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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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CONTENTS

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 or 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 People 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
MY	Measurement Year
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
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 and serious emotional disturbance (SMI/SED).[1]

The 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 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).[2] The CMS-constructed metrics often refer to definitions included in the specifications for established quality measures, but they did not go through the measure endorsement process and are intended only for monitoring the 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 (Chapter I) 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 quality measures and measure sets referenced in the technical specifications manual. Appendix B provides a list of value sets that are referenced 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 federal fiscal year (FFY) 2022 Adult and Child 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 metrics

There are 35 metrics representing five measurement domains, including the four section 1115 SMI/SED demonstration milestones identified in the SMDL (see Table 1). This set of

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

[2] SMDL #18-011 Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

metrics could change over time. For example, CMS may select new or remove established quality measures based on measure steward testing results and/or NQF endorsement.

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

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 can be constructed with data that are readily available to the state.
- ***Recommended metrics*** also provide important information on the operation of a demonstration, but might be more difficult to report than required metrics.

Table 1. Summary of section 1115 SMI/SED metrics

Measurement domain/milestone[a]	Total number of metrics	Number of required metrics[b]
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	8	6
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	8	6
Other SMI/SED Metrics	9	9
Total	**35**	**30**

[a] Milestones included in this table are from the SMDL #18-011. Each metric is listed under a primary milestone above. However, some metrics may address multiple milestones

[b] The number of required metrics is a subset of the total number of metrics.

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 or calendar year.[3] Table 2 lists the number of metrics by milestone for each measurement period. The state should use the measurement periods for established quality measures that are provided in the specifications for those measures. Section B provides detailed instructions for identifying the measurement period for each metric.

[3] For states with a broader section 1115 demonstration, states should use the SMI/SED demonstration year as the measurement period for all CMS-constructed annual metrics that have a measurement period of a year.

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

Demonstration milestones[a]	Number of metrics		
	Annual[b]	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	8	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	7	0	1
Other SMI/SED Metrics	6	3	0
Total	**25**	**3**	**7**

[a] Milestones included in this table are from the SMDL #18-011.

[b] Annual includes metrics that use demonstration year or calendar year as the measurement period.

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

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 new antipsychotic prescriptions). Additional details are available for each metric in Chapter II.

Definitions of SMI. For some metrics, the state is required to report using two different definitions of SMI: the standardized definition of SMI and its state-specific definition of SMI. CMS acknowledges that the standardized definition of SMI is 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 this definition as method to gather relatively standardized data from the state, but also allows the state to use a state-specific definition of SMI.

Note that metrics that require reporting using the two definitions of SMI are identified under the subpopulation categories row for each metric in Chapter II of this manual.

- ***Standardized definition of SMI.*** We refer to the National Committee for Quality Assurance (NCQA) definition of SMI as the "standardized definition of SMI."[4] NCQA defines individuals with SMI as those who meet at least one of the following criteria within the

[4] 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 People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)) from the FFY 2022 Adult Core Set.

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, intensive inpatient (IOP), community mental health center, electroconvulsive therapy, observation, ED, nonacute inpatient, telehealth, telephone visit, or e-visit or virtual check-in 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, 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 more details.

- ***State-specific definition of SMI***. For the purpose of the demonstration, the state may have its own criteria that it uses to identify individuals with SMI. As such, the state is asked to provide its own definition of SMI within the "SMI – SED definitions" tab of Part A of its monitoring protocol workbook (1115 SMI Monitoring Protocol Workbook.xlsx). We refer to this definition as the "state-specific definition of SMI." The state-specific definition of SMI may use diagnoses and inclusion criteria that are narrower, broader than, or equal to those used by the standardized definition of SMI. Note that if a state's demonstration includes only individuals with SMI (i.e., the demonstration does not also include individuals with SED), values reported for the state-specific definition of SMI may equal those reported for the overall demonstration reporting category.

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 (see "CMS-provided" in Table 3). For each CMS-provided subpopulation category, CMS provides guidance on how to define the subpopulation, as well as examples of how the state may identify the subpopulation. The state may propose alternate approaches to calculating these subpopulations in its monitoring protocol. The metric specifications in Chapter II of this manual list the subpopulations for which the metric should be calculated in addition to the full SMI/SED demonstration population. Note that values reported for complementary subpopulation values should sum up to the value of the overall demonstration reporting category. For example, the sum of values reported for "dual-eligible" and "Medicaid only" should equal the value of "demonstration reporting".
- ***State-specific subpopulation categories***. The state may identify additional subpopulation categories specific to its demonstration (see "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. In cases where states report state-specific metric(s), the state should

also identify subpopulation categories for each state-specific metric, if applicable. See Section B for more information about the option for states to report state-specific metrics.

- *Geographic area.* While not required, CMS strongly encourages states to report metrics by geographic area. Reporting data by geographic area can help states contextualize evaluation findings, understand baseline disparities, track early demonstration experiences, and inform course corrections in demonstration implementation.
- *QRTPs that are IMDs.* Any state that claims federal financial participation (FFP) for services provided in Qualified Residential Treatment Programs (QRTPs) that are Institutions for Mental Disease (IMDs) is required to report performance for Average Length of Stay metrics (Metrics #19a and 19b) separately for QRTPs that are IMDs.

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

Subpopulation categories	Required or recommended	Description
CMS-provided		
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] Include both full- and partial-benefit dual-eligible status. 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)[c]	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. If applicable, the state can use definition from its SUD demonstration to define this subpopulation. Another option is for the state to use the T-MSIS claims-based algorithm to identify beneficiaries with a SUD diagnosis.
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. The reference period the state can use to determine this subpopulation is specified in the CMS Chronic Conditions Data Warehouse.

TABLE 3 (continued)

Subpopulation categories	Required or recommended	Description
State-specific		
QRTPs that are IMDs	Required[d]	If the state claims FFP for services provided in QRTPs that are IMDs, the state is required to report performance for Average Length of Stay metrics (Metrics #19a and 19b) separately for QRTPs that are IMDs.
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, urban/rural area).
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 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.

[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.

[c] For reference, the T-MSIS claims-based algorithm to identify beneficiaries with a SUD diagnosis can be accessed at https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf/index.html.

[d] Any state that claims FFP for services provided in QRTPs that are IMDs is required to report performance for certain metrics for QRTPs that are IMDs. Other states are not required to report this subpopulation.

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. Metrics are listed in numerical order within each domain.

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

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source(s)	Demonstration	Subpopulation Categories[b]							
							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]: Ensuring quality of care in psychiatric hospitals and residential settings														
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	TJC	Recommended	Calendar Year	Medical record review or claims	X								
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	Required	Calendar Year	Claims	X								
Milestone 2[a]: Improving care coordination and transitions to community-based care														
4[d]	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	CMS	Required	Calendar Year	Claims	X								
6[d,e]	Medication Continuation Following Inpatient Psychiatric Discharge	CMS	Required	Calendar Year	Claims	X								
7	Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	NCQA	Required	Calendar Year	Claims	X								
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	NCQA	Required	Calendar Year	Claims	X								
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	NCQA	Required	Calendar Year	Claims	X								

TABLE 4 (continued)

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source(s)	Demonstration	Subpopulation Categories[b]								
							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
10	Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	NCQA	Required	Calendar Year	Claims	X								
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	Demonstration Year[c]	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	Demonstration Year[c]	State data on cause of death, linked to claims	X		X						
Milestone 3[a]: Increasing access to continuum of care including crisis stabilization services														
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

TABLE 4 (continued)

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source(s)	Demonstration	Subpopulation Categories[b]							
							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
19a	Average Length Of Stay In IMDs	None	Required	Demonstration Year[c]	Claims	X								
19b	Average Length Of Stay In IMDs (IMDs receiving FFP only)	None	Required	Demonstration Year[c]	Claims	X								
20	Beneficiaries With SMI/SED Treated In an IMD For Mental Health	None	Required	Demonstration Year[c]	Claims	X								
Milestone 4[a]: Earlier identification and engagement in treatment including through increased integration														
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	Demonstration Year[c]	Claims	X	X	X	X	X	X	X	X	X
23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	NCQA	Required	Calendar Year	Claims or Claims and Medical Records	X								
24	Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	CMS	Recommended	Calendar Year	Claims or electronic medical records	X								
25	Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	CMS	Recommended	Calendar Year	Claims or electronic medical records	X								
26[f]	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	NCQA	Required	Calendar Year	Claims	X								

TABLE 4 (continued)

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source(s)	Demonstration	Subpopulation Categories[b]							
							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
29[d]	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA	Required	Calendar Year	Claims	X								
30	Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	CMS	Required	Calendar Year	Claims	X								
Other SMI/SED Metrics														
32[g]	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	None	Required	Demonstration Year[c]	Claims	X								
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Inpatient or Residential	None	Required	Demonstration Year[c]	Claims	X								
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not Inpatient or Residential	None	Required	Demonstration Year[c]	Claims	X								
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Inpatient or Residential	None	Required	Demonstration Year[c]	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								

TABLE 4 (continued)

Metric	Metric name	Measure Steward	Required or recommended	Measurement Period	Data source(s)	Demonstration	Subpopulation Categories[b]							
							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
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	Demonstration Year[c]	Claims	X								
40	Per Capita Costs Associated With Treatment For Mental Health In an IMD Among Beneficiaries With SMI/SED	None	Required	Demonstration Year[c]	Claims	X								

[a] Milestones included in this table are from the SMDL #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] For states with a broader section 1115 demonstration, states should use the SMI/SED demonstration year as the measurement period for all demonstration year metrics.

