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MANUAL

Medicaid Section 1115 Substance Use Disorder 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
AD	Adult Core Set
AMA	American Medical Association
AOD	Alcohol or other drug
ASAM	American Society of Addiction Medicine
ASSIST	Alcohol, Smoking Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
BH	Behavioral Health
CAGE AID	CAGE Adapted to Include Drugs
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid & CHIP Services
CMS	Centers for Medicare & Medicaid Services
COB-AD	Concurrent Use of Opioids and Benzodiazepines
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble
CPT	Current Procedural Terminology
DAST	Drug Abuse Screening Test
DNR	Do Not Resuscitate
DY	Demonstration Year
ED	Emergency Department
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee for Service
FFY	Federal Fiscal Year
FUA-AD	Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
FUM-AD	Follow-up after Emergency Department Visit for Mental Illness
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
IAD	Identification of Alcohol and Other Drug Services
ICD	International Classification of Diseases

IET-AD	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMD	Institution for Mental Diseases
IOP/PH	Intensive Outpatient Care/Partial Hospitalization
MAT	Medication-Assisted Treatment
MC	Managed Care
MLD	Mediation List Directory
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NQF	National Quality Forum
NPI	National Provider Identifier
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer
OUD	Opioid Use Disorder
PMDA	Performance Metrics Database and Analytics
POS	Place of Service
PQA	Pharmacy Quality Alliance
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SMDL	State Medicaid Director Letter
STC	Special Terms and Conditions
SUB	Substance Use
SUD	Substance Use Disorder
TJC	The Joint Commission
T-MSIS	Transformed Medicaid Statistical Information System
UB	Universal Billing
USC	University of Southern California
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 a Medicaid section 1115 substance use disorder (SUD) demonstration.[1]

The Center for Medicaid and CHIP Services (CMCS) selected section 1115 SUD demonstration monitoring metrics (hereafter referred to as "metrics") with input from subject matter experts and members of the state technical advisory group for Medicaid monitoring and evaluation. These metrics consist of (1) established quality measures endorsed by 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 1, 2017 (SMDL #17-003).[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 SUD demonstrations (hereafter referred to as "SUD demonstrations").

An important goal of monitoring SUD 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 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 Core Set measures, and finally, Appendix E includes additional guidance for calculating the set of service utilization metrics developed for SUD demonstrations.

A. Overview of section 1115 SUD metrics

There are 37 metrics representing seven measurement domains, including five of the six section 1115 SUD demonstration milestones identified in the SMDL (see Table 1). This set of 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 SUD demonstration metrics reporting:

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

[2] SMDL #17-003 Strategies to Address the Opioid Epidemic.
Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

Required or recommended. Metrics are either required or recommended.

- ***Required metrics*** provide information that is critical for monitoring the success of SUD 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 SUD demonstration metrics

Measurement domain/milestone[a]	Total number of metrics	Number of required metrics[b]
Assessment of Need and Qualification for SUD Treatment Services	4	2
Milestone 1: Access to Critical Levels of Care for OUD and other SUDs	8	8
Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria	2	2
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for Medication-Assisted Treatment for OUD	2	2
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	6	4
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care	5	4
Other SUD-Related Metrics	10	3
Total	**37**	**25**

[a] Milestones included in this table are from the SMDL #17-003. There are no CMS-provided metrics related to Milestone 3 (Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities).

[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.

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

Measurement domain/milestone[a]	Number of metrics		
	Annual[b]	Quarterly	Monthly
Assessment of Need and Qualification for SUD Treatment Services	1	0	3

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

Table 2 (continued)

Measurement domain/milestone[a]	Number of metrics		
	Annual[b]	Quarterly	Monthly
Milestone 1: Access to Critical Levels of Care for OUD and other SUDs	1	0	7
Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria	2	0	0
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for Medication-Assisted Treatment for OUD	2	0	0
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	5	0	1
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care	5	0	0
Other SUD-Related Metrics	6	3	1
Total	**22**	**3**	**12**

[a] Milestones included in this table are from the SMDL #17-003. There are no CMS-provided metrics related to Milestone 3 (Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities).

[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 SUD demonstration. Note that for most metrics, demonstration reporting focuses on the subset of Medicaid beneficiaries targeted by the SUD demonstration—that is, Medicaid beneficiaries with SUD. However, some metrics focus more broadly on the Medicaid population (for example, metrics measuring overdose deaths or opioid prescribing) or on non-beneficiary populations (for example, provider availability metrics). Additional details are available for each metric in Chapter II.

Subpopulation categories. Some subpopulations have unique treatment needs with respect to SUD. 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 SUD demonstrations, including one recommended and four required 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 SUD demonstration population.
- ***State-specific subpopulation categories.*** The state may identify additional subpopulation categories specific to its demonstration ("state-specific subpopulation categories" 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 demographic data can help states contextualize evaluation findings, understand baseline disparities, track early demonstration experiences, and inform course corrections in demonstration implementation.

Table 3. Subpopulation categories reporting for section 1115 SUD demonstrations

Subpopulation categories	Required or recommended	Description
CMS-provided		
Age group	Required	Age groups defined as children <18, adults 18–64, 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]
Pregnancy status	Required	Determine pregnancy status (i.e., pregnant, not pregnant) based on ever qualifying for the pregnant subpopulation during the measurement period. The state should use code sets developed for the year of data the state is analyzing. The state should include women in the pregnant subpopulation if they have had a pregnancy code during the measurement period or in the two months prior to the measurement period.[c] Both males and females are included in the not pregnant subpopulation. For example, the state could use the pregnancy codes provided in the MACBIS Pregnancy Code List available 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.
Criminal justice status	Required	Determine criminal justice status (i.e., criminally involved, not criminally involved) based on ever qualifying for the criminally involved subpopulation during the measurement period. There is no standard method for identifying criminal justice status; the state should identify a method for flagging criminal involvement (such as by matching Medicaid beneficiaries to data from state law enforcement agencies).

Table 3 (continued)

Subpopulation categories	Required or recommended	Description
OUD diagnosis	Recommended	The state can monitor some metrics for SUD diagnosis overall as well as for OUD diagnosis specifically. Determine the OUD subpopulation by identifying beneficiaries who have at least one claim with a diagnosis code listed under the HEDIS MY 2021 Opioid Abuse and Dependence Value Set.
State-specific		
Delivery system	Recommended	If the state's SUD 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 SUD 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 SUD 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 SUD 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 SUD who are experiencing homelessness).

[a] The T-MSIS data dictionary can be accessed at https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/t-msis-data-dictionary/index.html.

[b] Additional information on defining dual-eligible populations is available on Medicaid.gov. See, for example, https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/functional-areas/integrated-medicare-medicaid-data.pdf, and https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/data-analytics/index.html.

[c] For example, for monthly metrics reported for February 2022, the state should include women in the pregnant subpopulation if they had a pregnancy code in the measurement month (i.e., 02/01/2022 – 02/28/2022) or the two months prior to the measurement month (12/1/2021 – 01/31/2022). Likewise, for annual metrics reported for calendar year 2021, the state should include women in the pregnant subpopulation if they had a pregnancy code in the measurement year (i.e., 01/01/2021 – 12/31/2021) or the two months prior to the measurement year (i.e., 11/01/2020 – 12/31/2020). When identifying pregnancy codes, the state should look at both inpatient and outpatient claims to avoid undercounting the number of pregnant women in the demonstration population.

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 SUD demonstration metrics, by measurement domain[a]

Metric	Metric name	Measure steward	Required or recommended	Measurement period	Data source(s)	Demonstration	Subpopulation categories[b]				
							Age group	Dual-eligible status	Pregnancy status	Criminal justice status	OUD diagnosis (recommended)
Assessment of Need and Qualification for SUD Treatment Services											
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	None	Recommended	Month	Medical record review or claims	X	X	X	X	X	
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	None	Recommended	Month	Claims	X	X	X	X	X	X
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	None	Required	Month	Claims	X	X	X	X	X	X
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	None	Required	Demonstration Year[c]	Claims	X					X
Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs											
6	Any SUD Treatment	None	Required	Month	Claims	X	X	X	X	X	X
7	Early Intervention	None	Required	Month	Claims	X	X	X	X	X	X
8	Outpatient Services	None	Required	Month	Claims	X	X	X	X	X	X
9	Intensive Outpatient and Partial Hospitalization Services	None	Required	Month	Claims	X	X	X	X	X	X
10	Residential and Inpatient Services	None	Required	Month	Claims	X	X	X	X	X	X
11	Withdrawal Management	None	Required	Month	Claims	X	X	X	X	X	X
12	Medication-Assisted Treatment	None	Required	Month	Claims	X	X	X	X	X	X
22	Continuity of Pharmacotherapy for Opioid Use Disorder[d]	USC	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]				
							Age group	Dual-eligible status	Pregnancy status	Criminal justice status	OUD diagnosis (recommended)
Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria											
5	Medicaid Beneficiaries Treated in an IMD for SUD	None	Required	Demonstration Year[c]	Claims	X					X
36	Average Length of Stay in IMDs	None	Required	Demonstration Year[c]	Claims; State-specific IMD database	X					X
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for Medication-Assisted Treatment for OUD											
13	SUD Provider Availability	None	Required	Demonstration Year[c]	Provider enrollment database; Claims	X					
14	SUD Provider Availability – MAT	None	Required	Demonstration Year[c]	Provider enrollment database; Claims; SAMHSA datasets	X					
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD											
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	PQA	Required	Calendar Year	Claims	X					
19	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	PQA	Recommended	Calendar Year	Claims	X					
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	PQA	Recommended	Calendar Year	Claims	X					
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	PQA	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]				
							Age group	Dual-eligible status	Pregnancy status	Criminal justice status	OUD diagnosis (recommended)
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	None	Required	Month	Claims	X	X				X
27	Overdose Deaths (rate)	None	Required	Demonstration Year[c]	State data on cause of death	X	X				X
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care											
15	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)[e]	NCQA	Required	Calendar Year	Claims or EHR	X					
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	TJC	Recommended	Calendar Year	Medical record review or claims	X					
17(1)	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					
17(2)	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	NCQA	Required	Calendar Year	Claims	X					
25	Readmissions Among Beneficiaries with SUD	None	Required	Demonstration Year[c]	Claims	X					
Other SUD-Related Metrics											
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	None	Required	Month	Claims	X	X				X

Table 4 (continued)

Metric	Metric name	Measure steward	Required or recommended	Measurement period	Data source(s)	Demonstration	Subpopulation categories[b]				
							Age group	Dual-eligible status	Pregnancy status	Criminal justice status	OUD diagnosis (recommended)
26	Overdose Deaths (count)	None	Required	Demonstration Year[c]	State data on cause of death	X	X				X
28	SUD Spending	None	Recommended	Demonstration Year[c]	Claims	X					
29	SUD Spending Within IMDs	None	Recommended	Demonstration Year[c]	Claims	X					
30	Per Capita SUD Spending	None	Recommended	Demonstration Year[c]	Claims	X					
31	Per Capita SUD Spending Within IMDs	None	Recommended	Demonstration Year[c]	Claims	X					
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD[f]	NCQA	Required	Calendar Year	Claims	X					
33	Grievances Related to SUD Treatment Services[g]	None	Recommended	Quarter	Administrative records	X					
34	Appeals Related to SUD Treatment Services[g]	None	Recommended	Quarter	Administrative records	X					
35	Critical Incidents Related to SUD Treatment Services[g]	None	Recommended	Quarter	Administrative records	X					

[a] Milestones included in this table are from the SMDL #17-003. There are no CMS-provided metrics related to Milestone 3.

[b] 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 SUD demonstration year as the measurement period for all demonstration year metrics.

[d] Metric #22 is an established quality measure stewarded by USC: Continuity of Pharmacotherapy for Opioid Use Disorder. The specifications provided by the measure steward provide instructions for identifying the OUD population for this metric, which differ from the general guidance for identifying the OUD subpopulation provided in Table 3 of this document. The state should use the specifications provided by the measure steward to identify the OUD population for

Table 4 (continued)

this metric. Metric #22 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).

[e] Metric #15 is an adapted Adult Core Set measure: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD). This metric provides instructions for reporting beneficiaries in several diagnosis cohorts, including an opioid abuse or dependence cohort. These instructions differ from the general guidance for identifying the OUD subpopulation provided in Table 3 of this document. The state should use the specifications provided by the measure steward to identify the opioid abuse or dependence cohort for this metric.

[f] Metric #32 is an adjusted HEDIS measure: Access to Preventative/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD. 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] While the metrics on grievances and appeals are recommended, per 42 CFR 431.428(a)5, the state is required to include information about grievances and appeals from beneficiaries in the annual monitoring reports.

IMD = Institution for Mental Diseases; NCQA = National Committee for Quality Assurance; PQA = Pharmacy Quality Alliance; TJC = The Joint Commission; USC = University of Southern California.

B. Reporting guidance for section 1115 SUD metrics

This section provides reporting guidance applicable to section 1115 SUD demonstration 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) on the message.

Supplemental materials. Technical specifications for some established quality measures as well as established value sets and other resource materials are provided in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file 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 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 SUD Monitoring Metrics Supporting Information V5.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 Medicaid quality measure set (such as the Core Set of Adult Health Care Quality Measures for Medicaid [Adult Core Set]) or a measure steward (NCQA[4], Pharmacy Quality Alliance, The Joint Commission, and University of Southern California).[5] To help the state calculate these metrics, this document references the measure steward's or Core Set's measure specifications and associated value sets, provided in the 1115 SUD Monitoring Metrics Supporting Information V5.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.

[4] 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.

[5] Metrics that are established quality measures include: #15, 16, 17(1), 17(2) 18, 19, 20, 21, 22, and 32.

Determining measurement periods. To determine measurement periods, the state must first identify the start date of its SUD 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 SUD demonstration approval note that the SUD demonstration is effective January 1, 2021– December 31, 2026, the state should consider January 1, 2021 to be the start date of the SUD demonstration for purposes of monitoring.[6] In general, if SUD 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, the state should designate the first quarter for SUD 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 SUD 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 SUD demonstration's approval period. For example, if the SUD 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 SUD demonstration year schedule. For example, if the SUD demonstration began on March 1 or on any other day in March (e.g., March 15), the first measurement period is March 1 of the year in which the demonstration started through February 28 of the following calendar year.
- ***Established quality measures.*** For metrics that are established quality measures, the annual measurement period should align with a calendar year, with the first measurement period aligned with the calendar year in which the SUD demonstration started. For example, if the

[6] The effective date is defined as the first day the state ***may*** begin its SUD 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.

SUD 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 SUD 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 SUD demonstration approval note that the SUD demonstration is effective January 1, 2021 – December 31, 2026, the state should consider January 1, 2021 to be the start date of the SUD 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 SUD demonstration year (SUD DY1). For example, if the state's SUD demonstration began on March 1, 2021, the baseline period is March 1, 2021 – February 28, 2022.
  - If the state's SUD 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 reporting period.
  - For a state where the first SUD DY is less than 12 months, the state should report the 12 months preceding the end of SUD DY1 as its baseline period (including months before the start of the SUD demonstration). For example, if the state has a 10-month SUD 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 SUD 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 #22: Continuity of Pharmacotherapy for Opioid Use Disorder), the baseline period is the calendar year in which the SUD 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 SUD DY1 is less than 12 months, the state should use the last day of SUD DY1 to identify the appropriate calendar year for reporting. If the last day of SUD DY1 is December 31, the baseline period would be the same calendar year. For example, if a state has a 10-month SUD 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 SUD DY1 is any other date, the baseline period should be the prior calendar year. For example, if a state has a 10-month SUD 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 a SUD demonstration that begins March 1, 2021 as an example.

Table 5. Example of alignment between section 1115 SUD demonstration years and measurement periods

Section 1115 SUD Demonstration Start Date: March 1, 2021	SUD 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	
SUD 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
SUD DY2 March 1, 2022 - Feb 28, 2023	Month as defined in the baseline period row	Month as defined in the baseline period row	Quarter as defined in the baseline period row	Quarter as defined in the baseline period row	Jan 1, 2022	Dec 31, 2022
SUD DY3 March 1, 2023 - Feb 29, 2024					Jan 1, 2023	Dec 31, 2023
SUD DY4 March 1, 2024 - Feb 28, 2025					Jan 1, 2024	Dec 31, 2024
SUD DY5 March 1, 2025 - Feb 28, 2026					Jan 1, 2025	Dec 31, 2025

[a] This example does not apply to Metric #22, which is calculated over a two-year time period. For a SUD demonstration with a March 1, 2021 demonstration start date, the SUD DY1 measurement period for Metric #22 would be January 1, 2020 – December 31, 2021. For SUD DY2, the measurement period for Metric #22 would be January 1, 2021 – December 31, 2022.

[b] Baseline period for CMS-constructed and state-specific metrics is SUD DY1. Baseline period for established quality measures is the calendar year in which the SUD 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 SUD 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 SUD demonstration years that end July 31 through November 30: in the annual monitoring report
  - For a state with SUD demonstration years that end May 31 or June 30: in the first quarterly monitoring report of the next SUD demonstration year
  - For a state with SUD demonstration years that end February 28 through April 30: in the second quarterly monitoring report of the next SUD demonstration year
  - For a state with SUD demonstration years that end December 31 or January 31: in the third quarterly monitoring report of the next SUD demonstration year
- All other annual metrics should be reported in the first quarterly monitoring report of the next SUD 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 SUD 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 #22) 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 SUD 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 SUD 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 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 SUD 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 SUD demonstration metrics

Manual version	Measurement period for CMS-constructed metrics[a]	Measurement period for established quality measures (calendar year)[b]
Version 1.1	-	2017
Version 2.0	-	2018
Version 3.0	-	2019
Version 4.0	-	2020
Version 5.0	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 2019, the state should use Version 3.0 of the section 1115 SUD 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.

