaid costs for beneficiaries with SMI/SED who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year
Numerator	Total Medicaid costs associated with treatment for mental health within IMDs during the measurement period.
Denominator	Number of beneficiaries with SMI/SED with a claim for inpatient or residential treatment for mental health in an IMD during the reporting year. Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 51 - Inpatient Psychiatric Facility • 56 – Psychiatric Residential Treatment Center *HCPCS Codes:* ○ H0017 – Behavioral health; residential ○ H0018 – Behavioral health; short-term residential ○ H0019 – Behavioral health; long-term residential ○ T2048 – Behavioral health; long-term care residential *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2019 Inpatient Stay Value Set Step 2. Identify claims with a principal mental health diagnosis from the HEDIS 2019 Mental Health Diagnosis Value Set Step 3. Retain claims for inpatient or residential treatment in an IMD. (See the additional guidance section for a definition of IMDs). Only include IMDs receiving Federal Financial Participation under the demonstration. Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 - 3.
Metric calculation	Calculate per capita mental health spending by dividing spending on mental health treatment in the numerator by the number of beneficiaries in the denominator, as follows: Spending on mental health treatment / Number of beneficiaries
Additional guidance	Use the discharge date to identify claims in the measurement period for residential and inpatient services. Do not count expenditures for an ongoing stay during the measurement period if the patient is not discharged in that period. If a discharge date is not explicitly reported, identify all claims associated with a single stay and use the latest end date of service on the claims. Use one of the following approaches to combine claims for the same stay: • Combine claims for the same beneficiary, provider and admission date; or • If an admission date is not reported on all claims, combine claims for the same patient and provider that have less than a one day break between the end date of the first claim and the start date of the next claim. For example, if the end date of the first claim is December 18 and the start date of the next claim is December 19, then combine the claims as a single stay. However, if the second claim has a start date of December 20 or later, then do not combine the claims.

Metric #40: Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	
Metric element	**Description**
Additional guidance (continued)	An IMD is defined as a hospital, nursing facility, or other institution that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases. Only include IMDs receiving Federal Financial Participation under the demonstration. Some states have published lists of IMDs in which the designation is made by the state. If available, use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance. Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs. 5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases. a. When applying the 50 percent guideline determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Reporting level	Demonstration Model
Subpopulations	None
Relationship to other metrics	The Numerator for this metrics is the same as total costs calculated in metric #39
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

APPENDIX A

ESTABLISHED MEASURES AND MEASURE SETS REFERENCED IN TECHNICAL SPECIFICATIONS

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Table A.1 defines the established measures, measure sets, and measure set versions referenced in the specifications for these metrics.

Table A.1. Established measures and measure sets referenced in metric specifications

Metric Number	Metric name	Established measure name	Measure set	Measure set version/reporting period
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	SUB-2 Alcohol Use Brief Intervention Provided or Offered SUB-2a Alcohol Use Brief Intervention	The Joint Commission National Hospital Inpatient Quality Measures	5. 6 [B]
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Child Core Set	FFY 2019 [A]
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	CMS	2018 reporting [B]
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	Inpatient Psychiatric Facility Quality Reporting (IPFQR) program	2019 reporting
5	Medication Reconciliation Upon Admission	Medication Reconciliation Upon Admission	CMS	2018 reporting [B]
6	Medication Continuation Following Inpatient Psychiatric Discharge	Medication continuation following discharge	CMS	2018 reporting [B]
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	Child Core Set	FFY 2019 [A]
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Adult Core Set	FFY 2019 [A]
9	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	Follow-Up After Emergency Department Visit Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Adult Core Set	FFY 2019 [A]
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Adult Core Set	FFY 2019 [A]

Metric Number	Metric name	Established measure name	Measure set	Measure set version/reporting period
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) poor control (>9.0%) (HPCMI-AD)	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Adult Core Set	FFY 2019 [A]
24	Screening for Depression and Follow-up Plan: 18 years and Older (CDF-AD)	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Adult Core Set	FFY 2019 [A]
25	Screening for Depression and Follow-up Plan: Ages 12-17(CDF-CH)	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	Child Core Set	FFY 2019 [A]
26	Access to Preventive/ Ambulatory Health Services for Medicaid Beneficiaries with SMI	Access to Preventive/Ambulatory Health Services for Beneficiaries with SMI	HEDIS	2019 [B]
27	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA	[B]
28	Alcohol Screening and Follow-up for People with Serious Mental Illness	Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA	[B]
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics	HEDIS	2019 [B]
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	HEDIS	2019 [B]
31	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Child Core Set	FFY 2019 [A]

[A] Specifications for calculating Core Set metrics can be found in Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2019 Child and Adult Core Sets Specifications.

[B] For this measure, specifications are available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov

APPENDIX B

VALUE SETS REFERENCED IN METRIC SPECIFICATIONS

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Table B.1. HEDIS and other value sets referenced in metric specifications