[d] Metrics #3, 5, 27, and 28 were removed from the 1115 SMI/SED metrics in Version 3.0 Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics.

[e] Metric #6 should be calculated for the calendar year, and should be calculated over a two-year period (starting with the calendar year in which the demonstration began and the calendar year prior).

[f] 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.

[g] Metric #31 was removed from the 1115 SMI/SED 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 metrics

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

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

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 V4.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 "Point and Click" License 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 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 Healthcare Effectiveness Data and Information Set Measurement Year 2021 (HEDIS Measurement Year MY 2021) 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 the metric. Established value sets are provided in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file 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] or the Core Set of Adult Health Care Quality Measures for Medicaid [Adult Core Set]), or a measure steward (NCQA[5] or the Joint Commission), as specified.[6] To help the state calculate these metrics, this document references the measure steward's or Adult and Child Core Set's measure specifications and associated value sets, provided in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file accessible to the state through PMDA in the Reference Materials section.
- ***State-specific metrics.*** In addition to the established quality measures and CMS-constructed metrics, a state can propose metrics specific to its demonstration. These metrics are referred to as "state-specific metrics" within this document.

[5] NCQA recently updated the HEDIS schedule and naming convention. This manual version aligns with the HEDIS Measurement Year (MY) 2021 measure specifications and value sets. For more information on the schedule change, refer to https://www.ncqa.org/wp-content/uploads/2019/09/20190927_Future_of_HEDIS_Webinar.pdf

[6] Metrics that are established quality measures include: 1, 2, 4, 6, 7, 8, 9, 10, 23, 24, 25, 26, 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, 2021 – December 31, 2026, the state should consider January 1, 2021 to be the start date of the SMI/SED demonstration for purposes of monitoring.[7] In general, if SMI/SED is a component of a broader demonstration, for ease of demonstration monitoring reporting, the state should align the reporting quarters across demonstration policy components. That is, that the state should designate the first quarter for SMI/SED as the same time period as the first quarter for the broader demonstration, even if the demonstration years of the components are different. Please reach out to your CMS demonstration team for further guidance, copying the section 1115 demonstration monitoring and evaluation mailbox (1115MonitoringandEvaluation@cms.hhs.gov) on the message.

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 monitoring 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 on 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.

[7] 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 12/15/2021, with an effective date of 1/1/2022 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

- ***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, 2021, the first measurement period should be the 2021 calendar year (January 1, 2021 through December 31, 2021) to align with the measurement period for these measures in other quality reporting programs.

Determining baseline periods. To determine baseline 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, 2021 – December 31, 2026, the state should consider January 1, 2021 to be the start date of the SMI/SED demonstration for purposes of monitoring.

When reporting metrics, the state should use the following guidance for determining baseline periods:

- ***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 period is the first SMI/SED demonstration year (SMI/SED DY1). For example, if the state's SMI/SED demonstration began on March 1, 2021, the baseline period is March 1, 2021 – February 28, 2022.
    - 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 period on the first day of the month for monitoring purposes. This applies to all baseline periods (month, quarter, and year). For example, if a state's demonstration began on March 15, 2021 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 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, 2021 and ended December 31, 2021, the baseline period should be January 1, 2021 – December 31, 2021.
- ***Established quality measures****:* For metrics that are established quality measures, the calendar year in which the demonstration started is the baseline period. For example, if the state's SMI/SED demonstration began on March 1, 2021, the baseline period is January 1, 2021 through December 31, 2021.
    - For measures calculated over a two-year period (Metric #6: Medication Continuation Following Inpatient Psychiatric Discharge), the baseline 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 period would be the same calendar year. For example, if a state has a 10-month SMI/SED DY1 starting March 1, 2021 and

ending on December 31, 2021, the baseline period is January 1, 2021 – December 31, 2021 (calendar year 2021). If the last day of SMI/SED DY1 is any other date, the baseline period should be the prior calendar year. For example, if a state has a 10-month SMI/SED DY1 that started on September 1, 2021 and ended June 30, 2022, the baseline period is January 1, 2021 – December 31, 2021 (calendar year 2021).

For any clarifications on measurement periods and baseline periods, the state may send questions to the CMS demonstration team, copying the section 1115 demonstration monitoring and evaluation mailbox (1115MonitoringandEvaluation@cms.hhs.gov) on the message.

Table 5 below illustrates these guidelines, using an SMI/SED demonstration that begins March 1, 2021 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, 2021	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, 2021 - Feb 28, 2022 (baseline period)[b]	Mar 1 Apr 1 May 1 June 1 … Feb 1	Mar 31 Apr 30 May 31 June 30 … Feb 28	Mar 1 June 1 Sep 1 Dec 1	May 31 Aug 31 Nov 30 Feb 28	Jan 1, 2021	Dec 31, 2021
SMI/SED DY2 March 1, 2022 - Feb 28, 2023	Month as defined in the baseline reporting row	Month as defined in the baseline reporting row	Quarter as defined in the baseline reporting row	Quarter as defined in the baseline reporting row	Jan 1, 2022	Dec 31, 2022
SMI/SED DY3 March 1, 2023 - Feb 29, 2024					Jan 1, 2023	Dec 31, 2023
SMI/SED DY4 March 1, 2024 - Feb 28, 2025					Jan 1, 2024	Dec 31, 2024
SMI/SED DY5 March 1, 2025 - Feb 28, 2026					Jan 1, 2025	Dec 31, 2025

[a] This example does not apply to Metric #6, which is calculated over a two-year time period. For a SMI/SED demonstration with a March 1, 2021 demonstration start date, the SMI/SED DY1 measurement period for Metric #6 would be January 1, 2020 – December 31, 2021. For SMI/SED DY2, the measurement period for Metric #6 would be January 1, 2021 – December 31, 2022.

[b] Baseline period for CMS-constructed and state-specific metrics is SMI/SED DY1. Baseline period for established quality measures is the calendar year in which the SMI/SED demonstration started.

DY = Demonstration year

Reporting period. The reporting period is a demonstration quarter that defines the time period associated with each monitoring report. Reporting periods are associated with the overall

monitoring report, and not with individual metrics. The reporting period is expressed as a demonstration year and quarter (e.g. DY1Q3).

Calculating and reporting metrics. The state should report data to CMS in accordance with the schedule and format agreed upon in the approved monitoring protocol.

Given 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 and annual 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 as follows:
  - For a state with SMI/SED demonstration years that end July 31 through November 30: in the annual monitoring report
  - For a state with SMI/SED demonstration years that end May 31 or June 30: in the first quarterly monitoring report of the next SMI/SED demonstration year
  - For a state with SMI/SED demonstration years that end February 28 through April 30: in the second quarterly monitoring report of the next SMI/SED demonstration year
  - For a state with SMI/SED demonstration years that end December 31 or January 31: in the third 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.

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

Monitoring report name:	DY1Q1 report	DY1Q2 report	DY1Q3 report	DY1Q4 (annual) report[b]	DY2Q1 report	DY2Q2 report	DY2Q3 report
Monitoring 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	Due 60 days after quarter ends
Measurement periods, by reporting category							
Narrative information on implementation	DY1Q1	DY1Q2	DY1Q3	DY1Q4	DY2Q1	DY2Q2	DY2Q3
Grievances and appeals	DY1Q1	DY1Q2	DY1Q3	DY1Q4	DY2Q1	DY2Q2	DY2Q3
Other monthly and quarterly metrics	n.a.	DY1Q1	DY1Q2	DY1Q3	DY1Q4	DY2Q1	DY2Q2
Annual metrics that are established quality measures[a]	n.a.	n.a.	n.a.	A state with a DY ending 7/31 – 11/30: CY1	A state with a DY ending on 5/31 or 6/30: CY1	A state with a DY ending on 2/28 – 4/30: CY1	A state with a DY ending on 12/31 or 1/31: CY1
Other annual metrics	n.a.	n.a.	n.a.	n.a.	DY1	n.a.	n.a.

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

[a] 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 two-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.

[b] Per the STCs, the state's Q4 information that would ordinarily be provided in a separate fourth quarterly monitoring report should be reported as distinct information within the annual monitoring report. 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. Table 7 outlines the manual versions the state should use.

Table 7. Manual versions for section 1115 SMI/SED metrics

Manual version	Measurement period for CMS-constructed metrics[a]	Measurement period for established quality measures (calendar year)[b]
Version 2.0	-	2019[d]
Version 3.0	-	2020
Version 4.0	The state should use the latest version of the manual available[c]	2021

[a] For retrospective reporting of CMS-constructed metrics, the state should always use the latest version of the manual available.

[b] For retrospective reporting of established quality measures, the state should use the manual version that applies to the appropriate measurement period. For example, if a state is retrospectively reporting for calendar year 2020, the state should use Version 3.0 of the section 1115 SMI/SED technical specifications manual.

[c] The state should use any newly released version of the manual as soon as feasible, but no later than two quarters after the release of the latest version.

[d] Version 1.0 of the SMI/SED technical specifications manual included calendar year 2018 specifications of the established quality measures for illustrative purposes, but because no state had an approved SMI/SED demonstration in 2018, no state utilized Version 1.0 of the manual to calculate established quality measures. States should use Version 2.0 for the 2019 measurement period.