General guidance. When reporting SUD 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 SUD treatment services (for example private insurance or eligibility for Medicaid only after spend down); or (4) only eligible for family planning services.
- 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 SUD treatment 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 SUD metrics

Population of interest for CMS-constructed metrics	Metrics #
All beneficiaries with full benefits enrolled in Medicaid for any amount of time during the measurement period.	1, 2, 3, 6, 7, 8, 9, 10, 11, 12, 23, 24
All beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	4, 25, 28, 30
All beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. Limit to IMDs receiving federal financial participation (FFP).	5, 29, 31, 36
All beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period or the 30 days prior to the beginning of the measurement period.	26, 27

Note: Table excludes CMS-constructed metrics for which beneficiaries are not the population of interest: Metrics #13 (SUD Provider Availability), 14 (SUD Provider Availability – MAT), 33 (Grievances Related to SUD Treatment Services), 34 (Appeals Related to SUD Treatment Services), and 35 (Critical Incidents Related to SUD Treatment Services).

- *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 Core Set, refer to the technical specifications included in **Appendix D: Technical Specifications for Established Quality Measures Adapted from FFY 2022 Adult Core Set Measure Specifications**. For all other established quality measures, refer to the original measure specifications, provided in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible to the

state through Performance Metrics Database and Analytics (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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (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 SUD 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[7] 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[8] 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 technical specifications manual or other

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

[8] 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**.

considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD 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 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 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.

II. METRIC SPECIFICATIONS

This chapter presents technical specifications for each of the section 1115 SUD demonstration metrics. Reporting guidance that applies to all metrics can be found in Chapter I.

Metric #1: Assessed for SUD Treatment Needs Using a Standardized Screening Tool	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool 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	Count the number of unique beneficiaries (de-duplicated total) screened for a SUD treatment need using a standardized screening tool for SUD, including but not limited to: • Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) • Alcohol Use Disorders Identification Test (AUDIT) or AUDIT-C • Drug Abuse Screening Test (DAST or DAST-10) • CAGE AID • CRAFFT Screening Tool (for people under age 21)
Additional guidance	Do not include assessments related exclusively to tobacco use.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) State-specific subpopulations
Relationship to other metrics	None
Data source	Medical record review or claims
Claim type	If using claims, 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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three 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 number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period but not in the three months before the measurement period. Step 1. Identify claims for MAT, defined in one of the following HEDIS MY 2021 IET Value Sets or Medications Lists: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medication List • Opioid Use Disorder Treatment Medication List Step 2. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set In addition to a diagnosis code above, the claim must also have a code from any of the following HEDIS MY 2021 IET value set for identifying SUD treatment, another telehealth HCPCS code, a telephone CPT code, another online assessment CPT or HCPCS code, or a telehealth place of service code: *HEDIS MY 2021 IET Value Sets:* • IET Stand Alone Visits Value Set • IET Visits Group 1 Value Set with IET POS Group 1 Value Set • IET Visits Group 2 Value Set with IET POS Group 2 Value Set • Detoxification Value Set • ED Value Set • Inpatient Stay Value Set • Telephone Visits Value Set • Online Assessments Value Set *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 • G2251: Brief communication technology-based service by a qualified health care progression who cannot report evaluation and management services for an established patient

Metric #2 (continued)

Metric #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	
Metric element	**Description**
Numerator (continued)	*Telephone E&M CPT codes:* • 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, not originating from a related E/M service provided within the previous 7 days no leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes • 99442: 11-20 minutes • 99443: 21-30 minutes *Online assessment CPT 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 • 99444: Online evaluation and management services provided by a physician or other qualified health care professional *Online assessment HCPCS codes:* • 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 *Place of service:* • POS 10: Telehealth in patient's home Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Step 1 or Step 2 during the measurement period, but not in the three months before the measurement period.
Additional guidance	Beginning in Version 5.0 of the technical specifications manual, three telephone E&M CPT codes (99441, 99442, and 99443) and one online assessment CPT code (99444) were added to the numerator specification for this metric to capture services provided via telephone and online. In addition, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and one telehealth place of service code (10) were added to the numerator specification. NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. The Version 5.0 manual includes specifications and value sets that align with HEDIS MY 2021. The HEDIS MLD for MY 2021 is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. Previous versions of the MLD are also available in the NCQA Store. The state may use newer versions of the HEDIS MLD as they are released, even if those versions are not yet reflected in updated technical specifications, as long as they align with the applicable measurement period for a metric. For CMS-constructed metrics, the state should note the following: • For monthly or quarterly metrics, the state should use the MLD that aligns with the calendar year in which the measurement period occurs. For example, to report Metric #6 for December 2021, the state should use the MY 2021 MLD.

Metric #2 (continued)

Metric #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	
Metric element	**Description**
Additional guidance (continued)	• For annual metrics, the state should use the MLD that aligns with the calendar year in which the state's demonstration period ended. For example, to report Metric #28 for a demonstration year that ends on February 28, 2022, the state should use the MY 2022 MLD. • For other annual metrics that span more than one calendar year, such as Metric #4, for which the measurement period is the demonstration year and a 12-month look back period, the state should use the MLD that aligns with the calendar year in which the state's demonstration year ended. For example, to report Metric #4 for a demonstration year that ends on December 31, 2021, the state should use the MY 2021 MLD. Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads). Additional guidance on accessing HEDIS medication lists and 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: o Combine claims for the same beneficiary, provider and admission date; or o 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 receiving ***prescription medication***, identify claims in the measurement period using the date the prescription was filled. 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 metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	The approach to identify beneficiaries with SUD in this metric also applies to Metrics #3, 4, and 30.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #2 (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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #3: Medicaid Beneficiaries with SUD Diagnosis (monthly)	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis 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 number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period. For the OUD subpopulation, including any beneficiary with an OUD diagnosis during the measurement period and/or in the 11 months before the measurement period. Step 1. Identify claims for MAT, defined in one of the following HEDIS MY 2021 IET Value Sets or Medications Lists: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medication Lists • Opioid Use Disorder Treatment Medication Lists Step 2. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set In addition to a diagnosis code above, the claim must also have a code from any of the following HEDIS MY 2021 IET value set for identifying SUD treatment, another telehealth HCPCS code, a telephone CPT code, another online assessment CPT or HCPCS code, or a telehealth place of service code: *HEDIS MY 2021 IET Value Sets:* • IET Stand Alone Visits Value Set • IET Visits Group 1 Value Set with IET POS Group 1 Value Set • IET Visits Group 2 Value Set with IET POS Group 2 Value Set • Detoxification Value Set • ED Value Set • Inpatient Stay Value Set • Telephone Visits Value Set • Online Assessments Value Set *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 vide/image submission by patient and follow up with patient • G2250: Remote assessment of recorded video and/or images submitted by an established patient • G2251: Brief communication technology-based service by a qualified health care progression who cannot report evaluation and management services for an established patient

Metric #3 (continued)

Metric #3: Medicaid Beneficiaries with SUD Diagnosis (monthly)	
Metric element	**Description**
Numerator (continued)	*Telephone E&M CPT codes:* • 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, not originating from a related E/M service provided within the previous 7 days no leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes • 99442: 11-20 minutes • 99443: 21-30 minutes *Online assessment CPT 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 • 99444: Online evaluation and management services provided by a physician or other qualified health care professional *Online assessment HCPCS codes:* • 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 *Place of service:* • POS 10: telehealth in a patient's home Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Step 1 or Step 2 during the measurement period and/or in the 11 months before the measurement period.
Additional guidance	Beginning in Version 5.0 of the technical specifications manual, three telephone E&M CPT codes (99441, 99442, and 99443) and one online assessment code (99444) were added to the numerator specification for this metric to capture services provided via telephone and online. In addition, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and one telehealth place of service code (10) were added to the numerator specification. NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. The Version 5.0 manual includes specifications and value sets that align with HEDIS MY 2021. The HEDIS MLD for MY 2021 is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. Previous versions of the MLD are also available in the NCQA Store. The state may use newer versions of the HEDIS MLD as they are released, even if those versions are not yet reflected in updated technical specifications, as long as they align with the applicable measurement period for a metric.

Metric #3 (continued)

Metric #3: Medicaid Beneficiaries with SUD Diagnosis (monthly)	
Metric element	**Description**
Additional guidance (continued)	For CMS-constructed metrics, the state should note the following: • For monthly or quarterly metrics, the state should use the MLD that aligns with the calendar year in which the measurement period occurs. For example, to report Metric #6 for December 2021, the state should use the MY 2021 MLD. • For annual metrics, the state should use the MLD that aligns with the calendar year in which the state's demonstration period ended. For example, to report Metric #28 for a demonstration year that ends on February 28, 2022, the state should use the MY 2022 MLD. • For other annual metrics that span more than one calendar year, such as Metric #4, for which the measurement period is the demonstration year and a 12-month look back period, the state should use the MLD that aligns with the calendar year in which the state's demonstration year ended. For example, to report Metric #4 for a demonstration year that ends on December 31, 2021, the state should use the MY 2021 MLD. Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads). Additional guidance on accessing HEDIS medication lists and 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: o Combine claims for the same beneficiary, provider and admission date; or o 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 receiving ***prescription medication***, identify claims in the measurement period using the date the prescription was filled. • 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)
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	The approach to identifying beneficiaries with SUD in this metric also applies to Metrics #2, 4, and 30. In a given month, the beneficiaries included in the numerators of Metrics #23 and 24 should be counted once in the numerator in this metric.
Data source	Claims

Metric #3 (continued)

Metric #3: Medicaid Beneficiaries with SUD Diagnosis (monthly)	
Metric element	**Description**
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #4: Medicaid Beneficiaries with SUD Diagnosis (annually)	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis 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	The number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 12 months before the measurement period. For the OUD subpopulation, include any beneficiary with an OUD diagnosis during the measurement period and/or in the 12 months before the measurement period. Step 1. Identify claims for MAT, defined in one of the following HEDIS MY 2021 IET Value Sets or Medications Lists: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medication Lists • Opioid Use Disorder Treatment Medication Lists Step 2. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set In addition to a diagnosis code above, the claim must also have a code from any of the following HEDIS MY 2021 IET value set for identifying SUD treatment, another telehealth HCPCS code, a telephone CPT code, another online assessment CPT or HCPCS code, or a telehealth place of service code: *HEDIS MY 2021 IET Value Sets:* • IET Stand Alone Visits Value Set • IET Visits Group 1 Value Set with IET POS Group 1 Value Set • IET Visits Group 2 Value Set with IET POS Group 2 Value Set • Detoxification Value Set • ED Value Set • Inpatient Stay Value Set • Telephone Visits Value Set • Online Assessments Value Set *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 vide/image submission by patient and follow up with patient • G2250: Remote assessment of recorded video and/or images submitted by an established patient • G2251: Brief communication technology-based service by a qualified health care progression who cannot report evaluation and management services for an established patient

Metric #4 (continued)

Metric #4: Medicaid Beneficiaries with SUD Diagnosis (annually)	
Metric element	**Description**
Numerator (continued)	*Telephone E&M CPT codes:* • 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, not originating from a related E/M service provided within the previous 7 days no leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes • 99442: 11-20 minutes • 99443: 21-30 minutes *Online assessment CPT 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 • 99444: Online evaluation and management services provided by a physician or other qualified health care professional *Online assessment HCPCS codes:* • 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 *Place of service:* • POS 10: telehealth in a patient's home Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Step 1 or Step 2 during the measurement period and/or in the 12 months before the measurement period.
Additional guidance	Beginning in Version 5.0 of the technical specifications manual, three telephone E&M CPT codes (99441, 99442, and 99443) and one online assessment code (99444) were added to the numerator specification for this metric to capture services provided via telephone and online. In addition, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and one telehealth place of service code (10) were added to the numerator specification. NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. The Version 5.0 manual includes specifications and value sets that align with HEDIS MY 2021. The HEDIS MLD for MY 2021 is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. Previous versions of the MLD are also available in the NCQA Store. The state may use newer versions of the HEDIS MLD as they are released, even if those versions are not yet reflected in updated technical specifications, as long as they align with the applicable measurement period for a metric.

Metric #4 (continued)

Metric #4: Medicaid Beneficiaries with SUD Diagnosis (annually)	
Metric element	**Description**
Additional guidance (continued)	For CMS-constructed metrics, the state should note the following: • For monthly or quarterly metrics, the state should use the MLD that aligns with the calendar year in which the measurement period occurs. For example, to report Metric #6 for December 2021, the state should use the MY 2021 MLD. • For annual metrics, the state should use the MLD that aligns with the calendar year in which the state's demonstration period ended. For example, to report Metric #28 for a demonstration year that ends on February 28, 2022, the state should use the MY 2022 MLD. • For other annual metrics that span more than one calendar year, such as Metric #4, for which the measurement period is the demonstration year and a 12-month look back period, the state should use the MLD that aligns with the calendar year in which the state's demonstration year ended. For example, to report Metric #4 for a demonstration year that ends on December 31, 2021, the state should use the MY 2021 MLD. Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads). Additional guidance on accessing HEDIS medication lists and 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: o Combine claims for the same beneficiary, provider and admission date; or o 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 receiving ***prescription medication***, identify claims in the measurement period using the date the prescription was filled. 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 metric
Subpopulation categories	OUD diagnosis State-specific subpopulations
Relationship to other metrics	The approach to identifying beneficiaries with SUD in this metric also applies to Metrics #2, 3, and 30. The numerator in Metric #4 is the same as the denominator in Metric #30.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

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

Metric #4 (continued)

State-specific codes. The state may use state-specific treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #5: Medicaid Beneficiaries Treated in an IMD for SUD	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD 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. Limit to IMDs receiving federal financial participation (FFP). Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who received inpatient/residential treatment in an IMD for a SUD diagnosis within the measurement period Step 1. Identify claims for residential treatment with a discharge date in the measurement period: Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 55 – Residential Substance Abuse Treatment Facility *HCPCS Codes:* • H0010 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) • H0011 – Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) *UB Revenue Codes:* • 1002 – Residential treatment – chemical dependency Step 1b. Identify claims with a place of service, HCPCS, or UB Revenue code listed below and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Code Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set *Place of Service Codes:* • 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

Metric #5 (continued)

Metric #5: Medicaid Beneficiaries Treated in an IMD for SUD	
Metric element	**Description**
Numerator (continued)	Step 2. Identify claims for inpatient treatment that have a revenue code from the Inpatient Stay Value Set and a primary diagnosis code listed under one of the following HEDIS MY 2021 value sets: Diagnosis Code Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 3. Retain claims for inpatient/residential treatment in an IMD found in Step 1a or Step 1b or Step 2. (See the additional guidance section for a definition of IMDs.) Step 4. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Steps 1-3
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: o Combine claims for the same beneficiary, provider and admission date; or o 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. 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 published lists of IMDs in which the designation is made by the state. If available, use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance. Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

Metric #5 (continued)

Metric #5: Medicaid Beneficiaries Treated in an IMD for SUD	
Metric element	**Description**
Additional guidance (continued)	5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases (including SUD). a. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases (including SUD). When applying the 50 percent guideline determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	OUD diagnosis State-specific subpopulations
Relationship to other metrics	The definition of an IMD should be the same in Metrics #5, 29, 31, and 36. Metric #36 calculates the average length of stay in IMDs for the beneficiaries identified in Metric #5.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #6: Any SUD Treatment	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.
Population of interest	All beneficiaries with full benefits enrolled in Medicaid for any amount of time 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) enrolled in the measurement period receiving at least one SUD treatment service or pharmacy claim during the measurement period. Step 1. Identify claims for residential treatment Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 55 – Residential Substance Abuse Treatment Facility *HCPCS Codes:* • H0008 – Alcohol and/or drug services; sub-acute detoxification (hospital inpatient) • H0009 – Alcohol and/or drug services; acute detoxification (hospital inpatient) • H0010 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) • H0011 – Alcohol and/or drug services; acute detoxification (residential inpatient program inpatient) *UB Revenue Codes:* • 1002 – Residential treatment – chemical dependency Step 1b. Identify claims with a place of service, HCPCS, or UB Revenue code listed below and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Code Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set *Place of Service Codes:* • 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 Step 2. Identify claims for MAT, defined in one of the following HEDIS MY 2021 IET Value Sets or Medications Lists: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medication Lists • Opioid Use Disorder Treatment Medication Lists

Metric #6 (continued)

Metric #6: Any SUD Treatment	
Metric element	**Description**
Numerator (continued)	Step 3. Identify claims for other types of SUD treatment Step 3a. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 3b. Among claims identified in Step 3a, retain claims with any of the following HCPCS, CPT, or place of service codes or codes from any of the below value sets: *Early intervention CPT codes:* • 99408 (CPT code) – alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes • 99409 (CPT code) – alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; greater than 30 minutes *Early intervention HCPCS codes:* • H0049 (HCPCS code) – alcohol and/or drug screening • H0050 (HCPCS code) – alcohol and/or drug screening, brief intervention, per 15 minutes • G0396 (HCPCS code) – alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention, 15 to 30 minutes • G0397 (HCPCS code) – alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention, > 30 minutes *Telephone E&M CPT codes:* • 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, not originating from a related E/M service provided within the previous 7 days no leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes • 99442: 11-20 minutes • 99443: 21-30 minutes *Online assessment CPT 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 • 99444: Online evaluation and management services provided by a physician or other qualified health care professional

Metric #6 (continued)

Metric #6: Any SUD Treatment	
Metric element	**Description**
Numerator (continued)	*Online assessment HCPCS codes:* • 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 *Place of service code:* • 58 – Non-residential Opioid Treatment Facility *IAD HEDIS MY 2021 Value Sets:* • IAD Stand Alone Outpatient Value Set • Observation Value Set • Visit Setting Unspecified Value Set with a corresponding code from Outpatient POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Non-residential Substance Abuse Treatment Facility POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Telehealth POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Community Mental Health Center POS Value Set - Note: The state should ensure that the visit was in an outpatient setting, intensive outpatient, or partial hospitalization setting • IAD Stand Alone IOP/PH Value Set • Visit Setting Unspecified Value Set with a corresponding code from Partial Hospitalization POS Value Set Be sure to include any of the below services if they were billed with a code from the Telehealth Modifier Value Set or with a POS code 2 or 10, indicating a telehealth service: • IAD Stand Alone Outpatient Value Set • Observation Value Set • Visit Setting Unspecified Value Set with a corresponding code from Non-residential Substance Abuse Treatment Facility POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Community Mental Health Center POS Value Set • The state should ensure that the visit was in an outpatient setting *HEDIS MY 2021 IET Value Sets:* • Telephone Visits Value Set • Detoxification Value Set • ED Value Set • Inpatient Stay Value Set • Online Assessments Value Set

Metric #6 (continued)

Metric #6: Any SUD Treatment	
Metric element	**Description**
Numerator (continued)	*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 • G2251: Brief communication technology-based service by a qualified health care progression who cannot report evaluation and management services for an established patient Step 4. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Step 1a or Step 1b **OR** Step 2 **OR** Steps 3a and 3b
Additional guidance	Beginning in Version 5.0 of the technical specifications manual, three telephone E&M CPT codes (99441, 99442, and 99443) and one online assessment code (99444) were added to the numerator specification for this metric to capture services provided via telephone and online. In addition, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and two telehealth place of service codes (2 and 10) were added to the numerator specification. NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. The Version 5.0 manual includes specifications and value sets that align with HEDIS MY 2021. The HEDIS MLD for MY 2021 is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. Previous versions of the MLD are also available in the NCQA Store. The state may use newer versions of the HEDIS MLD as they are released, even if those versions are not yet reflected in updated technical specifications, as long as they align with the applicable measurement period for a metric. For CMS-constructed metrics, the state should note the following: • For monthly or quarterly metrics, the state should use the MLD that aligns with the calendar year in which the measurement period occurs. For example, to report Metric #6 for December 2021, the state should use the MY 2021 MLD. • For annual metrics, the state should use the MLD that aligns with the calendar year in which the state's demonstration period ended. For example, to report Metric #28 for a demonstration year that ends on February 28, 2022, the state should use the MY 2022 MLD. • For other annual metrics that span more than one calendar year, such as Metric #4, for which the measurement period is the demonstration year and a 12-month look back period, the state should use the MLD that aligns with the calendar year in which the state's demonstration year ended. For example, to report Metric #4 for a demonstration year that ends on December 31, 2021, the state should use the MY 2021 MLD.

