PRA Disclosure Statement *This information is being collected to assist the Centers for Medicare & Medicaid Services in program monitoring of Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations. This mandatory information collection (42 CFR § 431.428) will be used to support more efficient, timely and accurate review of states' monitoring report submissions of Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations, and also support consistency in monitoring and evaluation, increase in reporting accuracy, and reduction in timeframes required for monitoring and evaluation. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.*

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned metrics (Version 2.0, revised)

State	*[Enter State Name]*
Demonstration Name	*[Enter Demonstration Name]*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Metrics

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	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.
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	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.
3	All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20)	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.
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	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.

Standard information on CMS-provided metrics

Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority
EXAMPLE: Milestone 4	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*
Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended
Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required

	Baseline, annual goals, and demonstration target			Alignmer
State will report (Y/N)	**Baseline Reporting Period (MM/DD/YYYY--MM/DD/YYYY)**	**Annual goal**	**Overall demonstration target**	**Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)**
EXAMPLE: *Y*	*EXAMPLE:* *01/01/2020-12/31/2020*	*EXAMPLE:* *Increase*	*EXAMPLE:* *Increase*	*EXAMPLE:* *N*

nt with CMS-provided technical specifications manual	Phased-in r	
Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)	**State plans to phase in reporting (Y/N)**	**Report in which metric will be phased in (Format SMI/SED DYQ; Ex. DY1Q3)**
EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.	*EXAMPLE: Y*	*EXAMPLE: DY3Q1*

metrics reporting
Explanation of any plans to phase in reporting over time
EXAMPLE: *We are transitioning to a new tool to screen for depression in adults (i.e., we are transitioning from the Duke Anxiety-Depression Scale (DADS) to the Patient Health Questionnaire [PHQ-2 & PHQ-9]). We anticipate that this transition will be complete across sites by mid to late 2021 (DY2).*

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
5	Medication Reconciliation Upon Admission	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.
6	Medication Continuation Following Inpatient Psychiatric Discharge	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.
7	Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	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
8	Follow-up After Hospitalization for Mental Illness: Age 18 and older (FUH-AD)	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

Standard information on CMS-provided metrics						
Milestone or reporting topic	**Metric type**	**Reporting category**	**Data source**	**Measurement period**	**Reporting frequency**	**Reporting priority**
EXAMPLE: Milestone 4	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Electronic/paper medical records	Year	Annually	Recommended
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA-AD)	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 AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit
10	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	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 • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit
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)	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.
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)	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.

Standard information on CMS-provided metrics

Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority
EXAMPLE: Milestone 4	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required
Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required
Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended
Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period.
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)

Standard information on CMS-provided metrics						
Milestone or reporting topic	**Metric type**	**Reporting category**	**Data source**	**Measurement period**	**Reporting frequency**	**Reporting priority**
EXAMPLE: Milestone 4	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*
Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required
Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required
Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required
Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required
Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required
Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required
Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required
Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	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.
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period.
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period.
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	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%.
24	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	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.
25	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)	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.
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period.

Standard information on CMS-provided metrics						
Milestone or reporting topic	**Metric type**	**Reporting category**	**Data source**	**Measurement period**	**Reporting frequency**	**Reporting priority**
EXAMPLE: Milestone 4	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*
Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required
Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
27	Tobacco Use Screening and Follow-up for People with SMI or Alcohol or Other Drug Dependence	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: • Percentage of adults with SMI who received a screening for tobacco use and follow-up for those identified as a current tobacco user • Percentage of adults with AOD who received a screening for tobacco use and follow-up for those identified as a current tobacco user
28	Alcohol Screening and Follow-up for People with SMI	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.
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	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
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	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.