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

- ***Supporting measure specifications, value sets, and code lists.*** Many 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 metrics.

- ***Eligible population.*** To determine the eligible population for all metrics, the state should include Medicaid beneficiaries including Medicaid managed care (MMC), fee-for-service (FFS) and dual eligible individuals. The state should exclude beneficiaries from all metrics 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 SMI/SED treatment services; (4) only eligible for family planning services; or (5) inmates in a facility by operation of criminal law.

- The eligible population for each metric is further defined below for CMS-constructed metrics and established quality measures.
  - *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. In addition, beneficiaries with partial benefits are eligible for inclusion in metric calculations (using the same enrollment criteria as beneficiaries with full benefits) only if they are eligible to receive services described in the metric numerator. The exclusion criteria, outlined above, 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

Table 8 describes the population of interest for each CMS-constructed metric. Because the population of interest is determined based on beneficiaries' benefit status and length of enrollment in Medicaid during the measurement period it may include beneficiaries outside of the state-specific target population.

Table 8. Population of interest for CMS-constructed SMI/SED metrics

Population of interest for CMS constructed metrics	Metric #
All beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period	11, 12, 19a, 19b, 20, 22, 32, 33, 34, 35, 39, 40
All beneficiaries with full benefits enrolled in Medicaid for any amount of time during the measurement period.	13, 14, 15, 16, 17, 18, 21

Note: Table excludes CMS-constructed metrics for which beneficiaries are not the population of interest: metrics #36 (Grievances), 37 (Appeals), and 38 (Critical Incidents).

- *Established quality measures.* For metrics that are established quality measures, the state should first apply eligible population criteria provided by measure stewards for established quality measures before applying the above general guidance about eligible population. For measures in the Adult and Child Core Sets, refer to the technical specifications included in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2022 Adult and Child 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 V4.zip file accessible to the state 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 P) 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[8] 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[9] 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 2021, the updated specifications

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

[9] 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**.

for telehealth for NCQA measures are provided in more detail in the measure specifications.

C. Using technical specifications

Table 9 defines the elements included in specifications for metrics in Chapter II. The description column explains each metric element.

Table 9. 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 measure sets (such as Adult and Child 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 demonstration or calendar 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.

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II. METRIC SPECIFICATIONS

This chapter presents technical specifications for each of the section 1115 SMI/SED 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	The Joint Commission National Quality Measures 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.
Metric calculation	Calculation instructions are located in The Specifications Manual for Joint Commission National Quality Measures; see measure SUB-2, Alcohol Use Brief Intervention Provided or Offered, and measure SUB-2a, Alcohol Use Brief Intervention.
Additional guidance	The specifications and value sets for this measure are available to the state on the Joint Commission webpage: https://manual.jointcommission.org/releases/TJC2021B/MIF0186.html 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)	Calendar 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: Specifications Manual for Joint Commission National Quality Measures version2021B. The Joint Commission measure is specified at the hospital level, however these metrics request reporting at the state level.

Metric #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 2022 Adult and Child 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)	Calendar 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 2022 Reporting, March 2022

Metric #3: All-Cause Emergency Department (ED) Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) (Removed)

The measure steward for Metric #3: All-Cause Emergency Department (ED) Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH-20) will not continue to maintain this established quality measure. Without continued maintenance, the specifications and codes for this metric may become outdated, which could create reporting challenges.

Starting with Version 3.0 of this technical specifications manual, CMS has removed Metric #3 for the purpose of SMI/SED demonstration monitoring. States should continue to report on ED Utilization through Metric #16: Mental Health Services Utilization – ED.

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 Inpatient Psychiatric Facility (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 with a discharge date within the measurement period
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.

METRIC #4 (continued)

Metric #4: 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	
Metric element	**Description**
Metric calculation (continued)	Step 3. Calculate the Denominator: count of index admissions with discharge dates between January 1 and December 31. To identify index admissions, identify discharges with a psychiatric primary diagnosis included in the "Principal_DxICD10_CCS" tab of the IPF Readmission codebook. The list of diagnoses uses a modified version of the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software (CCS) ICD - 10 groupings. The state can use the "Modified CCS" and "ICD-10-CM" columns in the "Principal_DxICD10_CCS" tab to group ICD-10 Codes into clinically coherent groups. 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.cms.gov/inpatient/measures/readmission/methodology Step 6. Calculate the rate of readmissions: number readmissions (Step 5) / number of index admissions (Step 3).
Additional guidance	For the purposes of SMI/SED demonstration monitoring, the state should calculate this metric for the population of interest (Medicaid beneficiaries) using a 12-month measurement period, even though the measure steward's specification refers to Medicare beneficiaries and a 24-month measurement period.
Measurement period (Metric type)	Calendar 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, June 2022

Metric #5: Medication Reconciliation Upon Admission (Removed)

The measure steward for Metric #5: Medication Reconciliation Upon Admission will not continue to maintain this established quality measure. Without continued maintenance, the specifications and codes this metric may become outdated, which could create reporting challenges.

Starting with Version 3.0 of this technical specifications manual, CMS has removed Metric #5 for the purpose of SMI/SED demonstration monitoring.

Metric #6: Medication Continuation Following Inpatient Psychiatric Discharge	
Metric element	**Description**
Measure sets/ endorsements	Medicare Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) 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. The measurement period for the measure is two years.
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 Inpatient Psychiatric Facility Quality Reporting Program Claims-Based Measure Specifications available at https://qualitynet.cms.gov/files/629784f90b1e560016832536?filename=FY2023_IPFQR_CBM_Specs.pdf
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**. All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications should be used as the denominator population for this metric. Enrollment in fee-for-service Medicare should not be considered an inclusion criterion.
Measurement period (Metric type)	Calendar Year (Established quality measure) [a]
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: Inpatient Psychiatric Facility Quality Reporting Program Claims-Based Measure Specifications, June 2022

[a] This metric should be calculated over a period of two calendar years.

Metric #7: Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 provider (see Appendix D Section II). 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 2022 Adult and Child 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)	Calendar Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	This metric is the same as Metric #8 except it is calculated for a different age group. Metric #7 calculates rates for children ages 6 to 17, whereas Metric #8 calculates rates for adults ages 18 and older.
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 2022 Reporting, March 2022

Metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), based on HEDIS specifications NQF #0576 Measure steward: NCQA
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 provider (see Appendix D Section II). 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 2022 Adult and Child 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)	Calendar Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	This metric is the same as Metric #7 except it is calculated for a different age group. Metric #7 calculates rates for children ages 6 to 17, whereas Metric #8 calculates rates for adults ages 18 and older.
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 2022 Reporting, March 2022

Metric #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 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)
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 2022 Adult and Child 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)	Calendar 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 2022 Reporting, March 2022

Metric #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 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)
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 2022 Adult and Child 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)	Calendar 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 2022 Reporting, March 2022

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 treatment stay for mental health. Two counts are reported: • Count of suicide or overdose deaths within 7 days of discharge • Count of suicide or overdose deaths within 30 days of discharge
Population of Interest	All beneficiaries 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.
Numerator	Count of the number of suicide or overdose deaths among the population of interest within 7 and 30 days of a discharge from an inpatient facility or residential treatment stay for mental health. 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 MY 2021 Inpatient Stay value set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. Step 2. Among claims identified in Steps 1a and 1b, retain claims for residential or inpatient treatment. Step 3. Retain only claims remaining after Step 2 with discharge dates that fall within the measurement period. Step 4. Determine the total number of unique beneficiaries (de-duplicated) associated with the claims identified in Steps 1-3. Step 5. Using state data (e.g., medical examiner data or death records) identify beneficiaries from Step 4 with the following ICD-10 codes for underlying cause of death and date 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. Using the beneficiaries remaining after Step 5, subtract the date of death in the state data 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 (continued)

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. Assigning claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service.
Measurement period (Metric type)	Demonstration 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 and claims data
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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 treatment for mental health. Two rates are reported: • Rate of suicide or overdose deaths within 7 days of discharge • Rate of suicide or overdose deaths within 30 days of discharge
Population of interest	All beneficiaries 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.
Numerator	The number of suicide or overdose deaths among beneficiaries in the denominator. 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) to identify beneficiaries with the following ICD-10 codes for underlying cause of death and date of death in the measurement period: • U03 (Intentional self-harm (suicide)) • 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 (Sequelae of intentional self-harm/event of undetermined intent) Step 3. Subtract the date of death in the state data 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	Population of interest with a discharge from an inpatient facility or residential stay for mental health. 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 MY 2021 Inpatient Stay value set Step 1b. Identify claims with a primary mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. Step 2. Among claims identified in Steps 1a and 2b, retain claims for residential or inpatient treatment. Step 3. Retain only claims remaining after Step 2 with discharge dates that fall within the measurement period.