Metric #6 (continued)

Metric #6: Any SUD Treatment	
Metric element	**Description**
Additional guidance (continued)	Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads). Additional guidance on accessing HEDIS medication lists and 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: o 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 receiving ***prescription medication***, identify claims in the measurement period using the date the prescription was filled. • To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service. This metric includes all SUD treatment services captured in Metrics #7 -12, in addition to any SUD treatment services not captured in those metrics. See **Appendix E: Additional Guidance for Section 1115 SUD Service Utilization Metrics #7-12** for more information on counting beneficiaries in Metrics #6 -12. The 1115 SUD Monitoring Metrics Supporting Information V5.zip file, which is accessible to the state through PMDA in the Reference Materials section, includes a crosswalk of value sets and codes (Metrics #7-12 Crosswalk) that identifies instances in which overlaps in coding occur, as well as guidance on assigning service codes to metrics in these instances.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	Any beneficiary receiving the services captured by Metrics #7-12 would also be counted once in the numerator of Metric #6, which assesses the number of unique beneficiaries who received at least one SUD treatment service of any type. Note that the sum of the numerators of Metrics #7-12 would not necessarily equal the numerator of Metric #6 because a beneficiary can be counted in the numerator of more than one of these metrics (Metrics #7-12) but will only be counted once in Metric #6. Beneficiaries counted in the numerator of Metrics #5, 23, and 24 should be counted once in the numerator of Metric #6
Data source	Claims

Metric #6 (continued)

Metric #6: Any SUD Treatment	
Metric element	**Description**
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #7: Early Intervention	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) 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 total) with a service claim for early intervention services (such as procedure codes associated with SBIRT) during the measurement period Step 1. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 2. Among claims identified in Step 1, retain claims with one of the following HCPCS or CPT codes: • H0049 (HCPCS code) – alcohol and/or drug screening • H0050 (HCPCS code) – alcohol and/or drug screening, brief intervention, per 15 minutes • G0396 (HCPCS code) – alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention, 15 to 30 minutes • G0397 (HCPCS code) - alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention, > 30 minutes • 99408 (CPT code) – alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes • 99409 (CPT code) – alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; greater than 30 minutes Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim 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.** **Appendix E: Additional Guidance for Section 1115 SUD Service Utilization Metrics #7-12** provides detailed guidance related to Metrics #7-12. See below for a summary of key guidance related to this metric: • If a given service qualifies for more than one of the level of care service utilization metrics (Metrics #7-10), the service should be assigned to only one metric based on the information below (in which Priority #1 is the highest priority level) o Priority #1 - Metric #10: Residential and Inpatient Services o Priority #2 - Metric #9: Intensive Outpatient or Partial Hospitalization Services o Priority #3 - Metric #7: Early Intervention o Priority #4 - Metric #8: Outpatient Services

Metric #7 *(*continued*)*

Metric #7: Early Intervention	
Metric element	**Description**
Additional guidance (continued)	• If a given service qualifies for one of the level of care metrics listed above and one of the two modality-based service utilization metrics (Metrics #11 and 12) the service should be assigned to both the level of care metric and the modality-based metric. • For more information, including guidance on assigning beneficiaries that receive services in multiple care settings on the same date and from the same billing provider to service utilization metrics, see **Appendix E.** The 1115 SUD Monitoring Metrics Supporting Information V5.zip file, which is accessible to the state through PMDA in the Reference Materials section, includes a crosswalk of value sets and codes (Metrics #7-12 Crosswalk) that identifies instances in which overlaps in coding occur, as well as guidance on assigning service codes to metrics in these instances. Assigning claims to a measurement period: • To count beneficiaries for this metric, identify claims qualifying for Step 2 above using the end date of service.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	All beneficiaries included in the numerator of this metric should also be included in the numerator of Metric #6. The state should develop Metrics #7-10 simultaneously; if a given service qualifies for more than one of these metrics, it should be assigned to only one metric based on the hierarchy provided in the additional guidance section above.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #8: Outpatient Services	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) 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 number of unique beneficiaries (de-duplicated total) with a claim for outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step-down care, and monitoring for stable patients) during the measurement period Step 1. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 2. Among claims identified in Step 1, claims with a code from any of the following HEDIS MY 2021 Value Sets, another telehealth HCPCS code, a telephone CPT code, another online assessment CPT or HCPCS code, or place of service code: *HEDIS MY 2021 Value Sets:* • IAD Stand Alone Outpatient Value Set • Observation Value Set • Visit Setting Unspecified Value Set with a corresponding code from Outpatient POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Non-residential Substance Abuse Treatment Facility Value Set • Visit Setting Unspecified Value Set with a corresponding code from Community Mental Health Center POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Telehealth POS Value Set • Online Assessments Value Set • Telephone Visits Value Set Note: The state should ensure that the visit was in an outpatient setting, and should include any of the above services billed with a code from the Telehealth Modifier Value Set, or with a POS code 2 or 10, indicating a telehealth service. *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 • G2251: Brief communication technology-based service by a qualified health care progression who cannot report evaluation and management services for an established patient

Metric #8 (continued)

Metric #8: Outpatient Services	
Metric element	**Description**
Numerator (continued)	*Telephone E&M CPT codes:* • 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, not originating from a related E/M service provided within the previous 7 days no leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes • 99442: 11-20 minutes • 99443: 21-30 minutes *Online assessment CPT 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 • 99444: Online evaluation and management services provided by a physician or other qualified health care professional *Online assessment HCPCS codes:* • 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 *Place of service code:* • 58 – Non-residential Opioid Treatment Facility Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Steps 1 and 2
Additional guidance	Beginning in Version 5.0 of the technical specifications manual, three telephone E&M CPT codes (99441, 99442, and 99443) and one online assessment code (99444) were added to the numerator specification for this metric to capture services provided via telephone and online. In addition, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and two telehealth place of service codes (2 and 10) were added to the numerator specification. 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**

Metric #8 (continued)

Metric #8: Outpatient Services	
Metric element	**Description**
Additional guidance (continued)	**Appendix E: Additional Guidance for Section 1115 SUD Service Utilization Metrics #7-12** provides detailed guidance related to Metrics #7-12. See below for a summary of key guidance related to this metric: • If a given service qualifies for more than one of the level of care service utilization metrics (Metrics #7-10), the service should be assigned to only one metric based on the information below (in which Priority #1 is the highest priority level) o Priority #1 - Metric #10: Residential and Inpatient Services o Priority #2 - Metric #9: Intensive Outpatient or Partial Hospitalization Services o Priority #3 - Metric #7: Early Intervention o Priority #4 - Metric #8: Outpatient Services • If a given service qualifies for one of the level of care metrics listed above and one of the two modality-based service utilization metrics (Metrics #11 and 12) the service should be assigned to both the level of care metric and the modality-based metric. • For more information, including guidance on assigning beneficiaries that receive services in multiple care settings on the same date and from the same billing provider to service utilization metrics, see **Appendix E.** The 1115 SUD Monitoring Metrics Supporting Information V5.zip file, which is accessible to the state through PMDA in the Reference Materials section, includes a crosswalk of value sets and codes (Metrics #7-12 Crosswalk) that identifies instances in which overlaps in coding occur, as well as guidance on assigning service codes to metrics in these instances. Assigning claims to a measurement period: • To count beneficiaries for this metric, identify claims qualifying for Step 2 above using the end date of service. Community Mental Health Centers (CMHCs, POS=53) can provide multiple levels of outpatient care. Therefore, use supplemental information to identify whether a service is intensive outpatient, partial hospitalization or other outpatient. Supplemental information could include other coding on the claim such as procedure or revenue codes from the IAD Stand Alone IOP/PH Value Set or AD Stand Alone Outpatient Value Set or state defined procedure codes that distinguish between intensive outpatient, partial hospitalization, or other outpatient. Likewise, supplemental information could be facility-level information, such as the services the facility is certified to provide to Medicaid beneficiaries.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	All beneficiaries included in the numerator of this metric should also be included in the numerator of Metric #6. The state should develop Metrics #7-10 simultaneously; if a given service qualifies for more than one of these metrics, it should be assigned to only one metric based on the hierarchy provided in the additional guidance section above.
Data source	Claims

Metric #8 (continued)

Metric #8: Outpatient Services	
Metric element	**Description**
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #9: Intensive Outpatient and Partial Hospitalization Services	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) 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 total) who have a service or pharmacy claim for intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy and other clinical services) during the measurement period Step 1. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 2. Among claims identified in Step 1, identify claims with a code from any of the following IAD HEDIS MY 2021 Value Sets: • IAD Stand Alone IOP/PH Value Set • Visit Setting Unspecified Value Set with a corresponding code from Partial Hospitalization POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Community Mental Health Center POS Value Set Note: The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting. Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim 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.** **Appendix E: Additional Guidance for Section 1115 SUD Service Utilization Metrics #7-12** provides detailed guidance related to Metrics #7-12. See below for a summary of key guidance related to this metric: • If a given service qualifies for more than one of the level of care service utilization metrics (Metrics #7-10), the service should be assigned to only one metric based on the information below (in which Priority #1 is the highest priority level) o Priority #1 - Metric #10: Residential and Inpatient Services o Priority #2 - Metric #9: Intensive Outpatient or Partial Hospitalization Services o Priority #3 - Metric #7: Early Intervention o Priority #4 - Metric #8: Outpatient Services • If a given service qualifies for one of the level of care metrics listed above and one of the two modality-based service utilization metrics (Metrics #11 and 12) the service should be assigned to both the level of care metric and the modality-based metric.

Metric #9 *(*continued*)*

Metric #9: Intensive Outpatient and Partial Hospitalization Services	
Metric element	**Description**
Additional guidance (continued)	• For more information, including guidance on assigning beneficiaries that receive services in multiple care settings on the same date and from the same billing provider to service utilization metrics, see **Appendix E.** The 1115 SUD Monitoring Metrics Supporting Information V5.zip file, which is accessible to the state through PMDA in the Reference Materials section, includes a crosswalk of value sets and codes (Metrics #7-12 Crosswalk) that identifies instances in which overlaps in coding occur, as well as guidance on assigning service codes to metrics in these instances. Assigning claims to a measurement period: • To count beneficiaries for this metric, identify claims qualifying for Step 2 above using the end date of service. CMHCs (POS=53) can provide multiple levels of outpatient care. Therefore, use supplemental information to identify whether a service is an intensive outpatient, partial hospitalization or other outpatient service (counted in Metric #8). Supplemental information could include other coding on the claim such as procedure or revenue codes from IAD Stand Alone IOP/PH Value Set or IAD Stand Alone Outpatient Value Set or state-defined procedure codes that distinguish between intensive outpatient, partial hospitalization, or other outpatient services. Likewise, supplemental information could be facility level information such as the services the facility is certified to provide to Medicaid beneficiaries.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	All beneficiaries included in the numerator of this metric should be included in the numerator in Metric #6. The state should develop Metrics #7-10 simultaneously; if a given service qualifies for more than one of these metrics, it should be assigned to only one metric based on the hierarchy provided in the additional guidance section above.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #10: Residential and Inpatient Services	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who use residential and/or inpatient services for SUD 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 total) who have a service for residential and/or inpatient services for SUD during the measurement period Step 1. Identify claims for residential treatment: Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 55 – Residential Substance Abuse Treatment Facility *HCPCS Codes:* • H0010 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) • H0011 – Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) *UB Revenue Codes:* • 1002 – Residential treatment – chemical dependency Step 1b. Identify claims with a place of service, HCPCS, or UB Revenue code listed below and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Code Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set *Place of Service Codes:* • 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 Note: The state should ensure that the claim represents a residential treatment service. Other outpatient services provided at a residential treatment facility to non-residential beneficiaries should not be included. Step 2. Identify claims that have a revenue code from the Inpatient Stay Value Set and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Code Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Steps 1a or 1b or 2

Metric #10 (continued)

Metric #10: Residential and Inpatient Services	
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.** **Appendix E: Additional Guidance for Section 1115 SUD Service Utilization Metrics #7-12** provides detailed guidance related to Metrics #7-12. See below for a summary of key guidance related to this metric: • If a given service qualifies for more than one of the level of care service utilization metrics (Metrics #7-10), the service should be assigned to only one metric based on the information below (in which Priority #1 is the highest priority level) o Priority #1 - table Metric #10: Residential and Inpatient Services o Priority #2 - Metric #9: Intensive Outpatient or Partial Hospitalization Services o Priority #3 - Metric #7: Early Intervention o Priority #4 - Metric #8: Outpatient Services • If a given service qualifies for one of the level of care metrics listed above and one of the two modality-based service utilization metrics (Metrics #11 and 12) the service should be assigned to both the level of care metric and the modality-based metric. • For more information, including guidance on assigning beneficiaries that receive services in multiple care settings on the same date and from the same billing provider to service utilization metrics, see **Appendix E**. The 1115 SUD Monitoring Metrics Supporting Information V5.zip file, which is accessible to the state through PMDA in the Reference Materials section, includes a crosswalk of value sets and codes (Metrics #7-12 Crosswalk) that identifies instances in which overlaps in coding occur, as well as guidance on assigning service codes to metrics in these instances. 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: o Combine claims for the same beneficiary, provider and admission date; or o 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.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations

Metric #10 (continued)

Metric #10: Residential and Inpatient Services	
Metric element	**Description**
Relationship to other metrics	All beneficiaries included in the numerator of this metric should be included in the numerator of Metric #6. The state should develop Metrics #7-10 simultaneously; if a given service qualifies for more than one of these metrics, it should be assigned to only one metric based on the hierarchy provided in the additional guidance section above.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #11: Withdrawal Management	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) 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 total) with a service or pharmacy claim for withdrawal management services during the measurement period Step 1. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 2. Among claims identified in Step 1, retain claims with a code in the HEDIS MY 2021 Detoxification Value Set. Step 3. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim 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.** **Appendix E: Additional Guidance for Section 1115 SUD Service Utilization Metrics #7-12** provides detailed guidance related to Metrics #7-12. See below for a summary of key guidance related to this metric: • If a given service qualifies for one of the level of care metrics (Metrics #7-10) and one of the two modality-based service utilization metrics (Metrics #11 and #12) the service should be assigned to both the level of care metric and the modality-based metric. • For more information, including guidance on assigning beneficiaries that receive services in multiple care settings on the same date and from the same billing provider to service utilization metrics, see **Appendix E.** The 1115 SUD Monitoring Metrics Supporting Information V5.zip file, which is accessible to the state through PMDA in the Reference Materials section, includes a crosswalk of value sets and codes (Metrics #7-12 Crosswalk) that identifies instances in which overlaps in coding occur, as well as guidance on assigning service codes to metrics in these instances.

