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MANUAL

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

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

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TABLES

METRICS

ACRONYMS

AAP	Adults' Access to Preventive/Ambulatory Health Services (measure)
AHA	American Hospital Association
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
CAH	Critical Access Hospital
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
CQM	Clinical Quality Measure
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
MC	Managed Care
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
PMDA	Performance Metrics Database and Analytics
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
QPP	Quality Payment Program
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
SNOMED	SNOMED Clinical Terms®
STC	Special Terms and Conditions
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 a state with Medicaid section 1115 demonstrations that focus on serious mental illness (SMI) and serious emotional disturbance (SED).[1]

Center for Medicaid and CHIP Services (CMCS) selected section 1115 SMI/SED demonstration monitoring metrics (hereafter referred to as "metrics") with input from subject matter experts and members of the state advisory group for Medicaid monitoring and evaluation. These metrics consist of (1) established quality measures endorsed by the National Quality Forum (NQF) or included in other Medicaid Quality Measures measure sets and (2) CMS-constructed implementation performance metrics to track the goals and milestones presented in the State Medicaid Director Letter (SMDL) dated November 13, 2018 (SMDL #18-011). The CMS-constructed 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 section 1115 SMI/SED demonstrations (hereafter referred to as "SMI/SED demonstrations").

An important goal of monitoring SMI/SED demonstrations is to identify trends that suggest the need for adjustment to improve demonstration performance. These metrics are designed to monitor demonstration performance while minimizing state reporting burden.

This technical specifications manual is organized as follows: Section A of this chapter provides an overview of the metrics, Section B provides reporting instructions that apply to the metrics, and Section C defines the elements included in each specification table. Chapter II presents technical specifications for each metric followed by appendices with supporting information for metric specifications. Appendix A lists the established measures and measure sets references in the technical specifications manual. Appendix B provides a list of value sets that are references throughout the technical specifications. Appendix C includes instructions on how to use supporting measure specifications, value sets, and code lists to calculate metrics. Appendix D provides the technical specifications for the adapted FFY 2020 Child and Adult Core Set measures. Appendix E provides the serious mental illness definition from National Committee for Quality Assurance (NCQA). Appendix F includes additional guidance for calculating standard deviations for Metric #19 Average Length of Stay (ALOS).

A. Overview of section 1115 SMI/SED demonstration monitoring metrics

There are 39 metrics representing several demonstration milestones (Table 1). This set of metrics could change over time, including adding or removing metrics. CMS may select new established quality measures based on measure steward testing results and/or NQF endorsement.

The following describes important parameters for SMI/SED demonstration metrics reporting:

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

Required or recommended. Metrics are either required or recommended.

- ***Required metrics*** provide information that is critical for monitoring the success of SMI/SED demonstrations and could be constructed with data that are readily available to the state.
- ***Recommended metrics*** might be more difficult to report than required metrics, but still provide important information on the operation of a demonstration.

Table 1. Summary of section 1115 SMI/SED monitoring metrics

Demonstration milestones[a]	Number of metrics[b]	
	Total	Required
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	2	1
Milestone 2: Improving Care Coordination and Transitions to Community-Based Care	10	7
Milestone 3: Increasing Access to Continuum of Care including Crisis Stabilization Services	8	8
Milestone 4: Earlier Identification and Engagement in Treatment including through Increased Integration	10	6
Other SMI/SED Metrics	9	9
Total	**39**	**31**

[a] Milestones included in this table are from the State Medicaid Director Letter #18-011 which can be accessed at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf.

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

Measurement period. This parameter identifies the measurement period (the data collection time frame) for each metric. The measurement period may be a month, quarter, or demonstration year. Table 2 lists the number of metrics by milestone for each measurement period. The state should use the measurement period for established quality measures that are provided in the specifications for those measures. Section B provides detailed guidance and reporting instructions for measurement period.

Table 2. Measurement period of section 1115 SMI/SED demonstration metrics by domain/milestone

Demonstration milestones	Number of metrics		
	Annual	Quarterly	Monthly
Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	2	0	0
Milestone 2: Improving Care Coordination and Transitions to Community-Based Care	10	0	0
Milestone 3: Increasing Access to Continuum of Care including Crisis Stabilization Services	2	0	6
Milestone 4: Earlier Identification and Engagement in Treatment including through Increased Integration	9	0	1
Other SMI/SED Metrics	6	3	0
Total	**29**	**3**	**7**

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

Demonstration reporting. The state should report on each metric for its SMI/SED demonstration. Note that for most metrics, demonstration reporting focuses on the subset of Medicaid beneficiaries targeted by the SMI/SED demonstration—that is, Medicaid beneficiaries with SMI/SED. However, some metrics focus more broadly on the Medicaid population (for example, metrics measuring hospitalization after mental illness or antipsychotic medication use). Additional details are available for each metric in Chapter II.

Subpopulation categories. Some subpopulations have unique treatment needs with respect to SMI/SED. Table 3 describes subpopulation categories on which the state can report for CMS-constructed metrics, including:

- ***CMS-provided subpopulation categories***. CMS has identified common subpopulation categories applicable to all SMI/SED demonstrations, including five recommended and two required reporting categories ("CMS-provided" in Table 3). For each CMS-provided subpopulation category, CMS provides guidance on how to define the subpopulations within each category, as well as examples of how the state may identify the subpopulations. The state may propose alternate approaches to calculating these subpopulations in its monitoring protocol. The metric specifications (Chapter II) of this manual list the subpopulations for which the metric should be calculated in addition to the full SMI/SED demonstration population. CMS provides guidance on which of the CMS-provided subpopulations are relevant for each metric.
- ***State-specific subpopulation categories***. There is one state-specific subpopulation category that is required: the state-specific definition of SMI. The state may identify additional subpopulation categories specific to its demonstration ("state-specific" in Table 3). For example, if a state implements its demonstration differently within different geographic areas or models of care, CMS recommends that the state report metrics separately for each area or model. Under those circumstances, reporting metrics only at the demonstration level could obscure important differences across areas or models. Because state-specific subpopulation categories are unique to the state's context and demonstration, the state has greater flexibility in proposing definitions and approaches for identifying these categories in its monitoring protocol. For each state-specific metric, the state should also identify subpopulation categories, if applicable.

Table 3. Subpopulation reporting for section 1115 SMI/SED demonstrations

Subpopulation Categories	Required or Recommended	Description
CMS-provided		
Standardized definition of SMI	Required	We refer to the National Committee for Quality Assurance (NCQA) definition of SMI as the standardized definition of SMI[2]. 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, schizoaffective disorder,bipolar disorder, or major depression, OR; (2) at least two visits in an outpatient, IOP, community mental health center visit, electroconvulsive therapy, observation, ED, nonacute inpatient, or telehealth setting, on different dates of service with a diagnosis of schizophrenia or schizoaffective disorder OR; (3) at least two visits in an outpatient, IOP, community mental health center visit, electroconvulsive therapy, observation, ED, nonacute inpatient, or telehealth setting on different dates of service with a diagnosis of bipolar disorder. See Table B.1 for applicable value sets and **Appendix E: Standardized Definition of SMI** for details.
Age group	Required	Age groups defined as: 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.
Dual-eligible status	Required	Determine dual-eligible status (i.e., dual-eligible [Medicare-Medicaid eligible], Medicaid only) as of the first day of the measurement period. For example, in Transformed Medicaid Statistical Information System (T-MSIS), dual-eligible status is determined by the eligibility file data element, DUAL-ELIGIBLE-CODE[a]. Additional resources for defining dual-eligible populations can be found on Medicaid.gov[b].
Disability	Recommended	Determine eligibility for Medicaid on the basis of disability (yes or no) 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	Recommended	Determine criminal justice status (i.e., criminally involved, not criminally involved) based on ever qualifying for this subpopulation during the measurement period. There is no standard methodology for identifying criminal justice status; the state 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 Substance Use Disorder (SUD)	Recommended	Determine co-occurring SUD (yes or no) for this subpopulation during the measurement period. The state 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.

[2] The version of the NCQA definition of SMI in Appendix E: Standardized Definition of SMI is based on the technical specification of Metric #23 (Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)) from the FFY 2020 Adult Core Set. 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 a state. CMS is using the NCQA definition as method to gather relatively standardized data from the state.

Subpopulation Categories	Required or Recommended	Description
Co-occurring physical health conditions	Recommended	Determine co-occurring physical health conditions for this subpopulation during the measurement period. The state 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.
State-specific		
State-specific definition of SMI	Required	The state may have their own distinct definition of SMI and report according to the definition it provides in its monitoring protocols, specifically within the document: 1115 SMI Monitoring Protocol Workbook.xlsx on the "Protocol-SMI & SED definitions" tab.
Delivery system	Recommended	If the state's SMI/SED demonstration services are provided through managed care (MC) for some beneficiaries and fee-for-service (FFS) for others, the state can report metrics separately for MC and FFS populations.
Geographic area	Recommended	If the state's SMI/SED demonstration operates differently within different geographic areas within the state, the state can report metrics by geographic area (e.g., by county).
Model of care	Recommended	If the state's SMI/SED demonstration operates differently within different models of care, the state can report metrics by model of care (e.g., by individual managed care organization or accountable care organization).
Other subpopulation	Recommended	If the state's section SMI/SED demonstration includes programs or services that target other subpopulations within its overall demonstration population, the state can report metrics for these subpopulations (e.g., Medicaid beneficiaries with SMI or SED who are experiencing homelessness).

[a] 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 are 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.

[b] Additional information on defining dual-eligible populations are 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.

IOP = intensive outpatient care; PH = partial hospitalization; ED = emergency department

Table 4 lists metrics by measurement domain and provides key reporting parameters, including the measurement period, data source, and CMS-provided subpopulation categories for each metric.