METRIC #12 (continued)

Metric #12: Suicide or Overdose Death Within 7 and 30 Days Of Discharge From an Inpatient Facility or Residential Treatment For Mental Health Among Beneficiaries With SMI or SED (rate)	
Metric element	**Description**
Denominator (continued)	Step 4**.** Determine the total number of unique beneficiaries (de-duplicated) associated with the claims identified in Steps 1-3.
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. Assigning claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service.
Measurement period (Metric type)	Demonstration 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 and claims data
Claim type	Not applicable

METRIC #12 (continued)

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of unique beneficiaries (de-duplicated) 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 from the HEDIS MY 2021 Inpatient Stay value set and have a principal diagnosis code in the HEDIS MY 2021 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.** Assigning claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service. 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_V4, Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in 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)

METRIC #13 (continued)

Metric #13: Mental Health Services Utilization – Inpatient	
Metric element	**Description**
Subpopulation categories (continued)	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 #14–#19, #32, #33, #39, and #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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 use intensive outpatient and/or partial hospitalization services related to mental health during the measurement period
Population of interest	All beneficiaries with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of unique beneficiaries (de-duplicated) who have a claim for intensive outpatient and/or partial hospitalization services related to mental health during the measurement period. Step 1**.** Identify claims with a principal mental health diagnosis using the HEDIS MY 2021 Mental Health Diagnosis value set. Step 2**.** Among claims identified in Step 1, retain claims with a code from any of the following HEDIS MY 2021 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 billed by a mental health provider (see Appendix D Section II) • MPT IOP/PH Group 2 with a corresponding code in Community Mental Health Center POS billed by a mental health provider (see Appendix D Section II) – 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). Step 3**.** Exclude any claims from Step 2 with a code in the Telehealth Modifier or Telehealth POS value sets or Telehealth POS=10. Step 4**.** Exclude any claims with a service date outside the measurement period. Step 5**.** Determine the total number of unique beneficiaries (de-duplicated) with claims remaining after Step 4.
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_V4, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in the Reference Materials section on PMDA.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics

METRIC #14 (continued)

Metric #14: Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization	
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 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, #39, and #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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of unique beneficiaries (de-duplicated) with an outpatient service related to mental health during the measurement period. Step 1. Identify claims with a principal mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS MY 2021 Value Sets: • MPT Stand Alone Outpatient Group 1 • MPT Stand Alone Outpatient Group 2 billed by a mental health provider (see Appendix D Section II) • Observation billed by a mental health provider (see Appendix D Section II) • (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, or Telehealth POS=10. Step 4. Exclude any claims from Step 3 with a service date outside the measurement period Step 5. Determine the total number of unique beneficiaries (de-duplicated) with claims remaining after Step 4.
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_V4, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in the Reference Materials section on PMDA.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metrics

METRIC #15 (continued)

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, #39, and #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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of unique beneficiaries (de-duplicated) who have a claim for emergency services for mental health during the measurement period. Step 1. Identify claims with a principal mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS MY 2021 Value Sets: • ED billed by a mental health provider (see Appendix D Section II) • 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, or Telehealth POS=10. Step 4. Exclude any claims from Step 3 with a service date outside the measurement period. Step 5. Determine the total number of unique beneficiaries (de-duplicated) with claims remaining after Step 4.
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_V4, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in 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 (continued)

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, #39, and #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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of unique beneficiaries (de-duplicated) 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 principal mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS MY 2021 Value Sets or another online assessment CPT code: *HEDIS MY 2021 Value Sets:* • Telephone Visits • Online Assessments • Visit Setting Unspecified with a corresponding code from (Telehealth Modifier or Telehealth POS or Telehealth POS=10) *Telehealth and virtual communication HCPCS codes:* • G0071: Communication technology-based services by rural health center or federally qualified health center, virtual communication or remote evaluation of recorded video/images, 5 minutes or more • G2012: Brief communication technology-based check-in by physician or other qualified health care professional, 5-10 minutes • G2010: Remote evaluation and interpretation of video/image submission by patient and follow up with patient • G2250: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment • G2251: Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion *Online assessment CPT and HCPCs codes:* • 98970: Qualified nonphysician health care professional online digital assessment 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 • 99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

METRIC #17 (continued)

Metric #17: Mental Health Services Utilization – Telehealth	
Metric element	**Description**
Numerator (continued)	• 99442: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion • 99443: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 21-20 minutes of medical discussion • 99444: Online E/M service provided by a physician or other qualified healthcare professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network • G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes • G2062: 11—20 minutes • G2063: 21 or more minutes Step 3. Exclude any claims from Step 2 with a service date outside the measurement period. Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims remaining after Step 3.
Additional guidance	Beginning in Version 3.0 of the technical specifications manual, three online assessment HCPCS codes (G2061, G2062, and G2063) were added to the numerator specification for this metric. Beginning in Version 4.0 of the technical specifications manual, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and four online assessment CPT codes (99441, 99442, 99443, and 99444) were added to the numerator specification for this metric. 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_V4, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in 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 #17 (continued)

Metric #17: Mental Health Services Utilization – Telehealth	
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, #39, and #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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of unique beneficiaries (de-duplicated) with a claim for any services related to mental health during the measurement period. Step 1. Identify claims with a principal mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. Step 2. Among claims identified in Step 1, retain claims with a code from any of the following HEDIS MY 2021 Value Sets or another online assessment CPT code: *HEDIS MY 2021 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 Community Mental Health Center 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 Community Mental Health Center 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 Community Mental Health Center visit was in an intensive outpatient or partial hospitalization setting. • MPT IOP/PH Group 2 with a corresponding code from Partial Hospitalization POS billed by a mental health provider (see Appendix D Section II) • MPT IOP/PH Group 2 with a corresponding code from Community Mental Health Center POS billed by a mental health provider (see Appendix D Section II) – The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting. • MPT Stand Alone Outpatient Group 1 • MPT Stand Alone Outpatient Group 2 billed by a mental health provider (see Appendix D Section II) • Observation billed by a mental health provider (see Appendix D Section II) • Visit Setting Unspecified with a corresponding code from Outpatient POS or ED POS or (Telehealth Modifier or Telehealth POS or Telehealth POS=10) • 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.

METRIC #18 (continued)

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

Numerator (continued)	• 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 billed by a mental health provider (see Appendix D Section II)
	• Telephone Visits
	• Online Assessments
	Telehealth and virtual communication HCPCS codes:
	• G0071: Communication technology-based services by rural health center or federally qualified health center, virtual communication or remote evaluation of recorded video/images, 5 minutes or more
	• G2012: Brief communication technology-based check-in by physician or other qualified health care professional, 5-10 minutes
	• G2010: Remote evaluation and interpretation of video/image submission by patient and follow up with patient
	• G2250: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
	• G2251: Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion
	Online assessment CPT and HCPCs codes:
	• 98970: Qualified nonphysician health care professional online digital assessment 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
	• 99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
	• 99442: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

METRIC #18 (continued)

Metric #18: Mental Health Services Utilization – Any Services	
Metric element	**Description**
Numerator (continued)	• 99443: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 21-20 minutes of medical discussion • 99444: Online E/M service provided by a physician or other qualified healthcare professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network • G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes • G2062: 11—20 minutes • G2063: 21 or more minutes Step 3**.** Exclude any claims from Step 2 with a service date outside the measurement period. Step 4**.** Determine the total number of unique beneficiaries (de-duplicated) with claims remaining after Step 3.
Additional guidance	Beginning in Version 3.0 of the technical specifications manual, three online assessment HCPCS codes (G2061, G2062, and G2063) were added to the numerator specification for this metric. Beginning in Version 4.0 of the technical specifications manual, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and four online assessment CPT codes (99441, 99442, 99443, and 99444) were added to the numerator specification for this metric. 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_V4, Measure: Mental Health Utilization [MPT]) in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in 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 #18 (continued)

Metric #18: Mental Health Services Utilization – Any Services	
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, #39, and #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.

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 #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 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.
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 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 MY 2021 Inpatient Stay value set

METRIC #19a (continued)

Metric #19a: Average Length Of Stay In IMDs	
Metric element	**Description**
Denominator (continued)	Step 1b**.** Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. 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 / Total 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.** Assigning claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service. 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.).

METRIC #19a (continued)

Metric #19a: Average Length Of Stay In IMDs	
Metric element	**Description**
Additional guidance (continued)	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)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations QRTPs that are IMDs[a]
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, #39, and #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.)

[a] Only states claiming FFP for QRTPs that are IMDs are required to report for this subpopulation. States should report each rate for the subset of beneficiaries with SMI discharged from an inpatient or residential stay in a QRTP that is an IMD as a state-specific subpopulation.

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 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.
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

METRIC #19b (continued)

Metric #19b: Average Length Of Stay In IMDs (IMDs receiving FFP only)	
Metric element	**Description**
Denominator (continued)	*UB Revenue Codes:* • 1001 – Residential treatment, psychiatric • From the HEDIS MY 2021 Inpatient Stay value set Step 1b. Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS MY 2021 Mental Health Diagnosis value set. 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 / Total 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.** Assigning claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service. 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).

METRIC #19b (continued)

Metric #19b: Average Length Of Stay In IMDs (IMDs receiving FFP only)	
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, 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. 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)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metrics
Subpopulation categories	State-specific subpopulations QRTPs that are IMDs[a]
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, #39, and #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.)

[a] Only states claiming FFP for QRTPs that are IMDs are required to report for this subpopulation. States should report each rate for the subset of beneficiaries with SMI discharged from an inpatient or residential stay in a QRTP that is an IMD as a state-specific subpopulation

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

METRIC #19b (continued)

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 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.
Numerator	The total number of unique beneficiaries (de-duplicated) 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 MY 2021 Inpatient Stay value set Step 1b**.** Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS MY 2021 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.