Metric #11 *(*continued*)*

Metric #11: Withdrawal Management	
Metric element	**Description**
Additional guidance (continued)	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: o Combine claims for the same beneficiary, provider and admission date; or o 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 metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	All beneficiaries included in the numerator of this metric should be included in the numerator in Metric #6.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #12: Medication-Assisted Treatment	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of beneficiaries who have a claim for MAT for SUD 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 number of unique beneficiaries (de-duplicated total) who have a claim for a MAT dispensing event for SUD during the measurement period Step 1. Identify claims with a code from the following HEDIS MY 2021 Value Sets or Medications Lists: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medication Lists • Opioid Use Disorder Treatment Medication Lists Step 2. Determine the total number of unique beneficiaries (de-duplicated) with at least one claim that meet the criteria in Step 1
Additional guidance	NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. The Version 5.0 manual includes specifications and value sets that align with HEDIS MY 2021. The HEDIS MLD for MY 2021 is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. Previous versions of the MLD are also available in the NCQA Store. The state may use newer versions of the HEDIS MLD as they are released, even if those versions are not yet reflected in updated technical specifications, as long as they align with the applicable measurement period for a metric. For CMS-constructed metrics, the state should note the following: • For monthly or quarterly metrics, the state should use the MLD that aligns with the calendar year in which the measurement period occurs. For example, to report Metric #6 for December 2021, the state should use the MY 2021 MLD. • For annual metrics, the state should use the MLD that aligns with the calendar year in which the state's demonstration period ended. For example, to report Metric #28 for a demonstration year that ends on February 28, 2022, the state should use the MY 2022 MLD. • For other annual metrics that span more than one calendar year, such as Metric #4, for which the measurement period is the demonstration year and a 12-month look back period, the state should use the MLD that aligns with the calendar year in which the state's demonstration year ended. For example, to report Metric #4 for a demonstration year that ends on December 31, 2021, the state should use the MY 2021 MLD. Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads). Additional guidance on accessing HEDIS medication lists and 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.**

Metric #12 *(*continued*)*

Metric #12: Medication-Assisted Treatment	
Metric element	**Description**
Additional guidance (continued)	**Appendix E: Additional Guidance for Section 1115 SUD Service Utilization Metrics #7-12** provides detailed guidance related to Metrics #7-12. See below for a summary of key guidance related to this metric: • If a given service qualifies for one of the level of care metrics (Metrics #7-10) and one of the two modality-based service utilization metrics (Metrics #11 and 12) the service should be assigned to both the level of care metric and the modality-based metric. • For more information, including guidance on assigning beneficiaries that receive services in multiple care settings on the same date and from the same billing provider to service utilization metrics, see **Appendix E.** The 1115 SUD Monitoring Metrics Supporting Information V5.zip file, which is accessible to the state through PMDA in the Reference Materials section, includes a crosswalk of value sets and codes (Metrics #7-12 Crosswalk) that identifies instances in which overlaps in coding occur, as well as guidance on assigning service codes to metrics in these instances. Assigning claims to a measurement period: • To count beneficiaries receiving ***prescription medication***, identify claims in the measurement period using the date the prescription was filled. • 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 metric
Subpopulation categories	Age group (required) Dual-eligible status (required) Pregnancy status (required) Criminal justice status (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	All beneficiaries included in the numerator of this metric should be included in the numerator in Metric #6.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #13: SUD Provider Availability	
Metric element	Description
Measure sets/ endorsements	None
Description	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.
Population of interest	SUD providers who were enrolled in Medicaid and qualified to deliver Medicaid services during the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of eligible SUD providers
Additional guidance	Standards for classifying, enrolling, and qualifying SUD providers vary by state. Sources for SUD provider data also vary by state. These data may be available in provider enrollment databases maintained by the state, managed care organizations, behavioral health organizations, or prepaid inpatient health plans. Depending on the state, a Single State Agency, other state agency, or a nongovernmental organization affiliated with national credentialing bodies may be responsible for licensure and certification of programs and counselors offering specialty SUD treatment; these agencies or organizations may maintain records that can be linked to Medicaid data on provider enrollment. The state may wish to report counts for provider subgroups. For example, the state could report subgroups based on: • **Licensure/certification.** SUD providers may include medical doctors, nurse practitioners, licensed clinical or master's-level social workers, licensed counselors, and other staff such as certified addiction counselors or peer specialists. • **Provider classification codes.** These codes define health care service providers by type or area of specialization. The state may have to link provider enrollment data to claims data to report on subgroups by provider classification codes if these codes are not included in provider enrollment databases. Claims include National Provider Identifier (NPI) numbers which can be mapped to provide taxonomy codes using the following crosswalk: http://download.cms.gov/nppes/NPI_Files.html
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	Providers counted in Metric #14 are a subset of the providers counted in this metric.
Data source	Provider enrollment database Claims (if necessary)
Claim type	If using claims, only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: The state should report this metric 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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other

Metric #13 *(*continued*)*

considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #14: SUD Provider Availability - MAT	
Metric element	**Description**
Measure sets/ endorsements	None
Description	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.
Population of interest	SUD providers who were enrolled and qualified to deliver Medicaid services during the measurement period and who meet standards to provide buprenorphine or methadone as part of MAT. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of eligible SUD providers who meet the standards to provide buprenorphine or methadone as part of MAT
Additional guidance	Standards for classifying, enrolling, and qualifying SUD providers vary by state. Sources for SUD provider data also vary by state. These data may be available in provider enrollment databases maintained by the state, managed care organizations, behavioral health organizations, or prepaid inpatient health plans. Depending on the state, a Single State Agency, other state agency, or a nongovernmental organization affiliated with national credentialing bodies may be responsible for licensure and certification of programs and counselors offering specialty SUD treatment; these agencies or organizations may maintain records that can be linked to Medicaid data on provider enrollment. To identify SUD providers who may provide buprenorphine or methadone, the state may need to link provider enrollment data to two data sources maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA): 1. Methadone can only be dispensed through an opioid treatment program certified by SAMHSA. SAMHSA maintains a public list of such programs at: https://dpt2.samhsa.gov/treatment/directory.aspx. 2. Buprenorphine may be prescribed or dispensed by qualified physicians in a variety of settings. Opioid treatment programs are allowed to offer buprenorphine. SAMHSA tracks the number of practitioners who have a waiver to dispense buprenorphine by state; see https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians. SAMHSA also maintains a locator for buprenorphine treatment practitioners at https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator The state may wish to report counts for provider subgroups. For example, the state could report subgroups based on: • **Buprenorphine and methadone providers.** The state may report providers separately based on whether the providers are qualified to provide buprenorphine or methadone as part of MAT. If a provider is qualified to provide both, count them in each group. Naltrexone is not included in this metric and should not be used as a provider subgroup because it may be prescribed by any provider with prescribing privileges. • **Licensure/certification.** SUD providers may include medical doctors, nurse practitioners, licensed clinical or master's-level social workers, licensed counselors, and other staff such as certified addiction counselors or peer specialists. • **Provider classification codes.** These codes define health care service providers by type, classification, and area of specialization. The state may have to link provider enrollment data to claims data to report on subgroups by provider classification codes if these codes are not included in provider enrollment databases. Claims include National Provider Identifier (NPI) numbers which can be mapped to provide taxonomy codes using the following crosswalk: http://download.cms.gov/nppes/NPI_Files.html

Metric #14 *(*continued*)*

Metric #14: SUD Provider Availability - MAT	
Metric element	**Description**
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	Providers counted in this metric are a subset of the providers counted in Metric #13.
Data source	Provider enrollment database Claims (if necessary) SAMHSA Opioid Treatment Program Directory (if necessary) SAMHSA Number of DATA-Waived Practitioners Newly Certified by Year (if necessary) SAMHSA Buprenorphine Treatment Practitioner Locator (if necessary)
Claim type	If using claims, 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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-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 #0004 Measure steward: NCQA
Description	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.
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 Core Set 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.** The Adult Core Set measure IET-AD: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment provides instructions for reporting beneficiaries in several diagnosis cohorts, including an opioid abuse or dependence cohort. For this metric, the state should report this cohort as instructed in the Adult Core Set technical specifications for measure IET-AD. Please use the measure steward's instructions for identifying the OUD population for this metric, which differs from the general guidance in Chapter I of this document.
Measurement period (Metric type)	Calendar Year (Established quality measure)
Reporting category	Annual metric that is an established quality measure
Subpopulation categories	None[a]
Relationship to other metrics	None
Data source	Claims or EHR
Claim type	Use 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

[a] This metric provides instructions for reporting beneficiaries in several diagnosis cohorts, including an opioid abuse or dependence cohort. These instructions differ from the general guidance for identifying the OUD subpopulation provided in Table 2 of this document. The state should use the specifications provided by the measure steward to identify the opioid abuse or dependence cohort for this metric.

Metric #16: SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge, SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	
Metric element	**Description**
Measure sets/ endorsements	The Joint Commission National Quality Measures Measure steward: The Joint Commission
Description	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse, at discharge, a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. The measure is reported as an overall rate which includes all patients to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. 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 (v2021B2); see measure SUB-3, Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge, and measure SUB-3a, Alcohol & Other Drug Use Disorder Treatment at Discharge.
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/TJC2021B2/MIF0221.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 metric that is an established quality measure
Subpopulation categories	None
Relationship to other metrics	None
Data source	Medical record review or claims
Claim type	Not specified

Note: Version of Specification: Joint Commission National Quality Measures Manual version 2021B2.
The Joint Commission measure is specified at the hospital level, however these metrics request reporting at the state level.

Metric #17(1): 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 Core Set 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 metric that is an established quality measure
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use 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 #17(2): 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 Core Set 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 metric that is an established quality measure
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Use 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 #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #2940 Measure steward: PQA
Description	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.
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 Core Set Measure Specifications.**
Additional guidance	Detailed instructions for accessing PQA 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 metric that is an established quality measure
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: Adult Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting, March 2022

Metric #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	
Metric element	**Description**
Measure sets/ endorsements	NQF #2950 Measure steward: PQA
Description	The percentage of individuals ≥ 18 years of age who received prescriptions for opioids from ≥ 4 prescribers AND ≥ 4 pharmacies within ≤ 180 days.
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications.
Metric calculation	Note that the measure steward's specifications refer to multiple types of payers. For the purpose of SUD demonstration monitoring, the state should calculate this metric for the Medicaid population. Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid. Instructions for calculating this metric are provided in the full measure specification (2022_PQA_MeasureManual_20220309_Opioids.pdf) in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible to the state through PMDA in the Reference Materials section.
Additional guidance	Detailed instructions for accessing the specifications and value sets for this measure 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 metric that is an established quality measure
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	
Metric element	**Description**
Measure sets/ endorsements	NQF #2951 Measure steward: PQA
Description	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.
Population of interest	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications.
Metric calculation	Note that the measure steward specifications refer to multiple types of payers. For the purpose of SUD demonstration monitoring, the state should calculate this metric for the Medicaid population. Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid. Instructions for calculating this metric are provided in the full measure specification (2022_PQA_MeasureManual_20220309_Opioids.pdf) in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible to the state through PMDA in the Reference Materials section.
Additional guidance	Detailed instructions for accessing the specifications and value sets for this measure 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 metric that is an established quality measure
Subpopulation categories	None
Relationship to other metrics	None
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	
Metric element	**Description**
Measure sets/ endorsements	FFY 2022 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) NQF #3389 Measure steward: PQA
Description	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.
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 Core Set Measure Specifications.**
Additional guidance	Detailed instructions for accessing PQA 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 metric that is an established quality measure
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: Adult Core Set Technical Specifications and Resource Manual for Federal Fiscal Year 2022 Reporting, March 2022

Metric #22: Continuity of Pharmacotherapy for Opioid Use Disorder	
Metric element	**Description**
Measure sets/ endorsements	Measure steward: USC NQF #3175
Description	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment.
Population of interest	All Medicaid beneficiaries within the initial population defined in the measure steward's specifications.
Metric calculation	Note that the measure steward's specifications refer to Medicare beneficiaries in the population definition. For the purpose of SUD demonstration monitoring, the state should calculate this metric for the Medicaid population. Instructions for calculating this metric are provided in the full measure specification (USC Measure Specifications and Value Set Directory) in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible to the state through PMDA in the Reference Materials section.
Additional guidance	Detailed instructions for accessing the specifications and code lists for this measure can be found in **Appendix C: How to use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** Note that the OUD code list for this metric is backwards compatible and should be applied to both the current measurement period and the look back period.
Measurement period (Metric type)	Calendar Year (Established quality measure)[a]
Reporting category	Annual metric that is an established quality measure
Subpopulation categories	None[b]
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: December 2017

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

[b] The specifications provided by the measure steward include instructions for identifying the OUD population, which differ from the general guidance for identifying the OUD subpopulation provided in Chapter I of this document. The state should use the specifications provided by the measure steward to identify the OUD population for this metric.

Metric #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Total number of ED visits for SUD per 1,000 beneficiaries in 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 number of ED visits for SUD during the measurement period Step 1. Identify all claims for ED visits during the measurement period using the HEDIS MY 2021 ED Value Set. Count each visit to an ED once, regardless of the intensity or duration of the visit. Step 2. Identify the dates of service for each visit identified in Step 1. Retain only visits with an end date of service within the measurement period. Count multiple ED visits on the same date of service as one visit. Step 3. Among claims retained in Step 2, identify the subset of claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 4. Calculate the number of ED visits meeting the criteria in Steps 1, 2, and 3.
Denominator	Number of beneficiaries in the population of interest When determining the subpopulation denominator, limit the overall population denominator to those beneficiaries meeting the criteria for the subpopulation of interest. For the OUD subpopulation, include any beneficiary with an OUD diagnosis during the measurement period and/or in the 11 months before the measurement period.
Metric calculation	Calculate the rate by dividing the number of ED visits in the numerator by the number of beneficiaries in the denominator and then multiply by 1,000, as follows: (Number of ED visits / Number of beneficiaries) * 1,000
Additional guidance	Instructions for accessing HEDIS value sets are provided in **Appendix C: How to use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics.** Use the service end date to identify claims in the measurement period. Count visits to the ED based on the discharge date.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) OUD diagnosis State-specific subpopulation
Relationship to other metrics	The denominator of this metric is the same as the denominator of Metric #24. The denominator for the OUD subpopulation for this metric is the same as the numerator for the OUD subpopulation in Metric #3.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #23 (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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Total number of inpatient stays per 1,000 beneficiaries in 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 number of inpatient discharges related to a SUD stay during the measurement period Step 1. Identify all inpatient stays (acute and nonacute) during the measurement period using the HEDIS MY 2021 Inpatient Stay Value Set. Step 2. Identify and exclude claims for residential treatment using the UB Revenue codes listed below: • 1001 – Residential treatment, psychiatric • 1002 – Residential treatment – chemical dependency Step 3. Identify the discharge date for the stay. Retain only stays with discharge dates that fall within the measurement period. Step 4. Among claims retained in Step 3, identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 5. Calculate the number of inpatient discharges meeting the criteria in Steps 1, 2, 3, and 4.
Denominator	Number of beneficiaries in the population of interest When determining the subpopulation denominator, limit the overall population denominator to those beneficiaries meeting the criteria for the subpopulation of interest. For the OUD subpopulation, include any beneficiary with an OUD diagnosis during the measurement period and/or in the 11 months before the measurement period.
Metric calculation	Calculate the rate by dividing the number of inpatient stays in the numerator by the number of beneficiaries in the denominator and then multiply by 1,000, as follows: (Number of inpatient stays / Number of beneficiaries) * 1,000

Metric #24 *(*continued*)*

Metric #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	
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.** Stays that occur in a residential setting should not be included in the numerator. Assigning claims to a measurement period: • To count beneficiaries using ***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: o Combine claims for the same beneficiary, provider and admission date; or o 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.
Measurement period (Metric type)	Month (CMS-constructed)
Reporting category	Other monthly and quarterly metric
Subpopulation categories	Age group (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	The beneficiaries counted in the denominator of this metric are the same those counted in Metric #23. The denominator for the OUD subpopulation for this metric is the same as the numerator (count) for the OUD subpopulation in Metric #3.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #25: Readmissions Among Beneficiaries with SUD	
Metric element	**Description**
Measure sets/ endorsements	None
Description	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.
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 count of 30-day readmissions: at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date
Denominator	The count of Index Hospital Stays
Metric calculation	Step 1: Identify the Eligible Population Among beneficiaries in the population of interest, identify beneficiaries with at least one claim during the measurement period with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value set Step 2: Calculate the Denominator: Count of Index Hospital Stays Step 2a. Among beneficiaries identified in Step 1, identify all acute inpatient discharges with any diagnosis in the first 11 months of the measurement year. To identify acute inpatient discharges: • Identify all acute and nonacute inpatient stays (HEDIS MY 2021 Inpatient Stay Value Set). • Exclude nonacute inpatient stays (HEDIS MY 2021 Nonacute Inpatient Stay Value Set). • Determine whether the discharge date for the stay falls in the first 11 months of the measurement year. Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. This measure includes acute discharges from any type of acute facility (including behavioral healthcare facilities). Step 2b. Address acute-to-acute direct transfers as described below in “Additional Guidance.” Exclude the hospital stay if the direct transfer’s discharge date occurs in the last 30 days of the measurement year. Step 2c. Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date. Step 2d. Exclude hospital stays for the following reasons: • The beneficiary died during the stay. • Female beneficiaries with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim. Note: For hospital stays where there was an acute-to-acute direct transfer (identified in Step 2), use both the original stay and the direct transfer stay to identify exclusions in this step. Step 2e. To calculate the count of Index Hospital Stays (i.e., the denominator), count the number of Index Hospital Stays that meet the criteria in Steps 2a-2d.

Metric #25 *(*continued*)*

Metric #25: Readmissions Among Beneficiaries with SUD	
Metric element	**Description**
Metric calculation (continued)	Step 3: Calculate the Numerator: Count of 30-day Readmissions (at least one acute readmission for any diagnosis within 30 days of the index discharge date): Step 3a. Among beneficiaries identified in Step 1, identify all acute inpatient stays with an admission date in the measurement year, excluding the first two days of the measurement year. To identify acute inpatient admissions: • Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). • Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). • Identify the admission date for the stay to determine whether it falls in the measurement year. Exclude stays with an admission date on the first two days of the year. Note: Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. If these stays are consolidated into a single event (for any reason), the original distinct inpatient stays must be used. Step 3b. Address acute-to-acute direct transfers as described below in "Additional Guidance." Step 3c. Exclude acute inpatient hospital admissions with any of the following on the discharge claim: • Female beneficiaries with a principal diagnosis of pregnancy (HEDIS MY 2021 Pregnancy Value Set) • A principal diagnosis for a condition originating in the prenatal period (HEDIS MY 2021 Perinatal Conditions Value Set) • Planned admissions using any of the following: o A principal diagnosis of maintenance chemotherapy (HEDIS MY 2021 Chemotherapy Encounter Value Set and Chemotherapy Procedure Value Set) o A principal diagnosis of rehabilitation (HEDIS MY 2021 Rehabilitation Value Set) o An organ transplant (HEDIS MY 2021 Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set) o A potentially planned procedure (HEDIS MY 2021 Potentially Planned Procedures Value Set) without a principal acute diagnosis (HEDIS MY 2021 Acute Conditions Value Set) Note: For hospital stays where there was an acute-to-acute direct transfer (identified in step 3b), use both the original stay and the direct transfer stay to identify exclusions in this step. Step 3d. For each Index Hospital Stay, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date. Step 3e. To calculate the count of 30-day Readmissions (i.e., the numerator), count the number of Index Hospital Stays (from Step 2e) with a readmission within 30 days of discharge. Step 4: Calculate the Readmission Rate: To calculate the readmission rate, divide the count of 30-day Readmissions (from Step 3e) by the count of Index Hospital Stays (from Step 2e). Note: A stay can be both an index admission and a readmission if it meets the criteria for both.