Table 4. Overview of section 1115 SMI/SED demonstration monitoring metrics, by measurement domain

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source	Subpopulation Categories [b]								
						Demonstration Reporting	Standardized Definition of SMI	Age Group	Dual-eligible status	Disability (Recommended)	Criminal Justice Status (Recommended)	Co-occurring SUD (Recommended)	Co-occurring physical health conditions (Recommended)	State-specific definition of SMI
	Milestone 1 [a]													
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	TJC	Recommended	Year	Medical record review or claims	X								
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	Required	Year	Claims	X								
	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)	CMS	Required	Year	Claims	X								
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	CMS	Required	Year	Claims	X								
5	Medication Reconciliation Upon Admission	CMS	Recommended	Year	Electronic/paper medical records	X								
6	Medication Continuation Following Inpatient Psychiatric Discharge	CMS	Required	Year	Claims	X								
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	NCQA	Required	Year	Claims	X								
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	NCQA	Required	Year	Claims	X								
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	NCQA	Required	Year	Claims	X								
10	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)	NCQA	Required	Year	Claims	X								

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source	Subpopulation Categories [b]								
						Demonstration Reporting	Standardized Definition of SMI	Age Group	Dual-eligible status	Disability (Recommended)	Criminal Justice Status (Recommended)	Co-occurring SUD (Recommended)	Co-occurring physical health conditions (Recommended)	State-specific definition of SMI
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	Recommended	Year	State data on cause of death, linked to claims	X		X						
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	Recommended	Year	State data on cause of death, linked to claims	X		X						
	Milestone 3 [a]													
13	Mental Health Services Utilization - Inpatient	None	Required	Month	Claims	X	X	X	X	X	X	X	X	X
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	None	Required	Month	Claims	X	X	X	X	X	X	X	X	X
15	Mental Health Services Utilization - Outpatient	None	Required	Month	Claims	X	X	X	X	X	X	X	X	X
16	Mental Health Services Utilization - ED	None	Required	Month	Claims	X	X	X	X	X	X	X	X	X
17	Mental Health Services Utilization - Telehealth	None	Required	Month	Claims	X	X	X	X	X	X	X	X	X
18	Mental Health Services Utilization - Any Services	None	Required	Month	Claims	X	X	X	X	X	X	X	X	X
19a	Average Length of Stay in IMDs	None	Required	Year	Claims	X								
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	None	Required	Year	Claims	X								
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	None	Required	Year	Claims	X								
	Milestone 4 [a]													
21	Count of Beneficiaries With SMI/SED (monthly)	None	Required	Month	Claims	X	X	X	X	X	X	X	X	X
22	Count of Beneficiaries With SMI/SED (annually)	None	Required	Year	Claims	X	X	X	X	X	X	X	X	X
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	NCQA	Required	Year	Claims, Medical Records	X								

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source	Subpopulation Categories [b]								
						Demonstration Reporting	Standardized Definition of SMI	Age Group	Dual-eligible status	Disability (Recommended)	Criminal Justice Status (Recommended)	Co-occurring SUD (Recommended)	Co-occurring physical health conditions (Recommended)	State-specific definition of SMI
24	Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	NCQA	Recommended	Year	Claims or electronic medical records	X								
25	Screening for Depression and Follow-up Plan: Ages 12–17 (CDF-CH)	NCQA	Recommended	Year	Claims or electronic medical records	X								
26[c]	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	NCQA	Required	Year	Claims	X								
27	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	NCQA	Recommended	Year	Claims	X								
28	Alcohol Screening and Follow-up for People with Serious Mental Illness	NCQA	Recommended	Year	Claims	X								
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA	Required	Year	Claims	X								
30	Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	CMS	Required	Year	Claims	X								
	Other SMI/SED Metrics													
32[d]	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	None	Required	Year	Claims	X								
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	None	Required	Year	Claims	X								
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	None	Required	Year	Claims	X								

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source	Subpopulation Categories [b]								
						Demonstration Reporting	Standardized Definition of SMI	Age Group	Dual-eligible status	Disability (Recommended)	Criminal Justice Status (Recommended)	Co-occurring SUD (Recommended)	Co-occurring physical health conditions (Recommended)	State-specific definition of SMI
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	None	Required	Year	Claims	X								
36	Grievances Related to Services for SMI/SED	None	Required	Quarter	Administrative records	X								
37	Appeals Related to Services for SMI/SED	None	Required	Quarter	Administrative records	X								
38	Critical Incidents Related to Services for SMI/SED	None	Required	Quarter	Administrative records	X								
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	None	Required	Year	Claims	X								
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	None	Required	Year	Claims	X								

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

[b] A state must report the state-specific definition of SMI for the metrics noted in the table. For CMS-constructed metrics, the state can identify additional subpopulations categories specific to their demonstration.

[c] Metric #26 is an adjusted HEDIS measure: Access to Preventative/Ambulatory Health Services for Adult Medicaid Beneficiaries with SMI. Although the technical specifications provided by the measure steward describe how to report the metric by age group, the state is not expected to report this subpopulation category for this metric.

[d] Metric #31 was removed from the 1115 SMI/SED monitoring metrics in Version 2.0 Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics

IMD = Institution for Mental Diseases; NCQA = National Committee for Quality Assurance; SMI/SED = Serious Mental Illness/Serious Emotional Disturbance; TJC = The Joint Commission

B. Reporting guidance for section 1115 SMI/SED monitoring metrics

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

Technical assistance. CMS offers technical assistance to help a state collect, report, and use the metrics. For technical assistance, contact the section 1115 demonstration monitoring and evaluation mailbox (1115MonitoringandEvaluation@cms.hhs.gov), copying the state's CMS demonstration team on the message.

Supplemental materials. Technical specifications for some established quality measures as well as established value sets and other resource materials are provided in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and also accessible to the state through Performance Metrics Database and Analytics (PMDA) in the Reference Materials section. To access the .zip file, the state should go to the Reference Materials section of PMDA and complete the National Measure Stewards Terms and Conditions 'Point and Click' Agreement. This agreement should automatically appear when a state downloads the technical specifications manual or supporting information .zip file.

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

- ***CMS-constructed metrics.*** Many of the metrics were constructed by CMS. The technical specifications for these metrics are included in this document (Chapter II). Many of these metrics reference HEDIS 2020 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 provided in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and are also accessible to the state through PMDA in the Reference Materials section.
- ***Established quality measures.*** Some metrics are established quality measures available from a Quality Measures measure set such as (the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP [Child Core Set], the Core Set of Adult Health Care Quality Measures for Medicaid [Adult Core Set], or measure steward (NCQA or the Joint Commission), as specified.[3] To help the state calculate these metrics, this document references the original measure specifications and associated value sets, provided in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual. These materials are also accessible to the state through PMDA in the Reference Materials section.
- ***State-specific 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-specific metrics" within this document.

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

Determining measurement periods. To determine measurement periods, the state must first identify the start date of its SMI/SED demonstration. For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* in the state's special terms and conditions (STCs). For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration for purposes of monitoring.[4]

When reporting metrics, the state should use the following guidance for determining the measurement period:

- ***CMS-constructed and state-specific metrics:***
    - *Monthly metrics.* For metrics where the measurement period is a month, the first measurement period is the first month in which the demonstration started (as defined by the start date of the demonstration's approval period), irrespective of the day of the month the demonstration started. For example, if the SMI/SED demonstration began on March 1 or on any other day in March (e.g., March 15), the first measurement period is March 1 through March 31. The second measurement period is April 1 through April 30. For each quarterly report, the state should submit data pertaining to the three months within the quarter.
    - *Quarterly metrics.* For metrics where the measurement period is a quarter, the first measurement period spans the first three months of the SMI/SED demonstration's approval period. For example, if the SMI/SED demonstration began March 1 or on any other day in March (e.g., March 15), the first quarterly measurement period is March 1 through May 31. The second quarterly measurement period is June 1 through August 31.
    - *Annual metrics.* For metrics where the measurement period is a year, the measurement period should align with the SMI/SED demonstration year schedule. For example, if the SMI/SED demonstration began on March 1 or on any other day in March (e.g., March 15), the first measurement period is March 1 of the year in which the demonstration started through February 28 of the following calendar year.
- ***Established quality measures.*** For metrics that are established quality measures, the annual measurement period should align with a calendar year, with the first measurement period aligned with the calendar year in which the SMI/SED demonstration started. For example, if the SMI/SED demonstration began March 1, 2019, the first measurement period should be the 2019 calendar year (January 1, 2019 through December 31, 2019) to align with the measurement period for these measures in other quality reporting programs.

[4] The effective date is defined as the first day the state ***may*** begin its SMI/SED demonstration, as indicated in the state's STCs. Note that in many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

Determining baseline reporting periods. To determine baseline reporting periods, the state must first identify the start date of its SMI/SED demonstration. For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* in the state's STCs. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration for purposes of monitoring.

- ***CMS-constructed and state-specific metrics****:* For CMS-constructed and state-specific metrics where the measurement period is a month, quarter, or year, the baseline reporting period is the first SMI/SED demonstration year (SMI/SED DY1). For example, if the state's SMI/SED demonstration began on March 1, 2019, the baseline reporting period is March 1, 2019 – February 29, 2020.
    - If the state's SMI/SED demonstration began on any day other than the first day of the month, the state should still start its baseline reporting period on the first day of the month for monitoring purposes. This applies to all baseline reporting periods (month, quarter, and year). For example, if a state's demonstration began on March 15, 2019 the state should consider March 1 as the beginning of its baseline period.
    - For a state where the first SMI/SED DY 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 SMI/SED demonstration). For example, if the state has a 10-month SMI/SED DY1 that began March 1, 2019 and ended December 31, 2019, the baseline reporting period should be January 1, 2019 – December 31, 2019.
- ***Established quality measures****:* For metrics that are established quality measures, the calendar year in which the demonstration started is the baseline reporting period. For example, if the state's SMI/SED demonstration began on March 1, 2019, the baseline reporting period is January 1, 2019 through December 21, 2019.
    - For measures calculated over a 2-year period (Metric #6: Medication Continuation Following Inpatient Psychiatric Discharge), the baseline reporting period is the calendar year in which the SMI/SED demonstration started and the prior year. For each subsequent reporting period, shift the period for the denominator forward by one year.
    - For a state 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, the baseline reporting period would be the same calendar year. For example, if a state has a 10-month SMI/SED DY1 starting March 1, 2020 and ending on December 31, 2020, the baseline reporting period is January 1, 2020 – December 31, 2020 (calendar year 2020). If the last day of SMI/SED DY1 is any other date, the baseline reporting period should be the prior calendar year. For example, if a state has a 10-month SMI/SED DY1 that started on September 1, 2019 and ended June 30, 2020, the baseline period is January 1, 2019 – December 31, 2019 (calendar year 2019).

To confirm the measurement and baseline reporting periods, contact the section 1115 demonstration monitoring and evaluation mailbox

(1115MonitoringandEvaluation@cms.hhs.gov), copying the state's CMS demonstration team on the message.

Table 5 below illustrates these guidelines, using an SMI/SED demonstration that begins March 1, 2019 as an example.

Table 5. Example of alignment between section 1115 SMI/SED demonstration years and measurement periods

Section 1115 SMI/SED Demonstration Start Date: March 1, 2019	SMI/SED Measurement Period					
	Month		Quarter		Year[a]	
	Start Date	End Date	Start Date	End Date	Start Date	End Date
	CMS-constructed and state-specific metrics				Established quality measures	
SMI/SED DY1 March 1, 2019 – Feb 29, 2020 (baseline reporting period)	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	Jan 1, 2019	Dec 31, 2019
SMI/SED DY2 March 1, 2020 – Feb 28, 2021	Month as defined in the baseline reporting period row	Month as defined in the baseline reporting period row	Quarter as defined in the baseline reporting period row	Quarter as defined in the baseline reporting period row	Jan 1, 2020	Dec 31, 2020
SMI/SED DY3 March 1, 2021 – Feb 28, 2022					Jan 1, 2021	Dec 31, 2021
SMI/SED DY4 March 1, 2022 – Feb 28, 2023					Jan 1, 2022	Dec 31, 2022
SMI/SED DY5 March 1, 2023 – Feb 29, 2024					Jan 1, 2023	Dec 31, 2023

[a] This example does not apply to Metric #6, which is calculated over a two-year time period.