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Acute Inpatient (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Acute Inpatient POS (HEDIS 2019)	• #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
AOD Abuse and Dependence (HEDIS 2019)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Y
AOD Procedures (HEDIS 2016)	• #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	N
Alcohol Disorders	• #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
Ambulatory Surgical Center POS (HEDIS 2019)	• #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y
Ambulatory Visits (HEDIS 2019)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	N
BH Stand Alone Acute Inpatient (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	Y
BH Acute Inpatient (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
BH Acute Inpatient POS (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
BH Stand Alone Outpatient/PH/IOP (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
BH Outpatient (HEDIS 2019)	• #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #7: Follow up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) • #8: Follow up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD) • #10:Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	
BH Outpatient/PH/IOP (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
BH Outpatient/PH/IOP POS (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
BH ED (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
BH ED POS (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
BH Stand Alone Nonacute Inpatient (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	Y
BH Nonacute Inpatient (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
BH Nonacute Inpatient POS (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
Bipolar Disorder (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	Y
Cholesterol Tests Other Than LDL (HEDIS 2019)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics	N
Community Mental Health Center POS (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Diabetes (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Diabetes Exclusions (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
ED (HEDIS 2019)	• #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #16: Mental Health Services Utilization - ED • #18: Mental Health Services Utilization - Any Services • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	Y
ED POS (HEDIS 2019)	• #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #16: Mental Health Services Utilization - ED • #18: Mental Health Services Utilization - Any Services • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	Y
ED Procedure Code (HEDIS 2016)	• #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	N
Electroconvulsive Therapy (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y
Glucose Tests (HEDIS 2019)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics	N
HbA1c Level 7.0-9.0 (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Level Greater Than 9.0 (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Level Less Than 7.0 (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Tests (HEDIS 2019)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Hospice (HEDIS 2019)	• #8:Follow up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD) • #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #10: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #31: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	Y
IET POS Group 1 (HEDIS 2019)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	Y
IET POS Group 2 (HEDIS 2019)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	Y
IET Stand Alone Visits (HEDIS 2019)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Y
IET Visits Group 1 (HEDIS 2019)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Y
IET Visits Group 2 (HEDIS 2019)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	Y
Inpatient Stay (HEDIS 2019)	• #13: Mental Health Services Utilization - Inpatient • #15: Mental Health Services Utilization - Outpatient • #19: Average Length of Stay in IMDs • #20: Beneficiaries With SMI/SED Treated in an IMD for Mental Health • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #33: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential • #34: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #35: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential • #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED • #40: Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Intentional Self-Harm (HEDIS 2019)	• #7: Follow up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) • #8: Follow up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD) • #10: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Y
LDL-C Tests (HEDIS 2019)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics	N
Major Depression (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
Mental Health Diagnosis (HEDIS 2019)	• #11: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count) • #12: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate) • #13: Mental Health Services Utilization - Inpatient • #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #17: Mental Health Services Utilization - Telehealth • #18: Mental Health Services Utilization - Any Services • #19: Average Length of Stay in IMDs • #20: Beneficiaries With SMI/SED Treated in an IMD for Mental Health • #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED • #40: Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Y
Mental Illness (HEDIS 2019)	• #7: Follow up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) • #8: Follow up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD) • #10: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Y
MPT IOP/PH Group 1 (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive outpatient and partial hospitalization • #17: Mental Health Services Utilization - Telehealth • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	N

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
MPT IOP/PH Group 2 (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive outpatient and partial hospitalization • #17: Mental Health Services Utilization - Telehealth • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	N
MPT Stand Alone Outpatient Group 1 (HEDIS 2019)	• #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	N
MPT Stand Alone Outpatient Group 2 (HEDIS 2019)	• #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	N
Nonacute Inpatient (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Nonacute Inpatient POS (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Nonacute Inpatient Stay (HEDIS 2019)	• #7: Follow up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) • #8: Follow up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Y
Outpatient POS (HEDIS 2019)	• #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y
Observation (HEDIS 2019)	• #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y
Online Assessments (HEDIS 2019)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Other Ambulatory Visits (HEDIS 2019)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	N
Other Bipolar Disorder (HEDIS 2016, HEDIS 2019)	• Standardized definition of SMI	N
Other Psychotic and Developmental Disorders (HEDIS 2019)	• #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Y
Outpatient (HEDIS 2019)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Partial Hospitalization/Intensive Outpatient (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y
Partial Hospitalization POS (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y
Schizophrenia (HEDIS 2016)	• Standardized definition of SMI • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	Y
Telehealth Modifier (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #17: Mental Health Services Utilization - Telehealth • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #33: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential • #34: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #35: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential • #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Telehealth POS (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #17: Mental Health Services Utilization - Telehealth • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #33: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential • #34: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #35: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	Y
Telephone Visits (HEDIS 2019)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	N
Transcranial Magnetic Stimulation (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	N
Transitional Care Management Services HEDIS 2019)	• #7: Follow up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) • #8: Follow up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	Y
Visit Setting Unspecified (HEDIS 2019)	• #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #17: Mental Health Services Utilization - Telehealth • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential	Y

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APPENDIX C

HOW TO USE SUPPORTING MEASURE SPECIFICATIONS, VALUE SETS, AND CODE LISTS TO CALCULATE METRICS

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Table C.1. How to use supporting measure specifications, value sets and code lists to calculate metrics

Metrics	Supporting Measure Specifications, Value Sets, and Code Lists	Instructions
CMS-constructed metrics that do not use supporting measure specifications or value sets: • #36: Grievances related to services for SMI/SED • #37: Appeals related services for to SMI/SED • #38: Critical incidents related to services for SMI/SED	None	None
CMS-constructed metrics that use HEDIS value sets. • #11: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count) • #12: Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate) • #13: Mental Health Services Utilization - Inpatient • #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #17: Mental Health Services Utilization - Telehealth • #18: Mental Health Services Utilization - Any Services • #19: Average Length of Stay in IMDs • #20: Beneficiaries With SMI/SED Treated in an IMD for Mental Health • #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED • #40: Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	*Value Sets:* • 1115 SMI Monitoring Metrics HEDIS Value Set Directory	*Value Sets:* • Step 1: Open "1115 SMI Monitoring Metrics HEDIS Value Set Directory.xlsx" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Filter the "Value Sets to Codes" tab to select value set names (column A) identified in metric specification • Step 3: Include listed codes (column D) when calculating metric

Table C.1. (*continued*)

Metrics	Supporting Measure Specifications, Value Sets, and Code Lists	Instructions
Established quality measures that use HEDIS specifications included in the Child and Adult Core Sets Measure Specifications technical specifications manual. • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #7: Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) • #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) • #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #10: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #24: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD) • #25: Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH) • #31: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	*Measure Specifications:* • The Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)and the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manuals for Federal Fiscal Year 2019 Reporting ○ Appendix D: Technical Specifications for Established Quality Measures Adapted From FFY 2019 Child and Adult Core Sets Measure Specifications *Value Sets:* • 1115 SMI Monitoring Metrics HEDIS Value Set Directory	*Measure Specifications:* • Step 1: Locate specifications for measures listed at left in Appendix D of this manual. *Value Sets:* • Step 1: Open "1115 SMI Monitoring Metrics HEDIS Value Set Directory.xlsx" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Filter the "Value Sets to Codes" tab to select value set names (column A) identified in metric specification • Step 3: Include listed codes (column D) when calculating metric

Table C.1. (*continued*)

Metrics	Supporting Measure Specifications, Value Sets, and Code Lists	Instructions
Established quality measures that use TJC specifications (and are not part of the Medicaid Adult Core Set). • #1: SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	*Measure Specifications:* • Specifications Manual for National Hospital Inpatient Quality Measures v5.4 *Code Sets:* • Appendix A .1 – ICD-10 Code Tables	*Measure Specifications:* • Step 1: Download manual (zip folder) from the TJC website (available at https://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx) • Step 2: Locate specification for SUB-2 in zip folder • Step 3: Follow the guidance in the measure specification to calculate the metric *Code Sets:* • Step 1: Download code sets from TJC website (available at https://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx) • Step 2: Locate Appendix A.1.pdf within zip folder, as described in the measure specification • Step 3: Filter the table to select the table numbers (column A) identified in the measure specification