Metric #25 *(*continued*)*

Metric #25: Readmissions Among Beneficiaries with SUD	
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.** Acute stays that also have non-acute codes should be included in the metric as acute stays. Stays with only non-acute codes should be excluded as noted in Steps 2 and 3a. For acute-to-acute direct transfers, keep the original admission date as the Index Admission Date, but use the direct transfer's discharge date as the Index Discharge Date. A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify acute-to-acute direct transfers: • Identify all acute and nonacute inpatient stays (HEDIS MY 2021 Inpatient Stay Value Set). • Exclude nonacute inpatient stays (HEDIS MY 2021 Nonacute Inpatient Stay Value Set). • Identify the admission and discharge dates for the stay.
Measurement period (Metric type)	Demonstration Year (CMS-constructed measure)
Reporting category	Other annual metric
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	None
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #26: Drug Overdose Deaths (count)	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration.
Population of interest	All beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period or the 30 days prior to the beginning of the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The number of overdose deaths among beneficiaries in the population of interest Identify beneficiaries with the following ICD-10 codes for underlying cause of death: • X40 – X44 (unintentional drug poisonings) • X60 – X64 (suicidal drug poisonings) • X85 (homicide drug poisoning) • Y10 – Y14 (drug poisoning of undetermined intent)
Additional guidance	Data sources for overdose deaths may vary by state. For example, the state may have access to a centralized state medical examiner system, or may have decentralized systems containing death records. When overdose 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 overdose deaths. To report on the OUD subpopulation for this metric, use the following definition: Among the drug overdose deaths, identify those with the following ICD-10 codes for contributing cause of death: • T40.1 (heroin) • T40.2 (natural and semisynthetic opioids) • T40.3 (methadone) • T40.4 (synthetic opioids other than methadone)
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	Age (required) OUD State-specific subpopulations
Relationship to other metrics	Beneficiaries counted in this metric are used to calculate the rate in Metric #27.
Data source	State data on cause of death
Claim type	Not applicable

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

State-specific codes. The state may use state-specific treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #27: Overdose Deaths (rate)	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration.
Population of interest	All beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period or the 30 days prior to the beginning of the measurement period. Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The number of overdose deaths among beneficiaries in the population of interest Identify beneficiaries with the following ICD-10 codes for underlying cause of death: • X40 – X44 (unintentional drug poisonings) • X60 – X64 (suicidal drug poisonings) • X85 (homicide drug poisoning) • Y10 – Y14 (drug poisoning of undetermined intent)
Denominator	Number of beneficiaries in the population of interest
Metric calculation	Calculate the rate by dividing the number of overdose deaths in the numerator by the number of beneficiaries in the denominator and then multiply by 1,000, as follows: (Number of overdose deaths / Number of beneficiaries) * 1,000
Additional guidance	Data sources for overdose deaths may vary by state. For example, the state may have access to a centralized state medical examiner system, or may have decentralized systems containing death records. When overdose deaths occur, coroners and medical examiners are instructed to record 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 overdose deaths. To report on the OUD subpopulation for this metric, use the following definition: Among the drug overdose deaths, identify those with the following ICD-10 codes for contributing cause of death: • T40.1 (heroin) • T40.2 (natural and semisynthetic opioids) • T40.3 (methadone) • T40.4 (synthetic opioids other than methadone)
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	Age group (required) OUD diagnosis State-specific subpopulations
Relationship to other metrics	Beneficiaries counted in this metric are the same as those counted in Metric #26. Metric #26 calculates a count, whereas Metric #27 expresses that count as a rate.
Data source	State data on cause of death
Claim type	Not applicable

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

State-specific codes. The state may use state-specific treatment, diagnosis, 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

Metric #27 *(*continued*)*

SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #28: SUD Spending	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Total Medicaid SUD spending during the measurement period.
Population of interest	Medicaid SUD spending among 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 on SUD treatment services during the measurement period Step 1. Identify claims for residential treatment Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 55 – Residential Substance Abuse Treatment Facility *HCPCS Codes:* • H0008 – Alcohol and/or drug services; sub-acute detoxification (hospital inpatient) • H0009 – Alcohol and/or drug services; acute detoxification (hospital inpatient) • H0010 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) • H0011 – Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) *UB Revenue Codes:* • 1002 – Residential treatment – chemical dependency Step 1b. Identify claims with a place of service, HCPCS, or UB Revenue code listed below and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Code Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set *Place of Service Codes:* • 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

Metric #28 (continued)

Metric #28: SUD Spending	
Metric element	**Description**
Numerator (continued)	Step 2. Identify claims with a code from the following HEDIS MY 2021 Value Sets or Medications Lists: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medication Lists • Opioid Use Disorder Treatment Medication Lists Step 3. Identify claims for other types of SUD treatment Step 3a. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 3b. Among claims identified in 3a, retain claims with any of the following HCPCS, CPT, or place of service codes or codes from any of the below value sets: *Early intervention CPT codes:* • 99408 (CPT code) – alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; 15 to 30 minutes • 99409 (CPT code) – alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services; greater than 30 minutes *Early intervention HCPCS codes:* • H0049 – alcohol and/or drug screening • H0050 – alcohol and/or drug screening, brief intervention, per 15 minutes • G0396 – alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention, 15 to 30 minutes • G0397 – alcohol and/or substance (other than tobacco) misuse structured assessment and brief intervention, > 30 minutes *Telephone E&M CPT codes:* • 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, not originating from a related E/M service provided within the previous 7 days no leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes • 99442: 11-20 minutes • 99443: 21-30 minutes *Online assessment CPT 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 • 99444: Online evaluation and management services provided by a physician or other qualified health care professional

Metric #28 (continued)

Metric #28: SUD Spending	
Metric element	**Description**
Numerator (continued)	*Online assessment HCPCS codes:* • 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 *Place of service code:* • 58 – Non-residential Opioid Treatment Facility *HEDIS MY 2021 IAD Value Sets:* *Outpatient services:* • IAD Stand Alone Outpatient Value Set • Observation Value Set • Visit Setting Unspecified Value Set with a corresponding code from Outpatient POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Non-residential Substance Abuse Treatment Facility POS Value Set • Visit Setting Unspecified Value Set with a corresponding code from Community Mental Health Center POS Value Set Note: The state should ensure that the visit was in an outpatient setting, and should include any of the above services billed with a code from the Telehealth Modifier Value Set, or with a POS code 2 or 10, indicating a telehealth service. *Intensive outpatient or partial hospitalization services:* • IAD Stand Alone IOP/PH Value Set • Visit Setting Unspecified Value Set with a corresponding code from Partial Hospitalization POS Value Set Note: The state should ensure that the visit was in an intensive outpatient or partial hospitalization setting. *HEDIS MY 2021 IET Value Sets:* • Telephone Visit Value Set • Detoxification Value Set • ED Value Set Value Set • Inpatient Stay Value Set • Online Assessments Value Set *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

Metric #28 (continued)

Metric #28: SUD Spending	
Metric element	**Description**
Numerator (continued)	Step 4. Retain claims that meet the criteria in Step 1a or 1b, or Step 2, or Step 3a and 3b. Step 5. Sum the total amount paid by Medicaid on FFS 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. Sum the amount paid by Medicaid for these managed care encounters identified in Step 4. 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 SUD encounters. • Determine the FFS cost to Medicaid for a service (such as by using an FFS Medicaid physician fee schedule) and apply that figure to encounter claims for the same service. This method may not be appropriate if there are no FFS claims for the same service types to use as a reference. Many states maintain the FFS fee schedules and frequently make them publicly available. • Use a Medicaid-to-Medicare Fee Index. These indices enable researchers to assume that Medicaid rates for a given service are set at a certain percentage of Medicare rates. In other words, they estimate the Medicaid fees for each state relative to the Medicare fees and provide a conversion factor. For each service, apply the conversion factor to the Medicare fee schedule to estimate the cost to Medicaid. o An example of Medicaid-to-Medicare fee comparisons is MACPAC's comparison of medical hospital payments between Medicaid and Medicare, available at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf. o The Medicare fee schedule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html. CMS's searchable Medicare Physician Fee schedule contains Medicare payment information for more than 10,000 services and can be found at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx. • Use Medicaid FFS equivalent amounts for encounter records reported in T-MSIS. 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 7. Sum the amount paid by Medicaid from Step 5 and Step 6 to determine total Medicaid SUD spending during the measurement period.

Metric #28 (continued)

Metric #28: SUD Spending	
Metric element	**Description**

Additional guidance	Beginning in Version 5.0 of the technical specifications manual, three telephone E&M CPT codes (99441, 99442, and 99443) and one online assessment code (99444) were added to the numerator specification for this metric to capture services provided via telephone and online. In addition, two early intervention CPT codes (99048 and 99409) and two telehealth place of service codes (2 and 10) were added to the numerator specification.
	
	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 receiving ***prescription medication***, identify claims in the measurement period using the date the prescription was filled.
	• To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service.
	
	If the state uses fee schedules to calculate this metric it should update them each year to reflect the 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, the 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.
	
	NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. The Version 5.0 manual includes specifications and value sets that align with HEDIS MY 2021. The HEDIS MLD for MY 2021 is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. Previous versions of the MLD are also available in the NCQA Store. The state may use newer versions of the HEDIS MLD as they are released, even if those versions are not yet reflected in updated technical specifications, as long as they align with the applicable measurement period for a metric.

Metric #28 (continued)

Metric #28: SUD Spending	
Metric element	**Description**
Additional guidance (continued)	For CMS-constructed metrics, the state should note the following: • For monthly or quarterly metrics, the state should use the MLD that aligns with the calendar year in which the measurement period occurs. For example, to report Metric #6 for December 2021, the state should use the MY 2021 MLD. • For annual metrics, the state should use the MLD that aligns with the calendar year in which the state's demonstration period ended. For example, to report Metric #28 for a demonstration year that ends on February 28, 2022, the state should use the MY 2022 MLD. • For other annual metrics that span more than one calendar year, such as Metric #4, for which the measurement period is the demonstration year and a 12-month look back period, the state should use the MLD that aligns with the calendar year in which the state's demonstration year ended. For example, to report Metric #4 for a demonstration year that ends on December 31, 2021, the state should use the MY 2021 MLD. Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads). Additional guidance on accessing HEDIS medication lists and 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 metric
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	Total spending identified in this metric is the numerator of Metric #30.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #29: SUD Spending Within IMDs	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.
Population of interest	Medicaid SUD spending among all beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. Limit to IMDs receiving federal financial participation (FFP). Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The sum of all Medicaid spending on inpatient/residential treatment for SUD provided within IMDs during the measurement period. Limit to IMDs receiving federal financial participation (FFP). Step 1. Identify claims for residential treatment: Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 55 – Residential Substance Abuse Treatment Facility *HCPCS Codes:* • H0010 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) • H0011 – Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) *UB Revenue Codes:* • 1002 – Residential treatment – chemical dependency Step 1b. Identify claims with a place of service, HCPCS, or UB Revenue code listed below and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Codes Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set *Place of Service Codes:* • 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 Step 2. Identify claims for inpatient treatment that have a revenue code from the Inpatient Stay Value Set and a primary diagnosis code listed under one of the following HEDIS MY 2021 value sets: *Diagnosis Code Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set

Metric #29 *(continued)*

Metric #29: SUD Spending Within IMDs	
Metric element	**Description**
Numerator (continued)	Step 3. Among records identified in Step 1a or 1b or 2, identify inpatient/residential treatment stays in IMDs. (See the additional guidance section for a definition of an IMD.) Step 4. Identify and retain all claims or encounter records associated with stays identified in Step 3. Step 5. Sum the total amount paid by Medicaid on FFS 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. Sum the amount paid by Medicaid for managed care encounters identified in Step 4. 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 SUD encounters. • Determine the FFS cost to Medicaid for a service (such as by using an FFS Medicaid physician fee schedule) and apply that figure to encounter claims for the same service. This method may not be appropriate if there are no FFS claims for the same service types to use as a reference. Many states maintain the FFS fee schedules and frequently make them publicly available. • Use a Medicaid-to-Medicare Fee Index. These indices enable researchers to assume that Medicaid rates for a given service are set at a certain percentage of Medicare rates. In other words, they estimate the Medicaid fees for each state relative to the Medicare fees and provide a conversion factor. For each service, apply the conversion factor to the Medicare fee schedule to estimate the cost to Medicaid. o An example of Medicaid-to-Medicare fee comparisons is MACPAC's comparison of medical hospital payments between Medicaid and Medicare, available at https://www.macpac.gov/wp-content/uploads/2017/04/Medicaid-Hospital-Payment-A-Comparison-across-States-and-to-Medicare.pdf. o The Medicare fee schedule is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html. CMS's searchable Medicare Physician Fee schedule contains Medicare payment information for more than 10,000 services and can be found at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx. • Use Medicaid FFS equivalent amounts for encounter records reported in T-MSIS. 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 7. To determine total Medicaid SUD spending during the measurement period, sum the net amount paid by Medicaid from Steps 5 and 6 excluding any room and board costs, if included in Steps 5 and 6.
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:

Metric #29 *(*continued*)*

Metric #29: SUD Spending Within IMDs	
Metric element	**Description**
Additional guidance (continued)	○ Combine claims for the same beneficiary, provider and admission date; or ○ If an admission date is not reported on all claims, combine claims for the same 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. If the state uses fee schedules to calculate this metric it should update them each year to reflect the 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, the state should not calculate managed care costs using a Medicaid-to-Medicare Fee Index in one year and the MEDICAID-FFS-EQUIVALENT-AMT field in other years. An IMD is defined as a hospital, nursing facility, or other institution that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care for people with mental diseases. The state may have published lists of IMDs in which the designation is made by the state. If available, use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance. Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs. 5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases (including substance use disorders). a. When applying the 50 percent guideline determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The total spending identified in this metric is used to calculate Metric #31. The definition of an IMD should be the same in Metrics #5, 29, 31, and 36.
Data source	Claims
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric #29 *(*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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #30: Per Capita SUD Spending	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Per capita SUD spending 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	Total Medicaid SUD spending during the measurement period Instructions for calculating the numerator of this metric can be found in the specifications for Metric #28.
Denominator	The number of unique beneficiaries (de-duplicated total) who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 12 months before the measurement period. Step 1. Identify claims for MAT, defined in one of the following HEDIS MY 2021 IET Value Sets or Medications Lists: • AOD Medication Treatment Value Set • Alcohol Use Disorder Treatment Medication Lists • Opioid Use Disorder Treatment Medication Lists Step 2. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set In addition to a diagnosis code above, the claim must also have a code from any of the following HEDIS MY 2021 IET value set for identifying SUD treatment, another telehealth HCPCS code, a telephone CPT code, another online assessment CPT code, or a telehealth place of service code: *HEDIS MY 2021 IET Value Sets:* • IET Stand Alone Visits • IET Visits Group 1 Value Set with IET POS Group 1 Value Set • IET Visits Group 2 Value Set with IET POS Group 2 Value Set • Detoxification Value Set • ED Value Set • Inpatient Stay Value Set • Telephone Visits Value Set • Online Assessments Value Set Note: The state should include any of the above services billed with a code from the Telehealth Modifier Value Set

Metric #30 *(*continued*)*

Metric #30: Per Capita SUD Spending	
Metric element	**Description**
Denominator (continued)	*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 • G2251: Brief communication technology-based service by a qualified health care progression who cannot report evaluation and management services for an established patient *Telephone E&M CPT codes:* • 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, not originating from a related E/M service provided within the previous 7 days no leading to an E/M service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes • 99442: 11-20 minutes • 99443: 21-30 minutes *Online assessment CPT 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 • 99444: Online evaluation and management services provided by a physician or other qualified health care professional *Online assessment HCPCS codes:* • 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 *Place of service:* • POS 10: telehealth in a patient's home Step 3. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1 or 2.
Metric calculation	Calculate per capita SUD spending by dividing spending on SUD treatment in the numerator by the number of beneficiaries in the denominator, as follows: Spending on SUD treatment / Number of beneficiaries

Metric #30 *(*continued*)*

Metric #30: Per Capita SUD Spending	
Metric element	**Description**

Additional guidance	Beginning in Version 5.0 of the technical specifications manual, three telephone E&M CPT codes (99441, 99442, and 99443) and one online assessment code (99444) were added to the numerator specification for this metric to capture services provided via telephone and online. In addition, two telehealth and virtual communication HCPCS codes (G2250 and G2251) and one telehealth place of service code (10) were added to the numerator specification.
	
	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 receiving ***prescription medication***, identify claims in the measurement period using the date the prescription was filled.
	• To count beneficiaries using ***other services***, identify claims in the measurement period using the end date of service.
	
	If the state uses fee schedules to calculate this metric it should update them each year to reflect the 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, the 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.
	
	NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. The Version 5.0 manual includes specifications and value sets that align with HEDIS MY 2021. The HEDIS MLD for MY 2021 is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. Previous versions of the MLD are also available in the NCQA Store. The state may use newer versions of the HEDIS MLD as they are released, even if those versions are not yet reflected in updated technical specifications, as long as they align with the applicable measurement period for a metric.
	
	For CMS-constructed metrics, the state should note the following:
	• For monthly or quarterly metrics, the state should use the MLD that aligns with the calendar year in which the measurement period occurs. For example, to report Metric #6 for December 2021, the state should use the MY 2021 MLD.
	• For annual metrics, the state should use the MLD that aligns with the calendar year in which the state's demonstration period ended. For example, to report Metric #28 for a demonstration year that ends on February 28, 2022, the state should use the MY 2022 MLD.
	• For other annual metrics that span more than one calendar year, such as Metric #4, for which the measurement period is the demonstration year and a 12-month look back period, the state should use the MLD that aligns with the calendar year in which the state's demonstration year ended. For example, to report Metric #4 for a demonstration year that ends on December 31, 2021, the state should use the MY 2021 MLD.