DY = Demonstration year

Metric calculation and reporting. The state 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 SMI/SED 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 monitoring report should contain (1) narrative information on implementation for the most recent demonstration quarter, (2) grievances and appeals metrics 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 a state with an SMI/SED demonstration year that ends January 31 or February 28: in the first quarterly monitoring report of the next SMI/SED demonstration year
  - For a state with an SMI/SED demonstration year that ends March 31 through November 30: in the annual monitoring report
  - For a state with an SMI/SED demonstration year that ends December 31: in the second quarterly monitoring report of the next SMI/SED demonstration year
- All other annual metrics should be reported in the first quarterly monitoring report of the next SMI/SED demonstration year, rather than in the annual monitoring report. This allows at least 90 days for claims run-out and other considerations for data completeness.

Table 6 illustrates these guidelines, which apply to both CMS-constructed and state-specific metrics.

Table 6. Reporting in quarterly and annual section 1115 SMI/SED monitoring reports

Report name:	DY1Q1 report	DY1Q2 report	DY1Q3 report	DY1Q4 (annual) report**	DY2Q1 report	DY2Q2 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	DY1Q1	DY1Q2	DY1Q3	DY1Q4	DY2Q1	DY2Q2
Grievances and appeals	DY1Q1	DY1Q2	DY1Q3	DY1Q4	DY2Q1	DY2Q2
Other monthly and quarterly metrics	n.a.	DY1Q1	DY1Q2	DY1Q3	DY1Q4	DY2Q1
Annual metrics that are established quality measures*	n.a.	n.a.	n.a.	A state with a DY ending 3/31 – 11/30: CY1	A state with a DY ending on 1/31 or 2/28: CY1	A state with a DY ending on 12/31: CY1
Other annual metrics	n.a.	n.a.	n.a.	n.a.	DY1	n.a.

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

* Metrics that are established quality measures should be calculated for the calendar year. Note that one established quality measure (Metric #6) should be calculated over a 2-year period (starting with the calendar year in which the demonstration began and the calendar year prior). All other metrics should be calculated for the SMI/SED demonstration year.

**Per the STCs, the state's fourth quarterly monitoring report (Q4) is also considered to be its annual monitoring report for the previous demonstration year. If the state's SMI/SED demonstration is part of a broader section 1115 demonstration, the state should consider its broader section 1115 demonstration Q4 monitoring report to be the state's annual monitoring report.

CY = calendar year; CY1 = the calendar year in which the demonstration began; DY = Demonstration year; Q = Quarter; n.a. = not applicable (information not expected to be included in the monitoring report)

Manual version. CMS will release an annual update of this technical specifications manual to incorporate updated specifications and/or value sets from national measure stewards of established quality measures included in the SMI/SED demonstration metrics. Additionally, the annual update to this manual may include clarifications and improvements to specifications for CMS-constructed metrics and to metrics reporting guidance. The state should use the manual versions as follows:

- ***CMS-constructed metrics.*** The state should use the latest version of the manual available (as identified by the version number) to calculate these metrics.

- ***Established quality measures.*** For measurement periods that occur within calendar year 2019, the state should use Version 2.0 of this manual (this version, August 2020). For later years, the state should use the version of the manual associated with the calendar year (for example, use Version 3.0 – the next annual update – to calculate established quality measures for calendar year 2020).

General guidance. When reporting 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: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics** for instructions on how to access and use these supporting materials to calculate monitoring metrics.
- ***Eligible population.*** The eligible population for each metric will vary based on whether the metric is a CMS-constructed metric or an established quality measure.
  - *All CMS-constructed metrics.* CMS-constructed 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 or SED services. 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 services described in the metric numerator.

    The metrics should exclude beneficiaries who are: (1) only entitled to restricted benefits based on alien status, (2) only entitled to restricted benefits based on Medicare dual-eligibility status including QMB, SLMB, QDWI and QI; (3) have a first source of payment other than Medicaid or Medicare for substance use disorder treatment services (for example private insurance or eligibility for Medicaid only after spenddown); (4) only eligible for family planning services; or (5) 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 any CMS-constructed metrics. 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.

The following additional criteria apply based on the measurement period of the CMS-constructed metric:

- For *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 CMS-constructed annual metric calculations, unless otherwise specified in the "population of interest" or "denominator" rows of the metric's technical specification.
- For *monthly and quarterly metrics,* beneficiaries with full benefits enrolled in Medicaid for any amount of time during the measurement period are eligible for inclusion in CMS-constructed monthly or quarterly metric calculations, unless otherwise specified in the "population of interest" or "denominator" rows of the metric's technical specification

For each CMS-constructed metric, the state should review the associated specification table in Chapter II to determine additional metric-specific eligibility criteria.

- *Established quality measures.* For metrics that are established quality measures, the state should use the technical specifications from the measure steward to determine eligibility criteria. For measures in the Medicaid Child and Adult Core Sets, refer to the technical specifications included in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Set Measure Specifications**. For all other established quality measures, refer to the original measure specifications, provided in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual. These materials are also accessible through PMDA in the Reference Materials section.

  Note that for some metrics that are established quality measures, Chapter II provides additional criteria beyond those specified by the respective measure steward that should be applied when calculating the metric. This information can be found under the "population of interest" and "metric calculation" rows in the technical specifications tables in Chapter II.

- ***Claim type.*** For CMS-constructed metrics, 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.*** The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. If the state would like to provide this information in an attachment, the state should enter "See attachment" in this column in Part A. See the latest Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance.

- ***Telehealth and state-specific service codes.*** In response to the 2019 Coronavirus (COVID-19) pandemic, CMS recognizes that many providers and facilities have shifted from in-person visits to telehealth or other service delivery models. To account for these changes in service delivery, the state should review its telehealth codes, as well as relevant state-specific service codes, to ensure these codes will accurately capture use of telehealth services or alternative service delivery models. The state may refer to the Telemedicine page on Medicaid.gov[5] for additional information regarding telehealth coding and policy considerations related to COVID-19.

    - *CMS-constructed metrics.* CMS-constructed metrics include telehealth HEDIS value sets (Online assessments, Telehealth Modifier, Telehealth POS, or Telephone Visits) where applicable. The state may wish to supplement the telehealth codes referenced in the metric specifications with state-specific codes that are not included in these value sets. The state should review the codes in the telehealth-related HEDIS value sets[6] and determine if additional codes are necessary to capture services performed via telehealth or other new service delivery models in response to COVID-19. The state should describe these state-specific telehealth and service codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance.
    - *Established quality measures.* For metrics that are established quality measures, the state should use the technical specifications and value sets from the measure steward as specified in this manual. The state should not supplement telehealth or other service coding with state-specific codes for these metrics. As established quality measures within this manual are to be reported for calendar year 2019, a future update of this manual and supporting materials will capture any changes to established quality measure technical specifications or value sets related to COVID-19 that are deemed necessary by the measure steward.

C. Using technical specifications

Table 7 defines the elements included in specifications for metrics in Chapter II. The description column explains each metric element.

[5] Telemedicine guidance is available on Medicaid.gov at: https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html.

[6] Detailed instructions for accessing the HEDIS value sets can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.

Table 7. Metric elements included in the 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.
Population of interest	Criteria for determining the population that should be included in each metric.
Numerator	When the metric is a rate, this element describes the numerator in the rate. 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	When the metric is a rate, this element describes the denominator in the rate. This element is not used in metrics that are counts or 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 calculate and 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 6 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.
Subpopulation categories	Describes the subpopulations that the state should report separately. Required subpopulations are identified with the notation (required).
Relationship to other metrics	Describes components of a metric that are used in other 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.

II. METRIC SPECIFICATIONS

This chapter presents technical specifications for each of the SMI/SED demonstration monitoring metrics. Reporting guidance that applies to all metrics can be found in Chapter I.

Metric #1: SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	
Metric element	**Description**
Measure sets/endorsements	Hospital Inpatient Quality Reporting Program 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. The measure is reported as an overall rate which includes all patients to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included.
Population of interest	All Medicaid beneficiaries within the denominator defined in the measure steward's specifications. The denominator includes all beneficiaries discharged from acute inpatient care with Length of Stay (Discharge Date minus Admission Date) less than or equal to 120 days.
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.qualitynet.org/files/5d0d3931764be766b0103221?filename=2-6-2-SUB-v5-6.pdf. Detailed instructions for accessing the measure specification and code set can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Medical record review or claims
Claim type	Not specified

Note: Version of Specification: Joint Commission National Hospital Inpatient Quality Measures version 5.6a. Specifications come from the greater IQR program manual.

Metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set), based on HEDIS specifications 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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims

Note: Version of Specification: Child Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

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	Measure steward: 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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Note that the measure steward's specifications refer to multiple denominators. For the purpose of SMI/SED demonstration monitoring, the state should calculate this metric for the Medicaid beneficiaries with SMI (denominator #4). Instructions for calculating this metric are provided in the full measure specification (pmh-20-ed-tech-specs-manual) provided to the state in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA. Calculation instructions are also located in Technical Specifications and Resource Manual for "All-cause emergency department utilization rate for Medicaid beneficiaries who may benefit from integrated physical and behavioral health care."
Additional guidance	Detailed instructions for accessing the value sets required for this metric are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**. The Technical Specifications and Resource Manual is available at https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/functional-areas/quality-measurement/physical-and-mental-health-integration-quality-measures/index.html.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: Version of Specification: Technical Specifications and Resource Manual, April 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 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.
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
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 critical access hospitals (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 admission date 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

Metric #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	
Metric element	**Description**
Metric calculation (continued)	To identify index admissions, identify discharges with a psychiatric primary 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.). • 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 index admissions 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 5. Exclude admissions considered planned Of the readmissions identified in Step 4, identify and exclude admissions considered planned as determined by the CMS 30-day Hospital-Wide Readmission (HWR) Measure Planned Readmission Algorithm, Version 4.0 available at: https://qualitynet.org/files/5d0d374b764be766b0101361?filename=2019HWRReport.pdf. Step 6. Calculate the rate of readmissions: number readmissions (Step 5) / 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://qualitynet.org/files/5df7a5ca62faad001ffd7a87?filename=FY20_IPFQR_CBM_Specs.pdf. For the purpose of SMI/SED demonstration monitoring, the state should use measure calculation instructions in this manual. Note that the measure steward's specifications refer to Medicare beneficiaries. For purpose of SMI/SED demonstration monitoring, the state should calculate this metric for the Medicaid beneficiaries described in the population of interest.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, and denied claims.)