METRIC #20 (continued)

Metric #20: Beneficiaries With SMI/SED Treated In an IMD For Mental Health	
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. – 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	Demonstration 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, #39, and #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.

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 #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 with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of unique beneficiaries (de-duplicated) in the population of interest who have SMI/SED-related treatment during the measurement period and/or in the 11 months before the measurement period as determined by applicable facility or provider claims.
Additional guidance	The state may use their discretion in identifying SMI/SED-related treatments and in identifying applicable facility or provider claims. Assigning facility or provider claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service.
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.)

METRIC #21 (continued)

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 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.
Numerator	Count the total number of unique beneficiaries (de-duplicated) in the population of interest who have SMI/SED-related treatment during the measurement period and/or in the 12 months before the measurement period as determined by applicable facility or provider claims.
Additional guidance	The state may use their discretion in identifying SMI/SED-related treatments and in identifying applicable facility or provider claims. Assigning facility or provider claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service.
Measurement period (Metric Type)	Demonstration 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.)

METRIC #22 (continued)

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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 People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 or type 2) who had hemoglobin A1c (HbA1c) in poor control (> 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 2022 Adult and Child 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)	Calendar 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 claims supplemented with 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 2022 Reporting, March 2022

Metric #24: Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 or 14 days prior to 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 eligible encounter.
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 2022 Adult and Child Core Sets Measure Specifications**
Additional guidance	None
Measurement period (Metric type)	Calendar Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	This metric is the same as Metric #25 except it is calculated for a different age group. Metric #24 calculates a rate for adults ages 18 and older, whereas Metric #25 calculates a rate for children ages 12 to 17.
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 2022 Reporting, March 2022

Metric #25: Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 or 14 days prior to 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 eligible encounter.
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 2022 Adult and Child Core Sets Measure Specifications.**
Additional guidance	None
Measurement period (Metric type)	Calendar Year (Established quality measure)
Reporting category	Annual metrics that are established quality measures
Subpopulation categories	None
Relationship to other metrics	This metric is the same as Metric #24 except it is calculated for a different age group. Metric #24 calculates a rate for adults ages 18 and older whereas Metric #25 calculates a rate for children ages 12 to 17.
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 2022 Reporting, March 2022

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 beneficiaries in the population of interest with claims during the measurement period with a diagnosis code (any diagnosis code on the claim) from the HEDIS 2021 Mental Health Diagnosis value set. **Step 2.** Using beneficiaries in Step 1 as the denominator population, follow instructions for calculating this metric found in the original HEDIS measure specifications (Adults' Access to Preventive/Ambulatory Health Services [AAP] measure in the NCQA Measure Specifications_V4.pdf and the HEDIS General Guideline 17_Hospice.pdf) provided in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in 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	Detailed 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)	Calendar 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: 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 MY 2021 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 (Removed)

Metric #28: Alcohol Screening and Follow-up for People with Serious Mental Illness (Removed)

The measure steward for Metric #27: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence and Metric #28: Alcohol Screening and Follow-up for People with Serious Mental Illness will not continue to maintain this established quality measure. Without continued maintenance, the specifications and codes this metric may become outdated, which could create reporting challenges.

Starting with Version 3.0 of this technical specifications manual, CMS has removed Metric #27 and Metric #28 for the purpose of SMI/SED demonstration monitoring.

Metric #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 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 2022 Adult and Child 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)	Calendar 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 2022 Reporting, March 2022

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 new antipsychotic prescriptions for Medicaid beneficiaries who meet the following criteria: • Age 18 years and older, and • 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	Full measure specifications and value sets used for calculating this metric are 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.
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)	Calendar 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, March 2022.

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 Child 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	All beneficiaries 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.
Numerator	Step 1. Identify claims with a principal mental health diagnosis from the HEDIS MY 2021 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 MY 2021 Value Sets or another online assessment CPT code: *HEDIS MY 2021 Value Sets* • MPT Stand Alone Outpatient Group 1 • MPT Stand Alone Outpatient Group 2 billed by a mental health provider (see Appendix D Section II) • Observation billed by a mental health provider (see Appendix D Section II) • (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). • MPT IOP/PH Group 2 with a corresponding code in Partial Hospitalization POS billed by a mental health provider (see Appendix D Section II) • MPT IOP/PH Group 2 with a corresponding code in Community Mental Health Center POS billed by a mental health provider (see Appendix D Section II) – 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). • ED billed by a mental health provider (see Appendix D Section II) • Visit Setting Unspecified with a corresponding code from ED POS

METRIC #32 (continued)

Metric #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not Inpatient or Residential	
Metric element	**Description**
Numerator (continued)	• 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 or Telehealth POS=10) • Telephone Visits • Online Assessments *Telehealth and virtual communication HCPCS codes:* • G0071: Communication technology-based services by rural health center or federally qualified health center, virtual communication or remote evaluation of recorded video/images, 5 minutes or more • G2012: Brief communication technology-based check-in by physician or other qualified health care professional, 5-10 minutes • G2010: Remote evaluation and interpretation of video/image submission by patient and follow up with patient • G2250: Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment • G2251: Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion *Online assessment CPT and HCPCs codes:* • 98970: Qualified nonphysician health care professional online digital assessment 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 • 99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion • 99442: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

METRIC #32 (continued)

Metric #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not Inpatient or Residential	
Metric element	**Description**
Numerator (continued)	• 99443: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 21-20 minutes of medical discussion • 99444: Online E/M service provided by a physician or other qualified healthcare professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network • G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes • G2062: 11—20 minutes • G2063: 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. Exclude any claims from Step 3 with a service date outside the measurement period. Step 5. Sum the total amount paid by Medicaid on the claims identified in Step 4. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT. Step 6. Identify the managed care mental health encounter records, exclude any records with a service date outside the measurement period, 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.

METRIC #32 (continued)

Metric #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not Inpatient or Residential	
Metric element	**Description**
Numerator (continued)	Step 7. Sum the amount paid by Medicaid from Step 5 and Step 6 to determine total Medicaid spending associated with services for mental health during the measurement period.
Additional guidance	Beginning in Version 3.0 of the technical specifications manual, three online assessment HCPCS codes (G2061, G2062, and G2063) were added to the numerator specification for this metric. Beginning in Version 4.0 of the technical specifications manual, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and four online assessment CPT codes (99441, 99442, 99443, and 99444) were added to the numerator specification for this metric. 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)	Demonstration 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, #39, and #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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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	All beneficiaries 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.
Numerator	Step 1**.** Identify beneficiaries with a primary mental health diagnosis from the HEDIS MY 2021 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 BH Acute Inpatient value set • HEDIS 2016 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 MY 2021 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 (or Telehealth POS=10), 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**.** Exclude any claims from Step 3 with a discharge date outside the measurement period. Step 5**.** Sum the total amount paid by Medicaid on the claims from Step 4. If using T-MSIS data to calculate this metric, this data element is named TOT-MEDICAID-PAID-AMT.

METRIC #33 (continued)

Metric #33: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED –Inpatient or Residential	
Metric element	**Description**
Numerator (continued)	Step 6. Identify the managed care mental health encounter records, exclude any encounter records with a discharge date outside the measurement period, 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 7. Sum the amount paid by Medicaid from Step 5 and Step 6 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)	Demonstration 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, #39, and #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.

METRIC #33 (continued)

Metric #33: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED –Inpatient or Residential	
Metric element	**Description**
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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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	All beneficiaries 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.
Numerator	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period.
Denominator	Count the total number of unique beneficiaries (de-duplicated) in the population of interest who have SMI/SED-related treatment during the measurement period and/or in the 12 months before the measurement period as determined by facility or provider claims. .
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	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. Please see Metric #22 for further instructions for denominator calculation and Metric #32 for further instructions for numerator calculation. 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.
Measurement period (Metric type)	Demonstration 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, encounter data
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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to

METRIC #34 (continued)

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	All beneficiaries 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.
Numerator	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period.
Denominator	Count the total number of unique beneficiaries (de-duplicated) in the population of interest who have SMI/SED-related treatment during the measurement period and/or in the 12 months before the measurement period as determined by facility or provider claims.
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	The numerator for this metric 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. Please see Metric #22 for further instructions for denominator calculation and Metric #33 for further instructions for numerator calculation. 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.
Measurement period (Metric type)	Demonstration 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, encounter data
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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version of the Section 1115 SMI/SED Monitoring Protocol Instructions for further guidance. If the state would like to

METRIC #35 (continued)

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 national 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	All beneficiaries 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.
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 MY 2021 Inpatient Stay value set Step 1b**.** Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS MY 2021 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. • 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.

METRIC #39 (continued)

Metric #39: Total Costs Associated With Treatment For Mental Health In an IMD Among Beneficiaries With SMI/SED	
Metric element	**Description**
Numerator (continued)	• 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	Assigning claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using other services, identify claims in the measurement period using the end date of service. 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.