Metric #30 *(continued)*

Metric #30: Per Capita SUD Spending	
Metric element	**Description**
Additional guidance (continued)	Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/?ReturnUrl=%2fDownloads). Additional guidance on accessing HEDIS medication lists and 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 metric
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	The total SUD spending in this metric is the same as the numerator in Metric #28, and the denominator in this metric is the same as the numerator in Metric #4.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #31: Per Capita SUD Spending within IMDs	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Per capita SUD spending within IMDs 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. Limit to IMDs receiving federal financial participation (FFP). Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period. Instructions for calculating the numerator can be found in Metric #29.
Denominator	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the reporting year. Step 1. Identify claims for residential treatment: Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 55 – Residential Substance Abuse Treatment Facility *HCPCS Codes:* • H0010 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) • H0011 – Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) *UB Revenue Codes:* • 1002 – Residential treatment – chemical dependency Step 1b. Identify claims with a place of service, HCPCS, or UB Revenue code listed below and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Codes Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set *Place of Service Codes:* • 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 Step 2. Identify claims for inpatient treatment that have a revenue code from the Inpatient Stay Value Set and a primary diagnosis code listed under one of the following HEDIS MY 2021 value sets: Diagnosis Code Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set

Metric #31 *(*continued*)*

Metric #31: Per Capita SUD Spending within IMDs	
Metric element	**Description**
Denominator (continued)	Step 3. Retain claims for inpatient/residential treatment in an IMD. (See the additional guidance section for a definition of IMDs). Step 4. Determine the total number of unique beneficiaries (de-duplicated) with claims that meet the criteria in Steps 1-3.
Metric calculation	Calculate per capita SUD spending by dividing spending on SUD treatment in the numerator by the number of beneficiaries in the denominator, as follows: Spending on SUD treatment / Number of beneficiaries
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: o Combine claims for the same beneficiary, provider and admission date; or o 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. 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 may have published lists of IMDs in which the designation is made by the state. If available, use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance. Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.). 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs.

Metric #31 *(*continued*)*

Metric #31: Per Capita SUD Spending within IMDs	
Metric element	**Description**
Additional guidance (continued)	5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases (including substance use disorders). a. When applying the 50 percent guideline determine whether <u>each</u> patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	State-specific subpopulations
Relationship to other metrics	For this metric, the numerator is the same as in Metric #29, and the denominator is the same as in Metric #5. The definition of an IMD should be the same in Metrics #5, 29, 31, and 36.
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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

Metric #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	
Metric element	**Description**
Measure sets/ endorsements	Adjusted HEDIS measure Measure steward: NCQA
Description	The percentage of Medicaid beneficiaries with SUD 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. Among Medicaid beneficiaries, identify claims during the measurement period with a diagnosis code (any diagnosis code on the claim) listed under one of the following HEDIS MY 2021 Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 2. Using beneficiaries with claims identified in Step 1 as the denominator population, follow instructions for calculating this metric, provided in the full measure specifications (SUD_Measure.pdf and the HEDIS_Gen_Guideline_17_Hospice.pdf) in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible to the state through PMDA in the Reference Materials section. Note that the measure steward's specifications refer to multiple types of payers. For purpose of SUD demonstration monitoring, the state should calculate this metric for the Medicaid population.
Additional guidance	Detailed instructions for accessing the specifications and value sets can be found 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 Medicaid beneficiaries with SUD 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 metric that is an established quality measure
Subpopulation categories	None[a]
Relationship to other metrics	Beneficiaries identified for this metric are also identified for Metric #25.
Data source	Claims
Claim type	Include paid, suspended, pending, and denied claims.

[a] 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 #33: Grievances Related to SUD Treatment Services	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of grievances filed during the measurement period that are related to SUD treatment services
Population of interest	Grievances filed during the measurement period
Numerator	Number of grievances related to SUD treatment 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
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 #34: Appeals Related to SUD Treatment Services	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of appeals filed during the measurement period that are related to SUD treatment services
Population of interest	Appeals filed during the measurement period
Numerator	Number of appeals related to SUD 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. The state should report appeal types according to their own definition.
Additional guidance	None
Measurement period (Metric type)	Quarter (CMS-constructed)
Reporting category	Grievances and appeals
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 #35: Critical Incidents Related to SUD Treatment Services	
Metric element	**Description**
Measure sets/ endorsements	None
Description	Number of critical incidents filed during the measurement period that are related to SUD treatment services
Population of interest	Critical incidents filed during the measurement period
Numerator	The number of critical incidents related to SUD treatment 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	Critical incidents are defined by the state but generally refer to events or occurrences that cause harm to members or serve as indicators of risk to a member's health or welfare. Some states also use the term "serious" or "sentinel" events. Types of critical incidents might include abuse; neglect; exploitation; hospitalizations; emergency room visits; deaths determined to be because of abuse, neglect, or exploitation; involvement with the criminal justice system; medical administration errors; and other events.
Measurement period (Metric type)	Quarter (CMS-constructed)
Reporting category	Grievances and appeals
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 #36: Average Length of Stay in IMDs	
Metric element	**Description**
Measure sets/ endorsements	None
Description	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.
Population of interest	All beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. Limit to IMDs receiving federal financial participation (FFP). Additional guidance on identifying the eligible population is provided in Chapter I.
Numerator	The total number of days in an IMD for inpatient/residential discharges for SUD. 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 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 Step 1.
Denominator	The total number of discharges from an IMD for beneficiaries with an inpatient or residential treatment stay for SUD. Limit to IMDs receiving FFP. Step 1. Identify qualifying IMD discharges for inpatient or residential treatment for SUD during the measurement period. This method may be specific to each state; some states maintain centralized databases of IMD stays. Alternatively, states may be able to identify IMD stays in T-MSIS data or through other methods. Step 1a. Identify claims with a place of service, HCPCS, or UB Revenue code listed below: *Place of Service Codes:* • 55 – Residential Substance Abuse Treatment Facility *HCPCS Codes:* • H0010 – Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient) • H0011 – Alcohol and/or drug services; acute detoxification (residential addiction program inpatient) *UB Revenue Codes:* • 1002 – Residential treatment – chemical dependency Step 1b. Identify claims with a one place of service, HCPCS, or UB Revenue code listed below and a primary diagnosis code listed under one of the following HEDIS MY 2021 Value Sets: *Diagnosis Codes Value Sets:* • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set *Place of Service Codes:* • 56 – Psychiatric Residential Treatment Center

Metric #36 *(*continued*)*

Metric #36: Average Length of Stay in IMDs	
Metric element	**Description**
Denominator (continued)	*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 Step 2. Identify claims for inpatient treatment that have a revenue code from the Inpatient Stay Value Set and a primary diagnosis code listed under one of the following HEDIS MY 2021 value sets: Diagnosis Code Value Sets: • Alcohol Abuse and Dependence Value Set • Opioid Abuse and Dependence Value Set • Other Drug Abuse and Dependence Value Set Step 3. Retain claims from Step 1a or 1b or 2 for inpatient/residential treatment in an IMD. (See the additional guidance section for a definition of IMDs). Step 4. De-duplicate and sum the discharges from Step 3 to identify the total number of discharges from an IMD for beneficiaries with a primary SUD diagnosis (see "Additional guidance" below for more information about the process for de-duplicating).
Metric calculation	Calculate the mean length of stay by dividing the total number of days in an IMD in the numerator by the total 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: o Combine claims for the same beneficiary, provider and admission date; or o 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. 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 may have published lists of IMDs in which the designation is made by the state. If available, use those lists to identify facilities; obtain the associated billing provider IDs, and identify claims in Steps 1a or 1b associated with those provider IDs. Otherwise, refer to the State Medicaid Manual for additional regulatory guidance.

Metric #36 *(*continued*)*

Metric #36: Average Length of Stay in IMDs	
Metric element	**Description**
Additional guidance (continued)	Per the guidance in Section 4390 of the State Medicaid Manual, the following five criteria should be used to evaluate whether the overall character of a facility is that of an IMD: 1. The facility is licensed as a psychiatric facility. 2. The facility is accredited as a psychiatric facility. 3. The facility is under the jurisdiction of the state's mental health authority. (This criterion does not apply to facilities under the state's mental health authority that are not providing services to mentally ill persons.) 4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs. a. When applying the 50 percent guideline determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline. b. If more than 50 percent of the patients are residing in the institution because of implications of mental health or substance use diagnoses, then the facility may be determined to be an IMD.
Measurement period (Metric type)	Demonstration Year (CMS-constructed)
Reporting category	Other annual metric
Subpopulation categories	OUD diagnosis State-specific subpopulations
Relationship to other metrics	This metric calculates average length of stay in IMDs for the beneficiaries identified in Metric #5. The definition of an IMD should be the same in Metrics #5, 29, and 31.
Data source	Claims State-specific IMD database
Claim type	If using claims, only use paid claims. (Do not use suspended, pending, or denied claims.)

Note: 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 treatment, diagnosis, 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 SUD treatment. If the service code can be for either mental health or SUD services, then a SUD 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 technical specifications manual or other considerations" (column P) in Part A (monitoring protocol workbook) of its monitoring protocol submission. See the latest Section 1115 SUD Monitoring Protocol Instructions for further guidance.

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
15	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	n.a.	Adult Core Set	FFY 2022[a]
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	n.a.	Specifications Manual for Joint Commission National Quality Measures	2021B2
17(1)	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]
17(2)	Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	n.a.	Adult Core Set	FFY 2022[a]
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	n.a.	Adult Core Set	FFY 2022[a]
19	Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)	n.a.	PQA	2022[b]
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (2019 update) (OHDMP-2019)	PQA	2022[b]
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	n.a.	Adult Core Set	FFY 2022[a]
22	Continuity of Pharmacotherapy for Opioid Use Disorder	n.a.	University of Southern California	2017[c], 2021[b]
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	Adults' Access to Preventive/Ambulatory Health Services (AAP)	HEDIS	2021[b]

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

[b] Specifications for established quality measures that are not part of the Core Set are available in 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible to the state through PMDA in the Reference Materials section.

[c] Specifications for this metric have not changed since 2017; however, the code list has been updated for 2022.

n.a. = not applicable

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APPENDIX B

VALUE SETS AND CODE LISTS REFERENCED IN METRIC SPECIFICATIONS

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

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Alcohol Abuse and Dependence (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #5: Medicaid Beneficiaries Treated in an IMD for SUD • #6: Any SUD Treatment • #7: Early Intervention • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization Services • #10: Residential and Inpatient Services • #11: Withdrawal Management • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries • #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries • #25: Readmissions Among Beneficiaries with SUD • #28: SUD Spending • #29: SUD Spending Within IMDs • #30: Per Capita SUD Spending • #31: Per Capita SUD Spending Within IMDs • #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) • #36: Average Length of Stay in IMDs	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Opioid Abuse and Dependence (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #5: Medicaid Beneficiaries Treated in an IMD for SUD • #6: Any SUD Treatment • #7: Early Intervention • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization Services • #10: Residential and Inpatient Services • #11: Withdrawal Management • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries • #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries • #25: Readmissions Among Beneficiaries with SUD • #28: SUD Spending • #29: SUD Spending Within IMDs • #30: Per Capita SUD Spending • #31: Per Capita SUD Spending Within IMDs • #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) • #36: Average Length of Stay in IMDs	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Other Drug Abuse and Dependence (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #5: Medicaid Beneficiaries Treated in an IMD for SUD • #6: Any SUD Treatment • #7: Early Intervention • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization Services • #10: Residential and Inpatient Services • #11: Withdrawal Management • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries • #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries • #25: Readmissions Among Beneficiaries with SUD • #28: SUD Spending • #29: SUD Spending Within IMDs • #30: Per Capita SUD Spending • #31: Per Capita SUD Spending Within IMDs • #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP) • #36: Average Length of Stay in IMDs	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
IET Stand Alone Visits (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and older (FUA-AD) • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5
IET Visits Group 1 (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
IET Visits Group 2 (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5
IET POS Group 1 (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
IET POS Group 2 (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5
Telephone Visits (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #8: Outpatient Services • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #28: SUD Spending • #30: Per Capita SUD Spending • #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP)	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Online Assessments (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #8: Outpatient Services • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #28: SUD Spending • #30: Per Capita SUD Spending • #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP)	Y	SUD HEDIS VSD V5
IAD Stand Alone IOP/PH (HEDIS)	• #6: Any SUD Treatment • #9: Intensive Outpatient and Partial Hospitalization Services • #28: SUD Spending	N	SUD HEDIS VSD V5
Visit Setting Unspecified (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization Services • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #28: SUD Spending	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Partial Hospitalization POS (HEDIS)	• #6: Any SUD Treatment • #9: Intensive Outpatient and Partial Hospitalization • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #28: SUD Spending	Y	SUD HEDIS VSD V5
Partial Hospitalization or Intensive Outpatient (HEDIS)	• #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
Non-residential Substance Abuse Treatment Facility POS (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #28: SUD Spending	N	SUD HEDIS VSD V5
Community Mental Health Center POS (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #28: SUD Spending	Y	SUD HEDIS VSD V5
Electroconvulsive Therapy (HEDIS)	• #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
Ambulatory Surgical Center POS (HEDIS)	• #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
Ambulatory Visits (HEDIS)	• #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP)	N	SUD HEDIS VSD V5
Other Ambulatory Visits (HEDIS)	• #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP)	N	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Outpatient POS (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #28: SUD Spending	Y	SUD HEDIS VSD V5
Telehealth Modifier (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #28: SUD Spending • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5
Telehealth POS (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
IAD Stand Alone Outpatient (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #28: SUD Spending	N	SUD HEDIS VSD V5
Observation (HEDIS)	• #6: Any SUD Treatment • #8: Outpatient Services • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #28: SUD Spending	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
AOD Abuse and Dependence (HEDIS)	• #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y	SUD HEDIS VSD V5
AOD Medication Treatment (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #12: Medication-Assisted Treatment • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #28: SUD Spending • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5
Alcohol Use Disorder Treatment Medication List (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #12: Medication-Assisted Treatment • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #28: SUD Spending • #30: Per Capita SUD Spending	Y	See **Appendix C** for access instructions

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Opioid Use Disorder Treatment Medication List (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #12: Medication-Assisted Treatment • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #28: SUD Spending • #30: Per Capita SUD Spending	Y	See **Appendix C** for access instructions
Detoxification (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #11: Withdrawal Management • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #28: SUD Spending • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
ED (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries • #28: SUD Spending • #30: Per Capita SUD Spending	Y	SUD HEDIS VSD V5
Mental Illness (HEDIS)	• #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
Intentional Self-Harm (HEDIS)	• #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
Mental Health Diagnosis (HEDIS)	• #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
BH Outpatient (HEDIS)	• #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Inpatient Stay (HEDIS)	• #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #5: Medicaid Beneficiaries Treated in an IMD for SUD • #6: Any SUD Treatment • #10: Residential and Inpatient Stays • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) • #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries • #25: Readmissions Among Beneficiaries with SUD • #28: SUD Spending • #29: SUD Spending Within IMDs • #30: Per Capita SUD Spending • #31: Per Capita SUD Spending Within IMDs • #36: Average Length of Stay in IMDs	Y	SUD HEDIS VSD V5
Nonacute Inpatient Stay (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Pregnancy (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Perinatal Conditions (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Chemotherapy Encounter (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Chemotherapy Procedure (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Rehabilitation (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Kidney Transplant (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Bone Marrow Transplant (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Organ Transplant Other Than Kidney (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Introduction of Autologous Pancreatic Cells (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Potentially Planned Procedures (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Acute Condition (HEDIS)	• #25: Readmissions Among Beneficiaries with SUD	N	SUD HEDIS VSD V5
Benzodiazepines (PQA)[a]	• #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) • #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Y	PQA VSD V5
Opioids (PQA)	• #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) • #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	Y	PQA VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Opioids_COB (PQA)	• #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) • #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Y	PQA VSD V5
Palliative Care (PQA)	• #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) • #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) • #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)		PQA VSD V5
Cancer (PQA)[a]	• #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) • #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) • #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Y	PQA VSD V5
Sickle Cell Disease (PQA)[a]	• #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) • #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) • #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Y	PQA VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
Hospice Encounter (PQA)[a]	• #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) • #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) • #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Y	PQA VSD V5
Hospice Intervention[a]	• #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) • #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) • #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Y	PQA VSD V5
Hospice Encounter Value Set (HEDIS)	• #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5
Hospice Intervention Value Set (HEDIS)	• #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
NQF #3175 OUD Code List 2021	• #22: Continuity of Pharmacotherapy for Opioid Use Disorder	N	2021 USC Measure Specifications and Value Set Directory
MACBIS Ever Pregnant Code List	• #1: Assessed for SUD Treatment Needs Using a Standardized Screening Tool • #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #6: Any SUD Treatment • #7: Early Intervention • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization Services • #10: Residential and Inpatient Services • #11: Withdrawal Management • #12: Medication-Assisted Treatment	N	See **Appendix C** for access instructions
Joint Commission National Quality Measures Manual	• #16: SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge, SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	N	See **Appendix C** for access instructions
OUD Weekly Non Drug Service Value Set (HEDIS)	• #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y	SUD HEDIS VSD V5
OUD Monthly Office Based Treatment Value Set (HEDIS)	• #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y	SUD HEDIS VSD V5

Table B.1. (continued)

Value set name	Relevant metrics	Part of reported Core Set measure (Y/N)	File name
OUD Weekly Drug Treatment Service Value Set (HEDIS)	• #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Y	SUD HEDIS VSD V5

[a] Value set is included as part of a Core Set measure, but is also included as part of non-Core Set measures (i.e. Metric #19 and Metric #20).