Note: Version of Specification: Inpatient Psychiatric Facility Quality Reporting Program Claims-Based Measure Specifications, November 2019)

Metric #5: Medication Reconciliation Upon Admission	
Metric element	**Description**
Measure sets/endorsements	NQF #3317 Measure steward: CMS
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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
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	Instructions for calculating this metric are located in the full measure specification (IPQFR_Medication Rec on Admsn_specs) provided to the state in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA
Additional guidance	Detailed instructions for accessing the specifications can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Electronic/paper medical records
Claim type	Not applicable

Metric #6: Medication Continuation Following Inpatient Psychiatric Discharge	
Metric element	**Description**
Measure sets/endorsements	Based on NQF# 3205 Measure steward: CMS
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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric are located in the full measure specification (IPQFR_Medication Continuation_specs) and data dictionary (IPQFR_Medication Continuation_Data Dictionary) provided to the state in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA.
Additional guidance	Detailed instructions for accessing the specifications and data dictionary can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #7: Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set), based on HEDIS specifications 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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims

Note: Version of Specification: Child Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

Metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims

Note: Version of Specification: Adult Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

Metric #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), based on HEDIS specifications NQF #3488 Measure steward: NCQA
Description	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary 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 which the beneficiary received follow-up within 30 days of the ED visit (31 total days) • Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims

Note: Version of Specification: Adult Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

Metric #10: Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), based on HEDIS specifications NQF #3489 Measure steward: NCQA
Description	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary 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 days)
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims

Note: Version of Specification: Adult Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

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
Population of Interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	Count of the number of suicide or overdose deaths among the population of interest within 7 and 30 days of a mental health discharge date. 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 Value Set *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2016 BH Stand Alone Nonacute Inpatient Value Set • From the HEDIS 2020 Inpatient Stay Value Set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Steps 1a and 1b, retain claims 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. Step 4. Using the beneficiaries from step 3, retain only inpatient or residential treatment stays for mental health with discharge dates that fall within the measurement period. Step 5. 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 6. Subtract the date of death from the death record from the discharge date for any inpatient or residential treatment stay for mental health 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**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** Data sources for suicide deaths may vary by state. For example, a state may have access to a centralized state medical examiner system, whereas another state 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. A state 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
Subpopulation categories	Age groups (required) State-specific subpopulations
Relationship to other metrics	Beneficiaries counted in this metric are the same as those counted in Metric #12. Metric #11 calculates a count, whereas Metric #12 expresses that count as a rate.
Data source	State data on cause of death
Claim type	Not applicable

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the “Explanation of any deviations from the CMS-provided specifications” column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter “See attachment” in the appropriate column in Part A.

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
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The number of suicide or overdose deaths among beneficiaries in the population of interest. Step 1. Use the beneficiaries 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 inpatient or residential treatment stay for mental health 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.
Denominator	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 Value Set *UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS 2016 BH Stand Alone Nonacute Inpatient Value Set • From the HEDIS 2020 Inpatient Stay Value Set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Steps 1a and 2b, retain claims 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 #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**
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 number 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 number 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.
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** Data sources for suicide deaths may vary by state. For example, a state may have access to a centralized state medical examiner system, whereas another state 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. The state 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
Subpopulation categories	Age groups (required) State-specific subpopulations
Relationship to other metrics	Beneficiaries counted in this metric are the same as those counted in Metric #11. Metric #11 calculates a count, whereas Metric #12 expresses that count as a rate.
Data source	State data on cause of death
Claim type	Not applicable

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

Metric #13: Mental Health Services Utilization - Inpatient	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for any amount of time during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
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 all acute and nonacute inpatient stay claims that have a revenue code from the HEDIS 2020 Inpatient Stay Value Set and have a primary diagnosis code in the HEDIS 2020 Mental Health Diagnosis Value Set on the discharge claim. Step 2. Identify the discharge date for the stay. Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** 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. This measure is based on an NCQA HEDIS measure (MPT). Instructions for calculating the HEDIS version of this measure are provided for reference in the full measure specification (NCQA Measure Specifications_v2, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring physical health conditions

Metric #13: Mental Health Services Utilization - Inpatient	
Metric element	**Description**
Subpopulation categories (continued)	State-specific subpopulations
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #14 - #19, #32 - #33, and #39 - #40. Beneficiaries identified for this metric are a subset of the beneficiaries for Metric #18.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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 population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for any amount of time during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
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 primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS 2020 Value Sets: • Partial Hospitalization or Intensive Outpatient • (MPT IOP/PH Group 1; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code in Partial Hospitalization POS • (MPT IOP/PH Group 1; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code in Community Mental Health Center POS – The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting (the community mental health POS code can be used in settings other than intensive outpatient and partial hospitalizations) • MPT IOP/PH Group 2 with a corresponding code in Partial Hospitalization POS – The state should ensure that the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • MPT IOP/PH Group 2 with a corresponding code in Community Mental Health Center POS – The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting (the community mental health center POS code can be used in settings other than intensive outpatient and partial hospitalizations) – The state should ensure that the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set Step 3. Exclude any claims from Step 2 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.
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** This measure is based on an NCQA HEDIS measure (MPT). Instructions for calculating the HEDIS version of this measure are for reference provided in the full measure specification (NCQA Measure Specifications_v2, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and the Reference Materials section on PMDA.

Metric #14: Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization	
Metric element	**Description**
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring or physical health condition State-specific subpopulations
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. Beneficiaries identified for this metric are a subset of the beneficiaries for Metric #18.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

Metric #15: Mental Health Services Utilization - Outpatient	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for any amount of time during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
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 primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS 2020 Value Sets: • MPT Stand Alone Outpatient Group 1 • MPT Stand Alone Outpatient Group 2 – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • Observation – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • (Visit Setting Unspecified; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Outpatient POS • (Visit Setting Unspecified; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Community Mental Health Center POS – The state should ensure that the visit was in an outpatient setting (this POS code can be used in settings other than outpatient) • (Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Ambulatory Surgical Center POS Step 3. Exclude any claims from Step 2 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, 2, and 3.
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** This measure is based on an NCQA HEDIS measure (MPT). Instructions for calculating the HEDIS version of this measure are provided for reference in the full measure specification (NCQA Measure Specifications_v2, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and the Reference Materials section on PMDA.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics

Metric #15: Mental Health Services Utilization - Outpatient	
Metric element	**Description**
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring physical health conditions State-specific subpopulations
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. Beneficiaries identified for this metric are a subset of the beneficiaries for Metric #18.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

Metric #16: Mental Health Services Utilization - ED	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for any amount of time during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
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 primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS 2020 Value Sets: • ED – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • Visit Setting Unspecified with a corresponding code from ED POS • Visit Setting Unspecified with a corresponding code from Community Mental Health Center POS – The state should ensure 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 from Step 2 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, 2, and 3.
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** This measure is based on an NCQA HEDIS measure (MPT). Instructions for calculating the HEDIS version of this measure are provided for reference in the full measure specification (NCQA Measure Specifications_v2, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and the Reference Materials section on PMDA.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring physical health conditions State-specific subpopulations

Metric #16: Mental Health Services Utilization - ED	
Metric element	**Description**
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. Beneficiaries identified for this metric are a subset of the beneficiaries for Metric #18.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

Metric #17: Mental Health Services Utilization - Telehealth	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for any amount of time during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The number of unique beneficiaries (de-duplicated total) in the demonstration population with a service claim for telehealth services related to mental health during the measurement period. Step 1. Identify claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS 2020 Value Sets or another online assessment CPT code: *HEDIS 2020 Value Sets* • Telephone Visits • Online Assessments • Visit Setting Unspecified with a corresponding code from (Telehealth Modifier or Telehealth POS) • MPT IOP/PH Group 1 with a corresponding code from (Telehealth Modifier or Telehealth POS) • MPT IOP/PH Group 2 with a corresponding code from (Telehealth Modifier or Telehealth POS) - The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set *Online assessment CPT codes:* • 98970: Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes • 98971: 11—20 minutes • 98972: 21 or more minutes • 99421: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes • 99422: 11—20 minutes • 99423: 21 or more minutes Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** This measure is based on an NCQA HEDIS measure (MPT). Instructions for calculating the HEDIS version of this measure are provided for reference in the full measure specification (NCQA Measure Specifications_v2, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and the Reference Materials section on PMDA.
Measurement period (Metric type)	Month (CMS-constructed)

Metric #17: Mental Health Services Utilization - Telehealth	
Metric element	**Description**
Reporting category	Other monthly and quarterly metrics
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring physical health conditions State-specific subpopulations
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. Beneficiaries identified for this metric are a subset of the beneficiaries for Metric #18.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

Metric #18: Mental Health Services Utilization - Any Services	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for any amount of time during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
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 primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS 2020 Value Sets or another online assessment CPT code: *HEDIS 2020 Value Sets* • Inpatient Stay • Partial Hospitalization or Intensive Outpatient • MPT IOP/PH Group 1 with a corresponding code from Partial Hospitalization POS or Community Mental Health Center POS – The state 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 – The state 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 – The state 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 – The state should ensure that the visit was billed by a mental health practitioner using the Mental Health Practitioner • MPT IOP/PH Group 2 with a corresponding code from Community Mental Health Center POS – The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting – The state should ensure that the visit was billed by a mental health practitioner using the Mental Health Practitioner • MPT Stand Alone Outpatient Group 1 • MPT Stand Alone Outpatient Group 2 – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner • Observation – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner • Visit Setting Unspecified with a corresponding code from Outpatient POS or ED POS or (Telehealth Modifier or Telehealth POS)

Metric #18: Mental Health Services Utilization - Any Services	
Metric element	**Description**
Numerator (continued)	• 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 – The state should ensure that the visit was in an outpatient setting or where the organization can confirm that the visit was in an ED setting • Electroconvulsive Therapy with a corresponding code from Community Mental Health Center POS – The state should ensure that the visit was in an outpatient setting • Transcranial Magnetic Stimulation with a corresponding code from Community Mental Health Center POS – The state 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 or Telehealth POS) • MPT IOP/PH Group 2 with a corresponding code from (Telehealth Modifier or Telehealth POS) – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner • Telephone Visits • Online Assessments *Online assessment CPT codes:* • 98970: Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes • 98971: 11—20 minutes • 98972: 21 or more minutes • 99421: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes • 99422: 11—20 minutes • 99423: 21 or more minutes Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** This measure is based on an NCQA HEDIS measure (MPT). Instructions for calculating the HEDIS version of this measure are provided for reference in the full measure specification (NCQA Measure Specifications_v2, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and the Reference Materials section on PMDA.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics

Metric #18: Mental Health Services Utilization - Any Services	
Metric element	**Description**
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring physical health conditions State-specific subpopulations
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. Beneficiaries identified for this metric are a de-duplicated combination of the beneficiaries from Metrics #13-17.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

Metric #19a: Average Length of Stay in IMDs	
Metric element	**Description**
Measure sets/endorsements	None
Description	Average length of stay (ALOS) for beneficiaries in the demonstration discharged from an inpatient or residential stay in an IMD
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	CMS will ask the state 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. If a claim does not have a discharge date explicitly reported, the latest end date of service on a claim for the stay should be used as the discharge date. Only include stays for a given measurement period if the reported discharge date or proxy discharge date falls within the measurement period. Days should be counted as part of the length of the stay even if they are prior to the measurement period. If an admission date is not reported on the claim with the discharge date, look back 12 months from the beginning of the measurement period to identify claims associated with the same stay. If no admission date is reported on any of these claims, use the earliest date of service as the admission date. 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, long-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 during the measurement period. This method may be specific to each state; a state may a maintain centralized database of IMD stays. Alternatively, a state 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:* • 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 2020 Inpatient Stay Value Set Step 1b. Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set.

Metric #19a: Average Length of Stay in IMDs	
Metric element	**Description**
Denominator (continued)	Step 2. Among claims identified in Step 1 (1a and 1b), retain claims 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	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** 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. A state may have a published list of IMDs in which the designation is made by the state. If available, the state can use that list 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. – 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.