Table C.1. (*continued*)

Metrics	Supporting Measure Specifications, Value Sets, and Code Lists	Instructions
Established quality measures that use NCQA specifications and value sets that are part of HEDIS (and not part of the Medicaid Core set): • #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI • #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics	*Measure Specifications:* • NCQA Measure specifications *Value Sets:* • 1115 SMI Monitoring Metrics HEDIS Value Set Directory	*Measure Specifications:* • Step 1: Open "NCQA Measure specifications.pdf" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Locate specification for Adults' Access to Preventive/Ambulatory Health services (AAP) or Metabolic Monitoring for Children and Adolescents on Antipsychotics • Step 3: Follow the guidance in the measure specification to calculate the metric *Value Sets:* • Step 1: Open "1115 SMI Monitoring Metrics HEDIS Value Set Directory.xlsx" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Filter the "Value Sets to Codes" tab to select value set names (column A) identified in metric specification • Step 3: Include listed codes (column D) when calculating metric
Established quality measures that use NCQA specifications (and not part of HEDIS and not part of the Medicaid Core Set): • #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence • #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	*Measure Specifications:* • NCQA Measure specifications *Value Sets:* • 1115 SMI Monitoring Metrics HEDIS Value Set Directory	*Measure Specifications:* • Step 1: Open "NCQA Measure specifications.pdf" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Locate specifications • Step 3: Follow the guidance in the measure specification to calculate the metric *Value Sets:* • Step 1: Open "1115 SMI Monitoring Metrics HEDIS Value Set Directory.xlsx" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Filter the "Value Sets to Codes" tab to select value set names (column A) identified in metric specification • Step 3: Include listed codes (column D) when calculating metric

Table C.1. (*continued*)

Metrics	Supporting Measure Specifications, Value Sets, and Code Lists	Instructions
Established quality measures that use CMS specifications from the Inpatient Psychiatric Quality Reporting (IPFQR) program (and are not part of the Medicaid Adult Core Set). • #5: Medication Reconciliation Upon Admission • #6: Medication Continuation Following Inpatient Psychiatric Discharge	*Measure Specifications:* • IPFQR CMS Measure Specifications	*Measure Specifications:* • Step 1: Open "IPFQR_CMS_ Measure Specifications.zip" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Locate specifications • Step 3: Follow the guidance in the measure specification to calculate the metric
Established quality measures that are based on the CMS specifications from the Inpatient Psychiatric Quality Reporting (IPFQR) program. • #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	*Measure Specifications:* • Claims-Based Measure Specifications	*Measure Specifications:* • Step 1: Download the Claims-based measure Specifications (available at: https://www.qualitynet.org/files/5d0d3993764be766b0103982?filename=181203_FY19_IPFQR_CBM_Specs.pdf) • Step 2: Locate specification for 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF
Established quality measures that use CMS specifications (and are not part of the Medicaid Adult Core Set or IPFQR program). • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #30: Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	*Measure Specifications:* • PMH-20 Tech Specs Manual • Follow-up Care Specs *Value Sets:* • PMH-20 CCW Value Set • PMH-20 ED Value Set • PMH-20 SMI Value Set • Follow-up Care Codes	*Measure Specifications:* • Step 1: Open "Other_CMS_measurespecs_valuesets.zip" file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov). • Step 2: Locate specifications • Step 3: Follow the guidance in the measure specification to calculate the metric *Value Sets:* • Step 1: Open "Other_CMS_measurespecs_valuesets.zip" and find the appropriate value set or code file (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov).

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APPENDIX D

TECHNICAL SPECIFICATIONS FOR ESTABLISHED QUALITY MEASURES ADAPTED FROM FFY 2019 ADULT CORE SET MEASURE SPECIFICATIONS

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This appendix provides the technical specifications for the Child and Adult Core Set measures included in the 1115 SMI/SED monitoring metrics. These specifications have been adapted from state-level specifications for use in the 1115 SMI/SED demonstration.

I. MEASURE ELEMENT DEFINITIONS

Measurement period. The measurement period is the time frame for which the data should be collected (defined by start and end dates). The measurement period for each Core Set measure included in the 1115 SMI/SED monitoring metrics can be found in **Table D1**. For many measures, the denominator measurement period for FFY 2019 corresponds to calendar year 2018 (January 1, 2018–December 31, 2018). However, for some measures, the measurement period begins before the calendar year. For example, the Metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) requires states to review utilization and continuous enrollment prior to January 1, 2018 when constructing the denominator. This is referred to as a "look-back period" or a negative medication history review period.

Continuous enrollment. Continuous enrollment specifies the minimum amount of time that a beneficiary must be enrolled before becoming eligible for the measure. The continuous enrollment period is specified for each measure in **Table D1**.

Allowable gap. The allowable gap specifies the maximum amount of time a beneficiary can be unenrolled and still qualify for inclusion in the measure. The allowable gap is specified for each measure in **Table D1**.

Anchor date. Some measures include an anchor date, which is the date that an individual must be enrolled in the demonstration to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure's FFY 2019 measurement period (December 31, 2018). States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population. The anchor date (if any) is provided in the detailed measure specifications in the following section.

Hospice exclusion. Some Core Set measures included in the 1115 SMI/SED monitoring metrics exclude beneficiaries who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These beneficiaries may be identified using various methods, which may include but are not limited to enrollment data, medical record data, or claims/encounter data. The Hospice Value Set is available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov. States should remove these beneficiaries prior to determining a measure's eligible population and drawing the sample for hybrid measures. If a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed as a valid data error from the sample and replaced by a beneficiary from the oversample. Documentation that a beneficiary is near the end of life (e.g., comfort care, Do Not Resuscitate [DNR], Do Not Intubate [DNI]), or is in palliative care does not meet criteria for the hospice exclusion. This applies to the following metrics: 7, 8, 9, 10, 12 and 33.