Standard information on CMS-provided metrics

Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority
EXAMPLE: *Milestone 4*	*EXAMPLE:* *Established quality measure*	*EXAMPLE:* *Annual metrics that are an established quality measure*	*EXAMPLE:* *Claims* *Medical records*	*EXAMPLE:* *Year*	*EXAMPLE:* *Annually*	*EXAMPLE:* *Recommended*
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required
Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period.
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period.
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period.
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period.
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED.
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED.
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED.
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	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.
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	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.
Q1	*[Insert selected metric(s) for health IT question 1]*	

Standard information on CMS-provided metrics						
Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority
EXAMPLE: Milestone 4	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*
Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required
Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required
Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required
Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required
Health IT	State-specific					Required

#	Metric name	Metric description
EXAMPLE: 24 ***(Do not delete or edit this row)***	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: 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.*
Q2	*[Insert selected metric(s) for health IT question 2]*	
Q3	*[Insert selected metric(s) for health IT question 3]*	
State-specific metrics		
Add rows for any additional state-specific metrics		

Standard information on CMS-provided metrics						
Milestone or reporting topic	**Metric type**	**Reporting category**	**Data source**	**Measurement period**	**Reporting frequency**	**Reporting priority**
EXAMPLE: Milestone 4	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*
Health IT	State-specific					Required
Health IT	State-specific					Required

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - SMI/SED Definitions (Version 2.0, revised)

State	*[Enter State Name]*
Demonstration Name	*[Enter Demonstration Name]*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Definitions

Narrative description of the SMI/SED demonstration population

EXAMPLE[a]
Adults age 18 or older with serious mental illness or children under the age of 18 with a serious emotional disturbance living within the state.

	Serious Mental Illness (SMI)	Serious Emotional Disturbance (SED)
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*EXAMPLE*[a] **At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression, OR* **At least two visits in an outpatient, intensive outpatient (IOP), partial hospitalization (PH), emergency department (ED), or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia, OR* **At least two visits in an outpatient, IOP, PH, ED, or nonacute inpatient setting on different dates of service with a diagnosis of bipolar I disorder.*	*See SMI example for format and required information*
Codes used to identify population[b] *States may use ICD-10 diagnosis codes or state-specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD-10 codes with state-specific codes.*	*EXAMPLE*[a] **Schizophrenia: F20.0-F20.5, F20.81, F20.89* **Major depression: F32.0 - F32.4, F33.0 - F33.3* **Bipolar I disorder: F30.10-F30.13, F30.2 - F30.9*	*See SMI example for format and required information*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements[b] *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state-specific codes) used to identify/define service requirements.*	*EXAMPLE*[a] **Outpatient: 98960-98962, 99211-99215, G0155, G0176, G0177, G0409, 0510, 0513, 0515-0517*	*See SMI example for format and required information*

[a]The examples are based on a definition of SMI from the National Committee for Quality Assurance (NCQA). The examples provided are intended to be illustrative only. The example codes provided are not comprehensive.

[b]States may choose to include codes as separate tabs in this workbook.

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Subpopulations

	Planned subpopulation reporting	
Subpopulation category	Subpopulations	Reporting priority
EXAMPLE: *Age group* ***(Do not delete or edit this row)***	*EXAMPLE:* *Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)*	*EXAMPLE:* *Required*
Standardized definition of SMI	Individuals who meet the standardized definition of SMI	Required
State-specific definition of SMI	Individuals who meet the state-specific definition of SMI	Required
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended
Criminal justice status	Criminally involved, Not criminally involved	Recommended
Co-occurring SUD	Individuals with co-occurring SUD	Recommended
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended
[Insert row(s) for any state-specific subpopulation(s)]		

lations (Version 2.0, revised)

e]

			Alignment with CMS-provided t	
			Subpopulations	
Relevant metrics	**Subpopulation type**	**State will report (Y/N)**	**Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)**	**If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format: comma separated)**
EXAMPLE: Metrics #11, 12, #13, 14, 15, 16, 17, 18, 21, 22	*EXAMPLE: CMS-provided*	*EXAMPLE: Y*	*EXAMPLE: N*	*EXAMPLE: Children/Young adults (ages 12-21), Adults (ages 21-65)*
Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided			
Metrics #13, 14, 15, 16, 17, 18, 21, 22	State-specific			
Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided			
Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided			
Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided			
Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided			
Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided			
Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided			

echnical specifications manual	
Relevant metrics	
Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = “N”), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Y*	*EXAMPLE:*