Metric #19a: Average Length of Stay in IMDs	
Metric element	**Description**
Additional guidance (continued)	– 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
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The definition of an IMD should be the same in Metrics #19a, #19b and #20. The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. The group of IMDs in Metric #19b is a subgroup of this metric.
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: A state 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: Average Length of Stay (ALOS) Standard Deviations**.

The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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)
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	CMS will ask the state 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 receiving FFP. A beneficiary admitted and discharged on the same day is treated as a one-day stay. If a claim does not have a discharge date explicitly reported, the latest end date of service on a claim for the stay should be used as the discharge date. Only include stays for a given measurement period if the reported discharge date or proxy discharge date falls within the measurement period. Days should be counted as part of the length of the stay even if they are prior to the measurement period. If an admission date is not reported on the claim with the discharge date, look back 12 months from the beginning of the measurement period to identify claims associated with the same stay. If no admission date is reported on any of these claims, use the earliest date of service as the admission date. Step 2. Sum the total number of days in an IMD receiving FFP by summing the lengths of stay from the denominator.
Denominator	Separately for short-term, long-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; a state may maintain a centralized database of IMD stays. Alternatively, a state 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:* • 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 2020 Inpatient Stay Value Set Step 1b. Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set.

Metric #19b: Average Length of Stay in IMDs (IMDs receiving FFP only)	
Metric element	**Description**
Denominator (continued)	Step 2. Among claims identified in Step 1 (1a and 1b), retain claims for residential or inpatient treatment in an IMD. (See the additional guidance section for a definition of IMDs). Step 3. Limit the claims identified in Step 2 to claims for treatment in IMDs receiving federal financial participation. 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	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** 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. The state should limit to IMDs receiving federal financial participation (FFP). A state may have a published list of IMDs in which the designation is made by the state. If available, a state can use that list 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. 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. 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
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The definition of an IMD should be the same in Metrics #19a, #19b, and #20. The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. The IMDs included in Metric #19b are a subset of the IMDs in Metric #19a.
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: A state 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: Average Length of Stay (ALOS) Standard Deviations**.

The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

Metric #20: Beneficiaries With SMI/SED Treated in an IMD for Mental Health	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
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 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; a state may maintain centralized databases of IMD stays. Alternatively, a state may be able to identify IMD stays in T-MSIS data or through other methods. Only include IMDs receiving Federal Financial Participation under the demonstration. 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 • HEDIS 2020 Inpatient Stay Value Set Step 1b. Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among the claims identified in Step 1 (1a and 1b), retain claims for inpatient/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 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** 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. A state may have a published list of IMDs in which the designation is made by the state. If available, use that list 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 #20: Beneficiaries With SMI/SED Treated in an IMD for Mental Health	
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	Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The definition of an IMD should be the same in Metrics #19a, #19b and #20. The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #39 - #40. The IMDs included in Metric #19b are the same IMDs in Metric #20.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

Metric #21: Count of Beneficiaries With SMI/SED (monthly)	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for any amount of time during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have SMI/SED-related treatment during the measurement period and/or in the 11 months before the measurement period as determined by a qualifying facility or provider claims
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.**
Measurement period (Metric Type)	Month (CMS-constructed)
Reporting Category	Other monthly and quarterly metrics
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring physical health conditions State-specific subpopulations
Relationship to other metrics	The approach to identify SMI/SED beneficiaries also applies to Metric #22, which is an annual count
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

Metric #22: Count of Beneficiaries With SMI/SED (annually)	
Metric element	**Description**
Measure sets/endorsements	None
Description	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period
Population of interest	All beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have SMI/SED-related treatment during the measurement period and/or in the 12 months before the measurement period as determined by a qualifying facility or provider claims
Additional guidance	Instructions for identifying beneficiaries with the standardized definition of SMI can be found in **Appendix E: Standardized Definition of SMI.** Instructions for accessing HEDIS value sets are provided in **Appendix C: How to use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.**
Measurement period (Metric Type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	Standardized definition of SMI (required) State-specific definition of SMI (required) Age groups (required) Dual-eligible status (required) Eligible for Medicaid on the basis of disability Criminal justice status Co-occurring SUD Co-occurring physical health conditions State-specific subpopulations
Relationship to other metrics	The approach to identify SMI/SED beneficiaries also applies to Metric #21, which is a monthly count
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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 2020 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%
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims, Medical Records
Claim type	Include paid, suspended, pending, and denied claims

Notes: Version of Specification: Adult Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

Metric #24: Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #0418/0418e 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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims or electronic medical records
Claim type	Include paid, suspended, pending, and denied claims

Note: Version of Specification: Adult Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

Metric #25: Screening for Depression and Follow-up Plan: Ages 12–17 (CDF-CH)`	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set) NQF #0418/0418e 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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims or electronic medical records
Claim type	Include paid, suspended, pending, and denied claims

Note: Version of Specification: Child Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

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 age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications.
Metric calculation	Step 1. Identify claims during the measurement period with a diagnosis code (any diagnosis code on the claim) from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Using the claims in step 1 as the denominator population, follow instructions for calculating this metric found in the original HEDIS measure specifications (AAP Adults' Access to Preventive/Ambulatory Health Services [AAP] measure in the NCQA Measure Specifications_v2.pdf and the HEDIS General Guideline 17_Hospice.pdf) provided in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA. Note that the measure steward's specifications refer to multiple types of payers. For purpose of SMI/SED demonstration monitoring, the state should calculate this metric for the Medicaid population.
Additional guidance	Instructions for accessing the specifications and value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** This metric is an adjusted version of a HEDIS measure called Adults' Access to Preventive/Ambulatory Health Services (AAP). The state should use the HEDIS specification to calculate this metric among beneficiaries in the demonstration population identified in Steps 1 and 2 of the metric calculation section in this table.
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None[a]
Relationship to other metrics	None
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims

Note: Although the measure steward's specifications include instructions for reporting the metric by age group, the state is not expected to report the age subpopulation category for this metric.

Version of Specification: HEDIS 2020 Technical Specifications for Health Plans, Measure AAP: Adults' Access to Preventive/Ambulatory Health Services

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	NQF #2600 Measure steward: NCQA
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.
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric are located in the full measure specification (NCQA Measure Specifications_v2, Measure: NQF #2600) provided to the state in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual a and the Reference Materials section on PMDA.
Additional guidance	Instructions for accessing the specifications can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	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. The state 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	NQF #2599 Measure steward: NCQA
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
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric are located in the full measure specification (NCQA Measure Specifications_v2, Measure: NQF #2599), provided to the state in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA
Additional guidance	Instructions for accessing the specifications can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	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. The state 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 (APM-CH)	
Metric element	**Description**
Measure sets/endorsements	FFY 2020 Core Set of Child Health Care Quality Measures for Medicaid (Child Core Set), based on HEDIS specifications NQF #2800 Measure steward: NCQA
Description	The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • Percentage of children and adolescents on antipsychotics who received blood glucose testing • Percentage of children and adolescents on antipsychotics who received cholesterol testing • Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Measure Specifications**
Additional guidance	Instructions for accessing the specifications and value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use suspended, pending, and denied claims

Note: Version of Specification: Child Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2020 Reporting, March 2020

Metric #30: Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	
Metric element	**Description**
Measure sets/endorsements	NQF #3313 Measure steward: CMS
Description	Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications
Metric calculation	Instructions for calculating this metric are located in the full measure specification (NQF-3313 Specs) and value sets (NQF-3313 Value Set) provided to the state in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA
Additional guidance	Instructions for accessing the specifications and value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**
Measurement period (Metric type)	Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use paid, suspended, pending, and denied claims

Note: Version of Specification: Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication Measure (NQF 3313) Technical Specifications and Resource Manual, April 2019.

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

CMCS removed Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH) from the Adult Core Set because it is retired by the measure steward (NCQA) and is no longer available for use. Starting with Version 2.0 of this manual, CMS has removed Metric #31 for the purpose of SMI/SED demonstration monitoring.

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	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period
Population of interest	Medicaid mental health services costs among all beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	Step 1. Identify claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among the claims identified in Step 1, retain claims with a code from any of the following HEDIS 2020 Value Sets or another online assessment CPT code: *HEDIS 2020 Value Sets* • MPT Stand Alone Outpatient Group 1 • MPT Stand Alone Outpatient Group 2 - The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • Observation - The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • (Visit Setting Unspecified; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Outpatient POS • (Visit Setting Unspecified; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Community Mental Health Center POS - The state should ensure that the visit was in an outpatient setting (this POS code can be used in settings other than outpatient) • (Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code from Ambulatory Surgical Center POS • Partial Hospitalization or Intensive Outpatient • (MPT IOP/PH Group 1; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code in Partial Hospitalization POS • (MPT IOP/PH Group 1; Electroconvulsive Therapy; or Transcranial Magnetic Stimulation) with a corresponding code in Community Mental Health Center POS – The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting (the community mental health POS code can be used in settings other than intensive outpatient and partial hospitalizations)

Metric #32: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Not Inpatient or Residential	
Metric element	**Description**
Numerator (continued)	• MPT IOP/PH Group 2 with a corresponding code in Partial Hospitalization POS – The state should ensure that the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • MPT IOP/PH Group 2 with a corresponding code in Community Mental Health Center POS – The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting (the Community Mental Health Center POS code can be used in settings other than intensive outpatient and partial hospitalizations) – The state should ensure that the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • ED – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • Visit Setting Unspecified with a corresponding code from ED POS • Visit Setting Unspecified with a corresponding code from Community Mental Health Center POS – The state should ensure that the visit was in an ED setting (this POS code can be used in settings other than the ED) • Visit Setting Unspecified with a corresponding code from (Telehealth Modifier or Telehealth POS) • MPT IOP/PH Group 1 with a corresponding code from (Telehealth Modifier or Telehealth POS) • MPT IOP/PH Group 2 with a corresponding code from (Telehealth Modifier or Telehealth POS) – The state should ensure the visit was billed by a mental health practitioner using the Mental Health Practitioner Value Set • Telephone Visits • Online Assessments *Online assessment CPT codes:* – 98970: Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes – 98971: 11—20 minutes – 98972: 21 or more minutes – 99421: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes – 99422: 11—20 minutes 99423: 21 or more minutes Step 3. Among the claims identified in Step 2, exclude any claims with a code in the Inpatient Stay Value Set. Retain the remaining claims to calculate the cost. Step 4. Sum the total amount paid by Medicaid on the claims identified in Step 3. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT.