METRIC #39 (continued)

Metric #39: Total Costs Associated With Treatment For Mental Health In an IMD Among Beneficiaries With SMI/SED	
Metric element	**Description**
Additional guidance (continued)	An IMD is defined as a hospital, nursing facility, or other institution that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases. Only include IMDs receiving federal financial participation under the demonstration. 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. – 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. 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)	Demonstration 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

METRIC #39 (continued)

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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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	All beneficiaries 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.
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 MY 2021 Inpatient Stay value set Step 1b. Among the claims identified in Step 1a, retain claims with a primary mental health diagnosis from the HEDIS MY 2021 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

METRIC #40 (continued)

Metric #40: Per Capita Costs Associated With Treatment For Mental Health In an IMD Among Beneficiaries With SMI/SED	
Metric element	**Description**
Additional guidance	Assigning claims to a measurement period: • To count beneficiaries using ***residential and inpatient services***, use the stay discharge date to identify claims in the measurement period. Count only stays that include a discharge during the measurement 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 to assign the claim to a measurement period. 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 beneficiary 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. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service. Do not count claims for stays that are ongoing as of the end of the measurement period, meaning neither a discharge date nor an end date within the measurement period can be identified. 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. – 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)	Demonstration Year (CMS-constructed)

METRIC #40 (continued)

Metric #40: Per Capita Costs Associated With Treatment For Mental Health In an IMD Among Beneficiaries With SMI/SED	
Metric element	**Description**
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 #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 P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest version 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	Specifications Manual for Joint Commission National Quality Measures	2021B
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	n.a.	Child Core Set	FFY 2022 [a]
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	2020 reporting
6	Medication Continuation Following Inpatient Psychiatric Discharge	n.a.	Inpatient Psychiatric Facility Quality Reporting (IPFQR) program	2020 reporting
7	Follow-up After Hospitalization for Mental Illness: Ages 6 to17 (FUH-CH)	n.a.	Child Core Set	FFY 2022 [a]
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	n.a.	Adult Core Set	FFY 2022 [a]
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	n.a.	Adult Core Set	FFY 2022 [a]
10	Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	n.a.	Adult Core Set	FFY 2022 [a]
23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	n.a.	Adult Core Set	FFY 2022 [a]
24	Screening for Depression and Follow-up Plan: 18 years and Older (CDF-AD)	n.a.	Adult Core Set	FFY 2022 [a]
25	Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	n.a.	Child Core Set	FFY 2022 [a]

TABLE A.1 (continued)

Metric Number	Metric name	Established measure name (if different from the metric name)	Measure set	Measure set version
26	Access to Preventive/ Ambulatory Health Services for Medicaid Beneficiaries with SMI	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS	2021 [b]
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	n.a.	Child Core Set	FFY 2022 [a]
30	Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	n.a.	Technical Specifications and Resource Manual: NQF 3313	2021

[a] Specifications for calculating established quality measures that are part of the Adult and Child Core Sets can be found in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2022 Adult and Child Core Sets Specifications**.

[b] Specifications for established quality measures that are not part of the Adult and Child Core Set are available in 1115 SMI Monitoring Metrics Supporting Information V4.zip file 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 metrics. HEDIS and other value sets listed in Table B.1. are located in the file "1115 SMI Monitoring Metrics HEDIS Value Set Directory_V4.xlsx" which can be found in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file 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 Adult and Child Core Set measure (Y/N)
Acute Inpatient (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Acute Inpatient POS (HEDIS MY 2021)	• Standardized definition of SMI • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Advanced Illness (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
AOD Abuse and Dependence (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
Ambulatory Surgical Center POS (HEDIS MY 2021)	• #7: Follow-up After Hospitalization for Mental Illness: Ages 6 to17 (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: Age 18 and Older (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
Ambulatory Visits (HEDIS MY 2021)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	N
Behavioral Healthcare Setting (HEDIS MY 2021)	• #7: Follow-up After Hospitalization for Mental Illness: Ages 6 to17 (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 Adult and Child Core Set measure (Y/N)
BH Acute Inpatient (HEDIS 2016)	• #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)	N
BH Stand Alone Acute Inpatient (HEDIS MY 2021)	• Standardized definition of SMI • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #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 People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
BH Outpatient (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (FUM-AD) • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
BH Stand Alone Nonacute Inpatient (HEDIS MY 2021)	• Standardized 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) • #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 People 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 Adult and Child Core Set measure (Y/N)
BH Nonacute Inpatient (HEDIS 2016)	• #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)	N
Bipolar Disorder (HEDIS MY 2021)	• Standardized definition of SMI • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Cholesterol Lab Test (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Cholesterol Test Result or Finding (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Community Mental Health Center POS (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (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 People 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
Diabetes (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Diabetes Exclusions (HEDIS MY 2021)	• #23: Diabetes Care for People 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 Adult and Child Core Set measure (Y/N)
ED (HEDIS MY 2021)	• Standardized definition of SMI • #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #16: Mental Health Services Utilization – ED • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
ED POS (HEDIS MY 2021)	• Standardized definition of SMI (HEDIS MY 2021) • #16: Mental Health Services Utilization – ED • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Electroconvulsive Therapy (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (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 People 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 MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Frailty Diagnosis (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Frailty Encounter (HEDIS MY 2021)	• #23: Diabetes Care for People 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 Adult and Child Core Set measure (Y/N)
Frailty Symptom (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Glucose Lab Test (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Glucose Test Result or Finding (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
HbA1c Level Greater Than 9.0 (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Level Greater Than or Equal to 7.0 and Less Than 8.0 (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Level Greater Than or Equal to 8.0 and Less Than or Equal to 9.0 (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Level Less Than 7.0 (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
HbA1c Lab Test (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
HbA1c Test Result or Finding (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Hospice Encounter (HEDIS MY 2021)	• #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 or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Hospice Intervention (HEDIS MY 2021)	• #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 or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older(FUM-AD) • #23: Diabetes Care for People 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 Adult and Child Core Set measure (Y/N)
IET POS Group 1 (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
IET POS Group 2 (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
IET Stand Alone Visits (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
IET Visits Group 1 (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
IET Visits Group 2 (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y

TABLE B.1 (continued)

Value Set Name	Relevant metrics	Part of reported Adult and Child Core Set measure (Y/N)
Inpatient Stay (HEDIS MY 2021)	• #7: Follow-up After Hospitalization for Mental Illness: Ages 6 to17 (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 or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (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 People 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 MY 2021)	• #7: Follow up After Hospitalization for Mental Illness: Ages 6 to17 (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: Age 18 and Older (FUM-AD)	Y
LDL-C Lab Test (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y

TABLE B.1 (continued)

Value Set Name	Relevant metrics	Part of reported Adult and Child Core Set measure (Y/N)
LDL-C Test Result or Finding (HEDIS MY 2021)	• #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Y
Major Depression (HEDIS 2016)	• Standardized definition of SMI	N
Mental Health Diagnosis (HEDIS MY 2021)	• #7: Follow-up After Hospitalization for Mental Illness: Ages 6 to17 (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: Age 18 and Older (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
Mental Illness (HEDIS MY 2021)	• #7: Follow-up After Hospitalization for Mental Illness: Ages 6 to17 (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: Age 18 and Older (FUM-AD)	Y

TABLE B.1 (continued)

Value Set Name	Relevant metrics	Part of reported Adult and Child Core Set measure (Y/N)
MPT IOP/PH Group 1 (HEDIS MY 2021)	• #14: Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization – Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	N
MPT IOP/PH Group 2 (HEDIS MY 2021)	• #14: Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization – Any Services • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential • #34: Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	N
MPT Stand Alone Outpatient Group 1 (HEDIS MY 2021)	• #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 MY 2021)	• #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 MY 2021)	• #23: Diabetes Care for People 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 Adult and Child Core Set measure (Y/N)
Nonacute Inpatient POS (HEDIS MY 2021)	• Standardized definition of SMI • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Nonacute Inpatient Stay (HEDIS MY 2021)	• #7: Follow up After Hospitalization for Mental Illness: Ages 6 to17 (FUH-CH) • #8: Follow up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Observation (HEDIS MY 2021)	• 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 to 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 or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #15: Mental Health Services Utilization – Outpatient • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People 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

TABLE B.1 (continued)

Value Set Name	Relevant metrics	Part of reported Adult and Child Core Set measure (Y/N)
Online Assessments (HEDIS MY 2021)	• Standardized definition of SMI • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #17: Mental Health Services Utilization – Telehealth • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People 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 • #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 MY 2021)	• #26: Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	N
Other Bipolar Disorder (HEDIS MY 2021)	• Standardized definition of SMI • #23: Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Other Psychotic and Developmental Disorders (HEDIS MY 2021)	• #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Y
OUD Weekly Non-Drug Service (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
OUD Monthly Office Based Treatment (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
OUD Weekly Drug Treatment Service (HEDIS MY 2021)	• #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y
Outpatient (HEDIS MY 2021)	• #23: Diabetes Care for People 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 Adult and Child Core Set measure (Y/N)
Outpatient POS (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (FUM-AD) • #15: Mental Health Services Utilization – Outpatient • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People 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
Palliative Care Encounter (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Palliative Care Intervention (HEDIS MY 2021)	• #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD_	Y
Palliative Care Assessment (HEDIS MY 2021)	• #23: Diabetes Care for People 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 Adult and Child Core Set measure (Y/N)
Partial Hospitalization or Intensive Outpatient (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (FUM-AD) • #14: Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People 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
Partial Hospitalization POS (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (FUM-AD) • #14: Mental Health Services Utilization – Intensive Outpatient and Partial Hospitalization • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People 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 MY 2021)	• #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Y

TABLE B.1 (continued)