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: • #13: SUD Provider Availability • #14: SUD Provider Availability – MAT • #26: Drug Overdose Deaths (count) • #27: Overdose Deaths (rate) • #33: Grievances Related to SUD Treatment Services • #34: Appeals Related to SUD Treatment Services • #35: Critical Incidents Related to SUD Treatment Services	None	None
CMS-constructed metrics that use HEDIS value sets. • #5: Medicaid Beneficiaries Treated in an IMD for SUD • #7: Early Intervention • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization Services • #10: Residential and Inpatient Services • #11: Withdrawal Management • #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries • #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries • #25: Readmissions Among Beneficiaries with SUD • #29: SUD Spending Within IMDs • #31: Per Capita SUD Spending within IMDs • #36: Average Length of Stay in IMDs	*Value Sets:* • SUD HEDIS VSD V5	*Value Sets:* • Step 1: Open “SUD HEDIS VSD V5.xls” (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible through 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
CMS-constructed metrics that use HEDIS value sets and HEDIS medication lists. • #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #4: Medicaid Beneficiaries with SUD Diagnosis (annually) • #6: Any SUD Treatment • #12: Medication-Assisted Treatment • #28: SUD Spending • #30: Per Capita SUD Spending	*Value Sets:* • SUD HEDIS VSD V5 *Medications Lists*: • HEDIS MY 2021 and 2022 Medications Lists	*Value Sets:* • Step 1: Open "SUD HEDIS VSD V5.xls" (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through 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. *Medications Lists:* • NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store. • Step 1: Determine the applicable year(s) of the MLD for a metric's measurement period. • Step 2: Access the NCQA Store. For example, the 2021 MLD is located at https://store.ncqa.org/hedis-my-2021-medication-list-directory.html. • Step 3: Create an NCQA account, if necessary, and then request access to the applicable Medication List Directory. • Step 4: Download the applicable Medication List Directory from https://My.NCQA.Org

Table C.1. (continued)

Metrics	Supporting measure specifications, value sets, and code lists	Instructions
Established quality measures that use HEDIS specifications included in the Adapted Adult Core Set technical specifications. • #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • #17(1): Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) • #17(2): Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	*Measure Specifications:* • The Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2022 ○ **Appendix D: Technical Specifications for Established Quality Measures Adapted From FFY 2021 Adult Core Set Measure Specifications** *Value Sets:* • SUD HEDIS VSD V5	*Measure Specifications:* • Step 1: Locate specifications for measures listed at left in **Appendix D** of this manual. *Value Sets:* • Step 1: Open "SUD HEDIS VSD V5.xls" (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Filter the "2022 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 PQA specifications included in the Adapted Adult Core Set technical specifications. • #18: Use of Opioids at High Dosage in Persons Without Cancer (COB-AD) • #21: Concurrent Use of Opioids and Benzodiazepines (OHD-AD)	*Measure Specifications*: • The Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2022 ○ **Appendix D: Technical Specifications for Established Quality Measures Adapted From FFY 2022 Adult Core Set Measure Specifications** *Value Sets:* • PQA VSD V5	*Measure Specifications:* • Step 1: Locate specifications for measures listed at left in **Appendix D** of this manual. *Value Sets:* • Step 1: Open 'PQA VSD V5.xls' (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Locate the "value_sets_other" tab • Step 3: Search for value set using column A • Step 4: Include listed codes when calculating the metric *Medications* • Step 1: Open 'PQA VSD V5.xls' (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Locate the "value_sets_meds"" tab • Step 3: Search for value set using column A • Step 4: Include listed codes when calculating the 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 Core Set). • #16: SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge, SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	*Measure Specifications:* • https://manual.jointcommission.org/releases/TJC2021B2/MIF0221.html *Code Sets:* • https://manual.jointcommission.org/releases/TJC2021B2/AppendixATJC.html • https://manual.jointcommission.org/releases/TJC2021B2/AppendixCTJC.html	*Measure Specifications:* • Step 1: Refer to the measure specifications at https://manual.jointcommission.org/releases/TJC2021B2/MIF0221.html • Step 2: Follow the guidance in the measure specification to calculate the metric *Code Sets:* • Step 1: Refer to the code sets, identified in the specifications, at https://manual.jointcommission.org/releases/TJC2021B2/AppendixATJC.html and https://manual.jointcommission.org/releases/TJC2021B2/AppendixCTJC.html
Established quality measures that use PQA specifications (and are not part of the Adult Core Set). • #19: Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) • #20: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP)	*Measure Specifications:* • 2022_PQA_MeasureManual_20220309_Opioids.pdf *Value Sets:* • PQA VSD V5	*Measure Specifications:* • Step 1: Open "2022_PQA_MeasureManual_20220309_Opioids.pdf " file (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Locate specifications for Use of Opioids from Multiple Providers in Persons Without Cancer (OMP), and for Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) in file • Step 3: Follow the guidance in the measure specification to calculate the metric

Table C.1. (continued)

Metrics	Supporting measure specifications, value sets, and code lists	Instructions
Established quality measures that use PQA specifications (and are not part of the Adult Core Set). (continued)		*Value Sets:* • Step 1: Open "PQA VSD V5.xls" (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Navigate to "value_sets_other" table • Step 3: Locate correct value set using drop down in Column A • Step 4: Include listed codes when calculating the metric *Medications* • Step 1: Open 'PQA VSD V5.xls' (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Locate the "value_sets_meds"" tab • Step 3: Search for value set using column A • Step 4: Include listed codes when calculating the metric

Table C.1. (continued)

Metrics	Supporting measure specifications, value sets, and code lists	Instructions
Established quality measures that use USC specifications (and are not part of the Adult Core Set). • #22: Continuity of Pharmacotherapy for Opioid Use Disorder	*Measure Specifications:* • USC Measure Specifications *Value Sets:* • USC Value Set Directory	*Measure Specifications:* • Step 1: Open "2021 USC Measure Specifications and Value Set Directory.docx" file (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Locate specifications for Continuity of Pharmacotherapy for Opioid Use Disorder • Step 3: Follow the guidance in the measure specification to calculate the metric *Value Sets:* • Step 1: Open "2021 USC Measure Specifications and Value Set Directory.docx" file (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials section on PMDA). • Step 2: Locate the excel file named "NQF 3175 OUD Code List 2021 version" embedded within the specifications document on page 5, including tabs "ICD-10 Diagnosis Codes," "NDC," and "HCPCS codes." • Step 3: Include listed ICD-10 (column A), NDC (columns F, G, H) and HCPCS codes (column A) of respective tabs when calculating the measure, as described in the measure specification.

Table C.1. (continued)

Metrics	Supporting measure specifications, value sets, and code lists	Instructions
Established quality measures that use HEDIS specifications (and are not part of the Adult Core Set). • #32: Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	*Measure Specifications:* • SUD_Measure.pdf • HEDIS_Gen_Guideline_17_Hospice.pdf *Value Sets:* • SUD HEDIS VSD V5	*Measure Specifications:* • Step 1: Open the "SUD_Measure.pdf" and the "HEDIS_Gen_Guideline_17_Hospice.pdf" files (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible 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 and the HEDIS general guidance document to calculate the metric. *Value Sets:* • Step 1: Open “SUD HEDIS VSD V5.xls” file (available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible through 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 when calculating metric.

Table C.1. (continued)

Metrics	Supporting measure specifications, value sets, and code lists	Instructions
Pregnancy subpopulation • #1: Assessed for SUD Treatment Needs Using a Standardized Screening Tool • #2: Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis • #3: Medicaid Beneficiaries with SUD Diagnosis (monthly) • #6: Any SUD Treatment • #7: Early Intervention • #8: Outpatient Services • #9: Intensive Outpatient and Partial Hospitalization Services • #10: Residential and Inpatient Services • #11: Withdrawal Management • #12: Medication-Assisted Treatment	*Measure Specifications:* • NA *Value Sets:* • MACBIS Pregnancy Code List	*Measure Specifications:* • Step 1: Navigate to Table 3 of this manual. Recommended guidance on identifying the pregnancy subpopulation included. The state is not required to use this method for identifying the pregnancy subpopulation. *Value Sets:* • Step 1:Download the files "MIH Reference Codes" and "MIH Technical Specifications" from https://www.medicaid.gov/medicaid/data-systems/macbis/medicaid-chip-research-files/transformed-medicaid-statistical-information-system-t-msis-analytic-files-taf/index.html. • Step 2: Include listed codes from the "Ever Pregnant" tab when identifying pregnancy subpopulation, and refer to the "MIH Technical Specifications" for further guidance to use the codes.

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APPENDIX D

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

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This appendix provides the technical specifications for the Adult Core Set measures included in the section 1115 SUD monitoring metrics. These specifications have been adapted from state-level specifications for use in the section 1115 SUD 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 Adult Core Set measure included in the section 1115 SUD monitoring 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 #15: Initiation and Engagement of Alcohol and Other Drug or Dependence Treatment (IET-AD) 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 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, Metric #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD) requires continuous enrollment throughout the measurement year (January 1-December 31) and allows one gap in enrollment of up to 31 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, birthdate, or a delivery 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. SUD monitoring metrics #15, 17(1), 17(2), 18 and 21 include a required hospice exclusion. For these measures, the 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 include case management program data. The Hospice Encounter Value Set and Hospice Intervention Value Set are provided in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file accessible through the Reference Materials section in PMDA.

States should remove these beneficiaries as they determine the measure's eligible population.

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. SUD monitoring metrics #15, 17(1), and 17(2) 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.

Telehealth. Some Adult Core Set measures included in the section 1115 SUD monitoring metrics are HEDIS measures. HEDIS measure consider synchronous telehealth, telephone visits, and asynchronous telehealth (e-visits, virtual checks-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. 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 telehealth 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 SUD monitoring metrics adapted from FFY 2022 Adult Core Set measures

Measure	FFY 2022 Measurement Period[a]		
	Denominator	Numerator	Continuous Enrollment Period
Metric #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Index episode start date (IESD): January 1, 2021 – November 14, 2021 Negative diagnosis history review: November 2, 2020 – September 15, 2021 (60 days prior to IESD)	Initiation of AOD Treatment: January 1, 2021 – November 27, 2021 (Within 14 days of the IESD) Engagement of AOD Treatment: January 2, 2021 – December 31, 2021 (Day after initiation encounter through 34 days after the initiation date)[b]	November 2, 2020 – December 31, 2021 (60 days prior to IESD through 47 days after the IESD)
Metric #17(1): 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, 2021 – December 31, 2021 (ED visit date through 30 days after visit date)
Metric #17(2): 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 #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Index Prescription Start Date (IPSD): January 1, 2021 – October 3, 2021	January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021[c]
Metric #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Index Prescription Start Date (IPSD): January 1, 2021 – December 2, 2021	January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021[c]

[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 enrollee birthdate, prescription or treatment start dates, and discharge dates). For these measures, two ranges are shown. The first date range

Table D.1 (continued)

identifies the full range of possible dates that 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] Applies to all rates: Alcohol or dependence rate, Opioid abuse or dependence rate, Other drug abuse or dependence rate, and Total AOD abuse or dependence rate.

[c] No more than one gap in continuous enrollment of up to 31 days during the measurement year.

II. TECHNICAL SPECIFICATIONS

Metric #15: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Measure Steward: National Committee for Quality Assurance

A. Description

Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- **Initiation of AOD Treatment.** Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis
- **Engagement of AOD Treatment.** Percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- Two rates are reported: initiation of AOD treatment and engagement of AOD treatment. For each rate, report the following AOD diagnosis cohorts:
  - Alcohol abuse or dependence
  - Opioid abuse or dependence
  - Other drug abuse or dependence
  - Total AOD abuse or dependence
- The total AOD abuse or dependence rate is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. Report beneficiaries with multiple diagnoses on the Index Episode claim only once for the total rate for the denominator.
- Exclude beneficiaries from the denominator for both rates (initiation of AOD treatment and engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.
- 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 Appendix D, Section I. Measure Element Definitions.
- This measure requires that Medication-Assisted treatment (MAT) services match the diagnosis category of the index episode identified in the denominator in order to count towards the numerator of the engagement rate. Depending on the diagnosis used in the denominator (e.g., opioid abuse or dependence and alcohol abuse and dependence), a corresponding MAT medication should be used to satisfy the numerator.
- NCQA's Medication List Directory (MLD) for Alcohol Use Disorder Treatment Medications and Opioid Use Disorder Treatment 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).
- The electronic specification for FFY 2022 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ep/2021/cms137v9.

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 Disclaimer section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	January 1 to November 14 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.
Index episode	The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. For ED or observation visits that result in an inpatient stay, the inpatient discharge is the Index Episode.
Dates of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the IESD, negative diagnosis history and numerator events).
IESD	Index Episode Start Date (IESD). The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification, or ED visit (not resulting in an inpatient stay), the IESD is the date of service. For an inpatient stay or for detoxification that occurred during an inpatient stay, the IESD is the date of discharge. For detoxification (other than detoxification that occurred during an inpatient stay), the IESD is the date of service. For ED and observation visits that result in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort). For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

Negative diagnosis history	A period of 60 days (2 months) before the IESD when the beneficiary had no claims/encounters with a diagnosis of AOD abuse or dependence. For an inpatient stay, use the admission date to determine the Negative Diagnosis History. For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. For direct transfers, use the first admission to determine the Negative Diagnosis History.
Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
AOD diagnosis cohorts	Report the following diagnosis cohorts: • Alcohol abuse or dependence • Opioid abuse or dependence • Other drug abuse or dependence • Total AOD abuse or dependence
Continuous enrollment	60 days (2 months) prior to the IESD through 47 days after the IESD (108 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefits	Medical, pharmacy, and chemical dependency (inpatient and outpatient). Note: Beneficiaries with detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	New episode of AOD abuse or dependence during the Intake Period. Follow the steps below to identify the eligible population, which is the denominator for both rates.

Event/ diagnosis (continued)	Step 1 Identify the Index Episode. Identify all beneficiaries in the specified age range who during the Intake Period had one of the following: • An outpatient visit, telehealth, intensive outpatient visit, or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: - IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependency Value Set, - OUD Weekly Non Drug Service Value Set with Opioid Abuse and Dependence Value Set - OUD Monthly Office Based Treatment Value Set with Opioid Abuse and Dependence Value Set - OUD Weekly Drug Treatment Service Value Set with Opioid Abuse and Dependence Value Set • A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay.

Event/ diagnosis (continued)	• A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set). For beneficiaries with more than one episode of AOD abuse or dependence, use the first episode. For beneficiaries whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD. Step 2 Select the Index Episode and stratify based on AOD diagnosis cohort. • If the beneficiary has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the beneficiary in the alcohol cohort. • If the beneficiary has a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), place the beneficiary in the opioid cohort. • If the beneficiary has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the beneficiary in the other drug cohort. • If the beneficiary has multiple substance use diagnoses for the visit, report the beneficiary in all AOD diagnosis stratifications for which they meet criteria. The total is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. Report beneficiaries with multiple diagnoses on the Index Episode only once for the total rate for the denominator. Step 3 Test for Negative Diagnosis History. Exclude beneficiaries who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set), or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List, Opioid Use Disorder Treatment Medications List, see link to Medication List Directory in Guidance for Reporting above) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

Event/ diagnosis (continued)	For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. Step 4 Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator 1: Initiation of AOD Treatment

Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the beneficiary is compliant.

If the Index Episode was an opioid treatment that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid service is considered initiation of treatment and the beneficiary is compliant.

If the Index Episode was not an inpatient discharge, the beneficiary must initiate the treatment on the start date of the Index Episode or in the 13 days after the Index Episode (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence

Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non Drug Service Value Set)
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set)
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to Medication List Directory in the Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set)
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List, see link to Medication List Directory in the Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in the Guidance for Reporting above), initiation on the same day as the IESD must be with different providers in order to count.

If a beneficiary is compliant for the Initiation numerator of any diagnosis cohort (alcohol, opioid, other drug), or for multiple cohorts, count the beneficiary once in the Total Initiation numerator. The "Total" column is not the sum of the diagnosis columns.

Exclude the beneficiary from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Numerator 2: Engagement of AOD Treatment

Step 1

Identify all beneficiaries compliant for the Initiation of AOD Treatment numerator.

For beneficiaries who initiated treatment via an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 2

Identify beneficiaries who had an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (OUD Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

For these beneficiaries, if the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), the beneficiary is numerator compliant for Engagement of AOD Treatment.

Step 3

Identify beneficiaries whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set, see link to the Medication List Directory in Guidance for Reporting above).

These beneficiaries are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

Step 4

Identify the remaining beneficiaries whose initiation of AOD treatment was not a medication treatment event (beneficiaries not identified in step 3).

These beneficiaries are numerator compliant if they meet either of the following:

- At least one engagement medication treatment event
- At least two engagement visits

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement Visits

Any of the following beginning on the day after the imitation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
    2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set,
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set,
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A e-visit or virtual check-in (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non Drug Service Value Set)

Engagement Medication Treatment Events

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Alcohol Use Disorder Treatment Medications List, see link to Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the beneficiary is compliant for multiple cohorts, only count the beneficiary once for the Total Engagement numerator. The Total rate is not the sum of the diagnosis columns.

E. ADDITIONAL NOTES

- There may be different methods for billing intensive outpatient encounters 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 time frame for the rate.
- For beneficiaries in the “other drug abuse or dependence” cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.
- Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than for an opioid use disorder; therefore, pharmacy claims for methadone are not included in the medications

lists for this measure. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.

Metric #17(1): 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 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 same date of service).
  - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions.

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 Disclaimer 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 exclusions 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 principle diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Monthly Office Based Treatment Value Set with a principle diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- OUD Weekly Drug Treatment Service Value Set with a principle 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 #17(2): 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 same date of service).
  - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions.

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 Disclaimer 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 #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)

Measure Steward: Pharmacy Quality Alliance

A. DESCRIPTION

Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- Starting with the section 1115 SUD demonstrations: Technical Specifications for Monitoring Metrics Version 2 the rate is expressed as a percentage. In previous years, it was reported as a rate per 1,000 beneficiaries.
- The Pharmacy Quality Alliance provides the list of opioid medications used to calculate this measure in the "Value Sets – Medications" tab of the PQA VSD V5, which are available to states in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab, value set ID "Opioids." This file also contains additional guidance on MME conversion factors.
- More information on the Pharmacy Quality Alliance value set directory is available in the 2022_PQA_ValueSet_UserGuide.pdf, available to states in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice or palliative care at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10 codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice may be identified using the codes in the Hospice Encounter Value Set and Hospice Intervention Value Set or Palliative Care Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and NDC. Refer to the Disclaimer section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of measurement year.
Opioid	See medications listed in Table OHD-A.
Morphine milligram equivalent (MME)	Oral morphine milligram equivalent. The MME conversion factor used to retrospectively calculate daily MME to inform analyses of risks associated with opioid prescribing. MME conversion factors are available in the "Value Sets – Medications" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 90 days before the end of the measurement year (e.g., January 1 – October 3).
Opioid Episode	The period of time beginning on the date of the first fill (e.g., IPSD) of an opioid medication during the measurement year and ending on the date of the last fill of any opioid medication plus the days' supply of the last fill during the measurement year, minus 1. If the days' supply extends past the measurement year, the opioid episode length is truncated to the last day of the measurement year (e.g., December 31). The opioid episode must be 90 or more days during the measurement year.
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes (in the Hospice Encounter Value Set and the Hospice Intervention Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to states in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.)