Metric #32: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Not Inpatient or Residential	
Metric element	**Description**
Numerator (continued)	Step 5. Identify the managed care mental health encounter records and 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, the state 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. A state may 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. Step 6. Sum the amount paid by Medicaid from Step 4 and Step 5 to determine total Medicaid spending associated with services for mental health during the measurement period.
Additional guidance	A state that uses 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, a state 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. Instructions for accessing HEDIS value sets is provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #33, and #39 - #40. The total spending identified in this metric is used to calculate Metric #34, Per Capita Associated With Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential. Claims for services in Metrics #32 and #33 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period.
Population of Interest	Medicaid mental health services costs among all beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	Step 1. Identify beneficiaries with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among claims identified in Step 1, 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:* • 51 – Inpatient Psychiatric Facility • 56 – Psychiatric Residential Treatment Center • HEDIS 2016 BH Stand Alone Acute Inpatient Value Set • HEDIS 2016 HEDIS BH Acute Inpatient Value Set • HEDIS 2016 HEDIS BH Nonacute inpatient Value Set *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 • HEDIS 2016 BH Stand Alone Nonacute Inpatient Value Set • HEDIS 2020 Inpatient Stay Value Set Step 3. Among the claims identified in Step 2, exclude any claims with a code from the 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. Retain remaining claims to calculate costs. Step 4. Sum the total amount paid by Medicaid on the claims from Step 3. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT.

Metric #33: Total Costs Associated with Mental Health Services Among Beneficiaries with SMI/SED – Inpatient or Residential	
Metric element	**Description**
Numerator (continued)	Step 5. Identify the managed care mental health encounter records and 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, a state 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. A state may 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. Step 6. Sum the amount paid by Medicaid from Step 4 and Step 5 to determine total Medicaid spending associated with mental health during the measurement period.
Additional guidance	A state that uses 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, a state 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. Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
Measurement period (Metric type)	Year (CMS constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32, and #39 - #40. The total spending identified in this metric is used to calculate Metric #35, Per Capita Associated With Mental Health Services Among Beneficiaries with SMI/SED - Not Inpatient or Residential. Claims for services in Metrics #32 and #33 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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 in the demonstration population during the measurement period
Population of interest	Medicaid mental health services costs among all beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period
Denominator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility or provider claims to qualify as being in the population of interest 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	A state that uses 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, a state 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. Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The numerator for this metric is the same as total spending calculated in Metric #32. The denominator is the same as the numerator in Metric #22, or the annual count of unique enrolled beneficiaries that qualify as having SMI/SED-related treatment. Claims for services in Metrics #34 and #35 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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 inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period
Population of interest	Medicaid mental health services costs among all beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period
Denominator	Count the number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who have qualifying facility or provider claims that as being in the population of interest 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	A state that uses 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, a state 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. Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The numerator for this metrics is the same as total spending calculated in Metric #33. The denominator is the same as the numerator in Metric #22, or the annual count of unique enrolled beneficiaries that qualify as having SMI/SED-related treatment. Claims for services in Metrics #34 and #35 are mutually exclusive.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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
Population of interest	Grievances filed during the measurement period
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
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	None
Data source	Administrative records
Claim type	Not applicable

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

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
Population of interest	Appeals filed during the measurement period
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. A state should report appeal types according to its own definition.
Additional guidance	None
Measurement period (Metric type)	Quarter (CMS-constructed)
Reporting category	Grievances and appeals and qualitative information on referral into treatment
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	None
Data source	Administrative records
Claim type	Not applicable

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

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
Population of interest	Critical incidents filed during the measurement period
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
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	None
Data source	Administrative records
Claim type	Not applicable

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

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 in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year
Population of interest	Medicaid mental health services costs among all beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The sum of all Medicaid costs for inpatient or residential treatment for mental health within IMDs among beneficiaries in the demonstration population during the measurement period. 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; a state may maintain centralized databases of IMD stays. Alternatively, a state 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:* • 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 2020 Inpatient Stay Value Set Step 1b. Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among records identified in Step 1 (1a and 1b), retain 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 3. Use the remaining claims to identify FFS mental health claims. Step 4. Sum the total amount paid by Medicaid on the claims from Step 3. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT. Step 5. Identify managed care mental health encounter records and sum the amount paid by Medicaid for the encounters. There are several ways to estimate the amount paid by Medicaid on encounter claims: • If available, a state should use payment rates reported by managed care organizations to identify costs for mental health encounters.

Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED	
Metric element	**Description**
Numerator (continued)	• 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. A state may 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 an FFS basis. Step 6. Exclude any room and board costs, if included in steps 4 and 5. Step 7. Sum the net amount paid by Medicaid from steps 4, 5 and 6 to determine total Medicaid spending associated with treatment for mental health in an IMD during the measurement period.
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. A state that uses 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, a state 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.

Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED	
Metric element	**Description**
Additional guidance (continued)	A state may have a published list of IMDs in which the designation is made by the state. If available, use that list 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. Instructions for accessing HEDIS value sets are provided in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
Measurement period (Metric type)	Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The definition of an IMD should be the same in Metrics #19a, #19b and #20. The IMDs identified in this metric is a subset of the IMDs in Metric #19a, but the same group of IMDs in Metrics #19b and #20. The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, #32 - #33, and #40. The total spending identified in this metric is used to calculate Metric #40: Per Capita Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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 in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year
Population of interest	Medicaid mental health services costs among all beneficiaries in the SMI/SED demonstration population with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I. The SMI/SED demonstration population is defined as any beneficiary with an SMI/SED diagnosis in the measurement period and/or in the 12 months before the measurement period.
Numerator	Total Medicaid costs associated with treatment for mental health within IMDs during the measurement period
Denominator	Number of beneficiaries in the demonstration population with a claim for inpatient or residential treatment for mental health in an IMD during the reporting year. 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; a state may maintain centralized databases of IMD stays. Alternatively, a state 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:* • 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 2020 Inpatient Stay Value Set Step 1b. Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS 2020 Mental Health Diagnosis Value Set. Step 2. Among the claims identified in Step 1 (1a and 1b), 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 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 and 2.
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:

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)	• 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. Only include IMDs receiving Federal Financial Participation under the demonstration. A state may have a published list of IMDs in which the designation is made by the state. If available, use that list 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
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The definition of an IMD should be the same in Metrics #19a, #19b and #20. The IMDs identified in this metric is a subset of the IMDs in Metric #19a, but the same group of IMDs in Metrics #19b and #20. The approach to identify mental health diagnoses in this metric also applies to Metrics #13 - #19, and #32 - #33, and #39. The numerator in this metric is the total costs calculated in Metric #39: Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries with SMI/SED.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric for the population of interest and subpopulation categories specified in this table. Guidance on reporting by CMS-provided and state-specific subpopulation categories is provided in Chapter I.

State-specific codes. The state may use state-specific diagnosis, procedure, treatment, or other types of codes. When applicable, the state 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. If the service code can be for either mental health or SUD services, then a mental health diagnosis code must be included on the claim. The state should describe these state-specific codes in the "Explanation of any deviations from the CMS-provided specifications" column in Part A (monitoring protocol workbook) of its monitoring protocol submission. See Version 2.0 of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to upload this information in an attachment, the state should enter "See attachment" in the appropriate column in Part A.

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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 (if different from the metric name)	Measure set	Measure set version
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)	n.a.	Child Core Set	FFY 2020 [a]
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	n.a.	CMS	2019 reporting [b]
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	n.a.	Inpatient Psychiatric Facility Quality Reporting (IPFQR) program	2019 reporting
5	Medication Reconciliation Upon Admission	n.a.	CMS	2019 reporting [b]
6	Medication Continuation Following Inpatient Psychiatric Discharge	n.a.	CMS	2019 reporting [b]
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	n.a.	Child Core Set	FFY 2020 [b]
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	n.a.	Adult Core Set	FFY 2020 [b]
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	n.a.	Adult Core Set	FFY 2020 [b]
10	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD)	n.a.	Adult Core Set	FFY 2020 [a]
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) poor control (>9.0%) (HPCMI-AD)	n.a.	Adult Core Set	FFY 2020 [a]
24	Screening for Depression and Follow-up Plan: 18 years and Older (CDF-AD)	n.a.	Adult Core Set	FFY 2020 [a]
25	Screening for Depression and Follow-up Plan: Ages 12-17(CDF-CH)	n.a.	Child Core Set	FFY 2020 [a]
26	Access to Preventive/ Ambulatory Health Services for Medicaid Beneficiaries with SMI	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS	2020 [b]

Metric Number	Metric name	Established measure name (if different from the metric name)	Measure set	Measure set version
27	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	n.a.	NCQA	[b]
28	Alcohol Screening and Follow-up for People with Serious Mental Illness	n.a.	NCQA	[b]
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	n.a.	Child Core Set	FFY 2020 [b]
30	Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	n.a.	HEDIS	2020 [b]

[a] Specifications for calculating established quality measures that are part of the Medicaid Child and Adult Core Sets can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2020 Child and Adult Core Sets Specifications**.

[b] Specifications for established quality measures that are not part of the Core Set are available in 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and in the Reference Materials Section of PMDA

n.a. = not applicable

APPENDIX B

VALUE SETS REFERENCED IN METRIC SPECIFICATIONS

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Table B.1 identifies the value sets that are referenced in the monitoring metrics. HEDIS and other value sets listed in Table B.1. are located in the file "1115 SMI Monitoring Metrics HEDIS Value Set Directory_v2.xlsx" which can be found in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual, and are also accessible to the state through PMDA in the Reference Materials section.

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

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Acute Inpatient (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Acute Inpatient POS (HEDIS 2020)	• Standardized definition of SMI • #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
Advanced Illness (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
AOD Abuse and Dependence (HEDIS 2020)	• #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 Screening and Brief Counseling (2015)	• #28: Alcohol Screening and Follow-up for People with Serious Mental Illness	N
Alcohol Disorders (HEDIS 2020)	• #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
Ambulatory Surgical Center POS (HEDIS 2020)	• #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) • #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 • #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	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Ambulatory Visits (HEDIS 2020)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	N
BH Acute Inpatient (HEDIS 2016)	• #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #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) • #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 Acute Inpatient POS (HEDIS 2016)	• #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 Acute Inpatient (HEDIS 2016)	• Standardized definition of SMI • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #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) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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 Stand Alone Outpatient/PH/IOP (HEDIS 2016)	• #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 2020)	• Standardized definition of SMI • #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)	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
BH Outpatient/PH/IOP (HEDIS 2016)	• #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)	• #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)	• #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 POS (HEDIS 2016)	• #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) • #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) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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)	• #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #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) • #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 Nonacute Inpatient POS (HEDIS 2016)	• #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 • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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 Lab Test (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Cholesterol Test Result or Finding (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Community Mental Health Center POS (HEDIS 2020)	• Standardized definition of SMI • #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) • #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 • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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
Detoxification (HEDIS 2020)	• #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	N
Diabetes (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Diabetes Exclusions (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
ED (HEDIS 2020)	• 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) • #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) • #16: Mental Health Services Utilization - ED #18: Mental Health Services Utilization - Any Services • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) #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 2020)	• Standardized definition of SMI (HEDIS 2020) • #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 • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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 2020)	• Standardized definition of SMI • #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) • #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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
Frailty Device (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Frailty Diagnosis (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Frailty Encounter (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Frailty Symptom (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Glucose Lab Test (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Glucose Test Result or Finding (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
HbA1c Level 7.0-9.0 (HEDIS 2020)	• #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 2020)	• #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 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Lab Test (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
HbA1c Test Result or Finding (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Hospice Encounter (HEDIS 2020)	• #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)	Y
Hospice Intervention (HEDIS 2020)	• #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)	Y
IET POS Group 1 (HEDIS 2020)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	Y
IET POS Group 2 (HEDIS 2020)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD)	Y
IET Stand Alone Visits (HEDIS 2020)	• #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