Table D.1. Measurement Period for Denominators and Numerators for the 1115 SMI/SED Monitoring Metrics Adapted from FFY 2019 Child and Adult Core Sets Measures

	FFY 2019 Measurement Period[A]		
Measure	**Denominator**	**Numerator**	**Continuous Enrollment Period**
Metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	IPSD: January 1, 2018 – December 1, 2018 Negative medication history review: September 3, 2017 – August 3, 2018 (120 days before the IPSD)	October 3, 2017 – December 31, 2018 (90 days prior to IPSD through 30 days after the IPSD)	September 3, 2017 - December 31, 2018 (120 days prior to IPSD through 30 days after IPSD)
Metric #7: Follow-Up After Hospitalization for Mental Illness: Ages 6–17 (FUH-CH)	Discharge date: January 1, 2018 – December 31, 2018	7 Day Follow-up: January 2, 2018 – December 8, 2018 (7 days after discharge date) 30 Day Follow-up: January 2, 2018 – December 31, 2018 (30 days after discharge date)	January 1, 2018 – December 31, 2018 (30 days after discharge date)
Metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Discharge date: January 1, 2018 – December 1, 2018	7 Day Follow-up: January 2, 2018 – December 8, 2018 (7 days after discharge date) 30 Day Follow-up: January 2, 2018 – December 31, 2018 (30 days after discharge date)	January 1, 2018 – December 31, 2018 (30 days after discharge date)
Metric #9: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Emergency Department (ED) visit date: January 1, 2018 – December 1, 2018	7 Day Follow-up: January 1, 2018 – December 8, 2018 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)	January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)

Measure	FFY 2019 Measurement Period[A]		
	Denominator	Numerator	Continuous Enrollment Period
Metric #10: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	ED visit date: January 1, 2018 – December 1, 2018	7 Day Follow-up: January 1, 2018 – December 8, 2018 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)	January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)
Metric #23: Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HBA1c) Poor Control (>9.0%)(HPCMI-AD)	January 1, 2018 – December 31, 2018 Diabetes diagnosis: January 1, 2017 – December 31, 2018	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018[B]
Metric #24: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018	None
Metric #25: Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018	None
Metric #31: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)	First-time prescription dispense date: January 1, 2018- October 2, 2018 (Review prescriptions through December 31, 2018 to identify drug events for the denominator)	January 1, 2018 - December 31, 2018	January 1, 2018 – December 31, 2018[B]

[A] For some measures, the measurement period for the numerator, denominator, or continuous enrollment period varies depending on a specified date for each enrollee (such as prescription or treatment start dates and discharge dates). For these measures, two ranges are shown. The first date range identifies the full range of possible dates that states will need to use to calculate the measure for all measure-eligible enrollees. The text in parentheses describes the measurement period that should be used for each eligible enrollee.

[B] No more than one gap in enrollment of up to 45 days during the continuous enrollment period.

II. DEFINITION OF A MENTAL HEALTH PRACITIONER

The Child and Adult Core Sets define a mental health practitioner as a practitioner who provides mental health services and meets any of the following criteria:

- An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice
- An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice
- A Registered Nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC)

III. TECHNICAL SPECIFICATIONS

Metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure intends to assess use of psychosocial care as a first-line treatment for conditions for which antipsychotic medications are not indicated. This measure's value set contains typical forms of psychological services, such as behavioral interventions, psychological therapies, and crisis intervention.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions
- NCQA's Medication List Directory (MLD) of NDC codes for Antipsychotic Medications and Antipsychotic Combination Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, Modifier, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

Intake Period	January 1 through December 1 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 120 days (4 months) before the IPSD when the beneficiary had no antipsychotic medications dispensed for either new or refill prescriptions.

C. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year.
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gap during the continuous enrollment period.

Anchor date	IPSD.
Benefit	Medical, mental health, and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify all beneficiaries who were dispensed an antipsychotic medication (Antipsychotic Medications List and Antipsychotic Combination Medications List, see link to Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2 Test for Negative Medication History. For each beneficiary identified in step 1, test each antipsychotic prescription for a Negative Medication History. The IPSD is the dispensing date of the earliest antipsychotic prescription in the Intake Period with a Negative Medication History. Step 3 Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 120 days (4 months) prior to the IPSD through 30 days after the IPSD. Step 4: Exclusions (required) Exclude beneficiaries for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year meet criteria: • At least one acute inpatient encounter with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations meet criteria: - BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set) - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)

Event/diagnosis (continued)	• At least two visits in an outpatient, intensive outpatient, or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism, or other developmental disorder during the measurement year. Any of the following code combinations with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set), meet criteria: - An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) - An outpatient visit (BH Outpatient Value Set) - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) - An observation visit (Observation Value Set) - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Documentation of psychosocial care (Psychosocial Care Value Set) with or without a telehealth modifier (Telehealth Modifier Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.

Metric #7: Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- Percentage of discharges for which children received follow-up within 30 days after discharge
- Percentage of discharges for which children received follow-up within 7 days after discharge

Data Collection Method: Administrative

Guidance for Reporting:

- Follow the detailed specifications to (1) include the appropriate discharge when the patient was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the patient was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than (or equal to) the 7-day follow-up rate.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or be found on the same date of service.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or same date of service).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions
- Refer to Section II: Definition of a Mental Health Practitioner for the definition of a mental health practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, POS and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 6 to 17 as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay to determine whether it falls on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stays to determine whether they fall after December 1 of the measurement year. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge. If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis exclude both the original and the readmission/direct transfer discharge.

Exclusions	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient followup visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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

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

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

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set) A visit (FUH Visits Group 1 Value Set with FUH POS Group 1 Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set) A visit in a behavioral healthcare setting (FUH RevCodes Group 1 Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a mental health practitioner
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set) Transitional care management services (Transitional Care Management Services Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set;

Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a mental health practitioner

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)
- An observation visit (Observation Value Set) with a mental health practitioner
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)

D. ADDITIONAL NOTE

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the period specified (e.g., within 30 days after discharge or within 7 days after discharge).

Metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge
- Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge

Data Collection Method: Administrative

Guidance for Reporting:

- Follow the detailed specifications to (1) include the appropriate discharge when the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or be found on the same date of service.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or same date of service).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions
- Refer to Section II: Definition of a Mental Health Practitioner for the definition of a mental health practitioner.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, Modifier, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).
Event/diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay to determine whether it falls on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stays to determine whether they occur after December 1 of the measurement year. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge. If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay to determine whether it occurs within the 30-day follow-up period. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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

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

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

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

- An observation visit (Observation Value Set) with a mental health practitioner
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health practitioner, with or without a telehealth modifier (Telehealth Modifier Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the period specified for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

Metric #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported:

- Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- The denominator should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or be found on the same date of service.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or same date of service).
  - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, Modifier, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency. Note: Beneficiaries with detoxification-only chemical dependency benefits do not meet these criteria.

Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusion before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)

D. ADDITIONAL NOTES

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

Metric #10: Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:

- Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Data Collection Method: Administrative

Guidance for Reporting:

- The denominator should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or be found on the same date of service.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or same date of service).
  - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, Modifier, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Ages	Age 18 and older as of the date of the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health.

Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusion before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 4. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 5. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

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

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health

disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

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

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

D. ADDITIONAL NOTES

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

Metric #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is > 9.0%.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This is a NCQA owned and copyrighted measure that is not currently contained in HEDIS®.
- This measure includes LOINC codes. Use of the LOINC codes is optional for this measure. If LOINC codes are not available, the other code systems in the value set may be used instead.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions.
- NCQA's Medication List Directory (MLD) of NDC codes for Diabetes Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, Modifier, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/ diagnosis	Follow the steps below to identify beneficiaries with diabetes and serious mental illness. Step 1 Identify beneficiaries ages 18 to 75 as of the end of the measurement year. Step 2 Identify beneficiaries from step 1 with a diagnosis of serious mental illness. Beneficiaries are identified as having serious mental illness if they met at least one of the following criteria during the measurement year: • At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder using any of the following code combinations: - BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) - Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set OR • At least two of the following, on different dates of service, with or without a telehealth modifier (Telehealth Modifier Value Set) where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) or both encounters have any diagnosis of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set) - An outpatient visit (Visit Setting Unspecified Value Set) with Outpatient POS Value Set - An outpatient visit (BH Outpatient Value Set) - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set) - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) - An observation visit (Observation Value Set) - An ED visit (ED Value Set) - An ED visit (Visit Setting Unspecified Value Set with ED POS Value Set) - A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) - A nonacute inpatient encounter (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set) - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set)

Event/ diagnosis (continued)	Step 3 Identify beneficiaries from step 2 with diabetes. There are two ways to identify beneficiaries with diabetes: by claim/encounter data and by pharmacy data. The state must use both methods to identify the eligible population, but a beneficiary need only be identified by one to be included in this measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Beneficiaries who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years): • At least one acute inpatient encounter (Acute Inpatient Value Set), with a diagnosis of diabetes (Diabetes Value Set) without (Telehealth Modifier Value Set; Telehealth POS Value Set) • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), or nonacute inpatient encounters (Nonacute Inpatient Value Set), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) without telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set) Only one of the two visits may be a telehealth visit, a telephone visit or an online assessment. Identify telehealth visits by the presence of a telehealth modifier (Telehealth Modifier Value Set) or the presence of a telehealth POS code (Telehealth POS Value Set) associated with the outpatient visit. Use the code combinations below to identify telephone visits and online assessments: • A telephone visit (Telephone Visits Value Set) with any diagnosis of diabetes (Diabetes Value Set) • An online assessment (Online Assessments Value Set) with any diagnosis of diabetes (Diabetes Value Set) Pharmacy data. Beneficiaries who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. For prescriptions that can be used to identify beneficiaries with diabetes, refer to the Diabetes Medications List (see link to Medication List Directory in Guidance for Reporting above).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Use codes (see HbA1c Tests Value Set) to identify the most recent HbA1c test during the measurement year. The beneficiary is numerator compliant if the most recent HbA1c level is > 9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The beneficiary is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤ 9.0%.

If a state uses CPT Category II codes to identify numerator compliance for this measure, it must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the beneficiary is numerator compliant.

Value Set	Numerator Compliance
HbA1c Level Less Than 7.0 Value Set	Not compliant
HbA1c Level 7.0-9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

Exclusions (optional)

Beneficiaries who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

If the beneficiary was included in this measure based on claim or encounter data, as described in the event/ diagnosis criteria, the optional exclusions do not apply because the beneficiary had a diagnosis of diabetes.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion. The sample size should be 411, unless special circumstances apply. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure.

Numerator

The most recent HbA1c level (performed during the measurement year) is > 9.0% or is missing, or was not done during the measurement year, as documented through automated laboratory data or medical record review.

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical Record Review

At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The beneficiary is numerator compliant if the result for the most recent HbA1c level during the measurement year is > 9.0% or is missing, or if an HbA1c test was not done during the measurement year. The beneficiary is not numerator compliant if the most recent HbA1c level during the measurement year is ≤ 9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Exclusions (optional)

Identify beneficiaries who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

Metric #24: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)

Measure Steward: Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The denominator for this measure includes beneficiaries age 18 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  6. Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
  7. Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool.
- This measure can be calculated using administrative data only. Medical record review may be used to validate the state's administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report this measure.
- This measure contains both exclusions and exceptions:
  - Denominator exclusion criteria are evaluated before checking if a beneficiary meets the numerator criteria; a beneficiary who qualifies for the denominator exclusion should be removed from the denominator.
  - Denominator exception criteria are only evaluated if the beneficiary does not meet the numerator criteria; beneficiaries who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.
- For a beneficiary to meet the depression or bipolar disorder exclusion criteria, there must be an active diagnosis for one of these conditions documented prior to any encounter during the measurement period. An active diagnosis for depression/bipolar disorder in this case indicates the absence of an end date/time of the diagnosis. Patients with active antidepressant medications listed in their medical record without an active bipolar/depression diagnosis documented in their record should not be excluded from this measure.

- The original specification for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of 1115 SMI/SED demonstration reporting, there are two G codes included in the numerator to capture whether depression screening was done and if the screen was positive, whether a follow-up plan was documented.
- When multiple encounters that meet criteria for inclusion in the measure denominator take place in the measurement year, the most recent eligible encounter at which the screening took place should be used. The beneficiary should be counted in the denominator and numerator only once based on the most recent screening documented at the eligible encounter.
  - For example, if a beneficiary had a qualifying encounter in January of the measurement year and no depression screening was performed and then had a qualifying encounter in December of the same measurement year and had a depression screening, the encounter during December would be used for the measure denominator. If a beneficiary had an eligible encounter during January with a depression screening performed and an encounter during December with no screening performed, the January encounter would be used for the measure denominator.
- The date of encounter and screening must occur on the same date of service.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- Include all paid, suspending, pending, and denied claims.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/system/files/ecqm/measures/CMS2v7_1.html.