Value Set Name	Relevant metrics	Part of reported Adult and Child Core Set measure (Y/N)
Schizophrenia (HEDIS 2016)	• Standardized definition of SMI • #2: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) • #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Y
Telehealth Modifier (HEDIS MY 2021)	• 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 • #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 Adult and Child Core Set measure (Y/N)
Telehealth POS (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (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 People 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 Adult and Child Core Set measure (Y/N)
Telephone Visits (HEDIS MY 2021)	• 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 to 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 or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #17: Mental Health Services Utilization – Telehealth • #18: Mental Health Services Utilization – Any Services • #23: Diabetes Care for People 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 • #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
Transcranial Magnetic Stimulation (HEDIS MY 2021)	• #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 MY 2021)	• #7: Follow up After Hospitalization for Mental Illness: Ages 6 to17 (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 Adult and Child Core Set measure (Y/N)
Visit Setting Unspecified (HEDIS MY 2021)	• 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 to17 (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: Age 18 and Older (FUM-AD) • #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 People 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 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) • #32: Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED – Not Inpatient or Residential	*Value Sets:* • SMI HEDIS VSD V4	*Value Sets:* • Step 1: Open “SMI HEDIS VSD V4.xlsx” file (available in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in the Reference Materials section on PMDA). – Step 2: Filter the “MY 2021 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
• #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 specifications included in the Adult and Child 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 to17 (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 or Dependence: Age 18 and Older (FUA-AD) • #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older(FUM-AD) • #23: Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) • #24: Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD) • #25: Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH) • #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	*Measure Specifications:* • The Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) and the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manuals for Federal Fiscal Year 2021 Reporting – Appendix D: Technical Specifications for Established Quality Measures Adapted From FFY 2022 Adult and Child Core Sets Measure Specifications *Value Sets:* • SMI HEDIS VSD V4	*Measure Specifications:* • Step 1: Locate specifications for measures listed at left in **Appendix D** of this manual. *Value Sets:* • Step 1: Open "SMI HEDIS VSD V4.xlsx" file (available in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file in 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
Established quality measures that use TJC specifications (and are not part of the Adult and Child Core Set). • #1: SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUB-2)	*Measure Specifications:* • https://manual.jointcommission.org/releases/TJC2021B/MIF0186.html *Code Sets:* • https://manual.jointcommission.org/releases/TJC2021B/AppendixATJC.html • https://manual.jointcommission.org/releases/TJC2021B/AppendixCTJC.html	*Measure Specifications:* • Step 1: Refer to the measure specifications at https://manual.jointcommission.org/releases/TJC2021B/MIF0186.html • Step 2: Follow the guidance in the measure specification to calculate the metric *Code Sets:* • Step 1: Refer to the code sets at https://manual.jointcommission.org/releases/TJC2021B/AppendixATJC.html and https://manual.jointcommission.org/releases/TJC2021B/AppendixCTJC.html
Established quality measures that use NCQA specifications and value sets that are part of HEDIS (and not part of the Adult and Child 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:* NCQA Measure Specifications_V4*Value Sets:* • SMI HEDIS VSD V4	*Measure Specifications:* • Step 1: Open "NCQA Measure Specifications_V4.pdf" file (available in the 1115 SMI Monitoring Metrics Supporting Information V4.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 "SMI HEDIS VSD V4.xls" file (available in the 1115 SMI Monitoring Metrics Supporting Information V4.zip file provided with this manual, or through the Reference Materials section on PMDA). • Step 2: Filter the "2021 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 are based on the CMS specifications from the Inpatient Psychiatric Quality Reporting (IPFQR) program. • #6: Medication Continuation Following Inpatient Psychiatric Discharge	*Measure Specifications:* • Claims-Based Measure Specifications	*Measure Specifications:* • Step 1: Download the Claims-based measure Specifications (available at: https://qualitynet.cms.gov/files/629784f90b1e560016832536?filename=FY2023_IPFQR_CBM_Specs.pdf) • Step 2: Locate specification for 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an IPF and the Medication Continuation Following Inpatient Psychiatric Discharge
Established quality measures that use CMS specifications (and are not part of the Adult and Child Core Sets or IPFQR program). • #30: Follow-up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	*Measure Specifications:* • https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/techspecsmanual-nqf-3313.pdf *Value Sets:* • https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/nqf-3313-value-sets.xlsx	*Measure Specifications:* • Step 1: Refer to the measure specifications at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/techspecsmanual-nqf-3313.pdf • Step 2: Follow the guidance in the measure specification to calculate the metric *Value Sets:* • Step 1: Refer to the value sets at https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/nqf-3313-value-sets.xlsx

APPENDIX D

TECHNICAL SPECIFICATIONS FOR ESTABLISHED QUALITY MEASURES ADAPTED FROM FFY 2022 ADULT AND CHILD CORE SET MEASURE SPECIFICATION

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This appendix provides the technical specifications for the Adult and Child Core Set measures included in the 1115 SMI/SED 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 metrics can be found in **Table D.1**. For many measures, the denominator measurement period for FFY 2022 corresponds to calendar year 2021 (January 1, 2021–December 31, 2021). However, for some measures, the measurement period begins before the calendar year. For example, 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, 2021, 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 specified for each measure is shown in **Table D.1**. 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 D.1**. 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, 2021 for the FFY 2022 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 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 V4.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.

Deceased beneficiaries exclusion. SMI/SED metrics #2, 7, 8, 9, 10, 23, and 29 include a deceased beneficiary exclusion. For these measures, if a state can identify beneficiaries who die during the measurement year, these beneficiaries should be excluded consistently from all measures and indicators. These beneficiaries may be identified using various methods that include, but are not limited to, enrollment data, medical record review, claims/encounter data or supplemental data.

If a state excludes these beneficiaries, it should attempt to remove them as it determines the eligible population and prior to drawing the sample for hybrid measures. If during medical record review a beneficiary is found to be deceased, the beneficiary can be removed as a valid data error from the sample and replaced by a beneficiary from the oversample.[10]

Telehealth. Some Core Set measures included in the 1115 SMI metrics are HEDIS measures. HEDIS measures consider synchronous telehealth visits, telephone visits, and asynchronous telehealth (e-visits, virtual check-ins) as separate modalities.

- Synchronous telehealth requires real-time interactive audio and video telecommunications. A HEDIS measure specification that is silent about telehealth includes synchronous 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.

[10] Hybrid measures combine administrative claims data with data abstracted from member records during a medical record review. Metric #23 can be reported as a hybrid measure or a measure using administrative data only. If the state chooses to report this metric as a hybrid measure, it needs to replace any excluded beneficiaries who die during the performance year to ensure a sample size of 411, unless special circumstances apply. For more details, please see the hybrid specification section under Metric #23: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD).

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 synchronous telehealth is not eligible for use and should be excluded.

- A HEDIS measure specification will indicate when telephone visits are eligible for use by referencing the Telephone Visits value set.
- Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the beneficiary and the provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email. A HEDIS measure specification will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments value set.

Non-HEDIS measures will specify whether telehealth is allowed and what type of telehealth is included, if applicable.

Table D.1. Measurement Period for Denominators and Numerators for the section 1115 SMI/SED Metrics Adapted from FFY 2022 Adult and Child Core Sets Measures

	FFY 2022 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, 2021 – December 1, 2021 Negative medication history review: September 3, 2020 – August 3, 2021 (120 days before the IPSD)	October 3, 2020 – December 31, 2021 (90 days prior to IPSD through 30 days after the IPSD)	September 3, 2020 - December 31, 2021 (120 days prior to IPSD through 30 days after IPSD)
Metric #7: Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Discharge date: January 1, 2021 – December 1, 2021	7 Day Follow-up: January 2, 2021 – December 8, 2021 (7 days after discharge date) 30 Day Follow-up: January 2, 2021 – December 31, 2021 (30 days after discharge date)	January 1, 2021 – December 31, 2021 (30 days after discharge date)
Metric #8: Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Discharge date: January 1, 2021 – December 1, 2021	7 Day Follow-up: January 2, 2021 – December 8, 2021 (7 days after discharge date) 30 Day Follow-up: January 2, 2021 – December 31, 2021 (30 days after discharge date)	January 1, 2021 – December 31, 2021 (30 days after discharge date)
Metric #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Emergency Department (ED) visit date: January 1, 2021 – December 1, 2021	7 Day Follow-up: January 1, 2021 – December 8, 2021 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2021 – December 31, 2021 (ED visit date through 30 days after visit date)	January 1, 2020 – December 31, 2021 (ED visit date through 30 days after visit date)

TABLE D.1 (continued)

Measure	FFY 2022 Measurement Period[a]		
	Denominator	Numerator	Continuous Enrollment Period
Metric #10: Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	ED visit date: January 1, 2021 – December 1, 2021	7 Day Follow-up: January 1, 2021 – December 8, 2021 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2021 – December 31, 2021 (ED visit date through 30 days after visit date)	January 1, 2021 – December 31, 2021 (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, 2021 – December 31, 2021 Diabetes diagnosis: January 1, 2020 – December 31, 2021	January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021[b]
Metric #24: Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021	None
Metric #25: Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021	None
Metric #29: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021[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 PROVIDER

The Adult and Child Core Sets define a mental health provider as a provider who delivers 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)
- A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.
- A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).
    - Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:
        - The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to

participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act)

  - The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or country in which it is located

- Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:

  - Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a)(42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC
  - Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grants or funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC

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 U18 HS020503, from a measure developed by MedNet Medical Solutions

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 https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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) prior to 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) - A telephone visit (Telephone Visits value set) - An e-visit or virtual check-in (Online Assessments 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 to 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 provider. 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:

- For HEDIS, this measure has four reportable rates—ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). Metric #7 applies to beneficiaries ages 6 to 17 and Metric #8 applies to beneficiaries age 18 and older.
- 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 Appendix D Section II: Definition of a Mental Health Provider for the definition of a mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: 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

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 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 provider 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 provider 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 provider
- An outpatient visit (BH Outpatient value set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified value set) with (Partial Hospitalization POS value set) with a mental health provider
- 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; BH Outpatient value set; Observation value set; Transitional Care Management Services value set) with (Community Mental Health Center POS 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)
- A telehealth visit (Visit Setting Unspecified value set) with (Telehealth POS value set) with a mental health provider
- An observation visit (Observation value set) with a mental health provider

- Transitional care management services (Transitional Care Management Services value set), with a mental health provider
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting value set)
- A telephone visit (Telephone Visits value set) with a mental health provider.