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
IET Visits Group 1 (HEDIS 2020)	• #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 2020)	• #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 2020)	• #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) • #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 • #15: Mental Health Services Utilization - Outpatient • #16: Mental Health Services Utilization - ED • #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 • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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
Intentional Self-Harm (HEDIS 2020)	• #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

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
LDL-C Lab Test (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
LDL-C Test Result or Finding (HEDIS 2020)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
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 2020)	• #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) • #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 • #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)
Mental Health Practitioner (HEDIS 2020)	• #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) • #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 • #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
Mental Illness (HEDIS 2020)	• #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 2020)	• #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 • #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	N
MPT IOP/PH Group 2 (HEDIS 2020)	• #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 • #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	N

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
MPT Stand Alone Outpatient Group 1 (HEDIS 2020)	• #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 • #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	N
MPT Stand Alone Outpatient Group 2 (HEDIS 2020)	• #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 • #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	N
Nonacute Inpatient (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Nonacute Inpatient POS (HEDIS 2020)	• Standardized definition of SMI • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Nonacute Inpatient Stay (HEDIS 2020)	• #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

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Observation (HEDIS 2020)	• Standardized definition of SMI • #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) • #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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	Y
Online Assessments (HEDIS 2020)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI • #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	Y
Other Ambulatory Visits (HEDIS 2020)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	N
Other Bipolar Disorder (HEDIS 2020)	• Standardized definition of SMI • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Other Psychotic and Developmental Disorders (HEDIS 2020)	• #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Y
Outpatient (HEDIS 2020)	• #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Outpatient POS (HEDIS 2020)	• Standardized definition of SMI • #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) • #15: Mental Health Services Utilization - Outpatient • #18: Mental Health Services Utilization - Any Services • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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	Y
Partial Hospitalization or Intensive Outpatient (HEDIS 2020)	• Standardized definition of SMI • #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) • #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization - Any Services • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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)
Partial Hospitalization POS (HEDIS 2020)	• Standardized definition of SMI • #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) • #14: Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization - Any Services • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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	Y
Psychosocial Care (HEDIS 2020)	• #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Y
Schizophrenia (HEDIS 2016)	• Standardized definition of SMI • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #3: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Telehealth Modifier (HEDIS 2020)	• Standardized definition of SMI • #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 • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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	Y
Telehealth POS (HEDIS 2020)	• Standardized definition of SMI • #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) • #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 • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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	Y

Table B.1. (*continued*)

Value Set Name	Relevant metrics	Part of reported Core Set measure (Y/N)
Telephone Visits (HEDIS 2020)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse Dependence (FUA-AD) • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI • #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	Y
Tobacco Cessation Counseling (2015)	• #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	N
Transcranial Magnetic Stimulation (HEDIS 2020)	• #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 2020)	• #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 2020)	• Standardizied definition of SMI • #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) • #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 • #23: Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #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 • #21: Count of Beneficiaries With SMI/SED (monthly) • #22: Count of Beneficiaries With SMI/SED (annually)	*Value Sets:* • 1115 SMI Monitoring Metrics HEDIS Value Set Directory Version 2	*Value Sets:* • Step 1: Open "1115 SMI Monitoring Metrics HEDIS Value Set Directory_v2.xlsx" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA). • 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
• #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		
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)	*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 2020 Reporting – **Appendix D: Technical Specifications for Established Quality Measures Adapted From FFY 2020 Child and Adult Core Sets Measure Specifications** *Value Sets:* • 1115 SMI Monitoring Metrics HEDIS Value Set Directory Version 2	*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_v2.xlsx" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA). • 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
• #25: Screening for Depression and Follow-up Plan: Ages 12–17 (CDF-CH) • #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)		
Established quality measures that use TJC specifications (and are not part of the Medicaid Adult or Child Core Set). • #1: SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	*Measure Specifications:* • 2_6_2_SUB_v5_6.pdf *Code Sets:* • Appendix-A.1.xlxs *Data Dictionary:* • 1b_Alpha_DD.pdf	*Measure Specifications:* • Step 1: Download the measure specifications by clicking the Substance Use (SUB) link in Section 2 of https://qualitynet.org/files/5d84e2543a87ff001f33645e?filename=HIQR-Specs_Man_v5-6a.ZIP Step 2: Locate specification for SUB-2 in specifications manual. • Step 3: Follow the guidance in the measure specification to calculate the metric *Code Sets:* • Step 1: Download the ICD 10 Code table by clicking on the A.1 XLS file under the Appendices section of https://qualitynet.org/inpatient/specifications-manuals#tab3 • Step 2: Filter the "Appendix A.1_v5.6a"" tab to select Table Numbers (column A) identified in metric specification • Step 3: Include listed codes (column C) when calculating metric *Data Dictionary:* • Step 1: Download data dictionary by clicking on the 'Alphabetical Data Dictionary' file under the Section 1 of https://www.qualitynet.org/inpatient/specifications-manuals#tab3 • Step 2: Locate the relevant data elements as per the measure specifications

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): • Standardized definition of SMI (see **Appendix E: Standardized Definition of SMI**) • #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	*Measure Specifications:* • HEDIS Measure Specifications Version 2 *Value Sets:* • 1115 SMI Monitoring Metrics HEDIS Value Set Directory Version 2	*Measure Specifications:* • Step 1: Open "NCQA Measure Specifications_v2.pdf" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file provided with this manual, or through the Reference Materials section on PMDA). • Step 2: Locate specification for Adults' Access to Preventive/Ambulatory Health services (AAP) • Step 3: Follow the guidance in the measure specification to calculate the metric and use the HEDIS General Guideline 17_Hospice.pdf for the hospice exclusion *Value Sets:* • Step 1: Open "1115 SMI Monitoring Metrics HEDIS Value Set Directory_v2.xls" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file provided with this manual, or through the Reference Materials section on PMDA). • Step 2: Filter the "2020 Value Sets to Codes" tab to select value set names (column A) identified in metric specification. • Step 3: Include listed codes when calculating metric.

Table C.1. (*continued*)

Metrics	Supporting Measure Specifications, Value Sets, and Code Lists	Instructions
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_v2.pdf" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA). • 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_v2.xlsx" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA). • 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 CMS specifications developed for the Inpatient Psychiatric Quality Reporting (IPFQR) program (and are not part of the Medicaid Adult and Core Sets). • #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_v2.zip" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA). • 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://qualitynet.org/files/5df7a5ca62faad001ffd7a87?filename=FY20_IPFQR_CBM_Specs.pdf) • Step 2: Locate specification for 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF

Table C.1. (*continued*)

Metrics	Supporting Measure Specifications, Value Sets, and Code Lists	Instructions
Established quality measures that use CMS specifications (and are not part of the Medicaid Child and Adult Core Sets 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_v2.zip" file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA). • 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_v2.zip" and find the appropriate value set or code file (available in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual and the Reference Materials section on PMDA).

APPENDIX D

TECHNICAL SPECIFICATIONS FOR ESTABLISHED QUALITY MEASURES ADAPTED FROM FFY 2020 CHILD AND ADULT CORE SET MEASURE SPECIFICATIONS

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This appendix provides the technical specifications for the Adult and Child 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 2020 corresponds to calendar year 2019 (January 1, 2019–December 31, 2019). 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 the state to review utilization and continuous enrollment prior to January 1, 2019, 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 a measure and is determined by the measure steward. The continuous enrollment period is specified for each measure in **Table D1**. To be considered continuously enrolled, a beneficiary must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap (see next bullet).

Allowable gap. Some measures specify an allowable gap that can occur any time during continuous enrollment. 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**. For example, the Metric #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in enrollment of up to 45 days. Thus, a beneficiary who enrolls for the first time on February 1 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year, because this beneficiary has one 31-day gap (January 1–January 31). A beneficiary who switches between Medicaid or CHIP programs, delivery systems, or managed care plans should be included in a measure as long as there is no gap in Medicaid or CHIP coverage that exceeds the allowable gap specified in the measure.

Anchor date. Some measures include an anchor date, which is the date that an individual must be enrolled in the demonstration and have the required benefit 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 measurement period (for example, December 31, 2019 for the FFY 2020 measurement period). For other measures, the anchor date is based on a specific event, such as an ED visit date or prescription start date. The state 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 Section II of this appendix below.

Hospice exclusion. The SMI/SED monitoring metrics #2, 7, 8, 9, 10, 23, and 29 include a required hospice exclusion. For these measures, a state should 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 (Hospice Encounter Value Set; Hospice Intervention Value Set), or supplemental data. Supplemental data are data other than claims and encounters used by organizations to collect information about delivery of health services to their beneficiaries. An example of supplemental data includes case management program data. The Hospice Encounter Value Set and Hospice Intervention Value Set are provided in the 1115 SMI Monitoring Metrics Supporting Information v2.zip file accompanying this manual. These materials are also available to the state through PMDA in the Reference Materials section.

The state 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.

Telehealth. Some Core Set measures included in the 1115 SMI monitoring metrics are HEDIS measures that include synchronous telehealth (which requires real-time interactive audio and video telecommunications), telephone visits and online assessments, as appropriate. A HEDIS measure specification will indicate when telephone visits or online assessments are eligible for use in reporting. This applies to the following metrics: 2, 8, 10, and 23.

- A HEDIS measure specification that is silent about telehealth includes telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present).
- A HEDIS measure specification will indicate when telehealth is not eligible for use and should be excluded.

Table D.1. Measurement Period for Denominators and Numerators for the section 1115 SMI/SED Monitoring Metrics Adapted from FFY 2020 Adult and Child Core Sets Measures

	FFY 2020 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, 2019 – December 1, 2018 Negative medication history review: September 3, 2018 – August 3, 2019 (120 days before the IPSD)	October 3, 2018 – December 31, 2019 (90 days prior to IPSD through 30 days after the IPSD)	September 3, 2018 - December 31, 2019 (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, 2019 – December 31, 2019	7 Day Follow-up: January 2, 2019 – December 8, 2019 (7 days after discharge date) 30 Day Follow-up: January 2, 2019 – December 31, 2019 (30 days after discharge date)	January 1, 2019 – December 31, 2019 (30 days after discharge date)
Metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Discharge date: January 1, 2019 – December 1, 2019	7 Day Follow-up: January 2, 2019 – December 8, 2019 (7 days after discharge date) 30 Day Follow-up: January 2, 2019 – December 31, 2019 (30 days after discharge date)	January 1, 2019 – December 31, 2019 (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, 2019 – December 1, 2019	7 Day Follow-up: January 1, 2019 – December 8, 2019 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2019 – December 31, 2019 (ED visit date through 30 days after visit date)	January 1, 2019 – December 31, 2019 (ED visit date through 30 days after visit date)

Measure	FFY 2020 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, 2019 – December 1, 2019	7 Day Follow-up: January 1, 2019 – December 8, 2019 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2019 – December 31, 2019 (ED visit date through 30 days after visit date)	January 1, 2019 – December 31, 2019 (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, 2019 – December 31, 2019 Diabetes diagnosis: January 1, 2018 – December 31, 2019	January 1, 2019 – December 31, 2019	January 1, 2019 – December 31, 2019[b]
Metric #24: Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	January 1, 2019 – December 31, 2019	January 1, 2019 – December 31, 2019	None
Metric #25: Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH)	January 1, 2019 – December 31, 2019	January 1, 2019 – December 31, 2019	None
Metric #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	January 1, 2019 – December 31, 2019	January 1, 2019 – December 31, 2019	January 1, 2019 – December 31, 2019[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 a state 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 Adult and Child 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)

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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

Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS025296.