The following coding systems are used in this measure: CPT and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	Completion of a diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner's office that is filing the code.
Standardized tool	An assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Some depression screening tools are: • Adult Screening Tools (age 18 and older) Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety- Depression Scale

Standardized tool (continued)	(DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), and Quick Inventory of Depressive Symptomatology Self-Report (QID-SR) • Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale
Follow-up plan	Proposed outline of treatment to be conducted as a result of depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: • Additional evaluation for depression • Suicide risk assessment • Referral to a practitioner who is qualified to diagnose and treat depression • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Note: Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect. The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."

C. ELIGIBLE POPULATION

Age	Age 18 or older on date of encounter.
Event/diagnosis	Outpatient visit (Table CDF-A) during the measurement year.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population with an outpatient visit during the measurement year (Table CDF-A).

Table CDF-A. Codes to Identify Outpatient Visits

59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507

Numerator

Beneficiaries screened for depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen using one of the codes in Table CDF-B.

Table CDF-B. Codes to Document Depression Screen

G8431	Screening for depression is documented as being positive and a follow-up plan is documented
G8510	Screening for depression is documented as negative, a follow-up plan is not required

Exclusions

A beneficiary is not eligible if one or more of the following conditions are documented in the beneficiary medical record:

- Beneficiary has an active diagnosis of depression or bipolar disorder

Use the codes in Table CDF-C, CDF-D, and CDF-E to identify exclusions.

Table CDF-C. HCPCS Code to Identify Exclusions

Code	Description
G9717	Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

Table CDF-D. ICD-10 Codes to Identify Active Diagnosis of Depression (Exclusions)

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission

ICD-10 Code	Description
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

Table CDF-E. ICD-10 Codes to Identify Diagnosed Bipolar Disorder (Exclusions)

ICD-10 Code	Description
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate

ICD-10 Code	Description
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified

Exceptions

A beneficiary that does not meet the numerator criteria and meets the following exception criteria should be excluded from the measure denominator. However, if the beneficiary meets the numerator criteria, the beneficiary would be included in the measure denominator.

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

Table CDF-F. HCPCS Code to Identify Exceptions

Code	Description
G8433	Screening for depression not completed, documented reason

Metric #25: Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)

Measure Steward: Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The denominator for this measure includes beneficiaries ages 12 to 17 with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  8. Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
  9. Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool.
- This measure can be calculated using administrative data only. Medical record review may be used to validate the state's administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report this measure.
- This measure contains both exclusions and exceptions:
  - Denominator exclusion criteria are evaluated before checking if a beneficiary meets the numerator criteria; a beneficiary who qualifies for the denominator exclusion should be removed from the denominator.
  - Denominator exception criteria are only evaluated if the beneficiary does not meet the numerator criteria; beneficiaries who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.
- For a beneficiary to meet the depression or bipolar disorder exclusion criteria, there must be an active diagnosis for one of these conditions documented prior to any encounter during the measurement period. An active diagnosis for depression/bipolar disorder in this case indicates the absence of an end date/time of the diagnosis. Patients with active antidepressant medications listed in their medical record without an active bipolar/depression diagnosis documented in their record should not be excluded from this measure.
- The original specification for this measure included six G codes intended to capture whether individual providers reported on this measure. For the purpose of 1115 SMI/SED demonstration reporting, there are two G codes included in the numerator to capture whether depression screening was done and if the screen was positive, whether a follow-up plan was documented.
- When multiple encounters that meet criteria for inclusion in the measure denominator take place in the measurement year, the most recent eligible encounter at which the screening took place should be used. The beneficiary should be counted in the denominator and numerator only once based on the most recent screening documented at the eligible encounter.
  - For example, if a beneficiary had a qualifying encounter in January of the measurement year and no depression screening was performed and then had a qualifying encounter in December of the same measurement year and had a

depression screening, the encounter during December would be used for the measure denominator. If a beneficiary had an eligible encounter during January with a depression screening performed and an encounter during December with no screening performed, the January encounter would be used for the measure denominator.

- The date of encounter and screening must occur on the same date of service.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- Include all paid, suspended, pending, and denied claims.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/system/files/ecqm/measures/CMS2v7_1.html.

The following coding systems are used in this measure: CPT and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	Completion of a diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease or condition. This measure looks for the screening being conducted in the practitioner's office that is filing the code.
Standardized tool	An assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. Some depression screening tools are: • Adolescent Screening Tools (12-17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2 • Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale
Follow-up plan	Proposed outline of treatment to be conducted as a result of depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: • Additional evaluation for depression • Suicide risk assessment • Referral to a practitioner who is qualified to diagnose and treat depression

	• Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Note: Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression are advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect. The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."

C. ELIGIBLE POPULATION

Age	Ages 12 to 17 on date of encounter.
Event/diagnosis	Outpatient visit (Table CDF-A) during the measurement year.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population with an outpatient visit during the measurement year (Table CDF-A).

Table CDF-A. Codes to Identify Outpatient Visits

CPT	HCPCS
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96118, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444, G0502, G0503, G0504, G0505, G0507

Numerator

Beneficiaries screened for depression using a standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen using one of the codes in Table CDF-B.

Table CDF-B. Codes to Document Depression Screen

Code	Description
G8431	Screening for depression is documented as being positive and a follow-up plan is documented
G8510	Screening for depression is documented as negative, a follow-up plan is not required

Exclusions

A beneficiary is not eligible if one or more of the following conditions are documented in the beneficiary medical record:

- Beneficiary has an active diagnosis of Depression or Bipolar Disorder

Use the codes in Table CDF-C, CDF-D, and CDF-E to identify exclusions.