Cancer Diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year (in the Cancer Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.)
Sickle Cell Disease Diagnosis	Any beneficiary with an ICD-10 diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**).
Palliative Care	Any beneficiary with an ICD-10 diagnosis code for palliative care, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Palliative Care Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to states in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.)

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When 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 consecutive days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.

Event/Diagnosis	Use the steps below to determine the eligible population. Step 1 Identify beneficiaries with 2 or more prescription claims for opioids medications (Table OHD-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply. Step 2 Identify beneficiaries with an IPSD on January 1 through October 3 of the measurement year. Step 3 Identify beneficiaries with an opioid episode of 90 or more days during the measurement year. NOTE: Exclude days of supply that occur after the end of the measurement year. Step 4 Exclude beneficiaries who met at least one of the following during the measurement year: • Hospice • Cancer Diagnosis • Sickle Cell Disease Diagnosis • Palliative Care

Table OHD-A. Opioid Medications [a,b]

Benzhydrocodone	Hydrocodone	Morphine	Oxymorphone
Butorphanol	Hydromorphone	Opium	Pentazocine
Codeine	Levorphanol	Oxycodone	Tapentadol
Dihydrocodeine	Meperidine		Tramadol
Fentanyl	Methadone		

[a] Includes combination products

[b] Excludes the following: injectable formulations; opioid cough and cold products; and sufentanil (used in a supervised setting); and all buprenorphine products (as a partial opioid agonist is not expected to be associate with overdose risk in the same dose-dependent manner as doses for full agonist opioids).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Any beneficiary in the denominator with an average daily dosage ≥ 90 Morphine Milligram Equivalent during the opioid episode.

Follow the steps below to identify beneficiaries for the numerator:

Step 1

For each beneficiary in the denominator population, identify all opioid prescription claims during the opioid episode.

Step 2

Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation:

> [Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor = MME/day
>
> The "Quantity Dispensed" and "Days' Supply" comes from the prescription claim. Strength and MME conversion factor is determined by the NDC code and provided in the "Value Sets – Medications" tab of the PQA VSD V5.pdf value set directory.
>
> Example: 10 mg oxycodone tablets * (120 tablets / 30 days) * 1.5 = 60 MME/day

Step 3

Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1).

NOTE:

- If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim.
- Apply the MME through to the last day of the opioid episode, e.g., do not include days that extend beyond the end of the opioid episode.

Step 4

For each beneficiary, sum the daily MMEs across all days during the opioid episode.

Step 5

Calculate the average MME across all days during the opioid episode. The average daily MME = total MME / days in opioid episode. Calculate the average daily MME rounded to the nearest hundredth (e.g., 89.97597 is rounded to 89.98).

Step 6

Count the beneficiaries with an average daily dosage ≥ 90.00 MME during the opioid episode.

Rate

Divide the numerator by the denominator and multiply by 100.

E. Additional Notes

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Center for Disease Control and Prevention CDC Guideline for Prescribing Opioids for Chronic Pain and Guideline Resources.

The MME conversion factor is intended solely for research, analytical purposes, surveillance of population-level medication utilization, and other population-level monitoring purposes. This measure and oral MME conversion factors are NOT intended for any clinical decision-making by clinicians while prescribing opioids. Furthermore, the oral MME conversion factors of opioid analgesics DO NOT constitute any clinical guidance or recommendations for converting patients from one form of opioid analgesic to another. Please consult the manufacturer's full prescribing information for such guidance. For additional clinical guidance on oral MME conversion factors for some opioids commonly prescribed for treatment of chronic pain and additional information on calculations of daily oral MME, please see CDC's provider resources (https://www.cdc.gov/drugoverdose/prescribing/guideline.html#tabs-2-3).

Metric #21: Concurrent Use of Opioids and Benzodiazepines (COB-AD)

Measure Steward: Pharmacy Quality Alliance

A. DESCRIPTION

Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- The Pharmacy Quality Alliance provides the opioid medications used to calculate this measure in the "Value Sets – Medications" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab, value set ID "Opioids_COB."
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice or palliative care at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10 codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice may be identified using the codes in the Hospice Encounter Value Set and Hospice Intervention Value Set or Palliative Care Value Set available in the "Value Sets – Other" tab of the PQA VSD V5. These are available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5 .zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**.
- More information on the Pharmacy Quality Alliance value set directory is available in the 2022_PQA_ValueSet_UserGuide.pdf, available to states in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- When determining the eligible population, under Step 1 of the Event/Diagnosis, the process for counting the total days' supply where there are multiple prescriptions with overlapping days of supply depends on whether the prescriptions are filled on the same day or on different days.
    - If prescriptions are filled on the **same day,** states should count only the days' supply for the prescription filled with the longest supply toward the total. For example, if an individual had two prescriptions filled on October 15 during the measurement year, one with a 7-day supply and the other with a 30-day supply, of the two claims filled, the state should count only the 30 days' supply claim toward the cumulative days' supply
    - If prescriptions are dispensed on **different days** with overlapping days' supply, states should not account for overlapping days' supply. Each day of overlap should

be counted separately towards the total days' supply. For example, if a beneficiary has two claims that were dispensed during the measurement year, the first on January 15, 2019 for a 30-day supply, and the second, on January 20, 2019 for a 7-day supply, then the beneficiary's cumulative days' supply is 37 days.

- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and NDC. Refer to the Disclaimer section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
Opioid	See medications listed in Table COB-A.
Benzodiazepine	See medications listed in Table COB-B.
Concurrent Use	Overlapping supply for an opioid and a benzodiazepine for 30 or more cumulative days. Concurrent use is identified using the dates of service and days' supply of a beneficiary's prescription claims. The days of concurrent use is the count of days with overlapping days' supply for an opioid and a benzodiazepine.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 30 days before the end of the measurement year. (e.g.., January 1 – December 2).
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes (in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**).
Cancer Diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year (in the Cancer Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure**

	Specifications, Value Sets, and Code Lists to Calculate Metrics).
Sickle Cell Disease Diagnosis	Any beneficiary with an ICD-10 diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year (in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**).
Palliative Care	Any beneficiary with an ICD-10 diagnosis code for palliative care, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Palliative Care Value Set in the "Value Sets – Other" tab of the PQA VSD V5, available to the state in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file through the Reference Materials Section of PMDA. Additional instructions for accessing these files can be found in **Appendix C: How to Use Supporting Measure Specifications, Value Sets, and Code Lists to Calculate Metrics**).

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When 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 consecutive days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.
Event/Diagnosis	Use the steps below to determine the eligible population. Step 1 Identify beneficiaries with 2 or more prescription claims for opioid medications (Table COB-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescription can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply.

	• If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply. Step 2 Identify beneficiaries with an IPSD on January 1 through December 2 of the measurement year. Step 3 Exclude beneficiaries who met at least one of the following during the measurement year: • Hospice • Cancer Diagnosis • Sickle Cell Disease Diagnosis • Palliative Care

Table COB-A. Opioid Medications[a, b]

Benzohydrocodone	Hydrocodone	Morphine	Oxymorphone
Buprenorphine	Hydromorphone	Opium	Pentazocine
Butorphanol	Levorphanol	Oxycodone	Tapentadol
Codeine	Meperidine		Tramadol
Dihydrocodeine	Methadone		
Fentanyl			

[a] Includes combination products and prescription opioid cough medications.

[b] Excludes the following: injectable formulations; sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (e.g.., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries from the denominator with:

- Two or more prescription claims for any benzodiazepine (Table COB-B) with different dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days

Follow the steps below to identify beneficiaries for the numerator.

Step 1

From the denominator population, identify beneficiaries with two or more prescription claims with different dates of service for any benzodiazepine (Table COB-B) during the measurement year.

Step 2

Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioids and benzodiazepine prescriptions during the measurement year. Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of supply and overlap that occur after the end of the measurement year.

NOTE:

- If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days' supply.
- If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days' supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

Step 3

Count the number of beneficiaries with concurrent use for 30 or more cumulative days. This is the numerator.

Table COB-B. Benzodiazepine Medications[a, b]

Alprazolam	Clorazepate	Lorazepam	Temazepam
Chlordiazepoxide	Diazepam	Midazolam	Triazolam
Clobazam	Estazolam	Oxazepam	
Clonazepam	Flurazepam	Quazepam	

[a] Excludes injectable formulations.

[b] Includes combination products.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Center for Disease Control and Prevention CDC Guideline for Prescribing Opioids for Chronic Pain and Guideline Resources.

APPENDIX E
ADDITIONAL GUIDANCE FOR SECTION 1115 SUD SERVICE UTILIZATION METRICS #7-12

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Guidance counting beneficiaries. Beneficiaries should be counted in the numerator of each substance use disorder (SUD) treatment service utilization metric (Metrics #7-12) for which they received a service. For example, if during a given reporting period a beneficiary receives a screening service (Metric #7), a residential stay (Metric #10), and outpatient counseling (Metric #8), the beneficiary would be counted once in the numerator of each of these three metrics for that period. Any beneficiary receiving the services captured by Metrics #7-12 would also be counted once in the numerator of Metric #6, which assesses the number of unique beneficiaries who received at least one SUD treatment service of any type. Please note that the sum of the numerators for Metrics #7-12 would not necessarily equal the numerator of Metric #6 because a beneficiary can be counted in the numerator of more than one of these metrics (Metrics #7-12) but will only be counted once in Metric #6. Also, there are differences in the specifications for selecting services included in Metric #6 relative to the other metrics (for example, inpatient hospital services are only assigned to Metric #10 if the associated claims have a primary SUD diagnosis; however, inpatient hospital services are included in Metric #6 if there is any diagnosis of SUD in the associated claim). Please note that for each of these metrics (Metrics #6-12), the state should only count a beneficiary once even if the beneficiary received multiple services in that category during the reporting period. Thus, if a beneficiary received five outpatient services during the reporting period, the state would count the beneficiary only once in the numerator of Metric #8 (Outpatient Services).

This guidance further distinguishes between service utilization metrics that are based on the setting in which a service takes place (i.e., levels of care) (Metrics #7-10) and other service utilization metrics that capture a specific service (i.e., modality-based services) that can occur in multiple settings (Metrics #11 and 12). Under this guidance, a given service (such as withdrawal management) can be assigned to one level of care metric (for example, Metric #8: Outpatient Services) AND one treatment modality metric (in this case, Metric #11: Withdrawal Management), but not all services will be assigned to both types of metrics.

Table E.1 describes the metrics within each metric type category and how to determine which level of care to assign for a service. Because a service should only be assigned to one metric within each category and some codes overlap between the level of care metrics, this table includes a hierarchy for assigning services to the level of care metrics in which Priority #1 is the highest priority level. Below the table, we provide examples of how to handle special cases in which service codes overlap between these level of care metrics. Please note that there is no overlap in the service codes between the modality metrics as they are currently specified in the manual; therefore, guidance on assigning priority for these metrics is not provided in the table below.

Table E.1. Metric type and assignment priority within type

Assignment priority within metric type	Metric number and name
Metric Type: Level of Care Service Utilization Metrics	
Priority #1	Metric #10: Residential and Inpatient Services
Priority #2	Metric #9: Intensive Outpatient and Partial Hospitalization
Priority #3	Metric #7: Early Intervention
Priority #4	Metric #8: Outpatient Services
Metric Type: Modality-Based Service Utilization Metrics	
NA	Metric #11: Withdrawal Management
NA	Metric #12: Medication-Assisted Treatment

NA = not applicable.

- If a service meets the specifications for more than one of the level of care metrics (Metrics #7-10), the service should be assigned to only one of these metrics based on the metrics' assignment priority, which is outlined in Table E.1 above.
  - **EXAMPLE:** If a beneficiary receives the service H0050 (alcohol and/or drug screening, brief intervention, per 15 minutes), the beneficiary should be counted in the numerator of Metric #7 (Early Intervention). Please note that although the H0050 service code is also included in the IAD Stand Alone Outpatient Value Set referenced in Step 2 of Metric #8 (Outpatient Services), this service should not be counted in Metric #8 because it has a lower priority assignment than Metric #7.
- If a service meets the specifications for Metric #11 (Withdrawal Management), the service should be assigned to both Metric #11 and the appropriate level-of-care metric (Metrics #7, 8, 9, or 10), if determinable, since withdrawal management may take place in an outpatient, inpatient, or residential setting.
  - **EXAMPLE:** If a beneficiary receives the service H0010 (alcohol and/or drug services; sub-acute detoxification, residential addiction program inpatient), the beneficiary should be counted in the numerator of Metric #10 (Residential and Inpatient Services)—that is, the level of care, and Metric #11 (Withdrawal Management)—the treatment modality.
  - **NOTE:** Previous versions of this manual included a step to exclude claims with a code in the Detoxification HEDIS Value Set for Metric #8 (Outpatient Services) and Metric #9 (Intensive Outpatient and Partial Hospitalization). The updated manual recognizes that the withdrawal management services included in the Detoxification HEDIS Value Set may occur in any of the levels of care captured in Metrics #8, 9, and 10 and no longer lists this exclusion.
  - **NOTE:** While most of the codes in the Detoxification HEDIS Value Set referenced in Step 2 of the Metric #11 numerator specifications reference specific settings in which withdrawal management took place (e.g., H0010: Alcohol and/or drug services; sub-acute detoxification, residential addiction program inpatient), other codes in this value set do not define service setting (e.g., HZ2ZZZZ: Detoxification Services for Substance

Abuse Treatment); in these cases, the service would be assigned to Metric #11, only, without a corresponding assignment to Metrics #7, 8, 9, or 10.

- Generally, if a service meets the specification for Metric #12 (Medication-Assisted Treatment), the service should be assigned to Metric #12, only, since Metric #12 is defined using prescription claims or HCPCS codes representing medication administration that do not have overlap with value sets identifying level of care.
  - **EXAMPLE:** If a beneficiary receives MAT with an NDC of 00054018913 (buprenorphine/naloxone), the beneficiary should be counted in the numerator of Metric #12 (MAT), only.
  - **NOTE:** CMS anticipates that beneficiaries who receive MAT will likely also be counted in a level-of-care metric based on the type or location of associated services received (see below).
    - *Specific considerations for Metric #12 (Medication-Assisted Treatment).* Commonly, when a beneficiary receives a MAT service they will also receive medical evaluation, counseling or other services on the same date at the same provider. If additional services are received, these services may qualify the beneficiary to be assigned to a corresponding level of care metric. See below for additional guidance.
    - **EXAMPLE:** If the only service a beneficiary receives from a provider is J2315 (injection, naltrexone), this service would qualify the beneficiary to be assigned to Metric #12 only. However, if an evaluation and management service such as 99212 (established office visit) is also provided, then the evaluation and management service would qualify the beneficiary to be assigned to Metric #8 (Outpatient Services) and J2315 would still qualify the beneficiary to be assigned to Metric #12.
    - **EXAMPLE:** If a beneficiary is in an opioid treatment program and they receive H0020 (alcohol and/or drug services; methadone administration and/or service-provision of the drug by a licensed program) only, this service would qualify the beneficiary to be assigned to Metric #12 only. However, if H0020 and H0005 (alcohol and/or drug services; group counseling by a clinician) are billed on the same date, H0020 would qualify the beneficiary to be assigned to Metric #12 and H0005 would qualify the beneficiary to be assigned to the metric representing the level of care in which the group counseling service was provided.

Guidance on same-day services at the same billing provider. When calculating level of care service utilization metrics (Metrics #7-10), if a beneficiary receives services in multiple care settings on the same date and from the same billing provider, the beneficiary should be assigned to only one level of care on that date, based on the hierarchy described in Table E.2, in which Priority #1 is highest.

Table E.2. Same-day service assignment priority

Assignment priority	Metric number and name
Priority #1	Metric #10: Residential and Inpatient Services
Priority #2	Metric #9: Intensive Outpatient and Partial Hospitalization
Priority #3	Metric #8: Outpatient Services
Priority #4	Metric #7: Early Intervention

Note that the hierarchy for determining priority of same-day services differs from the hierarchy for determining service categorization presented in Table E.1. In cases where both hierarchies are applicable (that is, when a beneficiary receives services in multiple care settings on the same day, from the same billing provider, and at least one of these services meet the specifications for more than one service utilization metric), the state should first use the same day service assignment priority (Table E.2) and then use the level of care metric type and assignment priority (Table E.1).

- **EXAMPLE**: if a beneficiary is screened by a provider (H0049) and then receives outpatient assessment and intervention (G0397) services from the same billing provider on the same day, based on the same day service priority assignment (Table E.2) the beneficiary would be included in the numerator of Metric #8 (Outpatient Services), not Metric #7 (Early Intervention), because outpatient services (Metric #8) are a higher priority service than early intervention (Metric #7).
- **EXAMPLE:** If a beneficiary is screened (H0049) and then receives inpatient detoxification services (rev-0116) from the same billing provider on the same day, the beneficiary would be assigned to Metric #10 (Residential and Inpatient Services) based on the same day service assignment priority and Metric #11 (Withdrawal Management).

Under another scenario, if a beneficiary was discharged from an inpatient hospitalization on the same day that they received a telehealth counseling session from the same billing provider, the beneficiary would be counted in the numerator of Metric #10 (Residential and Inpatient Services) but not in the numerator of Metric #8 (Outpatient Services).

In contrast, if a beneficiary received outpatient counseling services on the same day that they entered a residential treatment program, the beneficiary would be counted in the numerator of Metric #8 (Outpatient Services) and Metric #10 (Residential and Inpatient Services), so long as there was no overlap between the billing providers of the outpatient and residential services.

A **crosswalk** that identifies instances in which value sets and codes overlap for Metrics #7-12 and provides guidance on assigning service codes to metrics in these cases, is available in the 1115 SUD Monitoring Metrics Supporting Information V5.zip file available to the state through PMDA in the Reference Materials section.

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