State *[Enter State Name]*
Demonstration Name *[Enter Demonstration Name]*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Reporting Schedule

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SMI/SED demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SMI/SED demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column E, select Y or N in column G, "Deviations from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e. column G= "N"), the state should describe these deviations in column H, "Explanation for deviations (if column G="Y")" and use column I, "Proposed deviations from standard reporting schedule," to indicate the SMI/SED measurement periods with which it wishes to overwrite the standard schedule (column F). All other columns are locked for editing and should not be altered by the state.

Table 1. Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SMI/SED reporting quarter:	
Reporting period (Format SMI/SED DYQ; Ex. DY1Q1)	
Start date (MM/DD/YYYY)[a]	
End date (MM/DD/YYYY)	
Broader section 1115 demonstration reporting period corresponding with the first SMI/SED reporting quarter, if applicable. If there is no boarder demonstration, fill in the first SMI/SED reporting period. (Format DYQ; Ex. DY3Q1)	
First SMI/SED report due date (per STCs) (MM/DD/YYYY)	
First SMI/SED report in which the state plans to report annual metrics that are established quality measures (EQMs):	
Baseline period for EQMs (Format CY; Ex. CY2019)	
SMI/SED DY and Q associated with report (Format SMI/SED DYQ; Ex. DY1Q1)	
Start date (MM/DD/YYYY)	

End date (MM/DD/YYYY)	
Dates of last SMI/SED reporting quarter:	
Start date (MM/DD/YYYY)	
End date (MM/DD/YYYY)	

Table 2. SMI/SED Demonstration Reporting Schedule

Dates of SMI/SED reporting quarter (MM/DD/YYYY - MM/DD/YYYY) Start date	End date	Report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DYQ; Ex. DY1Q3)	Reporting category
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics

For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DYQ; Ex. DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column G="Y")	Proposed deviations from standard reporting schedule (Format DYQ; Ex. DY1Q3)

				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics

				Narrative information Grievances and appeals Other monthly and quarterly metrics Annual availability assessment Annual metrics that are established quality measures Other annual metrics
				Narrative information Grievances and appeals Other monthly and quarterly metrics Annual availability assessment Annual metrics that are established quality measures Other annual metrics
				Narrative information Grievances and appeals Other monthly and quarterly metrics Annual availability assessment Annual metrics that are established quality measures Other annual metrics
				Narrative information Grievances and appeals Other monthly and quarterly metrics Annual availability assessment Annual metrics that are established quality measures Other annual metrics
				Narrative information Grievances and appeals Other monthly and quarterly metrics Annual availability assessment Annual metrics that are established quality measures Other annual metrics

				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics

				Narrative information
				Grievances and appeals
				Other monthly and quarterly metrics
				Annual availability assessment
				Annual metrics that are established quality measures
				Other annual metrics
Add rows for all additional demonstration reporting quarters				

Notes:

[a] **SMI/SED demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the effective date listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. 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.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to reported for each SMI/SED demonstration year and quarter. However, the state is not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

AA# refers to the Annual Assessment of the Availability of Mental Health Services ("Annual Availability Assessment") and the SMI/SED DY in which the Annual Availability Assessment will be submitted (for example, "AA1" refers to the Annual Availability Assessment that will be submitted with the state's annual monitoring report for SMI/SED DY1). Data in each Annual Availability Assessment should be reported as of the month and day indicated in the state's approved monitoring protocol. If the state cannot submit its Annual Availability Assessments when it submits its annual monitoring reports, it should propose and describe a reporting deviation in Columns G and H.