Table CDF-C. HCPCS Code to Identify Exclusions

Code	Description
G9717	Documentation stating the patient has an active diagnosis of depression or has a diagnosed bipolar disorder, therefore screening or follow-up not required

Table CDF-D. ICD-10 Codes to Identify Active Diagnosis of Depression (Exclusions)

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood

ICD-10 Code	Description
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

Table CDF-E. ICD-10 Codes to Identify Diagnosed Bipolar Disorder (Exclusions)

ICD-10 Code	Description
F31.10	Bipolar disorder, current episode manic without psychotic features, unspecified
F31.11	Bipolar disorder, current episode manic without psychotic features, mild
F31.12	Bipolar disorder, current episode manic without psychotic features, moderate
F31.13	Bipolar disorder, current episode manic without psychotic features, severe
F31.2	Bipolar disorder, current episode manic severe with psychotic features
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unspecified
F31.31	Bipolar disorder, current episode depressed, mild
F31.32	Bipolar disorder, current episode depressed, moderate
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.5	Bipolar disorder, current episode depressed, severe, with psychotic features
F31.60	Bipolar disorder, current episode mixed, unspecified
F31.61	Bipolar disorder, current episode mixed, mild
F31.62	Bipolar disorder, current episode mixed, moderate
F31.63	Bipolar disorder, current episode mixed, severe, without psychotic features
F31.64	Bipolar disorder, current episode mixed, severe, with psychotic features
F31.70	Bipolar disorder, currently in remission, most recent episode unspecified
F31.71	Bipolar disorder, in partial remission, most recent episode hypomanic
F31.72	Bipolar disorder, in full remission, most recent episode hypomanic
F31.73	Bipolar disorder, in partial remission, most recent episode manic
F31.74	Bipolar disorder, in full remission, most recent episode manic
F31.75	Bipolar disorder, in partial remission, most recent episode depressed
F31.76	Bipolar disorder, in full remission, most recent episode depressed

ICD-10 Code	Description
F31.77	Bipolar disorder, in partial remission, most recent episode mixed
F31.78	Bipolar disorder, in full remission, most recent episode mixed
F31.81	Bipolar II disorder
F31.89	Other bipolar disorder
F31.9	Bipolar disorder, unspecified

Exceptions

A beneficiary that does not meet the numerator criteria and meets the following exception criteria should be excluded from the measure denominator. However, if the beneficiary meets the numerator criteria, the beneficiary would be included in the measure denominator.

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

Table CDF-F. HCPCS Code to Identify Exceptions

Code	Description
G8433	Screening for depression not completed, documented reason

Metric #31: Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who were treated with antipsychotic medications and who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure was developed by the National Collaborative for Innovation in Quality Measurement, and has been included in HEDIS® since 2017. More information about this measure and six other measures developed for assessing safe and judicious use of antipsychotic medications in children and adolescents is available at http://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/chipra_1415-p011-1-ef_0.pdf.
- To be eligible for this measure, beneficiaries must have at least 90 days of continuous antipsychotic medication treatment during the measurement year. Continuous treatment can include different medications; however, first-time prescriptions for a beneficiary must be dispensed prior to October 3 to meet the eligibility criteria as described in Step 5 of the Denominator Specifications.
- Supplemental data may not be used for this measure.
- Include all paid, suspended, and pending claims when identifying the eligible population. Do not include denied claims when identifying the eligible population or assessing the numerator for this measure.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions.
- NCQA's Medication List Directory (MLD) of NDC codes for Antipsychotic Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis2019-final-ndc-lists/.

The following coding system is used in this measure: CPT, HCPCS, NDC, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in continuous enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/diagnosis	Beneficiaries with 90 days of continuous antipsychotic medication treatment during the measurement year. Use the steps below to determine the eligible population. Step 1 Identify beneficiaries in the specified age range who were dispensed an antipsychotic medication (Antipsychotic Medications List, see link to Medication List Directory in Guidance for Reporting above) during the measurement year. Step 2 Calculate continuous enrollment. The beneficiary must be continuously enrolled during the measurement year. Step 3 For each beneficiary, identify all antipsychotic medication dispensing events during the measurement year. Step 4 Identify start and end dates for drug events. Drug events are defined separately by drug using the Drug ID field in the Medication List Directory (MLD) of NDC codes, see link to Medication List Directory in Guidance for Reporting above. For each drug ID, sort dispensing events chronologically by dispense date. If there is more than one prescription for the same medication dispensed on the same day, use only the prescription with the longest days supply in the calculation. Starting with the first prescription in the measurement year determine if there is a second dispense date with the same Drug ID.

Event/diagnosis (continued)	• If there is no second dispensing event with the same Drug ID, the start date is the first prescription's dispense date and the end date is the start date plus the days supply minus one. For example, a January 1 prescription with a 30 days supply has an end date of January 30. • If there is a second dispensing event with the same Drug ID, determine if there are gap days (a gap of up to 32 days is allowed). Calculate the number of days between (but not including) the first prescription's dispense date and the second prescription's dispense date. If the number of days is less than or equal to the first prescription's days supply plus 32 days, the gap is less than or equal to 32 days and is allowed. The start date is the first prescription's dispense date and the end date is the second prescription's dispense date plus days supply minus one. Continue assessing all subsequent dispensing events with allowable gaps for the same Drug ID and adjust end dates as needed. - For example, a beneficiary has two dispensing events with the same Drug ID. The first is on July 1, with a 30 days supply. The second is on September 1, with a 30 days supply. The number of days between (but not including) the dispense dates is 61 (July 2–August 31). The gap is allowed because 61 is less than the first prescription's days supply plus 32 days (30 + 32 = 62). The start date is July 1 and the end date is September 30. • If there is a second dispensing event with the same Drug ID and there is a gap that exceeds the allowable gap, assign an end date for this drug event and follow the beginning of step 4 for the remaining dispensing events. A beneficiary can have multiple start and end dates per Drug ID during the measurement year. Continue assessing each dispensed prescription for each Drug ID until all dispensing events are exhausted. If a dispensing event goes beyond December 31 of the measurement year, assign the end date as December 31. Step 5 For each beneficiary, identify those with ≥90 consecutive treatment days. For each beneficiary, using the start and end dates from all drug events identified in step 4 (which may include events for the same or different medications and may include events with allowable gaps), determine all calendar days covered by at least one antipsychotic medication. If there were ≥90 consecutive calendar days, include the beneficiary in the measure.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Beneficiaries on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year. Do not include denied claims.

Use the steps below to determine the numerator.

Step 1

For each beneficiary, identify Drug ID, identify all drug events identified in step 4 of the event/diagnosis criteria (used to identify the eligible population [denominator]). Exclude denied claims and recalculate start dates and end dates (using steps 1-4 of the event/diagnosis criteria used to identify the eligible population [denominator]).