States must develop their own methods to identify mental health providers, using the definition of a mental health provider in Appendix D Section II: Definition of a Mental Health Provider.

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 required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

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

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

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

- For HEDIS, this measure has four reportable rates—ages 6 to 17, ages 18 to 64, age 65 and older, and Total (age 6 and older). Metric #7 applies to beneficiaries ages 6 to 17 and Metric #8 applies to beneficiaries age 18 and older.
- 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 Appendix D Section II: Definition of a Mental Health Provider for the definition of a mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems are for services, procedures, and diagnoses: 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

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 provider (see Appendix D Section II) 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 provider 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 provider (see Appendix D Section II)
- An outpatient visit (BH Outpatient value set) with a mental health provider (see Appendix D Section II)
- 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) with a mental health provider (see Appendix D Section II)
- A community mental health center visit (Visit Setting Unspecified value set; BH Outpatient value set; Observation Values Set; Transitional Care Management Services value set) with (Community Mental Health Center POS 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)
- A telehealth visit (Visit Setting Unspecified value set with Telehealth POS value set) with a mental health provider (see Appendix D Section II)

- An observation visit (Observation value set) with a mental health provider (see Appendix D Section II)
- Transitional care management services (Transitional Care Management Services value set) with a mental health provider (see Appendix D Section II)
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting value set)
- A telephone visit (Telephone Visits value set) with a mental health provider (see Appendix D Section II)

States must develop their own methods to identify mental health providers, using the definition of a mental health provider in Appendix D Section II: Definition of a Mental Health Provider.

D. ADDITIONAL NOTES

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

Metric #9: Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (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

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: 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, 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, regardless of the 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)
- OUD Weekly Non Drug Service value set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence value set)
- OUD Monthly Office Based Treatment value set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence value set)
- OUD Weekly Drug Treatment Service 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 e-visit or virtual check-in (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: Age 18 and Older (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

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: 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 the 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)
- A telephone visit (Telephone Visits value set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis value set)
- An e-visit or virtual check-in (Online Assessments 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)
- A telephone visit (Telephone Visits 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 e-visit or virtual check-in (Online Assessments 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 (within 30 days after discharge or within 7 days after discharge).

Metric #23: Diabetes Care for People 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) who had hemoglobin A1c (HbA1c) in poor control (> 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/3763/s/hedis-my-2020-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, Modifier, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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 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 (e.g., 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. Any of the following code combinations meet criteria: - 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 • At least two of the following, on different dates of service, 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) - A telephone visit (Telephone Visits value set) - An e-visit or virtual check-in (Online Assessments value set) **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 (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), e-visit or virtual check-ins (Online Assessments 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 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) 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).
Required exclusion	Beneficiaries receiving palliative care (Palliative Care Assessment value set; Palliative Care Encounter value set; Palliative Care Intervention value set) during the measurement year.
Optional exclusion	Exclude beneficiaries who meet any of the following criteria: Note: Supplemental and medical record data may not be used for this exclusion. 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), telephone visits (Telephone Visits value set), e-visits or virtual check-ins (Online Assessments 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). 3. Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set). 4. 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 Greater Than 9.0 value set	Compliant

Note: A lower rate indicates better performance for this indicator (e.g.., 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 polycystic ovarian syndrome, 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 laboratory data or medical record review.

Note: A lower rate indicates better performance (e.g., 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.

E. Additional

If a combination of administrative, supplemental or hybrid data are used, the most recent result must be used, regardless of data source, for the indicators that require use of the most recent result.

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 or 14 days prior to 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 eligible encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure includes beneficiaries age 12 and older. Metric #25 applies to beneficiaries ages 12 to 17 and Metric #24 applies to beneficiaries age 18 and older.
- The intent of the measure is to screen for depression in beneficiaries who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Beneficiaries who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.
- 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:
    - Those beneficiaries with a positive screen for depression during an outpatient visit using a standardized tool with a follow-up plan documented.
    - Those beneficiaries with a negative screen for depression during an outpatient visit using a standardized tool.
- The QPP claims/CQM specifications for this measure include six G codes intended to capture whether individual providers reported on this measure. For the purpose of reporting for this demonstration, 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 or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.
- The screening should occur during a qualifying encounter or up to 14 days prior to the date of the qualifying encounter.
- The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a beneficiary screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which does not include use of a standardized depression screening tool.

- Should a beneficiary screen positive for depression, a clinician could opt to complete a suicide risk assessment when appropriate and based on individual beneficiary characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- 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 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.
- Include all paid, suspended, pending, and denied claims.
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10.

This measure includes the following coding systems: CPT and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. The depression screening must be reviewed and addressed in the office of the provider on the date of the eligible encounter.
Standardized Depression Screening 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), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD) • **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	Documented follow-up for a positive depression screening must include one or more of the following: • 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: • 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 behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options 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, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 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, 99401, 99402, 99403, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

Numerator

Beneficiaries screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter 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:

- Beneficiaries who have been diagnosed with 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 had a diagnosis of depression or has had a diagnosis of bipolar disorder

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

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance

ICD-10 Code	Description
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

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

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

ICD-10 Code	Description
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 cognitive, functional, or motivational limitations may impact the accuracy of results

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 to 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 or 14 days prior to 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 eligible encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure includes beneficiaries age 12 and older. Metric #25 applies to beneficiaries ages 12 to 17 and Metric #24 applies to beneficiaries age 18 and older.
- The intent of the measure is to screen for depression in beneficiaries who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter used to evaluate the numerator. Beneficiaries who have ever been diagnosed with depression or bipolar disorder will be excluded from the measure.
- 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.
- 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 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 or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.
- The screening should occur during a qualifying encounter or up to 14 days prior to the date of the qualifying encounter.
- The measure assesses the most recent depression screening completed either during the eligible encounter or within the 14 days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a beneficiary screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which does not include use of a standardized depression screening tool.

- Should a beneficiary screen positive for depression, a clinician could opt to complete a suicide risk assessment when appropriate and based on individual beneficiary characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- 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 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.
- Include all paid, suspended, pending, and denied claims.
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms002v10.

This measure includes the following coding systems: CPT and HCPCS. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. The depression screening must be reviewed and addressed in the office of the provider on the date of the encounter.
Standardized Depression Screening 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	Documented follow-up for a positive depression screening must include one or more of the following: • 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: • 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 behavioral health, psychotherapy, pharmacological interventions, or additional treatment options. 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, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161, 97162, 97163, 97165, 97166, 97167, 99078, 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, 99401, 99402, 99403, 99483, 99484, 99492, 99493, 99384, 99385, 99386, 99387, 99394, 99395, 99396, 99397	G0101, G0402, G0438, G0439, G0444

Numerator

Beneficiaries screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter 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:

- Beneficiaries who have been diagnosed with 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 had a diagnosis of depression or has had a diagnosis of bipolar disorder

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

ICD-10 Code	Description
F01.51	Vascular dementia with behavioral disturbance

ICD-10 Code	Description
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F34.81	Disruptive mood dysregulation disorder
F34.89	Other specified persistent mood disorders
F43.21	Adjustment disorder with depressed mood
F43.23	Adjustment disorder with mixed anxiety and depressed mood
F53.0	Postpartum depression
F53.1	Puerperal psychosis
O90.6	Postpartum mood disturbance
O99.340	Other mental disorders complicating pregnancy, unspecified trimester
O99.341	Other mental disorders complicating pregnancy, first trimester
O99.342	Other mental disorders complicating pregnancy, second trimester
O99.343	Other mental disorders complicating pregnancy, third trimester
O99.345	Other mental disorders complicating the puerperium

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

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

ICD-10 Code	Description
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 cognitive, functional, or motivational limitations may impact the accuracy of results

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 U18 HS020503.

A. DESCRIPTION

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

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 I. Measure Element Definitions.
- NCQA's Medication List Directory (MLD) for Antipsychotic, Antipsychotic Combination, and Prochlorperazine medications are available to order free of charge in the NCQA Store (https://store.ncqa.org/index.php/catalog/product/view/id/3764/s/hedis-my-2021-medication-list-directory/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. 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.
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 People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)) from the FFY 2022 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, bipolar disorder, or major depression. 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)
- At least two of the following, on different dates of service, 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)
  - A telephone visit (Telephone Visits value set)
  - An e-visit or virtual check-in (Online Assessments value set)

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APPENDIX F

AVERAGE LENGTH 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)

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

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

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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