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 is available to order free of charge in the NCQA Store (http://store.ncqa.org/index.php/catalog/product/view/id/3741/s/hedis-2020-ndc). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads).

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, Modifier, NDC, POS, RxNorm, SNOMED, 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. Report two age stratifications and a total rate: • Ages 1 to 11 • Ages 12 to 17 • Total ages 1 to 17
Continuous enrollment	120 days (4 months) prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gaps in 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 in the specified age range who were dispensed an antipsychotic medication (Antipsychotic Medications List and Antipsychotic Combination Medications List, see link to the 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: Required Exclusions 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)

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), 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 or 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) 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 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

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 from the same visit.
- 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 from the save visit).
- 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, POS, Provider Taxonomy, SNOMED, 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 gaps in 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 the discharge claim 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 (use only the principal diagnosis on the discharge claim) 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 (use only the principal diagnosis on the discharge claim) 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 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 (Mental Health Practitioner Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health practitioner (Mental Health Practitioner 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 (Mental Health Practitioner Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health practitioner (Mental Health Practitioner Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set) with (Community Mental Health Center POS Value Set) with a mental health practitioner (Mental Health Practitioner 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 (Mental Health Practitioner Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health practitioner (Mental Health Practitioner Value Set)

- An observation visit (Observation Value Set) with a mental health practitioner (Mental Health Practitioner Value Set)
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health practitioner (Mental Health Practitioner 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).

The Mental Health Practitioner Value Set contains provider taxonomy codes and is included for a state that reports the measure using clinical data. If a state does not use the codes in the Mental Health Practitioner Value Set, it must map providers to a code in the value set for reporting. Only providers who meet the definition of "mental health practitioner" (Section II: Definition of a Mental Health Practitioner) are eligible to be mapped.

Because taxonomy codes are not found in claims data, a state must develop their own methods to identify mental health practitioners in claims data. Refer to Section II: Definition of a Mental Health Practitioner for the definition of "mental health practitioner."

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 from the same visit.
    - 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 from the same visit).
    - 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, POS, Provider Taxonomy, SNOMED 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 gaps in 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 the discharge claim 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 (use only the principal diagnosis on the discharge claim) 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 (use only the principal diagnosis on the discharge claim) 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 (Mental Health Practitioner Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health practitioner (Mental Health Practitioner 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 (Mental Health Practitioner Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health practitioner (Mental Health Practitioner Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set) with a mental health practitioner (Mental Health Practitioner 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 (Mental Health Practitioner Value Set)
- A telehealth visit: Visit Setting Unspecified Value Set with Telehealth POS Value Set with a mental health practitioner (Mental Health Practitioner Value Set)

- An observation visit (Observation Value Set) with a mental health practitioner (Mental Health Practitioner Value Set)
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health practitioner (Mental Health Practitioner 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).

The Mental Health Practitioner Value Set contains provider taxonomy codes and is included for a state that reports the measure using clinical data. If a state does not use the codes in the Mental Health Practitioner Value Set, it must map providers to a code in the value set for reporting. Only providers who meet the definition of "mental health practitioner" (refer to Section II: Definition of a Mental Health Practitioner) are eligible to be mapped.

Because provider taxonomy codes are not found in claims data, a state must develop their own methods to identify mental health practitioners in claims data. Refer to Section II: Definition of a Mental Health Practitioner.

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 which the beneficiary received follow-up within 30 days of the ED visit (31 total days)
- Percentage of ED visits 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 from the same visit.
    - 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 from the same visit).
    - 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, POS, SNOMED, 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 gaps in 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)
- 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)
- 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)
- 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 from the same visit.
    - 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 from the same visit).
    - 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, POS, SNOMED, 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 gaps in 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: 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 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)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis 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)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or 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)
- 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)
- 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)
- 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)
- 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)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or 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)

- 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)
- 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®.
- 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 Dementia Medications and Diabetes Medications is available to order free of charge in the NCQA Store (http://store.ncqa.org/index.php/catalog/product/view/id/3741/s/hedis-2020-ndc). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads)..

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, Modifier, NDC, POS, RxNorm, SNOMED, 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 or 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 method 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 one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge: 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. • At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telehealth visits (Telephone Visits Value Set), online assessments (Online Assessments Value Set), ED visits (ED Value Set), or nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge: 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 discharge date for the stay. 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 an outpatient 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. 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 the Medication List Directory in Guidance for Reporting above).

Exclusions	Exclude beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. At least one claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year 2. Any of the following during the measurement year or the year prior to the measurement year (count services that occur over both years): - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set), or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge: 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 discharge date for the stay. - At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set) - At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge: 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. - A dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above)

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Use codes (see HbA1c Lab Test Value Set; HbA1c Test Result or Finding 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%.

A state that uses CPT Category II codes to identify numerator compliance for this measure 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 Greater Than or Equal To 7.0 and Less Than 8.0 Value Set	Not compliant
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0 Value Set	Not compliant
HbA1c Level 7.0-9.0 Value Set	Not compliant
HbA1c Level Greater Than 9.0 Value Set	Compliant

Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

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.

Note: A lower rate indicates better performance for this indicator (i.e., low rates of poor control indicate better care).

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)

Refer to the Administrative Specification for exclusion criteria. 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:
  1. Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
  2. 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.
- This measure is intended to promote screening of beneficiaries never previously diagnosed with depression or bipolar disorder. As such, any beneficiary with an “active diagnosis” for depression/bipolar disorder would be excluded from the measure.
  - An “active diagnosis” for a depression/bipolar disorder is a diagnosis that starts prior to the start of the encounter and is still active at the start of the encounter. The diagnosis itself may or may not have an end date associated with it. If a beneficiary had a qualifying encounter in 2019, for example, and had a depression diagnosis in 2014 and the diagnosis did not have an end date/time prior to January 1, 2019, then the diagnosis is considered active and the beneficiary would be excluded from the measure calculation.
    - The codes to identify active diagnosis of depression (Exclusions) include both depression diagnoses and depression remission diagnoses because both indicate a prior diagnosis.
  - Beneficiaries 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 Quality Payment Program (QPP) claims/clinical quality measure (CQM) specifications 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 using an age appropriate standardized tool was done on the date of the eligible encounter and if the screen was positive, whether a follow-up plan was documented on the date of the positive screen.
- 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.
- If recommended follow-up includes additional screening, the additional screening must occur at the same encounter as the initial positive screen. The results of the additional screen are not necessary for data abstraction. An additional screen alone would not count toward a valid follow-up intervention to an initial positive screen.
- The screening tools listed in the measure specifications are examples of standardized tools. However, a state 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 2020 is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v8.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	A normalized and validated depression screening tool developed 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. Examples of depression screening tools include but are not limited to: • 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 (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 Examples of a follow-up plan include but are not limited to: • Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder • Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale • Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options • 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

CPT	HCPCS
59400, 59510, 59610, 59618, 90791, 90792, 90832, 90834, 90837, 92625, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

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

ICD-10 Code	Description
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
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

ICD-10 Code	Description
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
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:
  1. Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
  2. 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.
- This measure is intended to promote screening of beneficiaries never previously diagnosed with depression or bipolar disorder. As such, any beneficiary with an "active diagnosis" for depression/bipolar disorder would be excluded from the measure.
  - An "active diagnosis" for a depression/bipolar disorder is a diagnosis that starts prior to the start of the encounter and is still active at the start of the encounter. The diagnosis itself may or may not have an end date associated with it. If a beneficiary had a qualifying encounter in 2019, for example, and had a depression diagnosis in 2014 and the diagnosis did not have an end date/time prior to January 1, 2019, then the diagnosis is considered active and the beneficiary would be excluded from the measure calculation.
  - The codes to identify active diagnosis of depression (Exclusions) include both depression diagnoses and depression remission diagnoses because both indicate a prior diagnosis.
  - Beneficiaries 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 QPP claims/CQM specifications 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 using an age appropriate standardized tool was done and if the screen was positive, whether a follow-up plan was documented on the date of the positive screen.
- 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.
- If recommended follow-up includes additional screening, the additional screening must occur at the same encounter as the initial positive screen. The results of the additional screen are not necessary for data abstraction. An additional screen alone would not count toward a valid follow-up intervention to an initial positive screen.
- The screening tools listed in the measure specifications are examples of standardized tools. However, a state 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 2020 is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v8.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	A normalized and validated depression screening tool developed 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. Examples of depression screening tools include but are not limited to: • 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 Examples of a follow-up plan include but are not limited to: • Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder • Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale • Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options

Follow-up plan (continued)	• 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 beneficiary'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, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96146, 96150, 96151, 97165, 97166, 97167, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99340, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

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

Code	Description
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

ICD-10 Code	Description
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
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

ICD-10 Code	Description
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 removed 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 #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)

National Committee for Quality Assurance*

*Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS025296.

A. DESCRIPTION

Percentage of children ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

- Percentage of children and adolescents on antipsychotics who received blood glucose testing
- Percentage of children and adolescents on antipsychotics who received cholesterol testing
- Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing

Data Collection Method: Administrative

Guidance for Reporting:

- 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 II. Data Collection and Reporting of the Child Core Set.
- NCQA's Medication List Directory (MLD) for Antipsychotic, Antipsychotic Combination, and Prochlorperazine medications *are available to order free of charge in the NCQA Store* (http://store.ncqa.org/index.php/catalog/product/view/id/3741/s/hedis-2020-ndc). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads).

The following coding systems are used in this measure: CPT, HCPCS, LOINC, SNOMED, 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. Report two age stratifications and a total rate for each of the three indicators: • Ages 1 to 11 • Ages 12 to 17 • Total ages 1 to 17
Continuous enrollment	The measurement year.

Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the adolescent may not have more than a 1-month gap in coverage (i.e., an adolescent 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	At least two antipsychotic medication dispensing events (Antipsychotic Medications List, Antipsychotic Combination Medications List, Prochlorperazine Medications List, see link to the Medication List Directory in Guidance for Reporting above) of the same or different medications, on different dates of service during the measurement year.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Blood Glucose

Beneficiaries who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol

Beneficiaries who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.

Blood Glucose and Cholesterol

Beneficiaries who received both the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

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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. The following definition is based on the definition of SMI in Metric #23 (Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)) from the FFY 2020 Adult Core Set. NCQA defines individuals with SMI as those who meet at least one of the following criteria within the measurement period:

- 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; Major Depression 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; ; Major Depression 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 or 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)

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APPENDIX F

AVERAGE LENGHTH OF STAY (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, a state may be required to provide the standard deviation based on the mean in Metric #19.

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