Step 2

Identify concurrent antipsychotic medication treatment events as follows:

- For each beneficiary, identify the first day during the measurement year when the beneficiary was treated with two or more different antipsychotic medications (use the Drug ID to identify different drugs, see link to Medication List Directory in Guidance for Reporting above). This is the concurrent antipsychotic medication treatment event start date.
- Beginning with (and including) the start date, identify the number of consecutive days the beneficiary remains on two or more different antipsychotic medications. If the number of days is ≥90 days, the beneficiary is numerator compliant.
- If the number of consecutive days on multiple antipsychotic medications is <90 days, identify the end date and identify the next day during the measurement year when the beneficiary was treated with two or more different antipsychotic medications. If the number of days between the end date and the next start date is ≤15 days, include the days in the concurrent antipsychotic medication treatment event (concurrent antipsychotic medication treatment events allow a gap of up to 15 days).
- If the number of days between the end date and the next start date exceeds 15 days, end the event; using the new start date, continue to assess for concurrent antipsychotic medication treatment events.
- Continue this process until the number of concurrent antipsychotic medication treatment days is ≥90 consecutive days (i.e., the beneficiary is numerator compliant) or until the measurement year is exhausted (i.e., no concurrent antipsychotic medication treatment events were identified during the measurement year).

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APPENDIX E

STANDARDIZED DEFINITION OF SMI

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We refer to the National Committee for Quality Assurance (NCQA) definition of SMI as the standardized definition of SMI. NCQA defines individuals with SMI as those who meet at least one of the following criteria within the measurement period:

- At least one inpatient visit or two outpatient visits for schizophrenia OR
  - Schizophrenia is defined in the Schizophrenia value set (2019 Value Sets to Codes sheet, column D, rows471-542)
  - Inpatient visits are defined in
    - BH Stand Alone Acute Inpatient Value Set or (2016 Value Sets to Codes sheet, column D, rows 137-194)
    - BH Acute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 2-35) with BH Acute Inpatient POS Value Set (2016 Value Sets to Codes sheet, column D, rows 36-37)
  - Outpatient visits are in defined in:
    - BH Stand Alone Outpatient/PH/IOP Value Set (2016 Value Sets to Codes sheet, column D, rows 245-356) or
    - BH Outpatient/PH/IOP Value Set (2016 Value Sets to Codes sheet, column D, rows 84-117) with BH Outpatient/PH/IOP POS Value Set (2016 Value Sets to Codes sheet, column D, rows 118-136) or
    - ED Value Set (2019 Value Sets to Codes sheet, column D, rows 1197-1207) or
    - BH ED Value Set (2016 Value Sets to Codes sheet, column D, rows 38-58) with BH ED POS Value Set or (2016 Value Sets to Codes sheet, column D, rows 59)
    - BH Stand Alone Nonacute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 195-244) or
    - BH Nonacute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 60-80) with BH Nonacute Inpatient POS Value Set (2016 Value Sets to Codes sheet, column D, rows 81-83)
- At least one inpatient or two outpatient visits for bipolar I disorder, OR
  - Bipolar Disorder is defined in the Bipolar Disorder value set (2016 Value Sets to Codes sheet, column D, rows 378-426) OR Other Bipolar Disorder (2016 Value Sets to Codes sheet, column D, rows 464-470)
  - Inpatient visits are defined in
    - BH Stand Alone Acute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 137-194) or
    - BH Acute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 2-35) with BH Acute Inpatient POS Value Set (2016 Value Sets to Codes sheet, column D, rows 36-37)
  - Outpatient visits are in defined in:
    - BH Stand Alone Outpatient/PH/IOP Value Set (2016 Value Sets to Codes sheet, column D, rows 245-356) or

  - BH Outpatient/PH/IOP Value Set (2016 Value Sets to Codes sheet, column D, rows 84-117) with BH Outpatient/PH/IOP POS Value Set (2016 Value Sets to Codes sheet, column D, rows 118-136) or
  - ED Value Set (2019 Value Sets to Codes sheet, column D, rows 1197-1207) or
  - BH ED Value Set (2016 Value Sets to Codes sheet, column D, rows 38-58) with BH ED POS Value Set (2016 Value Sets to Codes sheet, column D, row 59) or
  - BH Stand Alone Nonacute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 195-244) or
  - BH Nonacute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 60-80) with BH Nonacute Inpatient POS Value Set (2016 Value Sets to Codes sheet, column D, rows 81-83)

- At least one inpatient visit for major depression

- Major Depression is defined in the Major Depression value set (2016 Value Sets to Codes sheet, column D, rows 438-463)
- Inpatient visits are defined in
  - BH Stand Alone Acute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 137-194) or
  - BH Acute Inpatient Value Set (2016 Value Sets to Codes sheet, column D, rows 2-35) with BH Acute Inpatient POS Value Set (2016 Value Sets to Codes sheet, column D, rows 36-37)

APPENDIX F

ALOS STANDARD DEVIATIONS

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For Metric #19, the state's goal should be to decrease the average length of stay in participating psychiatric hospitals and residential settings to achieve an overall demonstration target of no more than 30 days. If requested by CMS at the midpoint assessment, states may be required to provide the standard deviation based on the mean in Metric #19.

States should review the distribution of the lengths of stay data to assess normality of the data. If the length of stay data are skewed, states should determine if data transformation is appropriate. Table F.1 provides example transformation methods states may consider for skewed data. For example, a state with substantial right-skewed data may consider using log transformation to calculate the standard deviation. States should assess the normalization of the transformed data before proceeding to the standard deviation calculation.

Table F.1. Data distribution and transformation methods

Data Distribution	Transformation Methods
Moderate positive skew	*Square root*
Substantial positive skew[a]	*Logarithmic (Log 10)*
Moderate negative skew	*Reflect and Square root*
Substantial negative skew[a]	*Reflect and Logarithmic (Log 10)*

[a] Substantial skewness can be assessed using the rule of thumb of -1 to 1 amplitude.

Source: Tabachnick, B. G., & Fidell, L. S. (2007). Using multivariate statistics (5th ed.). Boston: Allyn and Bacon.

After reviewing the data's skewness and transforming the data, as appropriate, states should calculate the standard deviation of the data. Standard deviation can be calculated as:

$$\sigma = \sqrt{\frac{\sum (X - \mu)^2}{n}}$$

σ = population standard deviation

$\sum$ = sum of

μ = population mean

n = number scores in the sample

As requested by CMS at the midpoint assessment, states should provide CMS with the information in Table F.2.

Table F.2. State data for average length of stay and standard deviation

Data type	State data
Description of data	*E.g., normal, right skewed, left skewed, outliers present*
Data Transformation Used (if any)	*E.g., log 10 transformation*
Average Length of Stay *(transformed, if applying data transformation methods)*	*If not transforming data, use value from metric #19*.
Standard Deviation *(transformed, if applying data transformation methods)*	

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